

Selective Mutism and Social Anxiety Disorder: All in the Family?

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ABSTRACT

Objective: To examine the history of lifetime psychiatric disorders in the parents of children with selective mutism (SM) compared to parents of children in a control group. **Method:** Seventy parent dyads ($n = 140$) of children with lifetime SM and 31 parent dyads ($n = 62$) of children without SM were interviewed with the Structured Clinical Interview for *DSM-IV* (IV and II) anxiety disorders, mood disorders, avoidant personality disorder, and schizoid personality disorder modules via telephone. Interviewers were blind to proband status. The NEO Personality Inventory was also administered. **Results:** Lifetime generalized social phobia was present in 37.0% of SM parents compared to 14.1% of control parents ($\chi^2 = 10.98$; $p < .001$; odds ratio 3.6, 95% confidence interval 1.6–7.9). Avoidant personality disorder was present in 17.5% of the SM parents compared to 4.7% of control parents ($\chi^2 = 6.18$; $p < .05$; odds ratio 4.3, 95% confidence interval 1.3–14.9). The proportion of parents with other psychiatric disorders was not different between groups. SM parents had higher neuroticism and lower openness scores on the NEO Personality Inventory than control parents. **Conclusions:** These results support earlier uncontrolled findings of a familial relationship between generalized social phobia and SM. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(11):1464–1472. **Key Words:** selective mutism, child anxiety, social anxiety, genetics.

Selective mutism (SM) is defined as a consistent failure to speak in specific social situations, in which children are required to speak (e.g., school), despite speaking in other situations (American Psychiatric Association, 1994). According to *DSM-IV* criteria, SM is associated with significant impairment, has a duration of at least 1 month and is not due to a lack of knowledge or comfort with speaking a language or accounted for by the presence of a communication, psychotic, or pervasive

developmental disorder. Extant data suggest that SM usually begins in early childhood, often during the preschool years when a child is first required to speak in formal settings such as school and day care. Little is known about the naturalistic course of SM. The few studies that do exist suggest that even though mutism may frequently remit over time (Steinhausen et al., 2006), rates of “talking” behaviors remain lower than average (Bergman et al., 2002) and residual psychopathology such as social phobia and other anxiety disorders often persist (Steinhausen et al., 2006).

The etiology of SM is not well understood. Previous explanations suggest that overcontrolling or hostile parenting, intrapsychic conflicts, or past trauma contribute to the onset of SM; however, limited data exist to support these positions (Anstendig, 1999; Black and Uhde, 1995). Other studies suggest that child oppositionality may contribute to the refusal to speak, yet data are mixed in this regard (Cunningham et al., 2006; Yeganeh et al., 2003). To date, most research supports that SM is related to social phobia (SP) and that they share common etiologies.

Cross-sectional comorbidity rates between SM and SP range from 97% to 100% (Black and Uhde, 1995;

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Dummit et al., 1997), and characteristics such as shy, anxious, withdrawn, and serious are used to describe both those with SM and social anxiety alike (Kumpulainen et al., 1998; Steinhausen and Juzi, 1996). Findings from family history studies further support this relationship. In a study of personality characteristics of parents of 50 SM children and control parents (Kristensen and Torgersen, 2001) assessed with the Millon Clinical Multiaxial Inventory II (Millon, 1987), 39% of mothers and 32% of fathers of SM children were classified as shy/socially anxious versus 4% of mothers and 1% of fathers of controls. The avoidant and schizoid scales also predicted membership in the SM index group for mothers and fathers, respectively. Using a different assessment of temperament, parents of children with SM ($n = 38$) reported greater taciturnity in first-, second-, and third-degree relatives when compared to parents of control children ($n = 31$) (Steinhausen and Adamek, 1997). In the only family study that included a diagnostic assessment ($N = 30$ families with a child diagnosed with SM), 37% of the first-degree relatives had SM and 70% had SP (Black and Uhde, 1995). In that study, information was initially gathered by checklist format and then followed up by unstructured clinical interviews; a control group was not included.

Purpose of the Study

The present study builds on past findings in its assessment of personality traits and psychiatric disorders among parents of children with and without an SM diagnosis. In this study, we address some of the methodological limitations of previous research in this area by including a control group to provide appropriate comparisons; well-established semistructured diagnostic interviews rather than informal assessments; and multiple clinicians, blind to proband status to minimize diagnostic bias. In addition, this study also differs from previous research in its inclusion of SP subtypes. The generalized subtype of has been defined as the fear of most social situations (American Psychiatric Association, 1994), whereas the nongeneralized type refers to the fear of circumscribed situations, usually performance in nature. Data support differences in severity, comorbidity, and etiologies across the subtypes (Chavira et al., 2004; Wittchen et al., 1998), with some data suggesting that the generalized type may have a more temperamental and perhaps heritable basis

(Stein et al., 1998a,b; Stemmerger et al., 1995). Given these differences, we believed it necessary to delineate SP subtypes in this study.

Hypotheses

On the basis of previous findings suggesting a relationship between social anxiety and SM, higher rates of SP among parents of children with SM were expected. In particular, higher rates of the generalized type of SP were hypothesized. On a self-report personality assessment, higher scores on Neuroticism and lower scores on the Extraversion subscales were expected among the parents of children with SM when compared to controls.

METHOD

Design and Procedures

This study is part of a larger project that includes the collection of DNA samples from families of children with SM. A nationwide sample was recruited by means of two sources: a Web site sponsored by a nonprofit organization for children with SM (the Selective Mutism Group-Child Anxiety Network), and parent-oriented conferences organized by this same nonprofit group. The Selective Mutism Group Web site receives approximately 500,000 hits per month from parents, professionals, and educators worldwide. Parents who were interested in participating in the project completed a consent-to-contact form and were thereafter sent study consents/child assents and contacted by telephone or consented in person if recruited from the conferences. Control families were recruited through community advertisements posted in San Diego County and a university Web site advertising participation in research studies.

Families who returned their consent forms were screened over the telephone with the SM module of the Anxiety Disorders Interview Schedule for Children-Parent Report (ADIS-P/C; Silverman and Albano, 1996) and the Selective Mutism Questionnaire (SMQ; Bergman et al., 2001). Families assigned to the SM group had to endorse symptoms consistent with a lifetime diagnosis of SM for the child and at least a moderate amount of impairment in one of the domains assessed by the SMQ. Screening questions to exclude children with psychosis, developmental, or communication diagnosis were also taken from the ADIS-P/C and augmented by supplemental questions to adequately rule out these conditions. The first and last authors (D.A.C. and M.B.S.) discussed all of the cases that were questionable or excluded from the study. In those instances in which diagnoses remained questionable, the second author (E.S.B.) was asked to review a videotape of the child speaking at home to rule out the presence of a pervasive developmental disorder or significant communication disorder; this was necessary for five cases and resulted in the exclusion of two cases. Control families were eligible if their child did not screen positive for lifetime SM or the above-mentioned exclusionary diagnoses.

Appointments for telephone interviews with the parents were scheduled by a study coordinator who was not blind to proband diagnostic status. All of the interviewers were blind to proband status and as part of the introduction to the interview, it was requested that parents not reveal whether their child had previously

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