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Case Report
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Selective Mutism in Adults: A Case Study

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ABSTRACT

Selective mutism (SM) is a childhood behavioral disorder characterized by the inability to speak in one or more situations despite speaking in other situations. Selective mutism is included under anxiety disorders according to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. Many studies have demonstrated the relationship between severe social anxiety and the extreme reluctance or inability to speak in people with SM. These cases are often diagnosed through research in school-going children; data on adult periods are very limited. Symptoms related to social anxiety are also frequently observed in the families of children with SM. This situation is remarkable in terms of the genetic aspect of psychiatry. Adult patients with SM are often hidden among the symptoms of psychotic disorders. It can be recognized with a more detailed anamnesis of the patients, especially with their childhood history. In this study, a case who was treated with a diagnosis of psychotic disorder for many years and was found to have a diagnosis of SM during follow-up is presented in the light of literature findings. Our study may raise awareness in terms of drawing attention to the issue of SM, which is overlooked in childhood and hidden among other psychotic disorders in adulthood.

Keywords: Adulthood, selective mutism, psychotic disorder

INTRODUCTION

The term "aphasia voluntaria" for selective mutism (SM)/selective nonspeech first appeared in psychiatric literature in the 19th century and was used for children who prefer not to speak voluntarily in certain situations.[1] In SM, although the person has the ability to use the spoken language sufficiently, he/she does not speak or respond to certain environments or people for a long time.[2] In 1 study, the prevalence of SM was reported as 0.71%.[1] It has also been reported that immigrant, bilingual, and minority language-using children have a higher risk for SM, and the prevalence of the disorder may be 3 times higher in this population.[3] There are studies showing that girls are affected 1.2 times more than boys in SM, and this gender difference may be more pronounced among older children.[4,5] Family history data reveal a high prevalence of social phobia among the parents of children diagnosed with SM, such that the severity of SM symptoms in childhood may predict parental diagnosis of social phobia. There is evidence that individuals with variation of *CNTNAP2*, a gene affected in various types of language disorder, have an increased risk of SM.[6] Selective mutism is an anxiety disorder that begins in childhood.[7] The main symptom is the ability to speak but the inability to speak in certain social situations. In most people with SM, the disorder disappears by adolescence. However, in some cases, anxiety disorders become common later in life. Early diagnosis and treatment are needed to

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prevent symptoms from continuing and the development of other psychiatric disorders. Some long-term consequences for individuals with SM include phobic disorders, especially social phobia, persistent communication problems, and low self-confidence.[8] However, data on the long-term consequences of SM are limited.[9,10] The clinical presentation, etiology, and treatment approaches of SM in adulthood are not fully known. In this study, it was aimed to contribute to the current literature by discussing a case showing features of SM in adulthood in the light of clinical course findings.

CASE PRESENTATION

A 49-year-old, single, female patient was brought to the emergency department by her relatives due to irritability, not wanting to leave the house, and aggressive behavior toward her family and guests. It was learned that she had been consulting a physician with similar complaints for about 20 years, and risperidone 2 mg/day treatment was recommended with a diagnosis of psychotic disorder. The patient had recently exhibited aggressive behaviors, such as kicking out the guests coming home. There was no history of any medical or psychiatric illness in her personal or family history. Neurologic examinations and other system examinations revealed no pathologic findings. No abnormalities were detected in the hemogram, and biochemistry tests showed normal results. Cranial magnetic resonance imaging and electroencephalography reported normal findings.

During the interview, it was observed that she was constantly looking at the floor with her head in front of her. The patient understood what was said and responded to some questions by nodding her head. Affect was anxious, and mood was compatible with affect.

After psychiatric evaluation, risperidone 2 mg/day treatment was started for the patient who was diagnosed with another disorder with psychosis within the scope of schizophrenia, not defined according to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) diagnostic criteria. It was observed that the patient never left her room after being admitted to the ward and did not communicate verbally with other patients and healthcare workers. However, it was noticed that she talked, laughed, and joked with her relatives who came to visit her. The patient became agitated when insisted to participate in in-service activities and garden trips, and his treatment was adjusted to risperidone 4 mg/day. During the interview with the family members, it was learned that the patient had been withdrawn, timid, spoke in a low voice, communicated verbally only with her family, did not talk to strangers she did not like, and left the house much. It was learned that Laz language was mostly spoken at home, where she lived, and that she had difficulty going to school because Turkish was spoken in the classroom. It was also learned that the patient's mother was withdrawn, silent, anxious in social environments, usually spent time at home, and had no relationship with her neighbors. Attempts were made to communicate with the patient in her mother tongue, Laz language, with body movements, but verbal communication could not be established with the patient, who was found to understand what was said and could obey commands. After psychiatric evaluation and follow-up, the patient was diagnosed with SM according to *DSM-5* and was discharged on the 30th day of treatment to continue her treatment in the outpatient unit after informing her family. Afterward, it was observed that the patient regularly attended psychiatry outpatient clinic visits with her relative and did not talk to the physician during the examination, but her relative informed that the patient was better and more compliant. Cognitive behavioral therapy (CBT) was initiated. It was decided to reduce and discontinue the antipsychotic medication. Before the study, the patient and the patient's relatives were informed about the use of the information in the case report for academic purposes, and their consent was obtained.

DISCUSSION

There is not much information about the diagnosis and epidemiology of SM in adulthood. It is possible to evaluate these cases with different diagnostic and therapeutic approaches. In our case, the history of the patient, who was being followed up for psychotic disorder, was found to be compatible with SM. As in this patient, the evaluation of this behavioral attitude in childhood as timid and shy made it difficult to recognize the disease. Selective mutism is considered to be a part of social phobia in individuals with hearing loss, schizophrenia, and other psychotic diseases.[5,11] The fact that the presented case was followed for many years with a diagnosis of psychotic disorder and antipsychotic drug treatment is compatible with these results. However, it is noteworthy that there was no change in the patient's current condition despite using antipsychotic treatment for a long time. While the patient was receiving inpatient treatment, antipsychotic drug treatment was continued with the diagnosis of psychotic disorder, and the drug dose was increased. When the onset of the psychiatric disease history, clinical appearance, course, and observation in the ward were evaluated, it was concluded that the patient was compatible with the diagnosis of SM. However, it is not possible to say that the diagnosis of psychotic disorder and comorbid SM is completely excluded. The fact that the patient did not experience any negative effects after discontinuation of antipsychotic drug treatment and the positive developments in the outpatient clinic follow-up after discharge support the diagnosis of SM.

Studies have shown that the majority of children with SM also fulfill the diagnostic criteria for social anxiety disorder.[12] Evidence has been found that the families of these children also meet the diagnostic criteria for social anxiety disorder to a significant degree. A study by Chavira et al[13] revealed a high frequency of social phobia in the family history data of children with SM. Therefore, it supports that SM may be a developmental precursor of social phobia. In our case, the fact that the patient's parents met the criteria for social anxiety disorder confirms this study. It has also been reported that SM cases are observed more frequently in bilingual families. In a study by Toppelberg et al,[14] it was shown that the incidence of SM was higher in children in bilingual areas. In the same study, it was shown that the fact that these children showed SM findings in both languages was more significant for diagnosis than the difficulty in acclimatization.[14] In our case, the fact that Laz and Turkish were spoken in the village where the patient lived and that the patient showed symptoms of SM while speaking both languages was found to be compatible with the study. Information on the treatment of adult-onset SM is limited. It has been reported that selective serotonin reuptake inhibitors and CBT are beneficial in the treatment of SM in childhood and adolescence.[15] Cognitive behavioral therapy was preferred in the treatment approach of the case.

In conclusion, the diagnosis of SM is often overlooked in adults or is considered within the symptoms of other mental illnesses. As in our case, there are cases of SM in childhood that persist into adulthood. Therefore, it is important to take a detailed anamnesis and do a careful follow-up in order not to overlook cases.

Informed Consent: Written informed consent was obtained from the patients who agreed to take part in the study.

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