

Two Cases of Schizophrenia Showing Long-standing Mutism

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ABSTRACT

A patient with hebephrenic schizophrenia who had kept silent for 26 years and a patient with simple schizophrenia who had remained silent for three years were reported. It was presumed that this mutism would be one of the symptoms of psychotic speech disturbance. Discussion was centered on the possibility that this mutism is one of the ways of expressing autism by communicating with society nonverbally and that this mutism can be interpreted as selective negativism.

Key words: long-standing mutism; speech disturbance; elective negativism

INTRODUCTION

Autism is mentioned as the nuclear symptom of schizophrenia. It is not seldom that schizophrenics present mutism related to this autism, or derived from pathological experiences such as negativism and delusion or due to lack of volition or something beyond our comprehension. However, mutism observed over a long period of time in schizophrenics is very rare except where there is severe devastation of personality, and there have been few reports^{1,2)} which deal with this matter.

To two schizophrenics who had kept silent for a long period of time, we treated with neuroleptic drugs and found that they regained their ability to speak. The present paper reports results of our observations on these two cases.

CASE REPORTS

Case 1: 47-year old man

Life history: The fetal period and gestational period were normal. The mental and physical development in childhood was of the average. He graduated from a junior high school with average grades. Then, he began working as a factory hand. At age 19 he accidentally suffered a burn in the left foot, thereafter he has not had a regular job.

Family history: The father and mother are living and well. The patient is the eldest brother of eight siblings. The youngest brother had typical hebephrenia after graduation from a university and now he is admitted in a mental hospital. His uncle on the mother's side became mentally abnormal and committed suicide at age 18.

Pre-morbid personality is gentle, docile and nervous. He cared for his brothers and sisters well.

Present illness: After the accidental burn suffered at age 19 as mentioned earlier, he began to have doubts about living, became nihilistic and attempted to commit suicide with sleeping pills. Because of this episode he visited the Out-patients' Clinic Department of Psychiatry for medical examination. Various symptoms such as lack of volition, anthropobia and suicidal desire were observed and he was diagnosed as having hebephrenia. With electroconvulsive therapy (ECT), these symptoms disappeared several weeks later.

From age 21, however, delusions of persecution and auditory hallucinations were noticed. At the same time spontaneous speech decreased markedly. Grimaces and a forced smile became conspicuous. Hallucination and delusive symptoms disappeared by ECT but he would not make spontaneous speech and all his conversations were carried out in writing. After that, he was engaged in farming. [At around age 38 he began to take a training for a type picker at a colony for the physically handicapped. His skill at the colony was rated as good and his work efficiency was also good. He made himself understood to a clerk in charge of work and the communication to his co-workers by writing.

At age 40, he happened to be at home on vacation from the colony and met a disaster — total destruction of his house by fire, but he would not say a word. From age 44, pathological experiences such as delusions of persecution and auditory hallucinations appeared again and his work efficiency declined and his personal relations deteriorated. At age 46, he attempted to commit suicide by cutting his wrist with a knife and was admitted to the psychiatric ward of the hospital.

Findings on admission: Though cooperative in the medical consultation, he would not say a word and responded to the history taking by nodding or shaking his head. He tried to express his sufferings by making grimaces and striking his head with a fist.

Physical examinations: Otorhinolaryngological examination, EMG of the facial muscle, EEG and CT scan of the head showed no abnormal findings. Tests on peripheral blood, functions of the liver and the kidney and examination of cerebrospinal fluid were all negative. An interview under anesthesia with intravenous injection of diazepam was held twice without success.

On the ink-blots test performed after he became able to converse, he had difficulty in having a sympathetic feeling in personal cognition and tended to avoid human contact, but appeared to have a latent desire for personal contact. According to the Wechsler Adult Intelligence Scale (WAIS), his IQ was 86 in the verbal test and 84 in the performance test.

Clinical course after admission: Treatment with haloperidol was started. Four weeks later, while he was receiving 4 mg of haloperidol per day, he became able to pronounce vowel sounds, though in a small voice, from the second hospital week, to speak short words from the third week and to converse in simple sentences from the fourth week. But he seldom talked to his family members, and on the history taking, he tried to talk by writing.

The hallucinatory-delusory state did not disappear completely, but he took part positively in light work and came to have personal relations with patients showing mental subnormality. As an explanation of his long-standing mutism, he merely said, "My parents would not let me in a senior high school, though I had ability. So, I was resentful and shut my mouth".

He has no difficulty in conversing with the attending physician and nurses but still talks little to his family members.

Case 2: 33-year old man

The fetal period and the gestational period were normal. Since his mother died soon after giving birth, he was brought up by grandparents on the father's side and at age 1 he was adopted into the family of his father's elder sister. After graduating from a senior high school with average achievements, he became a clerk. At age 20, he was dismissed because of poor work performance. Soon after that, he ran away from home and wandered about from one slum to another as a vagrant.

At age 30, he was arrested for committing theft twice and served a

sentence. From the fifth month of imprisonment, he ceased to speak and would lie wrapped up in blanket all day. A diagnosis of prison psychosis was made by a psychiatrist at the time. After that, he was admitted to a mental hospital because of siteirgia and a marked general debility coupled with psychomotor excitation.

Family history: The father is living and well, bigoted and easily excited. There is no hereditary predisposition to schizophrenia.

Pre-morbid personality is shy, sensitive and asocial. He had no intimate friend.

Present illness: From around 18 years of age, he showed lack of volition and began refusing to take a bath and change his clothes.

Because his work attitude was bad and also because he was often absent without notice, he was fired. After that, he spent unproductive days at home. When the father admonished him, he ran away from home and was heard of no more (age 20). He settled down in the slums of big cities and would work as a day laborer when in the mood to work. He had no pathological experience such as auditory hallucinations and delusions until he was arrested by the police at age 30. From around the fifth month of imprisonment, he began to show insomnia, delusions of persecution and desire for death. At one time he took a warden for an executioner.

Findings on admission: General debility was conspicuous. With the eyes closed and mouth shut, he tried to refuse medical examination. When spoken to, he just made grimaces and shook the head.

Physical examination: Otorhinolaryngological examination was negative. Neither EEG nor ECG showed any abnormal findings. Malnutrition were observed at admission, but the nutritive conditions were improved rapidly. Examination on cerebrospinal fluid was negative.

An interview under anesthesia with intravenous injection of diazepam was held three times. On the history taking, he moved his lips but failed to vocalize and talk. Even at present when he is able to converse, he still refuses the ink-blot test and intelligence test; so, there are no available data. Judging from results of observations on his way of life in the ward, however, it appears unlikely that he has any serious intellectual defects.

Clinical course after admission: For a month after admission he lay in bed most of the time and continued taking a negative attitude, with eyes closed and his back turned to doctors and nurses. In a hazy state after administration of ECT, he murmured, "Mother". After awakening, however, he returned to the state of mutism. His contact with other

patients in the ward was not observed at all. Placed on administration of chlorpromazine 200 mg per day, murky expression and grimaces disappeared one month after admission, and he began to participate positively in the gardening work and volleyball from the second month. He started talking to himself, though hard to follow, from the third month. When spoken to by doctors and nurses, he would respond with a smile and was able to briefly communicate in writing.

At the sixth month, he would murmur "Well, let's work", or "It's about the time for getting up". From the eighth month, he would answer "Yes, or "No", when spoken to. With the turn of his third hospital year, his ability to speak was so improved that he had little trouble in carrying on daily conversation. To a question about a pathological experience, he gave a vague answer and just smiled wryly; so, details still remain obscure, but it was surmised that his delusion of persecution persisted for a time. As to the events he experienced while serving the prison term, he just replied, "I don't remember them". However, it is doubtful if he has psychogenic amnesia. Even at present, he never speaks to his family members.

DISCUSSION

Case 1 is hebephrenic schizophrenia which developed at age 19 and in which mutism lasted 26 years. Case 2 is simple schizophrenia which developed at the age of around 18; the patient spent a wandering life because of this disease, developed mutism while serving a prison term at age 30 and regained the ability to speak three years later. Autism is said to be one of the nuclear symptoms of schizophrenia. Autism is defined as loss of contact with the life in which the patient lives and this definition has been generally accepted. For schizophrenics whose personality is markedly devastated by lack of volition and apathy in addition to autism, or mutism is often present. Negativism and delusion are also accountable for mutism in many cases. However, there are very few reports on severe, longstanding mutism.

In Japan, Ito's report¹⁾ on one case of mutism lasting 12 years and nine months is the only one ever published. Speech disturbance without neurological abnormalities are considered to belong to psychotic speech disturbance or psychogenic speech disturbance. However, there is an opinion that it is doubtful whether psychotic speech disturbance can be interpreted as an expression of pathological psychiatric symptoms⁴⁾. While the presence of negativism, delusions and lack of volition may be assumed as the causes of mutism, the psychological process preceding

mutism is beyond our comprehension in psychotic speech disturbance.

In the two cases under review, the human function as a social being was impaired and their daily life was also largely restricted. With various symptoms of schizophrenia improved by the treatment, they recovered their ability to talk. It may be assumed from this fact that the mutism shown by them is one of the symptoms of schizophrenia.

That their severe mutism and lasting over a long period of time is probably because the activity of their intrapsychic world decreased and became empty in substance. Meanwhile from a psychogenic viewpoint, it cannot be ruled out that they had a desire to refuse to talk. Particularly, it is very suggestive that case 2 murmured "Mother" immediately after ECT. While they had difficulty in communication of will with speech, they were able to live in the society. Thus, their mutism may be interpreted as a sort of elective negativism.

In discussing mutism, mention should be made of observations of Kanner⁵⁾ on the childhood. He proposed that infantile mutism be classified into childhood schizophrenia, infantile, idiocy, deaf, hysteric and psychogenic mutism. The possibility of mutism being present is higher in infants than in adults. This is said to be related to mental conditions yet to be developed fully in childhood when the infants are acquiring the ability to speak^{2, 5)}. Kanner's classification cannot be applied to the adult cases reported here, but it may be possible to borrow the concepts of hysteric and psychogenic mutism advanced by him. Particularly in Case 2, the psychological inhibition called prison psychosis may be a contributory factor since he developed mutism under special conditions — in prison where convicted criminals are isolated forcibly from the society. However, his lack of speech continued even when he was transferred to a mental hospital and further to an open ward where it became possible for him to be with family members in a freer environment. This behavior cannot be attributed merely to hysteria arising from imprisonment. In Case 2, the unhappy childhood — adopted into other family shortly after the death of the mother — must have become a mental trauma and exerted a great influence on his life after he became an adult. In Cases 1 and 2, their contact with their family members is of the non-speech even when contact by speech is possible; they do not want to return to the society from the mental hospital and are quite satisfied with the life in the hospital. The cause of this long-standing mutism may be traced to their attitude of turning their back to the life in the society where an increase in contact by speech is inevitable.

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