Nitza
Katz-Bernstein

Selective Mutism in Children

Manifestations, Diagnosis, Therapy

3rd edition

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3rd revised Edition

Translation into English by Terry Moston

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Content

A Brief History

When I gave up my therapeutic work after 22 years in order to work at the University of Dortmund in Germany, I made a promise to myself to write a book on the therapy of (selectively) mute children. Working with them so impressed, influenced and fascinated me that I wanted to share the experience. The work in Dortmund made great demands on my time and energy. Apart from the routine of the university, the speech therapeutic clinic had to move house and the new, modular diploma course "Education and rehabilitation in disorders of language, communication and hearing" had to be established. Through cooperation with other countries new research and projects came about. Conferences meant other publications became necessary and this delayed the completion of this book.

From the start of my work as director of the outpatients facility for speech therapy, the dream of establishing a drop-in centre for children with (selective) mutism pursued me. I knew that there were not enough informed and specialised agencies for these children. I also knew how demanding and intensive the treatment of children is as well as the work with families and therapists.

An empirical survey by two trainee teachers about how widespread mutism in state schools in the regional state of North Rhine-Westphalia is gave this theme a new stimulus (Konrad/Kunze 2002). The need for information and treatment was evident. So we held an information event for professionals and concerned parents in the outpatient section for language therapy at the University of Dortmund. The first targeted requests about information and treatment began to reach us. The time was ripe, staff who were motivated and trained were there, and so the Mutism Facility was set up at the clinic. Today, the Speech Therapy Clinic of the University of Dortmund can look back over therapeutic and counselling work in over 200 cases of selective mutism in children and adolescents. Many of the therapeutic elements that are described in this book were taught during training and supervision to the relevant therapists and this will now feed into the practical work with the children.

When I told a school psychologist about the book I was in course of writing, she told me enthusiastically about a teacher who had succeeded in teaching a selectively mute child in her class to talk through pedagogically skilful interventions. I wanted to include this report in my book, as it strongly supported my interdisciplinary approach in relation to mutism and showed that skilful use of educational measures can achieve results. The report by Mrs Marosi is appended at the end of this book. At this point I would like to thank Mrs Marosi warmly. And very special thanks must go to Kerstin Bahrfeck-Wichitill, our long-serving therapist at the outpatient

clinic and lecturer in the teaching field, for her skilful and dedicated suggestions for this book through all the phases of its development.

Since 2005, the year of the first edition of this book, much has been done in the field of selective mutism. A current topic in research relates to the question as to whether selective mutism can be regarded as a phenomenon that can be included in the group of social phobias or anxiety disorders. For this purpose, in the present third edition current literature sources are included. We now also have the results of the world's first longitudinal study of selective mutism (originating in Switzerland) (Steinhausen 2006). There is also active international research which takes up issues of co-morbidity, the differential diagnosis of familial and cultural background in selective mutism.

The therapeutic intention put forward here to involve selectively-mute children in activities, roles and interactions is reinforced by recent language acquisition theories as proposed by Tomasello (2009; 2010) and Pellegrini (2009; 2010) and in German-speaking countries by Andresen (2002; 2005).

Important discoveries clearly demonstrate the developmental risk of selectively-mute children and confirm the use of speech therapy as an appropriate discipline, as well as the interdisciplinary and integrated approach which we have been practicing as a team in the speech therapy outpatient clinic of the University of Dortmund since 1995. We have recently christened this approach *DortMuT – Dortmund Mutism Therapy* (Katz-Bernstein et al. 2011). In our book based on case studies "Find courage to speak" (Katz-Bernstein et al. 2007) this interdisciplinary approach is concretised.

At the outpatient clinic at the University of Dortmund, which has been under the overall leadership of Dr. Katja Subellok since my retirement, the *Mutism Network* for Research, Education and Treatment has been greatly expanded and firmly established under the direction of Kerstin Bahrfeck-Wichitill.

Among experts, too, with whom we in Dortmund are in close contact, gratifying developments have occurred; study sites are increasingly integrating selective mutism in their programmes, study centres and surgeries are interlocking in research and training activities and a significant quantity of newer literature has been published in German. All these developments contribute to gathering new experiences and anchor selective mutism in the sphere of speech therapy in accordance with international efforts to develop it as a vital discipline in addition to psychotherapy and psychiatry.

A final remark: the literature of brain research, with which I have been working intensively in recent years, can confirm in a fascinating way my longtime therapeutic expertise and the developmental and language acquisition theories which I advocate. I have therefore inserted at the beginning of certain chapters quotes from the literature on brain research in order to

make clear the relationship with selective mutism and to link it with therapeutic experience.

Schaffhausen, in May 2011
Nitza Katz-Bernstein

Introduction

The aim of this book is to provide general information on (selective) mutism in children. Its main concern, however, is to offer suggestions about diverse, specific therapeutic and rehabilitative approaches and tools to teachers and therapists from different fields who work therapeutically with (selectively) mute children of different ages or teach or supervise them. It explains therapeutic components, processes and specifics related to children's disorders. Therapy and support can be adjusted depending on individual needs and indications of the child, according to the acquired competences, capabilities and responsibilities of the psychotherapist, the speech and language therapist and also the teacher who is responsible for the child.

For therapists with more experience, the book can enable an extension of their personal approaches or offer a confirmation, a deepening and/or systematisation of their interventions. For as Hartmann (1997), Bahr (1996) and Schoor (2002) emphasise, collections of case studies and individual documentation for this disorder are particularly important and valuable (Werder 1992). Only they can concretise therapeutic procedure and help to overcome helplessness, regression and stagnation which are in the nature of the course of therapy with these children.

Years of practical experience which are evidenced in this book as well as supervisory support and advice by therapists and teachers show how crisis-prone and fragile working with these children can be in their therapeutic and educational efforts. As a result, reliable information as well as professional support and assistance are indispensable, at least where there has been little experience in working with (selectively) mute children. This book aims to provide a building block of such expert support.

In addition, this book will offer an example of integrative approaches independently of any doctrinal dispute and any different fields of expertise (as defined by Miller et al. 2000; Fiedler 2000; Metzmacher et al. 1996; Metzmacher/Wetzorke 2004). (Selective) Mutism as a concrete disorder in childhood demands action where the need for integration is clear owing to its diversity and complexity.

My long-term therapeutic and supervisory work with children with (selective) mutism has increased my conviction that these children need specific approaches. The following factors indicate this.

1. Complexity and interdisciplinary nature of the disorder
2. Placing of therapeutic measures between psychiatry, psychotherapy, speech therapy, special and/or integrative pedagogy
3. The need to take account of different theoretical approaches for therapy
4. Necessity of specific therapeutic media
5. Working with the resistance which is almost always present

6. Special handling of fears and ambivalence within the child
7. Special concentration on speech therapy and language acquisition with non-speaking children
8. Necessity of "ideographic", interactive and psychodynamically oriented approaches
9. Defining and delimiting the work with parents and families, assisting in a change of environment, at children's care homes or as in-patients.

1. Complexity and interdisciplinary nature of the disorder: (Selective) Mutism is located at the intersection of a number of fields: medicine, child and adolescent psychiatry, psychotherapy, speech and communication therapy, pedagogy, special needs education, social education and social work (Hartmann 1997; Sharkey/McNicholas 2008). The respective decision as to which therapeutic, educational, and/or psychiatric interventions should be chosen and how these should be concretised and linked requires a coordinated case management. The absence of such management significantly reduces the chances for successful treatment and rehabilitation, which are of great importance for achieving prevention before puberty.

2. Placing of the therapeutic measures between the fields of psychotherapy, speech therapy, special and/or integrative teaching: One of the difficulties in the planning of therapy lies in the distinction between the disciplines which need to be selected as rehabilitative and therapeutic measures. The psychiatrist for children and adolescents, who is presented with a (selectively) mute child, is obliged to cooperate with different experts. In a further step, the doctor has to know whether a therapist trusts himself/herself to work with the (selectively) mute child and its family and if s/he is willing to take on responsibility. In addition, there is the difficulty of the diagnosis. A diagnosis is necessary at the start of therapy with a psychotherapist to determine the status of the development of speech and/or language comprehension by asking the parents and/or using recordings from home. An accurate diagnosis and differentiation of the disorder is usually difficult and often requires involving a speech therapist. Therefore, in order to diagnose an additional language delay and / or a different language disorder besides the (selective) mutism, which, according to different sources, may often be the case (Rösler 1981; Lempp 1982; Remschmidt et al. 2000; Cunningham 2004; McInnes 2004; Manassis et al. 2007; Sharkey /McNicholas 2008), including the aspect of speech therapy during psychotherapy is essential.

The speech therapist, however, is faced with mental and developmental characteristics and peculiarities, which s/he rarely meets in this magnitude and severity. The systemic work, i.e. the inclusion of parents, educators and teachers, presents the speech therapist with special transdisciplinary

demands. If necessary, s/he must pass on the counselling work with parents (see: Baumgartner 2008; Katz-Bernstein/Subellok 2009).

In order to best encourage and support a (selectively) mute child at school, the relevant education authorities and teachers have to rely on the aforementioned psychological and speech therapy diagnosis. Without active and concerted cooperation with teachers, it is inconceivable to address or generalise the symptom or those communicative and linguistic behaviour patterns which manifest themselves. Therefore, the mutual exchange of information and in particular the coordination of on-going interventions and the acquisition of specialised knowledge from other disciplines are unavoidable. A recent publication from the U.S. illustrates the expansion of opportunities in the education of these children (Kearney 2010).

3. Necessary consideration of different theoretical approaches to therapeutic methods: Unlike many other disorders, the treatment of children with (selective) mutism needs to include different modules in order to be successful (Katz-Bernstein 2002, Part III–VI of this book). Regardless of professional responsibilities, various possible levels of treatment should be presented so that the decisions for normal therapeutic and educational routines and support measures can be carried out more efficiently.

This book aims to offer integrated therapeutic blocks taken both from the different schools of psychotherapy, as well as various disciplines of child and adolescent psychotherapy and speech therapy/speech-orthopedagogy. Nowadays such integration finds widespread support in the light of research into psychotherapeutic factors (Fiedler 2000; Metzmacher/Wetzorke 2004; Miller et al. 2000; Petermann 1997). This should not be understood as a plea for a return to short-term therapies, since no scientific superiority over other methods in terms of time resources could be detected in favour of these modern therapies (Miller et al. 2000, 24). For the therapy of (selectively) mute children it is to be hoped that they can meet the demand for ever shorter interventions.

Rather, this book aims at achieving a high efficiency of therapy through different approaches and a targeted integration of methods. Neither a non-directive play therapy which pays little attention to the symptom, nor a strict behavioural programme, if the subject is a (selectively) mute child, can claim better efficiency if used as the sole approach. The various approaches and methods will be explained here in an overview.

The *procedural gathering of diagnostic data* includes both data from observations in the classroom, as well as those which are collected by school medical services and professionals in educational psychology, psychotherapy or speech therapy.

Case management can be implemented in an interdisciplinary team. *Clarifying the treatment, establishing methods for achieving a relationship*

and communication contains elements from systemic-oriented psychotherapy. However, this is built into a process-oriented set of dialogues and thereby gains a base in depth psychology.

The *Safe Place* is a therapy technique that is based on the concept of the "Safe Place" which comes from a practice popularised by Violett Oaklander (1981), supported by the theory of intermediate space of Winnicott (2002) and was developed as a blueprint for the work with severely traumatised patients (Reddemann 2001; Tinker/Wilson 2000; Greenwald, 2001). The concept of "Safe Place" was used for anxious, mute children and/or children with language disorders and elaborated praxeologically for Integrative Child Psychotherapy (Katz-Bernstein 1995).

The *strengthening* of the *"Alter Ego"* is borrowed from Adler's individual psychology (Adler1974) which considered "encouragement" as an important part of therapeutic work.

The *construction of a communicative behavioural* ability is a directive, but non-verbal type of therapy, and has been tested for many years in speech therapy work with children suffering from language delay (Franke 1996) or with stuttering (Katz-Bernstein 1982; 2003b).

Working with puppets and transitional objects (Petzold 1983; Tarr Kruger 1995) is based on 'Integrative Therapy' and was developed for psychotherapeutic work with children and young people (Petzold/Ramin 1991). It can be used especially for preschool age children and ones at the lower primary school level.

The *speech therapy measures* are derived from the work with children with delayed speech development. A psychodynamic view of the psychotherapy of children and adolescents allows the *inclusion of the level of symbolism and the use of narrative*. In this way, the therapist can suggest themes central to the silent child through the use of symbols, intervene psychodynamically in the events and gently enter into an interaction in dialogue with the child.

Building verbal communication (including transfer), which subsumes the symptom step by step, comes from behavioural-based therapeutic approaches and uses for example the creation of hierarchies of speech and silence, desensitising exercises, etc.

Working with inner voices is a technique taken from Gestalt therapy (Perls 2002), which has become well known by Schulz von Thun (1996) for developing organisational counselling as "work with the internal team". Working with ego-states was developed mainly for people with traumatic experiences (Hartmann 2009; 2010; Fritzsche/Hartmann 2010; Peichl 2007). Through the use of creative media, this kind of technique can be used in therapeutic work with (selectively) mute children and adolescents, in an age-appropriate and playful way.

The work of the *Guided Imagination* is a technique by Leuner, known as "catathymic imaginative picture experience" (Leuner 1986). It is used in

the systemic-oriented hypnotherapy with children (Mrochen 2001) and in Integrative Child and Adolescent Psychotherapy (Katz-Bernstein 2003b).

Cooperation with family members and professionals is derived in turn from systemic-oriented strategies and shows both ideas and peculiarities in working with parents of mute children, as well as the possibilities of working with teachers and social workers, medical and official professionals (see: Katz-Bernstein 2010b).

Other ideas and suggestions come from our many years of working with children as well as supervisory work which all gave me insight into hundreds of therapies. They arose during the search for ways to gain access to difficult-to-reach children. Many of these suggestions have been jointly developed within supervision groups that I led for many years. The supervision groups had as their main work child and adolescent psychotherapy and language and speech therapy.

All these facets, techniques and suggestions are not meant to be seen here as additive and should not lead to a mechanistic, fragmented approach. The careful inclusion of both cognitive and emotional processes by the therapist ensures that the work is well-founded from a psychodynamical point of view. This is intended to help the individual components of the therapy find a unifying and binding framework.

4. Use of special therapeutic media: Working with a child that refuses to speak is a challenge that both psychotherapists as well as speech therapists often (still) find unusual. Looking at case studies can help the reader better understand the use of special media and techniques.

5. Specific work with the resistance which is almost always present: A therapist working with (selectively) mute children, is often in difficult states of mind which arise from the resonance ("counter-transference") coming from the resistance and refusal apparent in the body language which the child communicates. In order to identify and understand these patterns of interaction and these processes, special therapeutic qualities are necessary which are largely learnable. Through literature, case studies and supervision, a sensitivity for dealing with these communication patterns can be developed. I consider the inclusion of this level in dealing with mute children as indispensable as the disorder is manifested in this particular body language.

6. Knowing how to deal with fears and ambivalences within the child: (Selective) Mutism is also described as anxiety disorder in the existing literature (Spasaro/Schaefer 1999) or as a symptom of its co-morbidity or as a corollary of it (Chavira et al. 2007; Cunningham et al. 2006; Kearney 2010; Kristensen 2000; Manassiset et al. 2007; Steinhausen et al. 2006; Vecchio/Kearney 2005; Yeganeh et al. 2003). Dealing with anxiety dis-

orders requires therapeutic knowledge and also special forms of didactic approaches in therapy. There is always an ambivalence between the wanting to be free of the symptom and the wanting to remain within familiar behaviour patterns. This routine, familiar behaviour is in fact a fear-management strategy, a solution for demands on the child's development which the child does not know how to solve differently. Through detailed case vignettes and examples, a number of possibilities for therapeutically dealing with fears and ambivalences inherent in the nature of this phenomenon emerge.

7. Special concentration on speech therapy and language acquisition with non-speaking children: Language deficits, delays in speech development and disorders, which, as research shows again and again, are often concealed behind mute behaviour (Bar-Haim et al. 2004; Cohan et al. 2006; Kearney 2010), require a specialisation which has similarities to the work with non-speaking persons (AAC - Alternative Augmentative Communication). However, unlike the work with non-speaking persons with severe physical or cognitive limitations, speech therapy work with mute children requires its own special character and a particular didactical form of therapy which will be discussed in this book and presented as a possible model.

Mention should be made of determining the degree and extent of language comprehension, of passive (and active) vocabulary, the level of syntactic-morphological development, fluency and articulation. Likewise, the ability to symbolise and narrate need to be checked. This "diagnosis under prolonged severe conditions" is necessary to determine the nature and extent of the disruption and to coordinate therapeutic interventions amongst the different experts.

Every delay and disruption in language development can be a primary or secondary potentiating factor for this disorder (see Kearney 2010). If a linguistic abnormality is identified, support in language acquisition can be an important element in overcoming mutism. In the course of such support in communication, symbolisation and language development, little response can be expected at first and it is conducted initially in a "void". It therefore requires a non-directive sort of language development, which is associated with other components of the therapy.

8. On the necessity of "ideographic", interactive and psychodynamically oriented approaches: (Selective) Mutism is constantly changing because of objective external factors, because of internal, developmental progression and the interaction between these. Therefore, an "idiographic" (Motsch 1992), individual case-oriented approach (Grohnfeldt 1996, also Petermann 1996) is almost inevitable. This requires the inclusion of quantifying, discriminating criteria which must be brought to bear on establishing criteria and procedures of a qualifying nature. This may mean that an on-going

critical examination and continuous adaptation of the treatment plan must be made. In most cases it makes sense to pursue a plan which can be readily adapted and changed. In order to distinguish, for example, whether a flexible change of method or whether persistence and perseverance using one particular method is therapeutically more useful, it requires case-specific insights into individual case histories that illustrate a differentiated approach and reflect themselves in how the relationship of the therapy is designed (see Katz-Bernstein 2008).

9. Choosing forms of working with or delimiting work with parents and families, helping during a change of environment, starting a stay in a children's home or in-patient care: Taking into account family members and the systemic dimension are essential in treating this disorder (Chavira et al. 2007; Kristkeitz 2011).

The failed social transition of the child from the parental home to the social context of the kindergarten and/or school can rarely be overcome without the support of the parents and the involvement of the teachers. If this circumstance applies to most psychologically related disorders as well as to speech disorders, the specificity and complexity of (selective) mutism and its serious consequences demand special attention to the family (Katz-Bernstein 1993; 2000; Katz-Bernstein/Subellok 2009). In an ideal case, successful cooperation can influence the therapy in a significantly positive manner.

Some parents of mute children find it difficult to support the treatment of the child by working with the therapist. These parents require time and patience on the part of the therapist. Therapists should sometimes expect, in addition to the good cooperation with motivated and concerned parents, also having to be content with minimal cooperation in some cases and yet still be willing to devote themselves fully to the child. Some parents will be encouraged to participate by unexpected progress of the child.

The risk of disappointment in working with families of (selectively) mute children is considerable when compared to interventions in idealised, systemic families which is the basis for many systemically oriented concepts. Often the parents belong to a different culture or social class in which it can be the case that the way the problem and its meaning are allotted have a different relevance than the public institutional norm. It is also possible that the parents speak the language poorly. This can affect the attitude to therapy or lead to misunderstandings and mutual suspicion as to expectations and agreements. There are also issues of encouragement measures at school, of clarifying the choice of the appropriate local places of support and, in rare cases, institutionalisation or hospitalisation of the child, to be agreed with the families. Above all, we concentrate on child-centred cooperation alongside the therapy (Katz-Bernstein 2000; Subellok/Katz-Bern-

stein 2006). This type of collaboration seems the most common, often the only possible and feasible way to deal with the parents.

As already mentioned, both the behaviour-modifying as well as the interactive, psychodynamic dimensions have been considered in this book. Taking a serious approach to the psychodynamic strategies communicated by body language belongs to the integrative, therapeutic view that is presented here (Katz-Bernstein et al. 2002). The inclusion of these strategies is demanding and not always easy, requires training and experience in order not to remain additive but to become fully integrative. It is nevertheless, in my opinion, trainable. For the treatment of (selectively) mute children such a combination seems to me to be useful and appropriate in most cases. It would be a loss if a loyalty to certain "psychotherapeutic ideologies" were to distort the view of how to gain access to these children (Miller et al. 2000; Fiedler 2000; Metzmacher/Wetzorke 2004).

Part I
Theoretical Approaches

1 What is (Selective) Mutism?

1.1 Definition and Appearance

The word "mutism" comes from "mutus" (Latin), meaning silent. For the well-known phenomenon of persistent silence the following designations are found in the literature:

Aphasia Voluntaria (Kussmaul 1877)
Voluntary mutism (Gutzmann 1894)
Total/elective mutism (Tramer 1934)
Elective mutism (ICD-10, F94.0)
Selective mutism (SM) – Selective mutism (DSM-IV)
Partial/Universal silence (Schoor 2002)

Mute children usually have the ability to speak. But they do not employ this in situations unfamiliar to them, in specific locations and/or with a specific group of people. They fall silent, freeze or communicate consistently and exclusively by means of gestures, facial expressions or written communications (Hartmann 1992).

> "Selective Mutism is a disorder of childhood characterised by the total lack of speech in at least one specific situation (usually the classroom), despite the ability to speak in other situations" (Dow et al. 1999, 19).

In the guidelines of the German Society for Child and Adolescent Psychiatry, the following definition is given:

> "Elective mutism is an emotional disorder of verbal communication. It is characterised by selectively talking with certain people or in defined situations. Articulation, receptive and expressive language of those affected are generally within the normal range, at most they are – based on the stage of development – only slightly impaired" (Castell/Schmidt 2003).

Hartmann (Hartmann 1997 based on Tramer 1934; Böhme 1983) distinguishes between *total mutism and elective mutism*. Total mutism is a total refusal to use spoken language while hearing is preserved, but more often occurs as a secondary symptom of psychotic disorders, major depressive disorders, etc. Talking and any other noise generated in the mouth, such as clearing the throat, coughing or sneezing is avoided in contact with all persons. Total mutism occurs extremely rarely in children. In elective mutism (Tramer 1934) certain people or definitely circumscribed contexts are cho-

sen with whom or in which talking is avoided (Friedman/Karagan 1973; Böhme 1983; Biesalski/Frank 1983; Becker/Sovàk 1983).

Elective mutism, on the other hand, is the commoner and more familiar disorder in which "after language acquisition has taken place, there is a denial of spoken language to a particular group of persons" (Hartmann 1997, 57). Castell and Schmidt recommend that as total mutism is rare not to count it as a separate group, but as a specific *expression* of mutism (Castell/Schmidt 2003, 1).

This book deals primarily with children with selective mutism. In order not to exclude children with total mutism, we will use the phrase (selective) mutism, and when repeated only the term "mutism" is used.

The transition in the use of the terms elective to selective mutism, which has taken place in the literature in the last forty years (Popella 1960; Asperger 1968; Böhme 1983; Saloga et al. 1983; Hartmann 1997, 22f.) requires a more comprehensive explanation.

The term *elective* suggests a freedom of choice about with which people, in what circumstances and at what locations talking takes place or not. Seen subjectively, in *selective* mutism such freedom does not exist. If a preschool or elementary school child encounters a situation in which it consistently refuses to speak and says nothing as its "coping strategy" (Bahr 1996), then we cannot speak of any voluntary nature in the traditional sense (Spasaro/Schaefer 1999, 2). It often requires considerable effort every day to fight the temptation to speak, to endure and maintain silence. And with both early mutism (4–6 years) and late mutism (6–8 years) we cannot speak of a conscious choice of a behavioural strategy, but rather of an intuitive solution. In an unfamiliar social situation, the child reacts according to the available behavioural repertoire that has been generalised (in the sense of Gehm 1991; Roth et al. 2010; Meroe 2002; Roth 1995; Roth et al. 2010). Thus, the use of the word *elective* could lead to trivializing the persistence and severity of the disorder. With parents, teachers and members of the family, this helplessness in the face of iron silence produces an angry response (Hartmann 1997, 40). This anger usually leads to a reinforcement and maintenance of the behaviour.

The issue of whether the mutism is voluntary is answered in recent literature sources from the U.S. and Great Britain as involving an anxiety disorder in the form of a social phobia, infantile childhood depression or a compulsive act (Hayden 1980; Dow et al 1999;. Kristensen 2000; Hartmann/Lange 2010; Yeganeh et al. 2003; Sharp et al. 2007; Carbone et al. 2010). In this type of disorder, the child is standing as it were under a "spell" or under pressure to cease speaking at certain locations or in certain situations and not to utter a sound. Such compulsion does not appear to be susceptible to voluntary control.

There is also further discussion in recent Anglo-American literature of a neurological aspect, arguing for a drug treatment as part of therapy. The

suggestion is to use drugs from the group of anti-depressive agents combatting compulsion and anxiety such as "Clomipramine", "Fluvoxamine" and "Prozac®" (Rapoport 1989; Wright et al. 1999). The need for drug therapy and long-term effects are controversial. Further, responsible research is certainly required, also on long-term effects, in order to clarify these relationships (see Manassis/Tannock 2008).

What, then, is selective mutism? The following definition can be found in the ICD-10 (Remschmidt/Schmidt 1994, 108):

F94.0: Elective Mutism

"A disorder that is characterised by a distinct, emotionally induced selectivity in speaking. The child shows his language competence in some situations but not in other situations. In most cases, the disorder first appears in early childhood. (…)

Most mutism is connected to significant personality characteristics, such as social anxiety, withdrawal, sensitivity or resistance. (…)

Typically, the child speaks at home or with close friends, but is mute at school or with strangers. (…)

Related term: **selective mutism**

Differential diagnosis:

It should be noted:

1. Transitory mutism as a part of separation anxiety disorder in young children (F93.0)
2. Specific developmental disorders of speech and language (F80)
3. Profound developmental disorders (F84)
4. Schizophrenia (F20)"

(ICD-10 1994, F9: behavioural and emotional disorders with onset in childhood and adolescence)

In the current literature, mutism is increasingly associated with anxiety and social phobias (Dow et al. 1999).

1.2 Diagnostic Criteria

"A Persistent inability to speak in **certain situations** (where speaking is expected, for example, at school), although normal speaking ability is present in other situations.
B The disorder **hinders** educational or work-related **performance** or social communication.
C The disorder lasts **at least a month** (and is not limited to the first month after starting school).
D The inability to speak is **not due to a lack of knowledge** of the spoken language which is required in the social situation or the fact that the person does not feel comfortable in that language.
E The fault **cannot be better explained** as a **communication disorder** (e. g. stuttering) and **does not occur exclusively during the course of a profound developmental disorder**, schizophrenia or other psychotic disorder."

(Sass et al. 1998, 155f.)

As mentioned in ICD-10, we often see children whose other language disorders are superimposed on mutism. In older psychoanalytic sources, the disorder is counted amongst hystericalphobia; in more recent findings it appears in neuroscience and brain research (see Hartmann 1997; 2002). As already mentioned, the state of research does not permit a linear, clear-cut etiology. Instead, organic and neurological components (Rapoport 1989), alterations in pre-, peri-and postnatal natural and exogenous factors, model learning, trauma, and/or cultural change and impediments to language acquisition are assumed to be mutually influencing, potentiating and favourable risk factors for the disorder (Hartmann 1997; Bahr 1996; Dow et al. 1999; Schoor 2002; Spasaro/Schaefer 1999; Kristensen 2000; Manassis et al. 2007).

The three forms of childhood fears are:

- separation anxiety disorder (extreme fear of separation from familiar caregivers),
- avoidance behaviour (excessive shying away from strangers, so that social relations are limited, shyness and lack of social contact) and
- over-anxiety disorder (excessive and unrealistic fears, coupled with feelings of extreme anxiety, obsessive worry about performance and general tenseness up to paralysis.

All of these forms are found in striking ways in mutism (see Thyer 1991, quoted by Petermann/Petermann 1996, 11f.). In the present debate about

the classification of selective mutism as an anxiety disorder, Carbone et al. (2010, 1058) have advanced the following arguments, which can be summarised as:

- The high co-morbidity of both disorders,
- the high rate of anxiety disorders in the families,
- similar temperament characteristics of the two types of disorders,
- the similarity of the therapeutic measures.

We should nevertheless be warned against a hasty appraisal and stigmatisation as a result of a mono-causal diagnosis in early childhood. Etiological and diagnostic findings are beneficial if they are used to initiate therapeutic and rehabilitative measures and are relevant in supporting dealing with stress factors for parents and other people who are charged with educational responsibilities of the respective child.

This "idiographic" aspect (Motsch 1996) is given special consideration in this book in its theoretical and practical considerations and approaches and also highlights the need for interdisciplinary cooperation and transdisciplinarity in planning and carrying out diagnosis and treatment.

1.3 Types of Mutism

There are various proposals on how to divide mutism in subgroups. The first important distinction is that between total and elective mutism (Tramer 1934, see Part I, Chapter 1.1)

Wallis (1957) organised the types of mutism according to etiological factors:

- mutism as a result of a psychosis
- mutism as a result of an organic brain abnormality
- mutism as a result of a psychogenic disorder

Biesalski (1973) tackles a mix of gradual appearance and etiology. Of interest here is the relationship of fluency disorders and mutism, which will be looked at later.

- Total mutism
- Elective Mutism
- Mutism as a result of an oral fluency disorder
- Mutism as a result of psychosis

Schmidbauer (1971) assigns the types of mutism according to the point in time of their appearance:

- Initial-mutism
- Reactive mutism

Spoerri (1986) points to the need for a separation of childhood from adulthood:

- Mutism in childhood (regression)
- Mutism in adults (schizophrenia, catatonic states, depression, paranoia and hysteria)

This distinction is essential for both adult psychiatry and for pediatrics and pedagogy. For the purposes of reaching a diagnosis and deciding on a therapy, mutism in childhood must be classified differently because of developmental-psychological and language development-related reasons. This is a developmental disorder, indeed often appropriate, which is in most cases transient, although it should be seen as a disorder which should be taken seriously as a risk factor. Mutism should however be weighted differently the longer it lasts and the older the child is. The age at which the mutism occurs is divided into two groups:

- Early mutism (from 3;4–4;1 years)
- Late-/ School mutism (from 5;5 years)

This classification indicates that the disorder is always associated with a transition – from an intimate family- circle to an exposed position and connected with adaptation to and integration into a new social group (Bahr 1996, 37ff.; Hartmann 1997, 67f.)

Lesser-Katz (1988) distinguishes two main groups in children:

- compliant, timid, anxious, dependent insecure
- noncompliant, passive-aggressive, avoidant

The division by Hayden (1980), an American specialist for mute children who examined 68 mute children is therapeutically relevant and helpful. This identifies four types of mutism, which describe the appearance, behavioural problems and psychosocial causes in more detail:

> **"Symbiotic mutism** characterised by a symbiotic relationship with a caregiver and a manipulative and negativistic attitude towards controlling adults."

> **"Speech phobic mutism** characterised by a fear of hearing one's voice accompanied by obsessive-compulsive behaviours."

> **"Reactive mutism** caused by a single depression and withdrawal."