Case Presentation: Selective Mutism

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SG

- 8yo female with no previous psychiatric history who presents with her parents.
- Parents are concerned about her mood; father reports that one night last week as he was putting her to bed she told him that she wanted to kill herself.
- Mother reports that there are days of sadness and crying when she will say that she feels sad for no reason.

SG

- Anxiety has gotten more noticeable.
- Ability to interact socially has become more reserved.
- Mother reports that she has always been quiet.
- Will complain of stomachaches when stressed or nervous.
- Teachers have noticed that she is not finishing her work.

History

- Saw a therapist once a week for 6 weeks in February 2014.
- When upset or angry will dig her nails into her forearm.
- Family psych hx:
  - Maternal grandmother- SAD, ADD
  - Maternal aunt- depression, ADD
  - Maternal aunt- ADD
  - Father- on antidepressant to help with mood issues from anti-epileptic medications
  - Great aunt and uncle- bipolar
  - Mother's first cousin- bipolar, SAD, eating disorder, substance use
  - Maternal 2nd cousins- alcoholism

History

- Medical hx: no significant medical history
- Allergies: NKDA
- Medications: Multivitamin
- Developmental History: milestones met on time or early
- Social history:
  - Lives with her mother, father, and 6yo sister. 18yo brother lives at college.
  - Attends Grove Elementary; 3rd grader

Mental Status

- Appearance: 8yo female that appears stated age, casually dressed with long dark hair, exhibiting appropriate hygiene and grooming. Poor eye contact.
- Attitude: guarded; difficult to engage
- Activity: sat on parent's lap and played with kindle during encounter
- Speech: minimal speech; indicated yes or no by nodding her head; when talking would whisper to her parents in very low volume.
- Thought Process: Linear thought process.
- Thought Content: No delusional thoughts or paranoia evident.
- SI/HI: Denies suicidal ideation. Denies homicidal ideation.
- Perception: No evidence of hallucinations of any kind. Denies AVH.
- Mood & Affect: Anxious, sad appearing.
- Judgment & Insight: Both limited.

DSM Classification

- In DSM IV, selective mutism was classified in the section "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence."
- It is now classified as an anxiety disorder, given that a large majority of children with selective mutism are anxious.
- The diagnostic criteria are largely unchanged from DSM-IV.

DSM V Diagnostic Criteria

- Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g. at school) despite speaking in other situations.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the 1st month of school).

DSM V Diagnostic Criteria

- The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Associated Features

- May include:
  - Excessive shyness
  - Fear of social embarrassment
  - Social isolation and withdrawal
  - Clinging
  - Compulsive traits
  - Negativism
  - Temper tantrums
  - Mild oppositional behavior

Associated Features

- Generally have normal language skills; though occasionally there may be an associated communication disorder.
- In clinical settings, children with selective mutism are almost always given an additional diagnosis of another anxiety disorder- most commonly, social anxiety disorder (social phobia).

Selective Mutism

- Has been described as a rare disorder, affecting fewer than 1% of school-age children.
- Etiological explanations have varied widely.
- In the more recent literature, authors have noted a resemblance between selectively mute children and socially phobic adults.

Development & Course

- Onset is usually before age 5, but the disturbance may not come to clinical attention until entry into school.
- Persistence is variable- clinical reports suggest that many individuals "outgrow" it.
- In some cases, selective mutism may disappear, but symptoms of social anxiety disorder remain.

Functional Consequences

- Social impairment
- Increasing social isolation
- Academic impairment
- Teasing by peers

Differential Diagnoses

- Communication disorders:
  - language disorder, speech sound disorder, childhood-onset fluency disorder, pragmatic communication disorder
- Neurodevelopmental disorders
- Schizophrenia and other psychotic disorders
- Social anxiety disorder (social phobia)

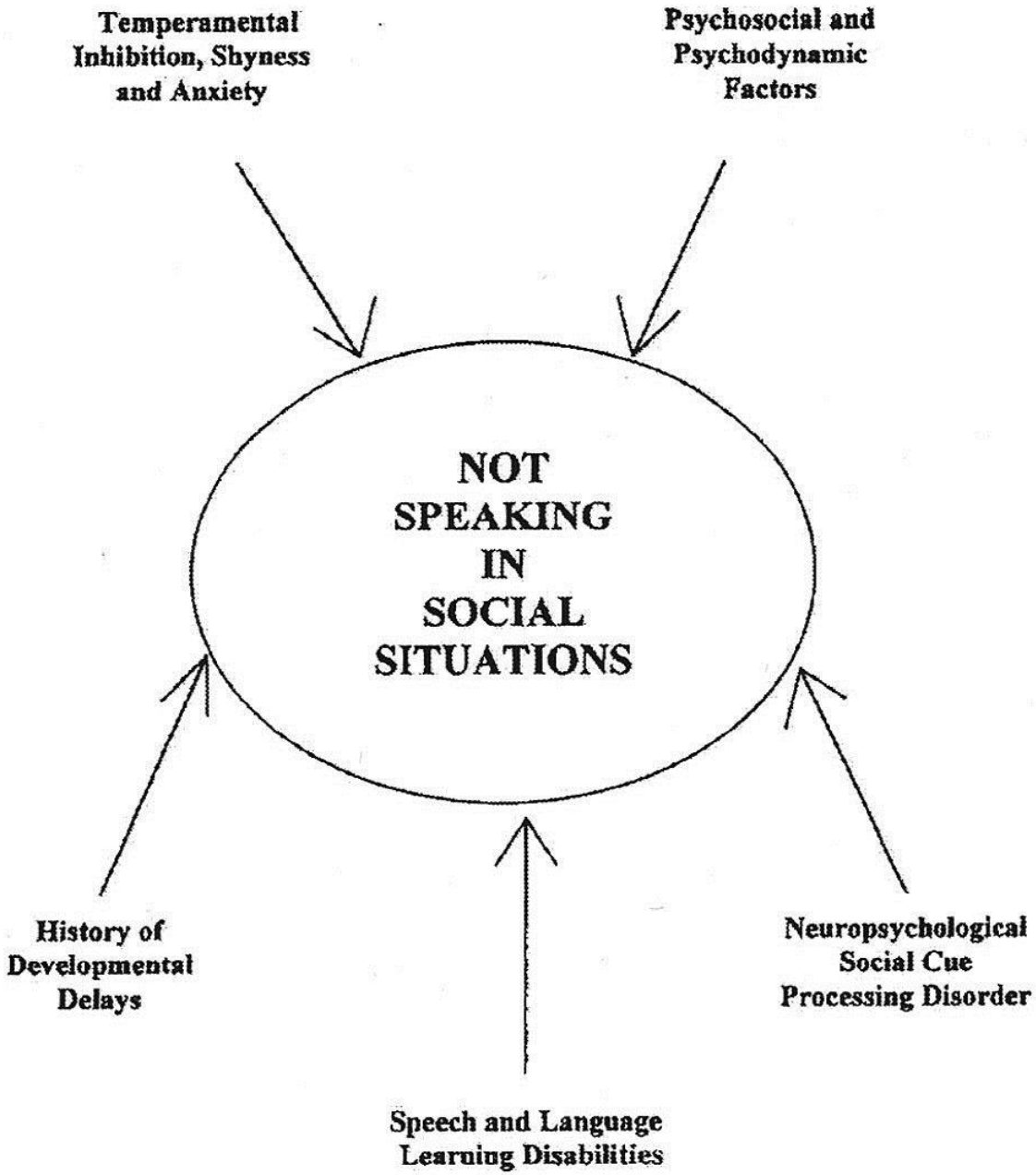

Fig. 1 Factors that may influence speech and social inhibition.

Comorbidities

- The most common are other anxiety disorders, most commonly social anxiety disorder, followed by separation anxiety disorder and specific phobia.
- Oppositional behaviors have been noted to occur in children with selective mutism, although these behaviors may be limited to situations requiring speech.
- Communications delays or disorders may also appear in some children with selective mutism.

Comorbidities

- Kolvin and Fundudis (1981) reported an increased incidence of elimination problems.
- Others found obsessive-compulsive features (Hayden, 1980; Kolvin and Fundudis, 1981; Wergeland, 1979), school phobia (Elson et al., 1965; Parker et al., 1960; Pustrom and Speers, 1964; Wright, 1968), and depression (Wilkins, 1985).

Assessment of Selectively Mute Children

Areas	Parental Interview	Clinical Interview
Symptoms	• Type of onset (insidious, sudden) • Past treatments and efficacy • Where and to whom the child will speak	• Observations from interacting with the child
Social interaction	• Ability to make and keep friends • Extent and pattern of participation in social activities • Degree of shyness/inhibition in familiar and foreign settings • Individuals to whom child will speak • Ability to communicate needs	• Observations of temperament made during interaction with child (shy? anxious? inhibited? interactive?)
Psychiatric	• Detailed assessment of psychiatric symptoms (use of a structured interview is preferred by some) • Family history of psychiatric problems and excessive shyness • Temperament during developmental stages	• Mental status examination
Medical	• Child's medical history, including illnesses or hospitalizations • Prenatal and perinatal history • Developmental history • Family medical history	• Physical examination, (including screening for neurological or oral-sensorimotor problems)
Audiological	• Frequency of otitis media • Any reported concerns about hearing problems	• Peripheral sensitivity (pure-tone and speech stimuli) • Tympanometry and acoustic reflex (for middle ear)
Academic and cognitive	• Review of academic achievement (grades, teacher reports)	• Standardized tests of cognitive skills and achievement
Speech and language	• Reported complexity and fluency of child's speech at home • Nonverbal communication (gestures, etc.) • Any history of speech and language delays • Detailed description of child's speech production, language use and comprehension • Discussion of environmental influences on language learning (bilingualism, etc.)	• Receptive language: assess using standardized tests • Expressive language: assess using audiotape and standardized testing, if possible (note lengh of utterances grammatical complexity, tone of voice) • Speech: assess using audiotape (note fluency, pronunciation, rhythm, stress, inflection, pitch, volume)

Treatment

- Only two controlled studies of treatment for selective mutism were found in the literature, one using behavioral therapy (Calhoun and Koenig, 1973) and the other using pharmacotherapy (using fluoxetine) (Black and Uhde, 1994).
- Both studies reported success in the treated group.

Behavioral Treatments

- Directed at extinguishing all reinforcement for the mutism, while simultaneously bolstering self-confidence and decreasing anxiety.
- Calhoun and Koenig (1973): involved 8 children.
- Stimulus fading, a technique similar to desensitization used to treat social phobia, has also been reported to be an effective approach.

School-Based Multidisciplinary Intervention

Goals	Specific Interventions
Decrease anxiety	• Child should not be forced to speak • Keep child in regular classroom unless special needs other than selective mutism supersede • Less emphasis on verbal performance (play nonverbal games) • Encourage relationships with peers • Cognitive-behavioral interventions: desensitization with relaxation • Coordinate school-based program with out-of-school interventions (individual and family psychotherapy, pharmacotherapy)
Increase nonverbal communciation	• Set up system for alternate means of communication (symbols, gestures, cards) • Small-group situations • Facilitate peer relationships
Increase social interaction	• Identify compatible peers for play in and out of school • Small-group situations • Activities that do not require verbal skills • Activities that encourage social skills
Increase verbal communication	• Structured behavioral modification plan: positive reinforcement for interactive and communicative behaviors, eventually reinforcement for speech • Speech and language therapy to develop linguistic skills • Pragmatically based language practice

Pharmacotherapy

- Golwyn and Weinstock (1990) described a 7yo girl who responded to phenelzine (up to 2mg/day) with improvement noted as early as 6 weeks.
- Balck and Uhde (1992) described a 12yo girl with elective mutism and social anxiety who responded to fluoxetine (20mg/day) and the response was maintained at 7 months.
- Black and Uhde (1994) completed a 12 week trial of fluoxetine in children.

References

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
- Dow, SP et al. "Practical Guidelines for the Assessment and Treatment of Selective Mutism." J. Am. Acad. Child Adolescent Psychiatry. 1995 July;34(7):836-46.