OBSERVATIONS ON ELECTIVE MUTISM IN CHILDREN.

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THERE is a distinct variety of mutism in children which Tramer (6) and others call "elective," i.e. partial, occurring *vis-à-vis* certain persons only. The children are "sensitives" in Kretschmer's sense, i.e. they are timid, shy, susceptible to teasing and irony, and come from an insecure milieu; the abnormality is often familial.

The Case of William.

A typical example of elective mutism is the case of William, aged 7 years, referred by his headmaster, because he never speaks to his teacher.

A similar disorder exists in another member of the family. The boy's grandfather goes about for prolonged periods without speaking. He will, for instance, go into the village post office-cum-general store, thrust half-a-crown under the grille, speechless, and when given in exchange the wrong thing, he just pushes it back and waits for the next offer, till finally the purchase is completed to his satisfaction.

There are 7 children between 1 and 12 years, William being the youngest of 5 boys, succeeded by two small sisters. No physical or mental disorders have been reported in them. According to the information from his mother, she had no difficulties with the patient when he was a baby. He was breast fed till 3 months of age, later bottle fed, and he thrived on both. The usual landmarks of development were reached at approximately normal times. He walked at 1 year, talked at 16 months. Teething and toilet training were normal. He was a contented baby, but at 3 years he stopped speaking to strangers, and has never spoken to any since except as detailed below. He started school at 5. At first it was difficult to make him go, but he finally settled down to it.

His mother says he will not do what he is asked to do. He will not even answer at table. He does not try to please his parents in any respect: He plays with other children, and talks and also fights with them, but, she adds, is not the instigator.

He often goes for a fortnight without speaking, but they think nothing of it as he has always been a "funny" boy. He will never talk if approached with questions, but speaks to his brothers and occasionally to his parents. An uncle reports, however, that William stayed with him for two weeks and spoke normally.

Mother thinks that he is a happy child. He is very destructive at home, but, she says, her other boys were worse. William sleeps well, has no nightmares; he is sociable, and particularly fond of one of his brothers. She also related that when she was pregnant with William she had wanted a girl, but it turned out to be a "big boy."

In order to evaluate these statements we have to consider the mother's and also the father's personality and the social background.

The father appears a rather ordinary person without manifest abnormalities, quite intelligent, but of variable co-operativeness and attitude to the Clinic. He works on an estate as an agricultural labourer. The cottage in which the family live belongs to the estate. It is neat and clean although poorly furnished, and in beautiful surroundings.

The mother is a thin, wiry-looking woman; was obviously good-looking in her day. She is neatly dressed and very decided in her views. She talks a great deal

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and seems to harbour a grudge against society. She is not in the least co-operative. She thinks we should not be able to do anything for the boy. Hence, she says, she was unwilling that the boy should attend the Clinic. The father, on the other hand, was anxious that the boy should do so.

Thus much for the initial interview. Later on it appeared that the Clinic was made a good pretext by the parents for quarrelling with each other. It was arranged that the boy should be conveyed to the Clinic from the school for a few times in order that it could be determined whether he was suitable for treatment. The mother still refused to accompany him.

Later it was possible to study her in a strange environment. She came to the Clinic in a rather aggressive mood. Though quite polite, she was very definite now that there was nothing whatever wrong with William, and she had no desire to let him have treatment. The P.S.W. and the doctor advised her to take him home without investigation if she felt that way. Shortly afterwards she re-appeared saying that her husband had seen the headmaster, and they had decided to let the boy have treatment. She was much less aggressive than before, but not very much material could be elicited from her, except that William was quite pleasurably excited at the prospect of coming to the Clinic. About her marital relations she had to say that the father was quick-tempered and not easy to live with, but he is interested in and helps with the children. William's behaviour was discussed with her, and it was pointed out that his condition was a disorder which should be treated at home with forbearance.

In the meantime *the teacher* was asked to observe William in the playground when he was with other children. He reported that the boy played with them but did not speak. Perhaps this was due to the teacher's, if distant, presence. At other times he was observed by ourselves speaking to other children. The teacher furthermore reported that the boy gave him trouble by kicking and screaming whenever he was asked to do something in class. Also the other members of the family who are at the school cause trouble except the one brother William is specially fond of, as remarked before. When one of the children is involved in a row, William will get up and join in by kicking the teacher. This behaviour had continued for some time till finally the teacher thrashed William. At present he seldom causes trouble at school, but still refuses to use pencil or chalk. Occasionally he writes numbers in his book, but not those that are being written on the blackboard for the pupils to copy. He is now due for promotion according to his age, but this would mean moving him to the same classroom as his brothers and the teachers are afraid of renewed outbursts.

The headmaster and the class-teacher consider William's as an urgent problem, as he is not able to benefit at all from the education provided for him. The opinion was formed by the psychologist and the P.S.W. who visited the school that the staff were exceptionally good and understanding, and that they had made a real effort to deal with the child's difficulties before they referred him to the Clinic, and that they were still keen on helping as far as is in their power. The teachers also considered the whole family as difficult and in need of help.

On examination *the child himself* appears physically healthy. Apart from measles at 4 he had never been seen by the doctor. He is a stocky, thick-set boy with facial features vaguely reminding of the mongol. He is flat-faced with black straight hair. His eyes are small and slanting, his mouth almost continuously open. His tongue is big, his limbs are short, his fingers broad, and especially his thumbs and middle fingers very short. The hand lines appear normal. He is very muscular for his age. There is no outstanding clumsiness, and his gait is normal. His motor co-ordination is satisfactory, his movements appear rather slow, but not uncertain. His facial expressions are adequately responsive. But it is noteworthy that he compresses his lips when speech might be expected. This appears typical for his condition, and has been observed in other cases. He eats and sleeps well, and he is, according to parents' and teachers' reports and the school doctor's examination of his general state of health, normal in every respect except speech. The school medical officer is of the opinion that there is no deafness, disease of the speech organs or other specific somatic abnormality. There is no history of brain or other nervous disease or injury. But thorough examination was impossible at our Clinic owing to the child's unco-operativeness. It was also impossible to give him tests of intelligence, of aphasia, etc.

When he came to the Clinic first William cried, screamed and struggled. He

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was sent to one of our play groups. After a time he cried quietly but still refused to play. When the crying had stopped he was given the Terman and Merrill intelligence test, but he never answered a question. A further attempt was made to interest him in the cubes and toys of the tests, but this also failed. He refused even to touch the material. When he was handed a toy he made no move to grasp it. If it was pressed into his hand he would hold it only so long as his fingers were held round it. As soon as the grip on his hand was relaxed he dropped the toy passively. He was tried with the board form of Raven's Progressive Matrices, and got as far as fingering the pieces but never attempted to place them. His ability to obey commands was tested by telling him to do things he might be presumed to be wanting to do: for instance, he was told that if he were to open the door he would be accompanied back to school at once. On such occasions the " command " was obeyed promptly. Further tests in obeying commands brought about a completely recalcitrant attitude. For example, when asked to open his mouth he would press his lips so tightly together and grip them with his teeth as to turn them white and bloodless.

We could demonstrate by recording his voice when he was at play alone with his brother that he spoke to him, if only in monosyllables. We have also heard him say " Thank you " to the P.S.W. when offered two pennies as a present, if he did say " Thank you," whilst he refused to say so for one penny. Reports that he swore fluently in the village were also verified.

The teachers' and parents' reports of William's conduct on various occasions confirm our observations in the Clinic, which suggest that the boy is not defective. In the absence of formal testing results an accurate estimate of his intelligence is impossible, but we have the impression that he may not even be dull.

Progress of treatment.—As mentioned before, on his first visit patient screamed, cried, and kicked the floor. He was taken to the playroom in the company of other children, but refused to take part in the games. This sort of behaviour continued for about a month. After William had been conveyed to the Clinic five times he still did not speak, but was very much more co-operative, although he still occasionally struggled and repeatedly screamed when he was to leave the car on his arrival at the Clinic. But he also blew the horn with alacrity, and formed an attachment to the play supervisor and the P.S.W.

For the next period there was no crying, but he still refused to take part in the playroom activities. During this time a number of visits were paid to the school, but little sign of improvement was noticed there. This state continued for about six months. By that time William could be coaxed into answering questions, if in monosyllables, but he talked only when the answer was suggested. The approach was changed then, and other children were instructed to draw him into the games. No adult took any notice of him at this time. It was noticed then that he spoke to the other children in whispers.

When no further progress seemed to be likely to develop the psychologist took on William and one other child together. The psychologist played some game with this one child. William was free to take part in the game, and was always invited and given his turn to play, but the game went on whether William joined in or not. In about a month William began to reach for the play material himself, counted his score, noted who had won and who had lost. He would now discuss the game with the psychologist. He began also to describe some drawings comparatively freely.

Since attending for almost a year he has produced one or two drawings, one of a tractor and a road roller going towards a little child whom he identified as his baby brother. This was taken as an expression of sibling rivalry. He often produces scribbles. He is somewhat improved, is less recalcitrant, sometimes joins other children in play, but rarely speaks spontaneously. Occasionally he may make monosyllabic whispered replies to questions addressed to him by other persons than the psychologist. On one occasion, quite recently, he drew what vaguely resembled a lorry. When he was praised for it, and asked what it was, his reply was misinterpreted as " lorry," but he was told it did not quite look like one, and a lorry was drawn for him as a model. He became angry and said " You are daft," and went on in this vein for some time, and finally it came out that what he had drawn was a " tractor." But a similar sustained performance has not been recorded since. Quite recently he has begun to talk freely at home, also to strangers, but continued as yet to be mute in school.

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Other Cases of Elective Mutism.

In view of the rarity of elective mutism it may be permissible in the following to quote at length extracts from other case reports.

In my own experience of more than an estimated 500 child guidance cases, I have come across only one before the reported one. The *little girl* in question, *7 years of age*, had an I.Q. of between 170 and 190, according to performance tests—the only tests that could be applied owing to her condition—she spoke spontaneously only to her school mates, occasionally to the headmistress and to her mother, but did not speak to her father or siblings, who were practically grown up. After 6 months' regular interviews once a week she began talking to me, and after a year she had so much improved that she spoke to most people, if reluctantly. There was no hereditary tainting, she got on well at school, and apart from maternal over-protection, which may well have been secondary, and apart from being the youngest of the family, no relevant points suggesting psychopathology were discovered. She was certainly "sensitive" in the above-defined sense.

The following is a short account of *Dr. Ruth Sandeman's case*. He was referred at the age of 10. His I.Q. was in the region of 115. In spite of his refusal to speak he was expected to qualify for a scholarship. He stopped speaking at three, except to father, mother, both grandmothers and an aunt and possibly one little girl. The children at school knew he could talk, but was thought not to do so even to them. He had had treatment since his fifth year, and had said two or three words to one of the therapists once.

On one occasion he was hypnotized without success. He had also a long Freudian analysis. He had it all pat that he stopped talking when he saw his father's artificial leg in the wardrobe when aged 3—this was verified—because he thought his mother had bitten the real leg off. During the interviews he produced plenty of humour of a rather cruel type. He was most frighteningly sadistic. He always talked with the doctor and also wrote and drew. He enjoyed a carpentry class he was sent to. It was suspected that many of the cruel things he said were quotations from his father. The mother proved none too co-operative. A more superficial aphonia existing besides the real difficulty was at once successfully tackled, but it was felt that the real problem remained unsolved.

The following case reported by *Tramer* ((6) and (7)) was that of a *boy of* 8. There is no significant heredity. His mother has been described as a shy child, but she was not shy at school. His five siblings had always been shy, and showed partial mutism, but less pronounced. They had improved at the age of 3 or 4, and the condition terminated before starting school. The patient had been shy since he was a little child. Walking at one year, talking at 2; toilet training normal. Since his seventh year he has been going to school, but does not talk during lessons or outside lessons to the teacher. He talks, however, in unison with other children, if there are more than two or three. During the intervals he talks to the children and is very outgoing. He likes school and is interested in it, and does his written work well. At home he talks about school and professes to like the teachers. He does not talk to his relatives, and does not accept presents from them. He talks to his father

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but not to other adults, but he does so to children and young people and is friendly with them. It took a year before he began talking to a lodger. He does not appear afraid of people or animals, and is said to be affectionate and obedient.

On examination he appeared normally developed physically; there were no medical findings. Judging from his writing and drawings which he does when requested, he appears normally intelligent; also his manual dexterity appears normal. His movements, however, are slow. During the examination he could not be induced to talk to the doctor. Looking at a picture book, he could not be induced to turn the leaves. If one was put into his hand, he would turn it over when told somewhat peremptorily "Now." He looked at the whole pictures, whilst at first he would only look at one detail at a time, and this only when the different parts of the picture were described to him. But he would not spontaneously turn over the pages. The same initial inhibition was observed in connection with other actions. He seemed unable to make a choice. This could only be overcome twice; asked whether "M" or "N" came after "L" he wrote spontaneously "M." He could at last be induced to do a drawing, which, however, did not reveal anything significant. He solved correctly arithmetical problems, but could not be induced to say "Yes" or "No." He was allowed to play with a torch. This was manifestly pleasurable to him, and it appeared that he suppressed his impulses to talk and allowed himself only mute lip movements. No psychological trauma could be discovered.

From the history given by his intelligent mother the following preliminary diagnosis resulted: A heredo-familial pathological fixation of a very early infantile form of reaction towards adults; a conditioned inhibitory reflex going back to the first year of life. Recommendation: Hypnosis, which for external reason could not be implemented; and temporary change of milieu by sending him to a holiday camp with his own teacher.

One year later he was seen again. His elective mutism was unchanged. When asked by the teacher to read or talk he would first blush, then sigh several times and blink his eyes anxiously. This would begin as soon as his neighbour had to start reading so that he knew it would be his turn next. At home he continued to behave inconspicuously but shyly towards strangers.

Entering the consulting room he smiled this time, stiffly stretched out his hand for a shake, produced the hand only very slightly, the arm in stiff adduction. He did not talk, but carefully observed all the doctor's movements. It appeared that his inhibition was slightly improving; his movements, however, were decidedly stiff. His arm when lifted by the doctor was kept in position, although it was apparently difficult for the patient to do so. His face was immovable except for the rotation of his eyes. When asked to write he reacted only when given specific orders what he should write. He complied with a request to draw; his drawings were childish, but bigger and opener this time. When asked questions he repeatedly gulped and blushed. His intellectual progress seemed normal.

Three years later his teacher described him as a good, industrious and very vivid pupil. He showed no shyness and there were no complaints.

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Mother reported that he had never relapsed, went on errands and was free from shyness towards strangers. Asked for the reason of his previous silence his mother could not obtain any information from him, and he told the P.S.W. that he did not know. He looked healthy and vigorous, and was perfectly polite towards the P.S.W., free and easy, and talked without hesitation.

Tramer (6) also describes the case of a *boy of* 5, the second youngest of 12 children. There was no heredity; one brother learnt to speak only at the age of 4, the patient himself at 2½. Toilet training was completed only at the age of 5. Walking and teething were normal. He always was different from the other children, and quarrelsome with them. He showed many compulsive symptoms. Sex play with other children was observed. He talked to mother, but very little to father and other children, unless he knew them well, to the doctor only in the mother's presence, and could not be bribed to do so. At the age of 7, after a short time at school, he did not talk to the teacher, nor did he reply to any questions. Outside school he talked with his school friends, and also at home, and was a very vivid child. On examination he was at first typically mutistic. He made speaking movements in response to approaches, but they were rudimentary, and did not result in speech. He was promised a coin if he said what it was, and this broke the mutism. Now he replied, but with inhibition and interrupted by typically mutistic symptoms. Only partial contact could be established. Intelligence, as far as assessed, was low-normal.

Heuyer and Morgenstern (quoted from (6)) relate the case of a *boy of* 9½ *years* who had started speaking at the age of 4, was mentally defective and suffered from enuresis until he was 8 years old. At the age of 5 his partial mutism changed into total mutism, but he continued to communicate by drawings. The authors claim that the cause of the disorder in this case was castration anxiety.

Discussion.

In discussing our own case we have to consider various possibilities of diagnosis.

If a child does not speak it is necessary to determine whether the behaviour is within the limits of normality, i.e. would a normal child of his age under comparable conditions talk or not.

Aphrasia (rather than "mutism" or "aphasia") is to be considered "normal" in children as old as three or four years. They may be intelligent, hear well; they may be neither over-protected, nor suffer under parental coercion and acquire all other psychological functions normally (Kanner, (3)). Often they suddenly start talking, to everyone's astonishment, in whole, well constructed phrases, and display a wealth of vocabulary which they have silently acquired.

Kanner (3) attributes great importance to parental attitudes in the establishment of mutism. "I have seen children whose silence is a part reaction to parental coerciveness," and quotes H. C. Schumacher as saying: "In certain susceptible children forceful attempts to make them conform may lead to mutism . . ." In these instances we may find a combination

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of "sensitive" traits and rebelliousness, the latter often being a symptom arising from a reaction-formation to the former.

Our case is clearly abnormal. The absence of signs indicating a lesion of the nervous system, the sensory apparatus and the organs of articulation and phonation, his occasional speaking, and the undoubted capacity for understanding the spoken word and executing certain commands, makes it almost certain that an organic lesion is absent. Also his intelligence level certainly does not explain his mutism. It appears that the crucial factor is emotional, and that the other relevant functions that if impaired might give rise to mutism are essentially intact.

Spieler (5) distinguishes the following types of (psychogenic) mutism: the hysterical, elective, thymogenic and ideogenic varieties. Schizophrenic should perhaps be added to this list. In hysterical and schizophrenic mutism the child will speak in an emergency, and so possibly simulate partial or even "elective" mutism. Kanner says with regard to mutism in childhood schizophrenia and infantile autism: "The patients do not talk because they are so detached that they have no need for verbal or other communication." Some of these children who had been mute all their lives amazed their parents by uttering well-adjusted and well-constructed sentences in emergency situations. But in childhood schizophrenia, in which may be included dementia infantilis, hyperkinetic disease and dementia praecocissima, there is a total disorganization of behaviour at all levels of integration (Vernon Kinross-Wright (4)). Partial mutism may occur in childhood schizophrenia, but it is accompanied by other characteristic changes, like withdrawal, loss of affect, catatonic features, deterioration of habits, etc. In dementia praecocissima there are found, besides the speech disturbance, depression, affective poverty, autistic manifestations and phonographism. In dementia infantilis there is an especially rapid and profound impairment of speech which proceeds almost to complete loss of speech via stuttering, echolalia, indistinct speech till only a few phrases remain. In hyperkinetic disease there is aimless and persistent hyperkinesis following any stimulus, lability of mood, negativism and perseveration, besides a disturbance of speech development. These diagnoses can be safely regarded as inapplicable in our case.

In *hysteria* the duration of mutism is measured in weeks or months and other hysterical symptoms will be present. Waterink and Vedder describe "*thymogenic mutism*," in which all other hysterical symptoms except mutism are absent. It may be doubted whether there is such an entity. "*Ideogenic mutism*," also recognized by these authors and others, is a condition in which the patient imagines that the organs of speech are diseased. Actually there may or may not be an accompanying disease of these organs. These conditions have to be rejected as a diagnosis in our case, as the child did speak, though rarely, and now frequently does speak. Most cases of elective mutism show certain common features. The onset is about the same age, between 3 and 5 years. There is no mental defect. There frequently seems to be a familial factor. There is relatively great resistance to treatment, although usually some improvement results. We may be inclined to suspect an early somatic, psychological or compound trauma.

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According to Jaspers (2), speech, besides its function as a means of communication and a tool for thinking, is a creative act (Werk). As such, it is, apart from its content, an expression of the psyche. We understand elective mutism as an unwillingness to make the effort of speaking under certain conditions. It is a quasi-aboulic symptom. Some psychoanalysts have alleged that the "mutism" of babies is based on a psychological protective mechanism. It is too "dangerous" to speak. Without being able to agree with this it may be thought that elective mutism, directed towards certain persons only, is a *protective mechanism*. Shyness combined with speech blocking in the presence of strangers, especially adults, is a normal early infantile trait. As an exaggerated form of this reaction a pathological fixation of this kind of shyness may come about. It is a form of archaic defence retained abnormally long. On this may come to be superimposed as an aggravating factor which reinforces the retention of shyness, an active contrariness. It is important in this connection to remember that the more passive understanding of speech normally develops earlier than the active use of speech. Children suffering from elective mutism are not arrested at, or regressed to, a stage in which there is no understanding of speech.

In our case practically all the pathognomonic signs exist. There is some hereditary tainting. The child is "sensitive," not defective; he understands; he speaks only to certain people, apparently according to order of apprehended "danger" a person may represent. The home background is insecure and partly hostile-rejecting. There is, however, no evidence of a trauma, somatic or psychological, which may have triggered off the symptom. Sensitivity and insecurity, combined with the handicap of dullness, not amounting to defectiveness, are quite capable of producing the necessary fear which leads to mutism towards "dangerous" persons. Whether the disorder is based on a constitutional retardation of the normal development of speech or on a psychological trauma (or perhaps on a continual traumatic situation and the reaction to it) is difficult to determine. Probably this, like other cases of elective mutism, has these two components, the relative strength of which may vary in different cases. While the psychogenic factor may be quite amenable to treatment, the constitutional is not so accessible. In our case the constitutional and developmental factor seems to be of secondary importance. It appears likely that further spontaneous slow improvement will occur with progressing development, although we feel that in view of the unfavourable family situation and heredity it is likely that considerable residues will persist.

Summary.

Our own, and several other cases of "elective mutism," a relatively rare disorder, are described. The children thus afflicted are "sensitives," often constitutionally predisposed, and come from an insecure milieu. The disorder has to be differentiated from other disorders in which partial mutism may occur. Elective mutism can be understood as a fixation at an early infantile level, on which an apprehended danger situation is met by a refusal to speak.

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