Clinical Case Rounds in Child and Adolescent Psychiatry

Selective Mutism

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The essential feature of Selective Mutism (SM) is the persistent failure to speak in specific social situations (e.g., school) where speaking is expected, despite speaking in other situations (American Psychiatric Association, 2000). The disturbance may significantly interfere with educational or occupational achievement or with social communication.

The following case is of a girl with a longstanding history of SM who became involved in treatment at a relatively late age. Despite extensive intervention efforts, she remains selectively mute. When discharged from our program, she had exhausted available treatment options. We have questions regarding differential diagnosis, her evolving personality, and any further treatment.

Case Presentation

Daisy (pseudonym), a 12-year-old white girl, was referred to the Child & Adolescent Mental Health Care Day Treatment Program at a local hospital for longstanding selective mutism. She had not spoken audibly outside of her home since she first learned to talk. She talks to her parents and her twin brother at home in an audible, appropriate voice. She depends on her parents for any verbal communication outside the home while she may use restricted non-verbal communication such as nodding.

Daisy avoids any group activities and had minimal interactions with peers. At school she would stand alone at recess. She performs well academically, except for class participation or oral presentations. She has no history of school refusal.

Daisy is particular about her attire and food. She wears the same velour clothes throughout the year regardless of weather. She eats about 5 different kinds of food items. These behaviors seem to be related to her difficulties with change, and tactile sensitivity. She has not demonstrated problems separating, or experienced panic attacks. There are no symptoms of depression, although her affect tends to be blunted.

With respect to family psychiatric history, her father described himself as shy by nature and reported that he learned to overcome this when entering the workforce. He is currently on an antidepressant for depression and anxiety. Daisy has four half siblings who were reported as shy, but no with history of selective mutism. Her twin brother is described to be an outgoing person with some behavioral problems. Daisy's family tends to be insular with limited social activities.

Daisy's developmental milestones were unremarkable, with no problems with speech and language development. She was assessed by a child and adolescent psychiatrist at the age of 11 years at the request of her school, and was diagnosed with Selective Mutism and Social Anxiety Disorder. She was on fluoxetine up to 40 mg daily for about one year with regular follow-up. When showing little improvement, she was referred to the Day Treatment Program for more intensive treatment.

On her initial assessment for day treatment, Daisy did not initiate interactions. She answered questions by nodding. When prompted to respond verbally, she whispered after a lengthy hesitation. She insisted that she had no problem.

On the Behavior Assessment System for Children (BASC), Parent Rating Scales, her

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parents rated her as displaying clinically significant withdrawn behavior, below-average leadership skills and adaptability. She showed average symptoms of anxiety, often preoccupied with worries, and some behavioral rigidity. Daisy reported no difficulties on the BASC, Self-Report of Personality-Child, and the Multidimensional Anxiety Scale for Children.

A number of sessions of speech-language therapy led to no improvement. She received intensive cognitive behavioral therapy (CBT) on a daily basis. She spoke to the therapist with a moderate tone of voice and was able to display a greater range of affect. However, she was not able to generalize this outside therapy sessions. Her therapist considered her lack of motivation to be a major contributing factor for her minimal improvement. She participated non-verbally in all aspects of the Day Treatment Program.

Pharmacologically, fluoxetine was discontinued as it was considered ineffective. Subsequently Daisy tried citalopram and fluvoxamine, but showed minimal response. Risperidone 1 mg daily was added to the antidepressant for six months, and then was discontinued as it did not provide any benefit. After one year of intensive treatment, she was discharged from the program with little improvement.

Over time Daisy looked increasingly different from her peers in appearance, attire and facial expression. She insisted on wearing the same shoes and velour clothes, which were getting smaller for her. Her affect is generally aloof and she has minimal social interactions. She appeared to be developing a schizoid personality style. Despite her selective mutism, she continues to do well academically.

There are a number of aspects to this case which may have contributed to her poor response to treatment. The patient came for treatment at age eleven, by which time the SM had been well entrenched and being accommodated by her parents and the school. Daisy was unable to identify any ways in which her mutism negatively impacted on her life. Moreover, her parents seemed to be of the opinion that she would “grow out of it”, especially as she spoke and interacted normally in the home. The family history of anxiety and shyness may have contributed to this opinion, as Daisy’s father and half-siblings were seen as having “grown out” of their shyness and were viewed as well-functioning adults. To date she has been able to function at school, albeit not socially, and speaking in whispers has been enough to ensure good grades. Lack of motivation may have been a significant contributing factor in her parents’ lack of follow through with the home behavior plan. In addition her family has limited social interactions outside the family, thereby limiting the opportunities for Daisy to speak publicly and modeling social interactions outside the home.

This case supports the current literature that children with SM are afflicted with anxiety. Black and Uhde (1995) suggested SM may be a symptom of social anxiety, rather than a distinct diagnostic syndrome. In contrast, Yeganeh et al. (2003) found there were no differences, based on child self-report in level of general anxiety. It was thought that mutism may attenuate anxiety, or adults might over-interpret the child’s mute behavior. Manassis et al. (2003) reported that children with SM showed similar levels of anxiety and academic ability as children with social phobia, but the SM children showed some language impairment relative to those with social phobia.

Steinhausen and Juzi (1996) reported shyness as the most prominent personality feature in children with SM. They also indicated parents described a pattern of withdrawn, anxious, depressed, and schizoid type of behavior with social relationship problems. In 12 years of follow-up of 45 patients, Remschmidt et al. (2001) reported a remission rate of 39%.

Treatment for SM has been considered difficult as many children are resistant to treatment. This is partially because children with SM are often negatively reinforced for their behavior by the withdrawal of repeated requests of them to speak. The longer the mutism exists, the more often it is reinforced and the harder it is to extinguish (Krysanski, 2003).

Behavioral approaches, based on principles of learning theory, have been the most frequently used treatment for SM (Dow et al., 1995). It is important that the focus in CBT be on emphasizing the child’s positive attributes, building confidence in social settings, and lowering the overall level of anxiety and worries. Medications, such as antidepressants, shown

to be helpful for treating social phobia have been increasingly used to treat children with SM (Dow et al., 1995).

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Commentary on Selective Mutism

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The authors present a good review of key aspects of treating selective mutism (SM) in relation to their case. They also demonstrate a concerted effort to treat a child with highly entrenched SM, using appropriate medical and psychological interventions. In addition, they could have considered a school-based behavior modification program, such as that described by Charles Cunningham (2000), in combination with medication. Such programs aim to address the common difficulty of generalizing behavioral gains from the therapist's office to school, but can be difficult to implement in cases like this one, where families are reluctant to participate in treatment. The latter point illustrates an unfortunate fact about evidence-based treatments in children: almost all have been evaluated in highly motivated populations. Some families do become more involved when presented with relevant research evidence (for example, the difference in long-term prognosis between selective mutism and "shyness", or subclinical levels of social anxiety), but not all. A small ray of hope may be found in the child's entering adolescence, where the desire to relate to peers and develop autonomy from family may motivate greater social interaction. Given her academic interests, she may also develop long-term career goals that will necessitate some social speech.

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