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Abstract

Mutism usually appears in children aged 3 to 5, although we can also encounter such cases in older children, even 10–12-year-olds. It affects girls more often than boys. The term comes from the word *mutus*, which means *dumb, silent*. Mutism is a disorder rooted in nervous disorders. Among the causes of mutism we must include, first of all, the experience of extreme stress, e.g. due to an accident or emotional trauma; numerous, not very strong but repetitive painful experiences, micro-lesions of the central nervous system, mental disease, pathological pregnancy or childbirth. In terms of ethology, clinical practice distinguishes two types of mutism: functional mutism (defined by psychiatrists as a psychopathological syndrome) and organic mutism (limited damage to speech organs or brain damage). The treatment involves conducting an individual therapy and an extensive family therapy. Every action taken must prevent the development of low self-esteem in a child, as well as its rejection by the peers. Overcoming silence happens slowly. The ability to communicate verbally appears gradually and a relapse of mutism may appear. The therapy should be conducted in a sensible way as children suffering from speech inability are usually fearful, very sensitive and often exhibit negative attitudes.

Keywords: mutism, mutism therapy, art.

„Pianino, które mówi" – przyczyny i terapia mutyzmu dzieci

Abstrakt

Mutyzm występuje zazwyczaj u dzieci w wieku między 3. a 5. rokiem życia, choć można spotkać także przypadki dzieci starszych, nawet 10–12-letnich. Dotyka częściej dziewczynki niż chłopców. Nazwa pochodzi od słowa *mutus*, co oznacza *niemy*, *milczący*. Mutyzm jest zaburze-

niem mowy na podłożu nerwicowym. Wśród przyczyn mutyzmu należy przede wszystkim wymienić: przeżycie bardzo silnego stresu, np. wskutek wypadku lub wstrząsu uczuciowego; wiele nie bardzo silnych, ale powtarzających się bolesnych przeżyć; mikrouszkodzenia ośrodkowego układu nerwowego, chorobę psychiczną; patologię ciąży i porodu. W praktyce klinicznej ze względu na etiologię wyodrębnia się dwa typy mutyzmu: mutyzm funkcjonalny (przez psychiatrów zaliczany do zespołów psychopatologicznych) i mutyzm organiczny (organiczne uszkodzenie organów mowy lub uszkodzenie mózgu). Leczenie polega na prowadzeniu psychoterapii indywidualnej oraz rozległej terapii rodzinnej. Wszystkie podejmowane działania muszą zapobiec rozwojowi niskiej samooceny u dziecka oraz odrzuceniu go przez rówieśników. Pokonywanie milczenia następuje powoli. Możliwość porozumiewania się słownego pojawia się stopniowo, mogą wystąpić nawroty mutyzmu. Terapię trzeba prowadzić rozważnie, gdyż dzieci dotknięte niemożnością mówienia zazwyczaj są lękliwe, bardzo wrażliwe i często wykazują postawy negatywistyczne.

Słowa kluczowe: mutyzm, terapia mutyzmu, sztuka.

Silence disturbs everybody – definitions and symptoms

Music is the most universal language of the world. Ada knows it well – a woman who has not uttered a word since she was six. The piano is the only tool thanks to which she can communicate her emotions and feelings. She is the main heroine of the film *The Piano*[1]. For the heroine of the film, the piano is the key to her unusual soul, closed for everybody else. The woman suffers from mutism. Music is used to communicate with the world. The piano bears the traces of her experience (her love declaration which was written on the key, which is a kind of external memory). It is a film on the power of music and the loneliness of a woman immersed in eternal silence. The heroine locks herself in silence. Her strong willpower makes her mute. She escapes into music. Playing the piano becomes like playing the emotions and playing on the emotions. The piano embodies her emotions, dilemmas and life. The silence of the heroine disturbs everybody.

Mutism is "the lack or the limitation of speech (oral expression) with intact speech comprehension and the possibility of communication in writing" (A. Herzyk, 1992). It appears without defined disorders in the structure and function of speech organs, which would make it difficult or impossible for the child to speak correctly. The term comes from the word *mutus*, which means *dumb, silent*. Mutism usually appears in children aged 3 to 5, although we can also encounter such cases in older children, even 10–12-year-olds. It affects girls more often than boys (E. Minczakiewicz, 1997). Seven children out of a thousand suffer from such disorders, which means that mutism appears twice as often as autism (*Journal of the American Academy of Child and Adolescent Psychiatry*, 2002).

[1] J. Chapman (Producer) & J. Campion (Director), (1993), *The Piano* [Motion Picture], Australia/New Zealand/France: Jan Chapman Productions & CiBy, 2000.

The first description was given in 1877 by a German doctor – Adolf Kussmaul. It was defined by the term *aphasia volentaria*, that is, voluntary aphasia. However, this name did not reflect the essence of the disorder because it falsely indicated that children consciously choose silence. In 1934, in the journal *Diagnostic and Statistical Manual of Mental Disorders,* a psychiatrist, Moritz Tramer published his research results which argued that the refusal to speak by people with mutism is not a choice but a disorder. He introduces the term *elective mutism* – planned mutism. Tramer's understanding of mutism was closer to the modern views but it was still associated with a mental disorder. The change in the attitude to people with mutism happened not earlier than in 1994. In this year the term *selective mutism* was introduced into DSM-IV, and this term correctly reflected the essence of this disorder.

According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10), mutism was entered into Group Three (F 90-F 98), which includes behavioural and emotional disorders that usually begin in childhood or in adolescence. The International Classification of Mental Disorders ICD-10 gives the following diagnostic criteria for selective mutism (F 94.1):

1. Language expression and comprehension demonstrated by a child at two standard deviations.
2. It is possible to confirm inability to speak in specific situations in which a child is expected to speak, despite speaking in other situations.
3. The duration of selective mutism exceeds 4 weeks.
4. The disorder is not explained by the lack of knowledge of the spoken language required in social situations.
5. The appearance of the total developmental disorder is excluded (*International Statistical Classification…*, 1997).

It is possible to stay silent in many ways. Causes and types of mutism

Mutism is a disorder rooted in nervous disorders. It results from the problems in relations between an individual and the environment. "In primitive societies, or among animals, human beings or living creatures are afraid of something that can harm them, and they get away from it as fast as they can frequently saving their life in this way" (L.B. Ames, S.M. Baker, F.L. Ilg, 1994). In the contemporary human world it does not happen otherwise: "a child escapes from what appears to him dangerous and harmful" (L.B. Ames, S.M. Baker, F.L. Ilg, 1994). The situation that is perceived by fearful children as difficult triggers different defence strategies. Some of them are reflected in communication disorders. Such a complicated human interaction as verbal

communication often causes the phenomenon of *communication fear*. Mutism is connected with a reaction caused by this fear. It is often linked with other speech disorders, such as: stuttering, logo phobia, shyness, oppositional behaviour. Some define mutism in the category of a specific form of protest neurosis (A. Bilikiewicz, 1992).

Among the causes of mutism we must include, first of all, the experience of extreme stress, e.g., due to an accident or emotional trauma; numerous, not very strong but repetitive painful experiences, micro-lesions of the central nervous system, mental disease, pathological pregnancy or childbirth; characteristic personality features, e.g., fearfulness, complexes. Other causes of mutism-like disorders are mockery, derision, humiliation, violation of child's dignity, drastic intimidation or bullying by parents, labelling, excessive restrictions and bans, deprivation of mental needs, improper family structure, and feeling of rejection by parents. "Also unstable home situation, educational errors, overprotectiveness and low family tolerance to stress. It happens when the whole family perceives the surrounding world as hostile and such an image is transferred onto a child. Generally, such children are fearful, excessively shy, perceiving strangers as threatening" (E. Kozanecka, 2001). Besides the above mentioned factors causing mutism, we must also pay attention to a difficult situation of a child raised in a bilingual family, its stay in a foreign country, language difficulties connected with it and subjecting a child to the influence of the second language between the first and the fifth year of life. Mutism may last several weeks, months or even years. Here it must be added that the longer the disorder lasts, the worse the prognosis is.

In terms of ethology, clinical practice distinguishes two types of mutism: functional mutism (defined by psychiatrists as a psychopathological syndrome) and organic mutism (limited damage to speech organs or brain damage) (A. Herzyk, 1992). It must also be emphasised that organic conditions may cause secondary psychological effects, which may increase child's mutism. Apart from that, there are several factors that may contribute to the inability of verbal communication, the most important of which are psychological reasons.

Functional mutism may be selective (elective), selective-situational or total. Selective (elective) mutism is demonstrated by a persistent refusal to speak, in at least one social setting, e.g., in hospital, at school, otherwise a child speaks and understands properly. The child talks in some situations and to a specific group of people, to others it does not. For example, a child talks to parents at home but does not communicate verbally at school with teachers or classmates. It can also happen that a child does not speak during lessons, but talks to teachers outside lessons. Sometimes a child stops speaking even with the closest persons while in the presence of strangers. According to H. Sulestrowska, a typical selective mutism appears at school. "A child does not talk to teach-

ers, however often does what other children do (writes, draws and counts in a copybook, sometimes also on the blackboard)" (H. Sulestrowska, 1992). Mutism is rarely accompanied by psychomotor inhibition or total inactivity during the lesson.

Situational mutism appears in children in new and difficult situations. It is usually transient, its symptoms appear the moment the child faces a new situation and they disappear when a child gets used to the surroundings. The symptoms appear when a child starts attending pre-school or school, and they usually persist for a few days to a few weeks. In order to communicate with the environment, a child uses writing or a non-verbal channel (e.g., gestures of nodding or denial, facial expression, etc.).

Total mutism is also defined as *hysteric mutism*. It is demonstrated when a child does not speak in any situation. Sometimes there may appear inarticulate sounds or voiceless whisper which replaces a language expression. A child may reply non-verbally (e.g., with head movements). There are neither any noticeable disorders in the structure and function of speech organs, nor motoric difficulties. Older children suffering from this kind of mutism may communicate with the environment by means of writing. Total mutism is psychogenic and often it is the child's reaction to threats or extremely difficult situations. It is an effect of shock or trauma. Before the therapy starts, it is important to establish the source of child's experience, which is not easy.

Overcoming silence. Mutism Therapy

If mutism does not recede after a few weeks or months, the prognosis gets worse. The treatment involves conducting an individual therapy and an extensive family therapy. Every action taken must prevent the development of low self-esteem in a child, as well as its rejection by the peers.

Selective mutism therapy uses two impact factors. One is aimed at the elimination of symptoms, while the other focuses on the elimination of the environmental factors that may cause mutism. These two actions are equally important and complement each other. Eliminating the causes of mutism is particularly important in the therapy. If a strict teacher is the cause of the disorder, the teacher or the school should be changed, whereas in an other situation, the therapy should involve the mother and the child, and the quality of its emotional bonds with the family home should be examined.

Overcoming silence happens slowly. The ability to communicate verbally appears gradually and a relapse of mutism may appear. The therapy should be conducted in a sensible way as children suffering from speech inability are usually fearful, very sensitive and often exhibit negative attitudes. It is very important to form a warm relationship with a child. A mute child will never

start speaking under threat or promise. Frequently, it does not feel the need to change the situation. Therefore, in the initial phase of the therapy, it is necessary to allow the child to express itself using non-verbal forms such as a drawing, a stage performance or by means of writing. It must be remembered that on no condition should people around the child stop communicating verbally.

While organising the therapy, it is also very important to work with the family which should accept the child's behaviour and refrain from criticism. The therapist should inform the nearest relatives about the disorder and try to establish its cause at the same time. Additionally, the therapist should outline the plan of the therapy and present all the actions he/she is going to take in relation to the child. Tension and anxiety in the child decreases if it does not feel any pressure from the environment but full understanding. The role of the parents in the therapy is limited to participating in the play with the child. The parent must focus on relaxing and unwinding the child, while remembering to encourage the child to be independent and to assist the child in developing relations with peers. It is important to teach the parent the skills and tools to be used in everyday work with the child.

The therapist should remember to praise the child for every word uttered by it, which encourages it to further speaking. The child gradually performs the tasks during which it may feel fear. These tasks are ordered alternately with relaxing exercises. During the whole period of the therapy, the therapist strives towards getting spontaneous speech from the child. It is important to keep verbal communication by rewarding the child. Achieving the result requires exceptional patience on the part of the therapist and the child's family. According to V. Axline, the therapy must be non-directive. The basic principles of the therapy which were presented by the author in the book *Play Therapy* are as follows: do not evaluate the child's behaviour, build self-acceptance and self-awareness, do not comment, treat the child with kindliness and complete acceptance (V. Axline, 1969).

Mutism therapy involves gradual lessening of the distance between the therapist and the child. There are 9 therapy stages distinguished. During the consecutive stages, first, the therapist is only a passive observer of the contacts between the child and an other person, then, the physical distance is shortened and the therapist gets closer to the child. Next, a non-verbal contact is made with the child and, in the end, a verbal contact is made:

Stage 1. The therapist is a passive observer of the contacts between the child and an other person the child usually talks to (most often with the mother). The task of the therapist is to observe in which situations it is possible to gain a verbal reply from the child. It should be registered whether and how the child reacts to verbal instructions and what its non-verbal instructions are like. During the first stage, a considerable physical distance from the child is recommended.

Stage 2. The therapist shortens the physical distance. He tries to get closer to the child, but does not talk to it directly. He can, e.g., make a conversation with the mother in its presence.

Stage 3. The therapist makes a direct non-verbal contact with the child (e.g., gives it a toy) and talks to it without demanding any verbal answers. The mother still plays the main role in the conversation.

Stage 4. The therapist demands non-verbal answer from the child. The mother is still close to the child and talks to it. At the end of this stage the therapist begins to replace the mother in the conversation.

Stage 5. The therapist turns directly to the child with a question demanding to make a gesture of nodding or denying, or a yes/no answer. The mother is still close to the child but does not talk to it.

Stage 6. Only the therapist talks to the child, while the mother is a passive observer. The tasks do not require continuous verbal answers from the child. They are mainly playing activities, e.g. playing with building blocks, drawing. During the task (e.g., making a drawing) the therapist asks the child questions without demanding any verbal answers. The child can answer with a gesture, facial expression or head movement. Older children can read aloud (captions under the pictures).

Stage 7. Mother is quite far from the child. The therapist may use some methods disinhibiting speaking (e.g., rhymes or poems). The therapist may describe pictures together with the child. At this stage the child gives verbal answers to the therapist's questions.

Stage 8. In the room there is only the therapist and the child. The following tasks are performed: discussing pictures, commenting on the actions performed by the child, answers to questions.

Stage 9. In the room there is a new person (besides the therapist and the child), to whom the child does not talk. It may be his pre-school teacher or a school teacher. The therapist takes the role of the mother, that is, the person the child already talks to. Next, the same stages as before are used (A. Herzyk, 1992).

In the therapy of a mutistic child it is important to give it encouragement and courage, as well as to help overcome its fear of verbal contact. While creating the therapy programme, the therapist should set the aims he/she wants to achieve. The aims should be within the reach of the child. During the therapeutic process, the child is encouraged to make elaborate statements, often beginning from automated sequences. The subject of the fear of speaking is also discussed. It is necessary to use the influence in various spheres of child's life, which enables the transition from non-verbal to verbal communication.

Art is a way to communicate emotions. The role of art in mutism therapy

Art may be one of the ways to treat mutism. Jerzy Vetulani in his lecture entitled "Art and the brain development" which was delivered in the International Centre of Culture in Cracow on 24 April 2014, emphasised that "art is a way to communicate emotions […]" (J. Vetulani, 2014). This statement refers to the content included in the work by Lew Tolstoy "Что такое исскуство?" of 1897: "Art is a human activity where one man consciously, by means of some external signs, communicates to others the feelings experienced by him, and others get infected with these feelings and experience them themselves" (as cited in Vetulani, 2014). According to J. Vetulani, the reception of art activates the brain: "Contemporary research on the neurobiology of art showed that its active and passive practising activates certain neural networks in the cerebral cortex" (J. Vetulani, 2014).

The therapy through art is called art therapy (*atreterapia* in Polish). *Arte* is a Latin word which refers to making something in a perfect way, brilliantly, and is derived from the word *ars* – art. Art therapy in its narrow sense means using art techniques in the therapy and diagnosis of mental and emotional disorders. In its broader sense it includes book therapy, music therapy, dance therapy and the therapy using film, theatre and arts (e.g., sculpture, graphics, and painting). The benefits of using arts in mutism therapy are considerable as art therapy is a way to communicate with the environment. Works of art created by man are an expression of his needs, views, thoughts, feelings and interests. Art strengthens the sense of self-esteem. It also offers a child to express through drawing its difficult experiences, including the fear of a situation.

Dance may play a great role in mutism therapy. Dance and movement psychotherapy uses dance and movement as a process of integration of a person in emotional, cognitive, physical and social spheres. Movement reflects individual thinking and experiencing emotions. The awareness of the body and movement leads to getting access to the source of the problem. Theatre therapy is also valuable in overcoming mutism. Children often speak more bravely by playing a specific role in a theatre performance or by voicing a character in a puppet show or presenting a sketch comedy in a cabaret performance.

While discussing the ways to overcome mutism, one must not forget music therapy. Music has accompanied people since ancient times. It has been considered a remedy for the soul and has played an important role in the education process. Music has an impact on the human nervous system; it activates or hinders the brain activity (K. Lewandowska, 2001). Treatment through singing can be used, the so-called singing therapy recognised as one of the most important methods in music therapy. This method enables observing emotional experience of a patient (A. Gąsienica-Szostak, 2003). During the process of

conducting music therapy, the therapist must proceed to reveal and release some negative emotions of the patient; to lessen the fear and decrease the muscle tension; to unlock the need for expression; to improve communication; to change improper psychophysical behaviour; to fulfil emotional needs; to reinforce self-esteem.

Conclusions

Summarising, it must be emphasised that mutism may affect children, teenagers and adults. Biologically, a mutistic person is capable of speaking. However, strong fear and social phobias make it impossible to speak. Mutism may also be connected with withdrawal. At the beginning of the therapy it is necessary to take care of proper relations with the child's parents, remembering to involve them in the therapeutic process. During the lessons in pre-school or at school, a mutistic child should feel safe and surrounded with understanding. Mutism may take various forms and each of them has different reasons. It is important to recognise them as soon as possible and organise proper help.

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