

## Treatment of a Child with Elective Mutism

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Classical psychiatry defines elective mutism (EM) as a "persistent refusal to talk in one or more major social situations, including school, despite ability to comprehend spoken language and to speak" (1:88). This disorder is not felt to have a biological cause and is unrelated to deafness, mental retardation, or autism (2:1887).

Since Tramer first described EM in children in 1934 (3), many etiologies have been proposed for this relatively rare disorder: family conflicts, fixation at the anal stage of development, early trauma or hospitalization before age three, speech phobia, overprotective mothers. Occurring more often in girls than in boys, the average age of onset has been reported at six years of age or below (4:739). Untreated and allowed to persist into adolescence, it often results in social and intellectual disability. No specific treatment modality (behavior modification, speech therapy, family therapy, hypnosis, individual psychotherapy, to name a few that have been tried) has been particularly helpful. Reports in the literature describe success using short-term nursery treatment (4:739-746), as well as the behavioral approach of stimulus fading (2:1889), but these refer to resolution of mutism and not necessarily the other "ancillary" symptoms exhibited by these children (extreme shyness, enuresis, constipation, encopresis).

All forms of therapy may be used by the medical orgonomist and are most effective when applied within the context of a functional, characterologic understanding of the patient. 1 Crist states, "The realm of investigation and treatment in orgone therapy is the child's functioning as a total organism, with emphasis on the interrelationship between psychic and somatic processes" (8:198). These principles are clearly demonstrated in the successful treatment of a young boy with EM as described in the following case history.

### Case History

M. is a five-year-old male, with an Asian mother and an American father, brought for treatment because of his refusal to speak in school. At age three M. was evaluated through the local school system and found to have a severe articulation and expressive language delay by the speech pathologist. An occupational therapy evaluation found generalized hypnotic musculature, incomplete head-eye disassociation (the ability to look at objects without moving the head), poor visual tracking ability, and limited tolerance for kinetic and vestibular stimuli. Psychological evaluation described great difficulty separating from mother, unsuccessful attempts at play therapy with refusal to interact with the examiner, and an incomplete Stanford-Binet because of refusal to speak. M. was placed in a "pre-school handicapped" class, given speech therapy three times a week, as well as occupational therapy, physical therapy, and other classroom activities. Over two years, his entire verbal communication with teachers and fellow

students was less than 10 words. He gestured, nodded, or pointed, and seldom interacted with his peers. At this point, his parents brought M. for treatment.

M.'s mother also expressed concern about his extreme shyness with strangers, his refusal to play with other children, his tendency to follow her around the house while emitting a low-level whine, his frequent facial grimacing at home and in public, and his production of an odd vibrating noise at school when frustrated. On the other hand, M.'s parents also described with pride his ability to memorize calendars and tell the day of the week a future date would fall on. Laughingly, they told how M. became upset if he saw the calendar turned to the wrong date. On several occasions, while in the family car, M. became anxious when he noticed a street sign had been removed. Although very talkative at home with his parents, he hid when company came over. He also never went to the barber because of his shyness (his other cut his hair).

M.'s mother described some improvement since enrollment in the pre-school handicapped class. He was a bit less shy, followed the teacher's instructions, and no longer shrieked and cried when his mother dropped him off at school. She noted, however, he never urinated or defecated at school, waiting until he got home. Recently, M. told his mother he liked being shy.

M., the product of a full-term pregnancy, was delivered vaginally using mid and low forceps, with good APGAR scores at birth. At three days of age, M. became jaundiced and shortly thereafter was hospitalized for three weeks in an incubator in a neonatal ICU for a possible apneic episode. He was finally discharged and remained on an apnea monitor until eight months of age. Phenobarbital was also taken until six months of age as treatment for the apnea episode, presumed secondary to a seizure disorder. Developmental milestones were reported toward the lower end of the normal range. Bowel and bladder training were achieved at age three after much difficulty. The final "technique" was having him stand in the corner if he soiled. M.'s mother described her son's chronic constipation, with bowel movements only 3 to 4 times each week. An ophthalmologic evaluation at three years of age was also done because he was "cross-eyed at times." No corrective prescription was given.

For my initial meeting with M., I was able to first observe him through a two-way mirror in a playroom with his parents. He was a large, stocky little boy with dull eyes and a notably flat, mask-like facial expression. His gaze was dysconjugate, sometimes showing either a left or right esotropia. Respirations were quite shallow with his chest hyperinflated and held high in inspiration. His movements were mechanical, and he reminded me of a sad little robot encased in an iron shell.

Immediately upon entering the treatment room, his parents began peppering him with questions: "What time is it, M.? Here, look at this, M. Why don't you do this, M.?" At one point M. picked up a toy telephone and said, "This doesn't work." Both parents converged on him, offering assistance and speaking at the same time. As his father took the toy away from M. to demonstrate its use, M. protested in a whiny, moaning, hypernasal voice, "N-o-o-o-o. Don't do that."

I entered the room and, since the people in M.'s life seemed to charge relentlessly after him, I quietly introduced myself. Instinctively holding back, not wishing to overwhelm him, I decided to let him come to me when he was ready.

We all sat around a table. M.'s mother directed him to sit next to me. M. put his fingers in his mouth, paced back and forth, and finally sat down next to her and across from me. He and I played a simple card game, seeing who turned over the higher card. When I won, M.'s mother asked him who won. In response, he stared straight ahead, avoided eye contact with anyone, and pointed to me, while making a groaning noise. I asked him who should go first on the next pair of cards. He turned away from me, leaning into his mother, and told her, "Mommy, do. Tell doctor, Mommy."

I asked M.'s father to leave the room. M., grimacing and grunting, said to his mother, "Where is Daddy go?" With his father gone, M. began jumping up and down, woofing like a dog. This did not have the appearance of gleeful play but rather a mechanical and disconnected expression of anxiety. When I asked his mother to leave, M. became quite anxious and whiny, clinging to her and looking around the room as if confused. She finally departed. M. paced, groaned, sat, and rocked for 60 seconds until he couldn't stand it any longer, then ran to the door searching for his mother. Finally, both parents came back into the room. M. picked up a toy camera, pretended to take a photo of me, and, without talking, showed me the picture. I said to him, "It gets scary when Mommy is outside." He replied, "Yeah," looking vacantly away from me.

My initial impression of M. was that of a pudgy little boy surrounded by parents who although decent, were remarkably contactless. In order to buffer himself against their constant onslaught, he encased himself in a protective shell, refusing to talk or move, holding back and holding on to the little contact he could find. He seemed miserable and stuck.

My first goal was just to make some degree of contact with M. He initially came to his sessions with either his mother or his father. He entered my office very tentatively, and I sat on the floor asking nothing of him and letting him explore. I had to tell his parents not to ask him to perform in the sessions but rather to leave him alone. M. became interested in a bucket containing assorted Legos, plastic soldiers, and other toys. M. took one piece from the bucket, looked at it, and returned it. After two weeks of this, of saying nothing to me and completely avoiding eye contact with me, M. took a plastic cup from the bucket, filled it with toy soldiers, raised it over his head, and emptied them onto the floor. He waited for some comment from his father or me, and when none came, he pronounced this a "cup-dump." I filled a cup with soldiers, emptied it, and repeated, "cup-dump." M. then continued to do several more cup-dumps with stifled but discernable pleasure. After two sessions of this, M. and I began smiling after each cup-dump. He next picked up the whole bucket, raised it over his head, and, after looking at me and his mother, emptied its contents onto the floor, saying with the beginning of a grin, "Big dump." For the next few visits, M. would do "big dumps," always scrupulously cleaning up by the end of the session. This progressed to more and more dumping, which M. practiced with relish and glee, smiling with the first facial expressions I had

seen besides his grimacing. Soon, he began refusing to clean up after dumping in my office. I looked at the pile on the floor and said, "Oh, look at the mess in my office!" In response, M. reached his hands into the pile of Legos and picked up a handful, throwing them in the air. He then put his hands into the remaining pile, thrashing and scattering the pieces about. M. became more and more excited with this activity, his formerly shallow respirations deepening with excitement and his eyes looking brighter. He continued, however, to avoid eye contact.

At this point, M.'s parents, having had initial reservations about the cost of therapy, needed reassurance that what they saw happening in my office was actually "doing something" for M. Despite their doubts, they were desperate and also surprised by the extent of M.'s interaction with me which, although minimal, was more than his usual response to strangers.

In the next session, M. began dumping on me. He had the bucket over me and I said, "No, not another dump on me!" He covered me with the bucket's contents, laughing. His parents, sitting there, soon became the reluctant, albeit assenting, recipients of more dumping.

Each time M. showed any excitement, he quickly contracted and became flat and immobile. I began biophysical work by tickling his cervical, thoracic, and lumbar paraspinal muscles. They were rock hard and moderately tender. He protested this but afterward looked more alive, breathed deeper, and even perspired. With my encouragement, he also began hitting me (discharge) after the tickling.

One day M.'s paternal grandmother, a domineering figure in the family, came along "to see what this is all about." After dumping on me and his mother several times, M. turned to his grandmother with a look that said, "You're next." M. dumped on her, laughed loudly, broke wind, and giggled. At the end of this session, he resisted leaving. Two weeks later, M.'s mother reported he was moving his bowels daily without difficulty and passing gas frequently with apparent delight.

In addition to dumping, M began shooting me with a toy gun. He was very tentative at first, quickly putting the gun down and whining. This prompted work on his paraspinal and occipital muscles, which elicited menacing faces, a karate stance, and an attack on me. I also began mimicking his whining, provoking his shouted "No!"

At this stage, M.'s parents were amazed at how much more outgoing he was becoming. They told me M. recently greeted all the guests when company came over. He even became obnoxious, turning off the TV when the adults were watching and didn't give him the attention he demanded. His mother commented he was becoming more like a "normal kid" but was now wearing her out. She knew M was easier to handle before, but she also realized he had to be allowed this new emotional expression.

At the next session, M. vigorously dumped on both his father and me. In between, he made angry faces at me, accompanied by hitting and kicking, and saying , "No!" I

responded with "Yes!" to each of his "No's" on and on, louder and louder. More aggressively, M. picked up the gun and fired it at his father who, feigning death, dramatically fell on the couch. M. began to whimper, "No, you're not shot," and lay down next to his father, crying. I told M., "Just because you get angry, doesn't mean Daddy will die." M. stopped crying abruptly, seemed to ponder this for a moment, and then got up and said vehemently, "Bad doctor," hitting me with an angry face, throwing Legos at me, and refusing to clean up the mess. This helped discharge the emotion, leaving him looking increasingly bright and contented.

Now, after two months of therapy, M's parents, in confidence, informed me he was talking in school daily and no longer grimacing. His teachers, aware of his treatment, reported more interaction with peers, including dumping, though he still refused to speak in groups larger than four children. Finally, M. amazed his parents by going over to a car salesman and shaking his hand when the family visited a dealership. Also, at this time, occupational and physical therapy were discontinued as evaluations from both disciplines now showed normal muscle tone and improved coordination.

At the next session, M. came in making rageful faces at me, although his eyes appeared dull. He took my hand and placed it on his occiput. After working the muscles there, his eyes converged without esotropia and brightened. As he left my office, however, I noticed his eyes diverge again and become dull.

With M.'s softening body armor and increased energy charge, the area of primary holding appeared to be his ocular segment. This was masked previously by mutism and shyness. These were more superficial, mostly anal defenses which yielded to treatment revealing the primary ocular block. The diagnosis of catatonic schizophrenia seemed likely.

I felt M. becoming more aggressive, moving tentatively from an anal to a more phallic position. Frequent retreats back to the anal level responded to the now-familiar "Yes/No," as well as to direct biophysical work on the paraspinal and occipital muscles. With the increased energetic push, M. looked biophysically brighter and more alive. Of concern, however, was his continued avoidance of eye contact with me. A decision was reached in supervision that further progress would necessitate M.'s parents leaving the therapy room.

At the next session, I asked M.'s mother to leave, explaining to M. she would be right outside. His face furious, he screamed, "No!" Pounding on the couch and crying his heart out, he looked the picture of abject misery. He seemed to be crying out all the misery borne of absent maternal contact. I repeatedly thwarted his attempts to get off the couch. Eventually, he began to laugh at this game, followed by more crying, until his mother returned 10 minutes later. As M. left the session, he ran back with an angry face to give me a kick.

Successive sessions repeated this scenario. Once, when his mother returned at the end of the session, M. told her, "I don't like Doctor." Then, smiling, he told her a joke, "What

do you have when you hang doctor upside down? Upside down doctor!" At the end of this session, despite his expressed hatred of me, he announced, "I don't want to go home, Mommy."

After the fourth session without his parents, M.'s crying lessened, and he resumed dumping with a vengeance. His voice became whiny, to which I said, "Now, don't scream loudly." Predictably, this provoked screaming. I'd cringe and he'd scream again. When it seemed he had discharged sufficiently, I suggested we have his mother come back in. He replied, "No, I don't want her back in."

Alone with me, M. found ways of keeping contact superficial. He began playing "TV game shows," asking questions as the host, artfully saying, "That is correct. Now we go to a commercial." We played "spin the chair" to encourage eye contact. We had to look at each other when the chair he was in stopped spinning. Other times, to encourage kicking, if the spinning chair didn't work, I tried to have M. follow my finger on a penlight with his eyes but he consistently refused. One day, in the midst of M.'s version of jeopardy, I said, "No, I want to talk to you." He said, "No, you can't talk to the Grouch." He turned his head, stubbornly staring away from me. He went to the door, opened it, and called out to his father, "Did you hear me say you can't talk to the Grouch?" His father said, "Tell the doctor how you memorized that book." M. replied with a loud, "NO!" and slammed the office door. At the end of the session, M. looked me right in the eye and said, "What's your favorite game?" This felt like his first directly spoken communication with me. He quickly withdrew and began whining. I mimicked him, and he exaggerated his whining, laughing with pleasure.

M.'s parents now told me he was initiating play with other children for the first time, having them over to his house. His mother also told me he no longer followed her around. Shortly after this, M. came to his session proudly displaying his first barbershop haircut.

M.'s subsequent therapy focused on improving his ocular functioning, keeping him mobilized by having him scream, and dealing with his stubbornness and pervasive "No!" These characterologic defenses reappeared and had to be addressed every time a new level of ocular contact was reached. I told him he was "Mr. No" to which he replied, "No, I'm not!" He now resisted direct biophysical work on his occiput more than before.

In the first few sessions of the last five months of M.'s therapy, he stopped dumping, began talking to me more, made more eye contact, and played games of his own making including me as an intimate rather than an audience member. He initiated throwing Koosh balls back and forth between us, with good eye contact. He became more physically affectionate, asking for as well as offering hugs.

In several sessions, he came in with dull eyes, unable to make contact, looking very stuck. At these times, direct biophysical work on the paraspinals and occiput elicited first anger, then sorrowful sobbing sometimes accompanied by calling for his mother. I gently told him it was all right to cry. Afterward, he looked clear and sparkling again. He

was more verbally expressive, and his face became quite animated. He took obvious pleasure in expressing excitement by opening his eyes wide, as in amazement. He now looked more phallic, often strutting into my office, and seldom reverted to his former whining and cringing behavior.

During a session two months prior to termination, M. picked up my penlight, had me roll my eyes, and then gave me the penlight to use on him. M. showed good, sustained tracking. "I thought you said you couldn't do this before," I said. M. replied, "I didn't say I couldn't do it. I didn't want to." M.'s eyes now stayed clear most of the time and seldom exhibited their former strabismic gaze. His parents noticed this as well and told me they were glad they had waited and not subjected him to corrective eye surgery, which had been offered by M.'s ophthalmologist. They also reported he had become "so emotional," crying during a movie recently. Again, I had to remind his parents of the necessity for them to accept and not criticize his emotional expression.

Because of M.'s dramatic classroom improvement, the school decided to mainstream him into a regular classroom. M.'s parents, citing this and monetary constraints, wanted to end his treatment. M. seemed able to hold onto gains made in therapy, and we began discussing termination. M. cried, hugging me, saying he didn't want to stop therapy. He remembered his early days of dumping and all the games we played together. He asked me for a flashlight as a going-away present.

At our final session, M. handed me a note he typed at school: "Dear Dr. Osborn, Today is my last day. I like playing with Koosh balls. To Dr. Osborn. From M." He hugged me, crying with deep sobs. I gave M. the flashlight he requested, his mother asking him why he wanted it. He told her, "I didn't want to have to take Daddy's."

One week after M.'s final session, I received a letter from him with his latest school picture. It showed a smiling, confident little boy. In the back, his mother wrote: "This is the first picture we've ever had of M. smiling. You don't know what this means to us."

## **Discussion**

Viewed from a psychological perspective, M. could have been seen as "anally fixated" while also displaying some autistic traits (e.g., social withdrawal, poor eye contact, facial grimacing, preoccupation with numbers, and being able to predict days of the week on future given dates). Viewed from a neurologic (somatic) perspective, M.'s history of an apneic episode at three days of age and a postulated underlying seizure disorder could lead to the conclusion that his behavior was "organic," secondary to presumed cerebral anoxic damage. Classical psychiatric literature describes the treatment of childhood EM with a multiplicity of modalities (behavioral therapy, individual psychotherapy, including play therapy, family therapy, speech therapy, etc.), specifically targeting discreet symptoms without integrating them into a treatment of the organism as a unified whole. None of these approaches sees the underlying identity between psyche and soma: the orgone energy function. The orgonomist understands character functionally as the consistent pattern of energy movement or blockage in the organism. A functional

characterologic approach allowed me to see M.'s elective mutism as one symptom of a much larger biophysical problem.

Given what we know about character, including the nature and effect of ocular blocking, M.'s behavior, as well as the somatic aspects of his character, are both understandable and treatable.

The fundamental methods used by the orgonomist in the treatment of a child are the same as those used in the treatment of adults. These have been well summarized by Baker (5, 9) and briefly comprise the following: (a) breathing to increase charge and heighten energy movement through the organism; (b) direct biophysical work on muscular armor to remove blocks to the energy flow; and (c) character analysis. All classical treatment modalities may be used by the orgonomist as aspects of his fundamental treatment approach: Keeping M. on the couch when he wanted to leave is behavioral therapy; working with toys (dumping Legos and toy soldiers and later playing with a toy pistol) is play therapy; helping M.'s family to tolerate his new levels of emotional liveliness is family therapy.

M.'s character type was initially viewed as anal, the expression of which masked the underlying ocular block. As the anal material was worked through, the phallic stage, natural for M.'s age (5:23), was reached, albeit with ocular repression. Here M.'s primary ocular blocking became more evident, necessitating therapeutic attention. The ocular split was evidenced by M.'s tendency to be very aware of my presence while also perceiving me, speaking to me, and speaking about me as if I were an inanimate object. As this resolved and he became better integrated, he became more personable, loving, and aggressive. Previous manifestations of ocular blocking and deep brain armoring (generalized hypotonia, poor visual tracking ability, and poor tolerance for kinetic and vestibular stimuli) improved greatly. He looked like a "normal kid" and was mainstreamed into a regular classroom where adjunctive therapies (physical, occupational, and speech) were not part of the curriculum. Remarkably, M.'s strabismus also improved dramatically as his ability to sustain eye contact increased, suggesting its functional origin in armoring of the ocular segment.

M.'s characterologic red thread was the stubborn "Mr. No" who withdrew and became immobilized as new levels of contact were attained. With each increase of energetic charge, his red thread had to be addressed repeatedly.

As termination approached, M. began to show increasing phallic competitiveness with his father. It is surmised that, because he was not going to continue in therapy, M. found a rather ingenious way to get what he wanted (the flashlight/large penis) and to avoid the anxiety of having to take his father's.

With the profound improvements achieved in therapy, it is hoped M. will continue to progress spontaneously in his development. Certainly, this hope is only possible because the major blocks crippling his young life have been overcome.

## Footnotes

1. Reich and Baker both thought a character diagnosis could not be made in children because the character is not finally fixed until puberty (5:142). Crist has stated one can describe the character type a child is "at risk for becoming" (6). Konia feels a character diagnosis can be made in a child, if the illness is severe enough (7).

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