PARADOXICAL INTERVENTION USING A POLARIZATION MODEL OF COTHERAPY IN THE TREATMENT OF ELECTIVE MUTISM: A CASE STUDY

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ABSTRACT: A case history is presented of a four and-a-half year-old electively mute child who was successfully treated by the authors. The treatment approach involved paradoxical interventions in the context of a polarization model of cotherapy in combination with behavioral techniques in a family therapy framework.

Elective mutism is defined as a selective refusal to speak, independent of intellectual endowment or neurological status (Hinsie and Campbell, 1976). Children with this disorder generally have normal language skills and elect to restrict their verbal communications to immediate family members.

These children are generally excessively shy, socially isolated and withdrawn, clinging, negativistic and use temper tantrums and other controlling or oppositional behavior in the home (American Psychiatric Association, 1980).

Electively mute children can be divided into two groups: 1) those who use refusal to speak in a coercive fashion in order to manipulate people and the immediate environment, and 2) those for whom speak-
ing is sufficiently anxiety producing so the child chooses to remain mute (Friedman and Kagan, 1973).

Rosenberg and Lindblad (1978) list the following observations regarding choice of symptom and underlying dynamics of electively mute children: 1) the child is extremely determined to hold onto his symptom and has an overwhelming need to control; 2) the symptom becomes an extremely effective passive-aggressive maneuver by the child and arouses extreme feelings of anger, frustration, and disappointment in the parents; 3) the home atmosphere is not conducive to expression of feelings.

Although the age of onset is usually before five, the disturbance may come to clinical attention only with entry to school. Therefore, the symptom may already be a routine of the child and more or less accepted by his surroundings. Even worse, it may have become integrated in the child's self-image and consequently, become highly resistant to psychotherapy (Mora, Devault and Schopler, 1962; Elson, et al., 1965; Wright, 1968).

Treating elective mutistic children can be very demanding and discouraging and cause feelings of helplessness, frustration, and anger in the therapists (Ruzicka and Sackin, 1974).

Reports of varying degrees of success and failure with different therapeutic approaches, including psychotherapy, psychoanalysis, hypnosis, behavior modification, family therapy, and combinations of the above, are reported in the literature (Meijer, 1979; Sluckin and Jehu, 1969; Browne, Wilson and Laybourne, 1963).

Elson and his coworkers (1965) concluded that superficial counseling, suggestion, and exhortation were quite ineffective as were insight or uncovering psychotherapy. Nolan and Pence (1970) have reported success with behavior modification techniques while Rosenberg and Lindblad (1978) concluded that family therapy is always indicated in cases of elective mutism.

In their view, the combination of a family and behavioral approach is essential in helping to remove the symptom of elective mutism in children and that either approach alone produces limited success. This combination, they feel, seems to ameliorate the symptom and change the dynamics that allowed for the development of the symptom. Continuing work with the family, according to them, also seems to serve to solidify the changes that have occurred in the child.

The literature on the treatment of elective mutism tends to focus on the anxiety or family dynamic component of the symptom and little attention is directed to the controlling, manipulating, negativistic,