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Case report

Dissociative Mutism in Childhood: Need to break the silence

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Abstract

Dissociative mutism is very rare in childhood. We present here a case of complete mutism of six months duration in a seven-year-old male child. Normal neurological and otorhinolaryngological examination pointed towards psychological nature of the problem and warranted a psychiatric evaluation. Detailed psychiatric evaluation could identify the stressor and psychotherapy provided relief within a few days. Dissociative mutism in childhood, if identified and referred early for psychiatric evaluation, can reduce the distress and duration of dysfunction associated with the disorder. Besides, it can also reduce unnecessary investigations and burden on the health care system.

Keywords: Dissociative mutism, functional mutism, childhood

Introduction

Dissociative mutism in childhood is a clinical entity with unclear nosological status, difficulty in diagnosis, unknown natural course, and absence of standard management protocol [1]. Mutism of functional nature in the absence of structural vocal cord lesions or neurological disorders is currently classified as Conversion disorder as per DSM-5 [2]. These patients pose a considerable burden on consulting time and resources in specialized clinical units. Early recognition of the

psychological nature of the condition often results in prompt intervention and response [3]. We report here a seven-year-old male child with complete mutism of six months duration with no relief with multiple medical consultations and prompt response to psychological interventions.

Case details

Master X, seven-year-old male child was brought to Pediatrics outpatient department (OPD) for not speaking for the last six months by his father and teacher. The child had stopped attending school, stopped going out to play, and had confined himself to his home. His appetite and sleep were normal, but communication had significantly reduced. He would only use hand gestures to communicate. General physical examination and neurological examination were normal. Oral cavity and oropharynx were normal. Fiber optic laryngoscopic examination by otorhinolaryngologist revealed no anatomic abnormality in the larynx and during a bout of cough his vocal cords were found to be moving normally with good apposition. This led to suspicion of the functional nature of the ailment and psychiatric consultation was sought. He was admitted to the psychiatry in-patient facility.

A diagnosis of Other Dissociative Disorders occurring in childhood and adolescence (F44.88) was made. During the detailed psychiatric evaluation, it was revealed that the child was a student of a state-run residential school and had the onset of symptoms while in the hostel. A frail-looking neat, and tidy boy clad in his school uniform, the patient remained silent and communicated sparsely with gestures during psychiatric interview. His father revealed his financial problems and cited these as the reason for the child's placement in the residential school. He also reported that the patient was second amongst the three siblings who were delivered at home and was vaccinated as per schedule. He was a very accommodative and obedient child.

Individual psychotherapy sessions were started, and he was initially engaged in play with toys and colors. He showed a preference for colors and started playing with them. The psychiatrist gradually started engaging him in play. He started communicating through gestures, and his facial expressions started improving.

Similar sessions were carried out daily, and it was noticed that the child was happy during the sessions. He was then taught relaxation exercises, and the suggestion was given under a state of relaxation. Behaviour therapy was then started with positive reinforcement, being given to his attempts of vocalizations. His father and ward staff were taught techniques of social reinforcement to be contingent on the vocalization of the child. The sessions were of 20-40 minutes in duration and were continued for about a week. Father was involved in the sessions and was taught to communicate with the child actively.

The child was evaluated for anxiety/depression during the interview sessions using pictures of anxiety and depression to which he denied. His father also refused any persistent observable sadness of mood or anxiety. It was only this period of mutism that he had become a bit withdrawn. His adaptive functioning, visuospatial responses, and behavior appeared appropriate for his age; Intelligence Quotient was 100 as per Gessel's Drawing Test [4]. During his psychotherapy sessions, the child reported being beaten up by his room-mates in the hostel following which his symptoms had appeared. A few more therapy sessions were continued to provide him with support, reassurance, and teach him coping skills.

Due to the response to psychotherapy and the ability of the child to engage in the therapy sessions, no pharmacological agent was administered.

Discussion

Dissociative disorders usually present as pseudo seizures or gait disturbances in children below ten years of age. They have female preponderance, which might be explained based on their higher risk of psychological or physical stress [5]. To date, there is only one instance of dissociative mutism in a child below ten years of age who needed speech therapy for management [6]. Our patient could achieve his premorbid level of speech with psychotherapy.

While stress is conventionally known to be aetiological in this disorder, DSM-5 identifies psychological stress as an associated feature [7, 2]. This might be an attempt to make a diagnosis of hysterical disorders easier as, in many cases, stress cannot be ascertained or identified. The immediate stress of being beaten up might have precipitated the disorder in our case, while the distal stress of socio-economic deprivation could have made him more vulnerable [5].

The removal of the child from his school, as well as his home, might have served a therapeutic purpose by separating him from his conflict zones. Adding to this was the appropriate handling of his unconscious conflict, which was manifesting as mutism. The supportive stance taken by both his father and his teacher could have further expedited the benefit of therapy. The child continues to receive education at the residential school and is under regular follow up in the Psychiatry OPD.

The child did not have characteristics of behavioral inhibition or social anxiety as reported by his father; behavioral inhibition and social anxiety are correlates of selective mutism. Recent research has shown that behavioral inhibition is a vulnerability factor for the appearance of social anxiety and selective mutism in children [8].

While a myriad of therapeutic techniques ranging from hypnosis, psychoanalysis to voice training, speech therapy, and vocal exercises have been described to be effective in the

management of hysterical mutism, no standard guidelines exist about their efficacy [9]. The choice of a technique is usually made on a case to case basis and preference of the therapist and his/her training.

Early response and achievement of the premorbid level of functioning within a short time demonstrates the fact that even long-standing hysterical disorders in childhood if managed sensitively, can bring about improvement clinically.

To conclude, dissociative mutism in childhood, when identified early and provided with necessary psychological treatment can bring prompt recovery and avoid unnecessary medical investigations.

Conflict of interest: None declared

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