SELECTIVE MUTISM: A REPORT OF 2 CASES FROM A SOUTH WEST NIGERIA HOSPITAL

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ABSTRACT

We report 2 cases of selective mutism, a childhood condition that is characterized by the persistent lack of speech in at least one social situation despite the ability to speak in other situations, from Nigeria. The novel aspect of this report is that it comes from the African continent and they deserve special mention because of the rarity of the diagnosis in this environment, reflected in the fact that there are no previous cases reported. This is due (at least in part) to the cultural misconceptions about the nature and cause of mental illness specific to this area and a low index of suspicion. Emphasis is placed on the need to educate the community about the occurrence of these problems as well as correct the cultural misconceptions to facilitate early diagnosis and need to create the ideal multidisciplinary settings that is crucial for successful management of these cases despite the challenge created by the local unavailability of necessary professionals.

Kew words: Selective mutism, elective mutism, multidisciplinary treatment

INTRODUCTION

For the first time from the African continent, we report two cases of selective mutism. These cases come from a teaching hospital in a semi-urban town in Nigeria. Since selective mutism is definitely not a newly described entity, it is interesting that cases from this area are just being reported. This, we believe is due to cultural issues specific to Africa.

In Africa, due to prevailing beliefs (culture, tradition and superstitions) there are many wrong perceptions of mental illness and its etiology. These usually lead to denial and delay in diagnosis as well as the abuse of children who are viewed as having mental illness. Examples of such beliefs include possession of evil spirits, punishment from gods, epilepsy, witchcraft, use of Indian hemp and alcohol¹ -³. The strongest is the ‘theory’ of supernatural causation that views mental illness as divine punishment and the mentally ill as deserving of their lot. These beliefs affect the seeking of medical care by persons affected and their relatives. There is widespread belief that orthodox medical care may be futile and help is more likely to be obtained from spiritualists and traditional
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Cases also are responsible for the stigmatizing attitudes and abuse of patients, for example, being locked up in the traditional healing centers. Nobody wants to be associated with a mentally ill person and the individual may be removed from the society. The end result is that a vast majority never reach the hospital. Where children are affected no one wants the suggestion that his child is mentally ill. These children end up ‘suffering in silence’ 8. It is therefore no wonder that until now we do not have cases reported from Africa.

We report 2 cases encountered during the course of our clinical practice in Ladoke Akintola University Teaching Hospital, Osogbo, Nigeria. One of these cases came through the otorhinolaryngology unit while the other came through the General Outpatient Clinic. Both were referred to the psychiatric unit.

CASE REPORT

CASE A

O.F. is 4yr old kindergarten II school boy who presented at the otorhinolaryngology clinic with 6 months history of inability to speak well, despite having achieved fluency of speech in the past. The onset of reduction in ability to speak was first noticed at school following a report given to the mother by the class teacher. However, the mother did not pay attention to this development since the child communicated normally with her, until she started noticing that her son’s volume of words reduced when interacting with the housemaid and older brother. He began to use monosyllables where before he would have used sentences. Of note in the history is that immediately preceding the onset of this problem, there was a history of extensive burns to the buttocks which he sustained after an accidental fall into hot water.

The patient had been consistently nurtured with English Language which every other member of the family speaks. There was no recent change in location with no extra demand for new Language acquisition and no evidence of stuttering or cluttering. There was no history suggestive of Schizophrenia or Autism and no family history of psychiatric disorders or evidence of delayed achievement of developmental milestones.

No structured report was obtainable from the class teacher though the parents report that she had been actually concerned about his quality of interaction in the class which has reduced over time.

Examination revealed a withdrawn boy who was mute during the examination. Examination of the ears and hearing assessment yielded normal results. A diagnosis of selective mutism was made.

Management strategy was to reinforce communication with gradual progression from non-verbal methods. Technique involving role-playing activities to lessen child’s anxiety and increase confidence was employed. There was no speech-language pathologist available in this center hence patient was referred to a private Nursery and Primary School in the town with a Proprietress who has a special interest in child psychology and special education.

The patient was scheduled to be brought to the psychiatric clinic at regular intervals of 4 weeks. The class teacher was requested to prepare non-structured reports about his progress to be made ready on each visit and the parents were also interviewed on each visit.
visit so as to note any improvement. Mental state assessments were done during the visits and patient’s general behavioral patterns over the visits were recorded.

After one year, some degree of improvement in his verbal expression was noted as he could willingly count numbers 1 to 20 and recite letters A-K on instruction during the interview. The teacher’s report also established improvement. Up to date, no autistic behavior has been observed.

CASE B

A.J is a 13 year old primary II school boy who was referred to the psychiatric unit from the General outpatient clinic on account of poor performance at school, undue Social withdrawal of 4 years duration and inability to speak properly for 9 years. His developmental milestones were normal until about three and a half years of age when he was noticed to have diminution in the volume of his speech. This was initially noticed by the mother who felt that he was being mischievous since there was no change in his verbal interaction with her. It was also noted that his teacher at has been complaining about his persistent refusal to talk in class which the mother did not take serious. This has contributed to his poor performance at school.

Over time, the language expression became much reduced which affected his relationship with siblings and playmates. At this point he was then taken to prayer houses and herbal homes with no improvement. Details of what was done at these places were not known. At age 8, there was noticeable improvement in the volume and fluency of his speech though this was still inadequate when compared with others of his age.

On examination, he was noticed to be withdrawn with attendant undue sadness. Although, he could obey verbal commands, it was extremely difficult to communicate with him. At times during the assessment he seemed to understand and respond to what was said to him, while at other times he just remained mute. After an extremely prolonged assessment session, he managed to explain that he was unable to fluently interact in class and satisfactorily articulate himself at play. He admitted to loss of interest and dwindling energy which had affected his academic performance. He had full comprehension of language and no evidence of stuttering or cluttering. There was no history suggestive of mental retardation, schizophrenia or a pervasive developmental disorder. Neither was there any history of seizure disorder or suggestive of any neurological disorder.

Mental state examination revealed a patient who was depressed with marked sense of hopelessness and worthlessness but no suicidal ideations. Cognitive functions were intact though performance was apparently below that expected for age.

To rule out a speech disorder due to an ontological problem, he was referred to the otorhinolaryngology for assessment. Surprisingly, though not unexpectedly, he communicated perfectly well with the otorhinolaryngologist. Otologic examination and hearing assessment was essentially normal.

The management plan instituted was to manage the significant depressive symptoms with Tab Amitriptilline 50mg nocte and supportive psychotherapy. There was no speech-Language pathologist to conduct formal speech therapy sessions. Attempts were made to involve the school in the management but this could not be done since the patients attends a public school with about 50-60 pupils in a class managed by one teacher who
Selective mutism is a childhood condition that is characterized by the persistent lack of speech in at least one social situation despite the ability to speak in other situations. Specific features of this disorder include 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. This disturbance usually interferes with education or occupational achievement or with social communication. The duration of the disturbance is at least one month and not limited to the first month of school. The failure to speak should not be due to a lack of knowledge of or lack of comfort with the spoken language required in the social situation. The disturbance is not better accounted for by a communication disorder e.g. stuttering and does not occur exclusively during the cause of a pervasive developmental disorder, schizophrenia or other psychotic disorder.

There are a number of hypotheses concerning the etiology of the disorder. Classically, it has been viewed as a psychologically determined inhibition or refusal. This impression is reinforced by the fact that many children with this disorder have histories of delayed onset of speech. Some studies have also shown that these children show high levels of social anxiety without notable psychopathology in other areas, according to parent and teacher rating. Hence selective mutism may not represent a distinct disorder but may be better conceptualized as a subtype of social phobia. In addition, similar to families with children who show other anxiety disorders; maternal anxiety, depression and heightened dependence needs are often noted in families of children with selective mutism.

Some children seem predisposed to selective mutism after early emotional or physical trauma. In such cases, some clinicians refer to the phenomenon as traumatic mutism rather than selective mutism. However, recent studies have suggested that this disorder has no association with trauma and child abuse. According to DSMIV, Selective mutism is a rare disorder that affects less than 1% of individuals in mental health settings and it is slightly more common in girls than in boys, the age of onset being usually between 3-8 years.

Our 2 cases classically illustrate selective mutism. The onset of the disorder was around 3yrs of age which is in keeping with previous studies and reports. However the
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two cases are males whereas most studies have shown that more girls are affected than boys.\textsuperscript{10,17} A particular study has however reported a higher incidence in boys.\textsuperscript{12}

In terms of etiology, case A was preceded by burns which may lend credence to the traumatic etiology.\textsuperscript{17} However, recent studies are beginning to highlight the role of genetic factors in the etiology of selective mutism. In follow up study of forty-five patients with selective mutism referred to a university department and a child guidance clinic within a 15yrs period and followed up for an average 12yrs, the main findings were: A high load of individual and family psychopathology was characteristic of the patients.

A poor outcome could be best predicted by the variable “mutism within the core family” at the time of referral.\textsuperscript{12} In another research report, it was found that psychiatric disorders were more frequently reported in the families of a selectively mute child.\textsuperscript{18}

For our two cases, there is no positive family history of mental illness. This may not be unconnected with the hesitation to give history of mental illness in the family because of the attendant perceived stigma especially in Africa.\textsuperscript{1}

Case B illustrates a possible outcome of selective mutism in harmony with a study that demonstrated about 39% remission rate in a particular cohort. For those who do not remit, there are residual communication problems, and they describe themselves as less independent, less motivated with regard to school achievement. They are also less self confident and less mature in comparison to a normal reference group.\textsuperscript{9}

Case B was managed for prominent depressive symptoms that actually affected his self image and school performance and was the reason for seeking consultation with the psychiatric department. He had earlier on been taken to a spiritualist, who had been managing him based on the conceptualization of the case as having supernatural spiritual origin; a usual explanation in a Nigerian cultural settings.\textsuperscript{4-6} There was thus a delay in intervention and by the time of presentation there was already a depressive illness. It is noteworthy that the parents are not educated and were not aware that orthodox medicine could help. They were advised to seek orthodox medical intervention four years after attending a spiritual home. This is in keeping with findings of previous studies of selected groups in Nigeria, suggesting that negative attitudes to mental illness and poor understanding of nature and possible orthodox intervention is common among the lower social economic class.\textsuperscript{19-20} This is also in keeping with the findings of study that have examined the pathway to care in Africa.\textsuperscript{20-21}

These findings have implications for management especially in Africa and developing countries of the word where many specialized behavioral scientists and other professionals necessary for the multidisciplinary approach to treatment are not common. The hallmark of such management is to adapt intervention to the peculiar needs of the child and his/her family. The intervention though may not be sophisticated as in developed countries but there are professional resources that could be employed to achieve the same therapeutic goal as the cases above attempted to illustrate. Where certain professionals are not available resources in the society for example the school teacher and special schools can be involved. Many such resources are already accepted in the communities. Of special note is that in this environment there are no standardized measures for description of treatment and level of improvement available. We would have to prepare and adopt formats that will be in keeping with the cultural peculiarities of our environment.
In addition, there is need for inter-disciplinary collaboration, enlightenment and involvement in the management of this disorder. This would include Psychiatrists, pediatricians, psychologists, otolaryngologists, speech and language pathologists and therapists and school teachers. This become quite clear as our cases illustrate that these professionals have served as links in the path way of identification and care for these children.

CONCLUSION

In conclusion, increasing public awareness for this disorder is very crucial in a developing country like Nigeria. This is necessary in order to sensitize the public about the incidence and manifestation of this disorder and to impart knowledge about the cause and nature of mental illness. School teachers and parents should be the immediate target group to facilitate early presentation so that appropriate care could be given promptly. Consultation- Liaison services should also be encouraged between clinical departments such as Psychiatry, Pediatrics and Otorhinolaryngology for earlier identification of these cases also to facilitate prompt and optimum management.

COMPETING INTERESTS

The author declares that the author has no competing interest.

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