“SPEECH IS SILVERN, BUT SILENCE IS GOLDEN”;
DAY HOSPITAL TREATMENT OF TWO
ELECTIVELY MUTE CHILDREN

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ABSTRACT: A review of the literature on diagnosis, etiology, treatment and family structure of electively mute children is offered. Exploration of countertransference issues, the multiple functions of silence in the treatment session and the parameters of psychoanalytically oriented psychotherapy with these difficult to treat children are presented. The merits of structured day hospital care of these children whose disorder requires intensive therapeutic effort are examined through a description of the clinical setting of a day hospital and two case examples.

REVIEW OF THE LITERATURE

The diagnostic entity known as elective mutism describes a symptom picture that is rarely seen, faintly if ever heard and until recently, infrequently written about in the American child psychiatry literature.

The first reference to this disorder was by the German physician, Kussmaul, in 1877. He used the term “aphasia voluntaria” to describe mentally sound people who refused to speak. Over the course of time it was variously known as “speech inhibition” (Chapin & Corcoran, 1947), “psychogenic mutism” (Mitscherlich, 1961) or “thymogetic mutism” (Waterink & Vedder, 1936). In 1934, Tramer coined the term “elective mutism” to describe those children that in selected settings and with selected people, choose not to speak. This is the diagnostic appellation that is now generally used.
The electively mute child is one who, while possessing the proven ability to speak and understand language, exhibits partial speech avoidance. In the majority of cases the child speaks freely to family members and within the confines of the home. Once outside the home, however, these children become steadfastly silent and maintain their muteness in the face of enticements, threats, criticism and peer pressure. The muteness pervades almost all social interactions outside the boundary of home and family.

Electively mute children are described as characteristically immature (Halpern et al., 1971) and as controlling and oppositional. In observing their behavior one often feels in the presence of an obstinate two-year-old who may not say “no” but exudes negativism in most of his or her actions. The electively mute child is also characterized as “slow to warm up” to use Thomas, Chess and Birch’s (1968) term. Frequently, they manifest problems of bladder or bowel control. Kolvin and Fundudis (1981) report that in their sample of 24 elective mutes 42% were enuretic and 17% were encopretic.

When one first encounters these children their vacant and withdrawn look is striking. Eye contact is avoided and it is an arduous task to assess the child’s affective state since so little is offered by way of facial expression or body gestures and of course there are no words to help anchor our diagnostic thoughts.

The symptom generally first presents itself when the child enters a school setting (Elson et al., 1965). The range in age of onset is usually from three to five years (Salfield, 1950) though some authors report onset as late as seven years (Goll, 1979). It is only slightly more common in girls and the prevalence in the general population is quite low with some authors reporting the incidence to be as low as half of one percent (Reed, 1963; Bradley & Sloman, 1975). Prior to the child’s school entrance many parents at first report no abnormalities in the use of spontaneous speech or the quality of social relatedness in the child. On closer investigation, however, one often uncovers long-standing pockets of excessive shyness pointing to the possibility of an insidious rather than acute onset to the symptom.

It is no coincidence that the appearance of the symptom frequently coincides with the child’s first major move out of the family system. Several authors refer to separation and abandonment issues (Browne et al., 1963) the intense mutual dependency between mother and child (Halpern et al., 1971; von Misch, 1952) and the isolated and closed nature of the mutists’ family (Goll, 1979; Halpern, 1971) in examining the etiological factors of the disorder. That separation difficulties frequently accompany a diagnosis of elective mutism was born out in one of the patients described in this paper.

In establishing the differential diagnosis for elective mutism Browne