Classification of Elective Mutism

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Abstract. In this study of 68 children displaying elective mutism, four types of mutism are distinguished: (a) symbiotic mutism, characterized by a symbiotic relationship with a caretaker and a submissive but manipulative relationship with others; (b) speech phobic mutism, characterized by fear of hearing one's own voice and use of ritualistic behaviors; (c) reactive mutism, characterized by withdrawal and depression which apparently resulted from trauma and (d) passive-aggressive mutism, characterized by hostile use of silence as a weapon. The prevalence of physical and sexual child abuse in all four groups was high. The classification of elective mutism into subgroups is clinically relevant for a better understanding of the etiology and for devising appropriate intervention.

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Elective mutism, a term first employed by Trainer (1934), has been used traditionally to describe those children who refuse to speak to all but a small number of intimates. This definition excludes all other nonpsychogenic forms of mutism, including hearing loss, aphasia, schizophrenia, and autism. Although the behavior is a perplexing problem to the families of preschool children, it becomes a seemingly insurmountable problem when the children enter the educational system. Consequently, the elective mutes become candidates for grade retention, special class placement, and frequently residential institutionalization, mounting failure on top of an already complex psychological problem.

LITERATURE REVIEW

Despite a considerable literature devoted to elective mutism since its identification in 1877 by Kussmaul, no large-scale studies of this specific problem have been undertaken. Hence etiology, dynamics, treatment, and even incidence rates remain uncertain. Several excellent exhaustive reviews of the literature currently exist, Browne et al. (1963), Elson et al. (1965), and Halpern et al. (1971) being among the best.

However, detailed systematic observation of a number of cases is lacking. Parker et al. (1960) present the most comprehensive American study with 27 youngsters in the Tacoma school system. Wright (1968) studied 24 cases. Spieler (1941) reviewed 50 European cases described in the literature but did not see these children himself. The rest of the literature deals with a small number of cases, usually 6 or fewer, and very often only a single case.

Elective mutism requires further attention because of the difficulty in creating a consistent profile of behavior (Chetnik, 1973; Misch, 1952; Reed, 1963; Waterink and Vedder, 1936; Weber, 1950); its resistance to treatment (Elson et al., 1965; Mora et al., 1962; Pustrom and Speers, 1964); the ungainly amount of time generally required (Chetnik, 1973; Mora et al., 1962; Nolan and Pence, 1970; Sines, 1967; Wassing, 1973); and the great amount of environmental restructuring necessary to produce change (Amman, 1958; Elson et al., 1965; Pangalila-Ratulangie, 1959; Reid et al., 1967; Sines, 1967; Wassing, 1973).

The study reported here was undertaken to establish the parameters of elective mutism by investigating a large sample so that the underlying disturbance might be seen more clearly.

METHODS

Population

Criteria for inclusion in the study were: (1) the child must have displayed normal speech and speech patterning in at least one previous circumstance for a period of 6 months or more; (2) the child must have displayed totally mute behavior in at least one major setting for a period of 8 weeks; (3) the child must have an IQ of 70 or more as substantiated by the WISC or Stanford-Binet; (4) the child must have been free of the diagnosis of psychosis, including autism. These criteria were arbitrarily set to assure inclusion of only those children who displayed elective, psychogenic mutism.

Along with the 68 children accepted in the study, 270 were rejected for possible contaminating factors. Of these 270 children excluded from the study, 23 (all having speech impairment or retardation) displayed behaviors characteristic of the 68 identified elective mutes and responded to treatment in a manner equivalent to the 68, thus emphasizing the arbitrary nature of some of the inclusion criteria.

Table I

Demography of Sample Population

	Girls	Boys*
Age range		
3—9 to 5—6	3	0
6—0 to 7—11	20	7
8—0 to 9—11	17	1
10—0 to 11—11	12	1
12—0 to 14—4	4	1
IQ range		
70 to 84	9	3
85 to99	15	4
100 to114	10	2
115 to130	15	3
131+	7	0
Race		
Black	2	1
Mexican-American	3	1
Native-American	3	2
White	48	8
Income **		
high ($5,573 or more per person)	15	3
middle ($3,829)	23	6
low ($2,396 or less)	18	4
Location		
Kansas	4	0
Minnesota	36	8
Montana	3	1
Oregon	5	0
Washington	8	3
Community Size ***		
urban (over 50,000)	14	2
suburban / small town (2,500 to 50,000)	30	6
rural (less than 2,500)	11	4

* The ratio of girls to boys in this segment of the study was approximately 6:1. However, the continued study with 122 children showed it to be closer to two girls to one boy (2:1).

** As established by the Bureau of Labor Statistics, U.S. Dept. of Labor, 1976.

*** As established by the U.S. Bureau of Census, 1976.

Procedures

Data on the children were compiled from direct observation, video-and audiotapes, written reports, questionnaires, and other pertinent written material such as school cumulative folders and psychological, psychiatric, and pediatric reports.

The children, who were seen sequentially over a 7-year period, were all referred by school districts. Any later referrals were initiated by mental health clinics and psychiatric facilities; however, almost all observations and interactions were done in the school setting, since there the problem was most acute. Consequently, schools always remained intimately involved and were requested to activate an outside referral from parents or clinical settings by submitting their own referral. The districts also bore primary financial responsibility in 57 (84%) cases. I functioned at first as a special education teacher within the district, and later as a professional affiliated with local universities. I saw all the children directly. (The wide geographical distribution resulted from my frequent moves while pursuing graduate degrees and experience.)

Parental permission was gained for access to records and video-and audiotaping privileges. Separate and/or joint conferences were held with parents, teacher, pediatrician, and other individuals who had been

involved with the child and his or her problem. Usually included in the last group were psychologists, psychiatrists, speech therapists, school psychologists, social workers, child protection workers, and principals. During the conference questionnaires were filled out by the individuals present and most conferences were audiotaped. Occasionally questionnaires were sent to individuals who could not attend a conference. The return rate on the questionnaires was high since the majority were filled out at the time they were presented. Other questionnaires which were mailed were also usually returned since I followed up unreturned questionnaires with phone calls or in-person pickups.

Parent questionnaires dealt with the mutism problem: when it started, how it was handled; the child's home behavior; family practices: discipline, chores; family attitudes: how the child got along with sibs, how the mother handled misbehavior; child's past developmental and physical history; perceived school behavior; and general information. Teacher questionnaires dealt with how the teacher saw and interacted with the child, his or her problem and family, and school behavior. Pediatrician questionnaires dealt primarily with developmental and medical history aspects and his or her involvement with the child's mutism. The general professional questionnaires further covered how the professional perceived the child, his or her mutism, and the child's interactions with the environment.

During conferences the questionnaires generally served as jumping-off points for further discussion and elaboration. All required information was then tallied on a master list in an attempt to ascertain which were and were not salient characteristics of elective mutism.

RESULTS

Four types of elective mutism were observed: symbiotic mutism, speech phobic mutism, reactive mutism, and passive-aggressive mutism (see table 2). Forty-four characteristics appeared frequently enough in the population to merit mention. Some occurred predominantly in only one or two subgroups. Others occurred frequently in all four groups. These characteristics are summarized in tables 3, 4, 5, and 6. The identifying features of each classification are discussed under the separate subheadings.

Table 2

Types of Elective Mutism

	Girls	Boys
Symbiotic (S)	24	7
Speech phobic (SP)	6	1
Reactive (R)	13	1
Passive - Aggressive (PA)	13	3

Because the study did not anticipate that four subgroups would be found, the analysis of data was complicated. Thus, results are reported in percentages, and the three control groups (normal, speech-delayed retarded, and neurotic) of 30 children each were dropped because three of the four subgroups became too small for reasonable statistical analysis. Moreover, the last control group, the neurotics, was difficult to compare because of the variety of neuroses, creating the need to subcategorize the control group itself.

Symbiotic Mutism

This classification embodies Salfield's (1950) Kretschmerian "sensitives". The most common type of elective mutism observed (N = 31), symbiotic mutism was characterized by four factors. First, all the children displayed a strong symbiotic relationship with a caretaker, most frequently (84%) the mother. The caretaker was a dominant, verbal individual who consistently met all the child's needs and was often openly jealous of the child's other relationships, especially outside the home. Second, the family constellation was always represented by one noticeably dominant, verbal parent and one noticeably passive, nonverbal or absent parent. In all but one instance (97%), the dominant parent was the mother. In no case where both parents were present was the father the dominant member. Third, despite the symbiotic's clinging, shy and sensitive exterior, this child was negativistic in his or her behavior toward controlling adults and situations. Fourth, the mutism appeared to serve a highly manipulative purpose for the child. Although a passive behavior, the mutism was not a tool of withdrawal; rather, it was the opposite. It was used as a very effective method of controlling the symbiotic mute's environment, and this manipulative, controlling attitude was evident in all the child's relationships, particularly with adults.

The dynamics of symbiotic mutism were not clear despite the obvious relationship with the caretaker. However, it was noted that when the symbiotic did begin talking, he had the most difficulty establishing speech with other adult figures who had a distinct controlling effect over his life, notably the classroom teacher. Perhaps the child feared another entrapping relationship, or perhaps was unwilling to shift loyalties from the caretaker to the caretaker substitute.

Speech Phobic Mutism

Although the least common type of elective mutism (N = 7), speech phobic mutism was perhaps the most dramatic and most easily identified. This group was characterized by the display of active fear of hearing one's own voice, use of ritualistic behavior to affect speech, and general motivation to regain speech.

Speaking or hearing his or her own voice on a recording device elicited from the child activation-syndrome behaviors such as rapid heartbeat, shallow breathing, sweating, and tremors. The child often attempted to leave the room or to plug his ears when a recording of his voice was played, even in the presence of those to whom he normally spoke. The speech phobic also typically engaged in ritualistic behaviors either in an attempt to induce himself to talk or to protect himself or others from the effects of his speech. Most of these rituals were physical movements, such as hand flaps or gestures, or repeated touching of body parts. Some children also used ritualistic verbalization. One 8-year-old girl, for instance, repeated the nonsense word "hoke-day-da" at every major pause in her discourse as a means, she stated, of keeping herself from saying "bad" things. All of the children regarded these behaviors as "magic spells" which would nullify the effects of their speech, so that they could start talking, keep talking, or talk only about the "right" things.

Another salient characteristic of the speech phobic child was the wide variety of obsessive-compulsive behaviors unrelated to speech which were demonstrated. All 7 children seen were decidedly compulsive about having things 'just so," such as always lining all the papers up in a certain way before starting the therapy session. If not allowed to engage in these activities, the speech phobic could not easily refocus his attention to the task at hand.

Interestingly, this was the only group that displayed decisive interest in regaining speech, and thus these children were motivated participants in therapy. Additionally, the speech phobic tended to be overtly communicative with the nonverbal methods such as gesturing, note writing, and sign language. This was noted to occur only minimally in the other three groups.

The dynamics behind the speech phobic mutism were not clear. However, in 4 cases one or both parents had been adamant with the child about not disclosing certain information about the family or child. Perhaps the child felt he might not be able to control his speech and the secret might come out. In one case the child had received a severe mouth injury around 2½ years of age, a formative period for speech, and was reported to have been electively mute thereafter. However, it was found repeatedly in the other categories that a mouth injury as a cause of mutism was rarely a major contributor but more often an attempt on the part of professionals to explain the mute behavior. In the other speech phobic cases, no definitive precipitant was found, although in one incident the appearance of the mutism was thought to coincide with an earlier traumatic event.

Reactive Mutism

Reactive mutism (N = 14) was characterized by the fact that the mutism was precipitated by a single or a series of traumatic events. For example, one girl had been raped at age 4 by the mother's boyfriend and from that point never spoke to men. In another case, during a family argument the child was slapped across the face and told to "shut up and never open your mouth again," which she promptly did. Mouth or throat injuries in the formative speaking years (1½ to 3 years) accounted for 4 cases, and 4 cases had no easily discernible preceding event. However, the child's behavior, response to intervention, and family dynamics indicated this classification. The event or events which induced the mutism was a trauma noted only by the child.

In addition to the mutism, all of the children displayed symptoms of moderate to severe depression, including suicide attempts and drug dependency. This category of children appeared to be the only genuinely withdrawn group among the four. The children in the other classifications were engaging in a passive behavior which inhibited social intercourse, but by its very use was generally effective in evoking particular reactions and interaction with others. Indeed, as unlikely as first glance would have it, this appears to be the

overriding reason for these types of mutism. Failure to speak on the part of the reactive appeared to be a manifestation of authentic withdrawal.

Much of the time the reactive child seemed rather dazed, perhaps an additional manifestation of his withdrawal. This child lacked facial expression, wearing a "mask" face which seldom varied with environmental stimuli. Similarly, most of the reactive mutes also lacked appropriate affect. Perhaps because of his general withdrawal, the reactive child's social behavior was generally quite poor, and he lacked most social graces such as greeting behavior and social play.

The dynamics of reactive mutism seemed to be the most obvious of the four at first inspection. Despite the simple cause-effect appearance of this group, the depression and the withdrawal concurrent with the mutism indicate that a more complex series of interactions must have been operating. From the number of children seen up to this time, no clear patterns have been established to indicate the deeper dynamics of this behavior.

Passive-Aggressive Mutism

The group of passive-aggressive mutes (N = 16) was characterized by using silence as a weapon, expressing clearly - albeit silently - hostility by defiant refusal to speak. Possibly in relation to this hostile use, the passive-aggressive displayed frequent antisocial behavior which was surprisingly violent at times. For instance, one 6-year-old girl abducted a 3-year-old boy living in her neighborhood, tied him to a tree, and sexually tortured him with a knife and matches. Four older passive-aggressives, all separate cases, were arrested for possession of a dangerous weapon. The passive-aggressive mute lacked facial expression much of the time and was a master at controlling affect. Although given on rare occasion to inadvertent displays of emotion (usually smiles or laughter), when aware, this child could competently withhold any indication of feelings, particularly vulnerable ones such as tears. The child had occasional periods of intense excitement that seemed unwarranted and more frequently periods of intense aggression which were diffuse and seemingly unprovoked, especially in light of the intensity.

The dynamics of this behavior evidently revolved around a child who had become a scapegoat, usually of his family and often of an unusually pathogenic environment. In this strong-willed child, the use of mutism seemed to be an attempt to choose something the child could control and use to manipulate a less controllable world around him.

Table 3

General Characteristics of Elective Mutism

	S	**SP**	**R**	**PA**
	N=31	7	14	16
	%	%	%	%
Onset of mutism				
all of life	55	14	29	0
preschool	32	86	57	50
at school entrance	6	0	0	0
6 to 9 years	6	0	14	31
9 to 12 years	0	0	0	19
Periods of total mutism	0	11	0*	19
Mouthing or whispering words	13	0	0	0
Mutism spontaneously stopping, restarting	0	0	7	38

*Continued study has shown that children in these groups may experience periods of total mutism.

Table 4

Personality Characteristics

	S	SP	R	PA
	N=31	7	14	16
	%	%	%	%
Submissive (home)	10	43	36	0
(school)	100	100	71	0
Phobic	90	100	86	63

Stubborn (home)	77	71	100	100
(school)	90	14	71	100
Severely withdrawn/catatonic-like (home)	0	0	21	31
(school)	6	0	79	6
Hostile/angry	6	0	14	94
Immature	100	100	93	0
Shy	3	86	32	0
Tantrums (home)	68	71	86	13
(school)	0	0	14	43
Frequent unprovoked crying (home)	35	43	86	0
(school)	10	43	57	0
Depression indicators *	6	14	100	56
Ritualistic, compulsive behavior	10	100	7	6
Antisocial behavior	10	0	14	82
Poor eater/sleeper	87	57	79	88
Nervous habits	100	100	100	100
Periods of intense aggression	0	0	0	56
Periods of intense excitement	0	0	0	43
Lack of affect (home)	29	57	86	63
(school)	55	43	100	100
'Mask' facial expression **	13	29	79	94
'Sad' facial expression	68	57	21	0
Repeatedly expresses unhappiness	93	100	100	88
'Walking on eggs' gait	87	100	100	43
Rigid, tense posture	93	86	86	25
Motor activity ***	10	86	86	25

* Such as aberrations in sleeping, eating; suicide attempts and comments; chemical dependency, alcoholism, hypoactivity.
** Face lacking any expression.
*** Such as hand flapping, rocking autistic-like or self-stimulating movements.

General Characteristics

Several features appeared to occur frequently among all or most of the groups and thus might be general indicators of the elective mutism disturbance.

Physical tension and rigidity were common; the child displayed a closed, tense posture, sitting or standing, and would not freely move his extremities, especially away from his body. This behavior was most severe in the reactive group (86%); some of the children actually appeared to have a deformity or degenerative muscular disease, although the results of physical examination were negative. Similarly, most engaged in a prominent gait best described as "walking on eggs." This gait highlights the difficulty of locomotion while the child remained tense and rigid in a slumped, defensive posture.

Fearfulness, phobias, and nervous habits were extremely common and ranged from the passive-aggressive's nervous boldness to the speech phobic's incapacitating fears. Many of the speech phobics (86%) and reactives (86%) also engaged in aberrant motor activity such as rocking, finger flicking, and hand flapping, which occasionally resulted in "autistic" labels. However, this activity seemed to have a definite purpose when it was used in my presence. These movements seemed to allow the child to regain concentration or to shut out outside stimuli very effectively. Conversely, these movements distracted the therapist and broke his concentration on the task at hand.

All groups except the passive-aggressive presented shy, timid, clinging behavior away from home, while at home the children tended to be demanding and stubborn. Immaturity in comparison with peers, especially among the first three groups, was a noticeable characteristic. A frequent comment from professionals, partic-

ularly regarding the children over 10 years, was how young they seemed for their chronological age.

Affect was influenced in all cases, varying from moderate flattening in the speech phobics, almost total flatness in the reactives, and controlled absence in the passive-aggressives. All children showed generally flattened affect at school (less at home), although unprovoked and/or prolonged crying episodes occurred as often as once a day in the first three groups.

The families of the elective mutes displayed considerable pathology. Corporal punishment was frequent and the amount of documented (Department of Public Welfare) child abuse was high: 77% of the children suffered abuse severe enough to warrant investigation by police and the assignment of a child protection worker. An additional 12% presented enough indicators to suspect abuse, although no formal documentation occurred, Of these documented cases, over half (57%) had experienced abuse severe enough to require ten or more days of hospitalization; and one case resulted in death. Moreover, 30% had documented (Department of Public Welfare) sexual abuse. Obviously this was the most frightening finding of the study.

The implications of this high rate of child abuse are not clear. Barbero and Shaheen (1967), Fischhoff et al. (1971), and Powell (1967) have provided a profile of the abused child that is remarkably similar to that of the elective mute.

If abuse causes the mutism, then surely it is cyclic, since the mutism subsequently causes further abuse. During the time I worked with the children, 64% of them suffered abuse. In almost all cases it resulted from the child's refusal to talk, as reported in police accounts of the abuse incident.

Table 5
Intellectual and Social Characteristics

	S	SP	R	PA
	N=31	7	14	16
Average IQ	94.6 %	104.3 %	109.2	118.9 %
School achievement				
above average	45	0	0	0
average	32	57	0	0
below average	23	43	100	100
Sociometric rank				
positive	90	43	0	0
negative	6	43	43	94
isolative	3	14	57	6
Socially inept	26	43	86	81
School placement				
regular class	77	57	57	50
special class	19	29	29	38
special school	3	14	14	13

Table 6
Family Background

	S	SP	R	PA
	N=3l	7	14	16
Symbiotic relationship	100	14	14	0
Dominant mother/passive or absent father	97	0	7	U
Parental depression *	3	0	43	0
History of familial shyness	10	29	71	6
Lack of family communication	87	86	100	69
Broken family	93	100	100	100
Alcoholism, chemical dependency (parent)	19	43	57	63
Incarceration (parent)	3	0	36	75
Persistent financial trouble	26	43	64	88
Persistent marital trouble	68	71	79	69
Physical abuse of child **	65	10	71	100
severe ***	35	57	50	63
Sexual abuse **	26	43	36	50

* As established by the MMPI (not given to all parents).

** Documented by Department of Public Welfare.
*** Requiring ten or more days of hospitalization; or resulting in death.

DISCUSSION

A large sample of cases of elective mutes has allowed a more lucid view of this confusing psychological phenomenon. Although no previous grouping of four types of elective mutism has been suggested, the majority of previously presented cases readily fall into these four groups. Misch (1952), Waterink and Vedder (1936), and Weber (1950) had all referred to the possibilities of separate subgroups.

Why create further labels and classifications in a field already teeming with them? These classifications allow for a more exact understanding of the problem and a better means of determining effective treatment. The classifications also will help educators to meet the child's needs more effectively in school and therapists to meet the needs of the family. Furthermore, the etiology of each of the four groups appears to be distinctly different; despite the similarity of the salient symptom, the underlying problems appear to be different and call for different interventions.

Three areas need further study. First, the incidence rate needs to be examined. Since 66 children were found within the span of two years in one metropolitan area with a total population of two million (Bureau U.S. Census, 1977) without any formal canvassing effort, it seems reasonable to assume that there are many more elective mutes than the literature indicates. Three possible reasons expressed occasionally by parents or school staff are: (a) the behavior occurs primarily among self-isolating families who try to solve their own problems without outside professional help; (b) it is not seen as serious enough to warrant the cost and trouble of clinical attention, especially if it is the only observed presenting problem, since even many professionals were willing to ignore aberrant behavior in the child if it did not interfere with the child's functioning; and (c) often the mute behavior occurs or becomes a serious problem only in school, thus receiving attention from the school staff while parents hesitate to contact outside help. One set of parents of a seriously disturbed electively mute 6-year-old boy staunchly refused requests to have the child seen by a psychiatrist because they maintained the school should assume full responsibility for the problem since it occurred there and not at home. They set a lawsuit in motion when the school district was unable to get the boy to talk in the course of 3 years, but still refused to have the child seen by a psychiatrist, even when the school district finally offered to help finance the evaluation.

A second area of needed investigation is further research on family dynamics. Obviously, before treatment can be further refined, some understanding of the family situation is needed.

Third, the neurological aspects should be investigated, particularly of the speech phobic and reactive groups. The strange, rolling gait is similar to that of some other brain-damaged children. Other left-brain functions such as abstract reasoning also seemed impaired in some of the children. Seventeen children had had neurological examinations and brain scans, all of which were negative. However, it would be of paramount importance to ascertain that no children were exhibiting behaviors resulting from neurological impairment—particularly in light of the high incidence of child abuse.

Three final factors appearing in this study are also worth mentioning. First, although in almost all other types of psychological disturbance in children the ratio of boys affected to girls affected is notably higher, elective mutism appears to be more common among girls. While no definite reason for this discrepancy was found, I believe a certain amount of social learning must be involved. Passive, clinging, shy behavior is tolerated in girls more than boys. Interestingly, boys displaying elective mutism were initially referred an average of 2.3 years earlier than girls with the same problems, indicating the greater tolerance of this behavior in females.

Second, familial shyness is often mentioned as a factor in the environment of the elective mute (Amman, 1958; Michaux, 1953; Misch, 1952; Morris, 1953; Parker et al., 1960; Salfield, 1950).
This was found to be true in this study as well, particularly in the symbiotic and reactive groups. However, like the mouth-injury hypothesis discussed earlier, this may be partially an artifact. Investigation into the home situation of the reactives uncovered frequent and often severe parental depression contributing significantly to a silent, morose home situation. In a number of cases, intervention and therapy with the family in connection with improvement of the mutism problem in the child showed marked change in the frequency of verbalization in the family. The family situation of the symbiotic provided less clarity on this matter; however, the verbally dominant mother often seemed to overpower the family interaction. In six

young adult sisters from a “symbiotic type” home, all of whom were markedly shy and quiet (the last two, a set of twins, were electively mute until late adolescence), a low-grade depression found in all six sisters may have contributed to what at first appeared to be a hereditary trait.

Finally, a major factor to be considered is the general lack of spontaneous remission of the elective mutism as the child ages. Only in mild cases of the symbiotic type have instances of spontaneous remission been substantiated, and these are very few. A small number of reactives (7%) and passive-aggressives (38%) spontaneously started talking, but all subsequently stopped again. In the second part of this study, which encompassed a total of 122 children, more and more referrals of children in late adolescence occurred. Unfortunately, the mutism was much more difficult to unseat after 10, 12, or 15 years of existence. Children over 15 years of age have been seen in all 4 groups. In the symbiotic group the disturbance still appears to be primarily neurotic and malleable, but in the other three groups, most of the adolescents are displaying prepsychotic or psychotic behavior, particularly a thought disorder. All of these children have a history of 10 or more years of elective mutism, and prior to adolescence the mutism was the only major presenting problem.

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