

BEHAVIOUR THERAPY FOR SELECTIVE MUTISM WITH MENTAL RETARDATION AND FEBRILE CONVULSION

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INTRODUCTION

Selective Mutism (SM) is characterized by an ongoing failure to speak in selected settings, specifically in a structured setting. This failure to speak is not due to a lack of knowledge, or comfort with the spoken language acquired within the social situation (American Psychiatric Association, 1994).

Marhoon et al, (2002) had assessed 40 children with SM and found that it manifested at preschool age, more commonly in boys, and was associated with early developmental risk factors. 75% of children with SM had pre-morbid speech and language abnormalities and 66% had oppositional and aggressive behavior. Shyness and excessive anxiety were the most common personality features. School and unfamiliar people created the social context in which these children most frequently did not speak.

Despite the vast array of treatments tried, results have been mixed (Carr & Afnan, 1989; Kehle et al, 1990; Rosenberg & Lundblad, 1978; Reed, 1963). Changing the child's environment such as placement in inpatient units or residential schools has resulted in some success (Elson et al, 1965). The most widely reported and successful intervention method has been behaviour therapy (Colligan et al, 1997; Bergman & Piacentini, 2002).

The present case is of SM with two co-morbid conditions thus warranting a unique combination of management techniques.

CASE

Master R.P. an eleven year old boy studying in first standard, was brought to the Out Patient Department (OPD) of Central Institute of Psychiatry, with chief complaints of not speaking

to anyone other than family members, complete silence in the presence of others, poor scholastic performance and occasional "naughty" behaviours at home. He had delayed language development i.e. he produced few sounds at the age of three years and complete speech was developed one year later. He was also described as a 'slow' child by his parents. He had a past history of two febrile convulsions at the age of three years. Carbamazepine 400 mg/day was started, as electroencephalograph (EEG) was indicative of very frequent slow wave discharges over Right Centroparietal region with phase reversal over central region. The drug was continued and consequently he continued to remain seizure free. He started schooling at the age of 6 years and performed very poorly at school.

The index patient was subsequently started on an anti-anxiety drug (Paroxetine, 12.5 mg/day) while continuing the anti-epileptic medication. At this point, he was referred for psychological intervention.

ASSESSMENT

A detailed interview was conducted with both the parents separately as well as together. The child's behaviour was observed with each of the parents and while sitting alone. On Developmental Screening Test (DST), Developmental Quotient (DQ) was 60, and on Vineland Social Maturity Scale (VSMS), Social Quotient (SQ) was 62, which was indicative of mild delay in development and adaptive functioning. No intelligence test could be administered because of the child's lack of communication. Parents also reported presence of problem behaviours like snatching, beating, throwing household articles, etc.

The child was asked to join group activities at the Child and Adolescence Psychiatric Unit. In order to observe his natural behaviour, his day was not structured. Initially, he used to cry for a very long time and rapport could not be established. He used to sit next to his mother in the group meeting and during play activities. Instructions had to be repeated many times before he would understand them. He was inattentive while studying. He had no concepts of colour, counting, etc. After a week of systematic observation an **A-B-C analysis** for behavioural modification was done as described below:

Antecedent -Group situations - like formal meetings, ward rounds etc.

Behaviour-Silence, withdrawal, crying when interaction was forced.

Consequences-Parents used to take him away, giving attention to his needs.

Appropriate reinforcers were identified which included eatables, social praise as well as parental attention.

THERAPY

Inpatient therapy was initiated to make him interactive through the use of non-verbal behaviour and monosyllabic words in the group setting. The mother was included as a co-therapist and was given four sessions of counseling, about the illness, therapy, her role, possible outcome and so on. The following combination of techniques was used:

Play activity: 30 to 45 minutes of play with other children requiring minimal verbal communication.

Desensitization for crying behaviour: It was hypothesized that crying is a manifestation of underlying anxiety. Principles of desensitization were used to deal with his crying behaviour. A hierarchy of increasingly difficult situations was prepared with the help of the mother. Progress to the next item on the hierarchy was based on patient's appearance of comfort in the situation. Accordingly, the hierarchy included, that the mother was initially allowed to stay in the group activities but had to sit opposite him. After two days, she was asked to sit outside the room but in a position from where she could be

seen. Two days later, she was asked to continue with her work in the ward, while he was attending the meeting. With every change in the hierarchy, the patient used to cry, which the treating team used to ignore. In the meeting, he used to sit quietly for which he was positively reinforced. Later, he was encouraged with clapping, followed by eatables, whenever he attempted to speak or tried to interact.

Activity scheduling: The child's day was structured on an hourly basis, including group activities, individual structured tasks and his favourite activities.

Behaviour contingency management: Parents were explained about the importance of reinforcement and punishment, and how to use these principles in daily life. A chart was prepared where all his good behaviours were rewarded with his favorite colour star. At the end of the day a total of five stars could be exchanged for one eatable item. Whereas, bad behaviour would be followed by mother's ignorance, and would result in delayed reinforcement, and restraining for 10 minutes at time. Although the child had problems in understanding the whole procedure, his problem behaviour reduced quickly. Parents were repeatedly explained about the need to not make reinforcers available outside the contingency management situation.

Parental counselling: Parents' expectation from the child as well as the need for long therapy was discussed. This was necessary as mother used to cry over her child's condition. She was explained about how the child can model her own behaviour. The positive qualities in the child were enumerated. She was asked not to fulfill the child's needs and demands instantly and to let him take initiative, and to keep herself busy.

After 20 therapy sessions, when one of the other patients asked him personal questions in the group meeting he replied in monosyllables. Clapping, social praise and eatable items followed this behaviour. He also started speaking to other staff members, when alone. Occasionally, he started

responding to strangers, with gestures.

Follow up sessions: After 40 sessions (two months) he was discharged and therapy was continued on an OPD basis. Contingency management was continued at home. The parents explained the patient's problem and therapy process to the school-teacher who was requested to follow this, at school. Initially, he had outbursts of problem behaviours. He would occasionally interact with guests who would visit.

After two more months of therapy sessions on OPD basis, the patient got ready to play with the psychologist. However, verbal interaction was limited. Finally intelligence tests were administered. On Gessel's Drawing Test (Verma et al, 1972) and Seguin Form Board Test, Indian norms (Verma et al, 1980) his mental age came below three years, translating into an IQ of 30, indicative of severe intellectual impairment. Parents were counselled about mental retardation. It was suggested that they send him to a school where basic concepts would be taught using special teaching methods. They were satisfied with the treatment as the child had started playing at school, interacting with the guests and going alone to a nearby shop.

DISCUSSION

This particular case was challenging due to the presence of intellectual impairment along with SM. Clinical diagnosis and history of convulsion were also indicative of neuropsychological deficits. Most of the studies indicate that children with SM are of average intelligence (Landgraten, 1975) and cooperate in performance intelligence tests (Mora et al, 1982). It was difficult to assess this child as he had low intelligence, poor writing skills and refusal to communicate verbally.

Limitations of the therapy included inadequate assessment, poor interaction with the school and inability to develop fluent speech in the child. However, his well-developed adaptive skill was an asset, as treatment could be focused on mutism, rather than imparting skill training. This case was interesting

as it shows how mutism can cover other underlying conditions. It also illustrates that with the parents' efforts, behaviour therapy can bring about change over the time.

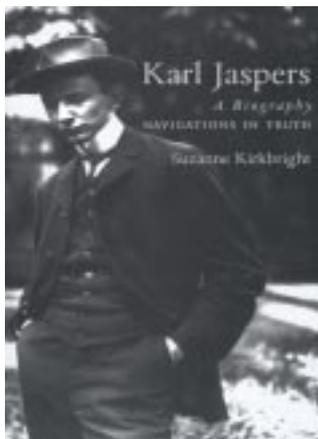
Future work should address issues like measurement of underlying anxiety/shyness, and teaching adaptive skills. Comparison of efficacy between various techniques of behaviour therapy would be of importance.

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Book Review...



Title : KARL JASPERS: A BIOGRAPHY. NAVIGATIONS IN TRUTH
Publisher : YALE UNIVERSITY PRESS, NEW HAVEN, LONDON
Year : 2004
Author : Suzanne Kirkbright
Price : \$35.00

INTRODUCTION

The German psychiatrist turned philosopher Karl Jaspers (1883-1969) wrote important works on psychopathology, systematic philosophy, and historical interpretation of existentialism. What is the current status of his concepts? Who still reads Karl Jaspers? Compared to influential giants of 20th-century German philosophy - Husserl, Heidegger, and so on, he has faded from the shelves of the libraries. At least in the English-speaking world, Jaspers is now remembered more for his writings on other thinkers, such as Nietzsche or Weber and his complex friendships with figures like Heidegger and Arendt, than for his own work. Even then for mental health professionals, his psychiatric masterpiece, *General Psychopathology* (1913) still stands apart, enlightening the path of budding psychiatrists and proving its point for the followers of this profession providing a benchmark for reference. If Jaspers's philosophy was preoccupied with those 'aspects of the human condition that defied rational understanding', then it is unsurprising that he was well suited to the exploration of mental illness. His work is outstanding for its vivid and penetrating descriptions of the psychopathology of his patients.

KARL JASPERS: A PRIMER

Karl Jaspers was born in Oldenburg, Germany, on Feb. 23, 1883. After graduation from the gymnasium in Oldenburg, he studied at Heidelberg, Munich, Berlin, and Göttingen. In 1909

Jaspers received the degree of doctor of medicine and began to specialize in psychiatry. For seven years thereafter he worked in the psychiatric clinic attached to the University hospital in Heidelberg. It was here that Jaspers began to work out a classification of basic personality types. With this work Jaspers acquired a position on the psychology faculty at Heidelberg. Jaspers' health was always fragile. From early childhood he suffered from bronchiectasis with cardiac decompensation. This required him to organize his limited energies with great care. Yet he accomplished much teaching and writing under these limitations and was helped greatly, particularly in his writing, by his wife, Gertrud Mayer, whom he married in 1910.

His work, influenced by discussions with his friend Max Weber and by the latter's theory of ideal types, culminated in Jaspers' first major work, *General Psychopathology* (1913). In this first major work Jaspers discovered one of the essential themes of his thought: "Man is always more than what he knows, or can know, about himself." From Immanuel Kant, Jaspers learned that man, the source of all objective inquiries, cannot himself be known through objective inquiry. In his next major work, *The Psychology of World Conceptions* (1919), Jaspers explored the range of fundamental world views, in relation to which individual people find their own identity. He also began to explore those "boundary situations" in life that force individuals to face up to the meaning of their unique existence. These include the awareness of one's sexuality, suffering and conflict, shame, betrayal, and guilt, and the death of loved

ones and the awareness of one's own death. In this way Jaspers inferred that concentration on the individual self and its experiences contribute to the distinguishing mark of existentialism. In 1921 he was given a chair in philosophy at Heidelberg University.

In his following contributions, *Philosophy* (3 vols. 1932), *Philosophical Logic* (1947), and *Philosophical Faith* (1948), Jaspers developed a view of philosophy as a never-ending search for his total vision. Jaspers' philosophical faith maintained that the man, finding himself dependent and inadequate, is open to a transcendence that grounds and supports his existence and maintains his freedom. His opinions were put to a severe test after the Nazis came to power. Always critical of Nazism, Jaspers was forced to retire in 1937 and was forbidden to publish in 1938. His wife, a Jew, was under constant threat, and the couple had already been scheduled for deportation to a death camp, when the U.S. army entered Heidelberg in April 1945. Jaspers shifted to Switzerland and after many testing years under constant threat, took a chair of philosophy at Basel in 1949 and spent the next two decades writing on topical questions as German guilt, demythologizing of the Gospels and of the atom bomb, in addition to large-scale historical works. He died after a stroke on Feb. 26, 1969, in Basel at the age of 86 years (Clark, 2002).

ABOUT THE AUTHOR: SUZANNE KIRKBRIGHT

Throughout his life, Karl Jaspers recorded his experiences and reflections in diaries and correspondence. Suzanne Kirkbright is a lecturer in German at Aston University, Birmingham, England. She completed the research for this biography during her stay as a guest scholar and Alexander von Humboldt Research Fellow at Heidelberg University. Suzanne Kirkbright demonstrates that she is familiar with the wide range of Jaspers's work -- from its early focus on psychology and medicine to the existential philosophy of the middle years to the deeply political critique of German culture and society of the post World War era. Using primary sources

unavailable to previous Jaspers' scholars--including diaries and extensive personal correspondence from both Jaspers' family and his wife Gertrud, Kirkbright has written a biography that celebrates Jaspers as one of the "good Germans" in an era marked by German political repression, violence, and terror under Nazi influence. Kirkbright's fluency in German and translational skills makes this biography especially valuable for English-speaking audiences. Her scholarly care is excellent, with abundant footnotes providing original German translation for quotations. She also obtained the support of Jaspers' last research assistant and controller of the Jaspers archive in Marburg which allowed her to access the diaries and correspondence and even some unpublished manuscript pages that have never before been translated.

ABOUT THE BOOK

This comprehensive biography is the first attempt in English to explore extensive writings of Karl Jaspers that illuminate not only Jaspers' life and relationships but also the ideas he proposed in many of his published works. The biography is aptly divided into six parts preceded by a chronology of important life events in Jaspers' life and a brief introduction which entails a comprehensive prelude for the reader and ends with a comprehensive appendix having personal letters of Jaspers, his family and friends.

Relying heavily on this family correspondence as a constant point of reference for narrating and interpreting Jaspers's personal history, Kirkbright acknowledges that she "seeks to illuminate the connection between Jaspers' life and works." To this extent, she claims, "his life can be seen in this biography to have been dedicated to illuminating the implications of truth with reference to the guiding light of reason"(p.xx). As she unfolds her story, the first part emerges to be a tale of an upper middle-class son of a privileged family in northern Germany who, despite an early illness that perforated his lung and threatened his life, emerged to start a successful career as a University professor. Abandoning his early study of law at Freiburg and Heidelberg, Jaspers moved to Berlin

where he took up the study of medicine. Later he moved to Göttingen and then back to Heidelberg as he began in earnest to be trained as a psychologist. The second part deals with consolidation of his professional life and his marriage to Gertrud Meyer. Kirkbright finds that the social obstacles to their union presents Jaspers with a new challenge of integrating his own need for intimate partnership and his reliance on his own family. Despite the fact that he lived most of his life away from his parents, Jaspers clearly always remained a loyal and earnest son to them. Enno, his younger brother's life and death suggested that he may have suffered from a condition like manic-depressive illness which finally culminated into suicide which was uncommon during that time. Kirkbright does not state this but the documentation in the book is speculative of Jaspers' brother's contribution. Kirkbright also addresses Jaspers' relationships with others, like Heidegger, Hannah Arendt and Max Weber, with an amount of detail that is informative, though not to a degree that was as revealing as her descriptions of his family relationships. After his father, Max Weber appears to have the strongest influence on Jaspers, not only in his personal rectitude and political liberalism, but also in his university career. Kirkbright demonstrates how Weber was the main influence on helping Jaspers to settle into an appointment in the department of Philosophy despite lack of formal training in that field. Kirkbright is at her best when on the basis of these intimate family relations--his father's artwork, his brother's suicide, Gertrud's cousin's nervous breakdown--she makes important connections to Jaspers' written work.

Further in part three and four, Kirkbright explained how Jaspers shared struggles during the Nazi years when, because of their "mixed marriage", both were in desperate danger from the Gestapo and even going so far as to plan a mutual suicide pact in the event of their capture as they would keep a bottle of poison in the bathroom. Out of these terrible personal experiences, Kirkbright explains how, Jaspers became a leader in the Heidelberg community and in Germany at large in trying to orient the nation to the post-war era. He immediately set about discussing the question of German guilt. Although

the biography deals evasively about Jaspers's presence as a teacher, doctoral advisor, and colleague, we do find sections on Jaspers public persona, which are coloured by a respect, reverence and admiration. Further in the concluding parts, the book explains how, in 1948 Jaspers and his wife accepted an invitation to Basel in Switzerland and remained there until his death in 1969, and why did Jaspers leave Germany to go to Basel, especially, at a time when he was at the peak of his university power and his national prestige? Many Germans apparently resented him for his "desertion" when he was most needed in the post-war period. This is perhaps a question in Jaspers' personal life which Kirkbright seems to have failed to answer. Kirkbright has also discussed Jaspers' attempts to migrate overseas during the Nazi era and his potential attempt to move to Oxford that was eventually rejected by analytic philosophers in the UK. This book shows a real commitment to philosophical rigour and scholarly precision, which Jaspers carried throughout his life. In the concluding section, this book explains Hannah Arendt reunion with Jaspers when he tried out to pass on his philosophical academic legacy to her as he submits examiner's report for her Doctoral Thesis.

CONCLUDING REMARKS: A CRITICAL REVIEW

In her book, Kirkbright refuses to criticize Jaspers's work or address its evolutionary limitations. If Jaspers' works are to be revived for their philosophical significance then they will have to be questioned at their root. His ethical positions on atomic warfare and social responsibility were also given a miss. Jaspers' existential notions of "limit situations" and "metaphysical guilt" tied to the political and cultural world of 20th-century German life do not provide an anchor to develop notions for the postmodern era. Anyone unfamiliar with Jaspers' work will find these questions meaningful. Because of Kirkbright's respectful stance, we will probably need to wait for another, more philosophically engaged biography before we can properly assess the relevance of Jaspers' thought for understanding these pressing issues. There are certain obvious flaws in the language and the method of narration

adapted by Kirkbright. The language is sometimes difficult to comprehend and narration of footnotes seems to be inept at times.

It seems at times that Kirkbright is deriving inferences from secondary sources rather than writings of Jaspers even when she had an exclusive access to many primary sources. For a scholar of mental health however it is probably worth a quick glance because of the value of Suzanne Kirkbright's source material. This book is recommended to anyone who is interested in learning about a man who has written pearls of phenomenology and philosophy that paved the roots for

modern existentialism.

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