Case Report / Olgu Sunumu
doi: 10.18678/dtfd.1092388

Duzce Med J, 2022;24(2):212-214
Düzce Tıp Fak Derg, 2022;24(2):212-214

17-year-old Selective Mutism Case without Treatment for A Long Time

Uzun Süredir Tedavisiz Kalan 17 Yaşındaki Selektif Mutizm Olgusu

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ABSTRACT

Selective mutism is a rare childhood anxiety disorder characterized by the inability to speak in certain social situations in which speech is expected, despite speaking fluently in other situations. The average age of onset for selective mutism is 2 to 5 years old, but symptoms may not be noticed until starting school. The cause is still not known and the prevalence varies between 0.03% and 1%. Psychopharmacology and psychotherapeutic approaches are recommended in the treatment. Although the treatment is difficult, early diagnosis is one of the good prognostic factors. In this case report, we aimed to discuss the psychiatric and sociocultural functionality of a 17-year-old adolescent with selective mutism. Our case is remarkable as she has not been treated for many years. Her treatment continues with psychopharmacological and psychotherapeutic interventions. Recognition of selective mutism and getting support on this issue will help to solve the problem.
Keywords: Selective mutism; treatment; adolescent.

ÖZ

Selektif mutizm, başka durumlarda akıcı konuşmaya rağmen, konuşmanın beklendiği belirli sosyal durumlarda konuşamama ile karakterize, nadir görülen bir çocukluk çağı anksiyete bozukluğudur. Selektif mutizm için ortalama başlangıç yaşı 2 ila 5 yaş arasındadır, ancak çocuklar okula başlayana kadar semptomlar fark edilmeyebilir. Nedeni tam olarak bilinmemektedir; yaygınlığı %0,03 ile %1 arasında değişmektedir. Tedavisinde psikofarmakoloji ve psikoterapötik yaklaşımlar önerilmektedir. Tedavisi güç olmakla birlikte erken tanı iyi prognostik faktörlerden biridir. Bu olgu sunumunda, selektif mutizmli 17 yaşındaki bir ergenin psikiyatrik ve sosyokültürel işlevselliğini tartışmayı amaçladık. Olgumuz uzun yıllar tedavi edilmediği için dikkat çeken bir vaka olma özelliğine sahiptir. Tedavisi psikofarmakolojik ve psikoterapötik girişimlerle devam etmektedir. Selektif mutizmin fark edilmesi ve bu konuyla ilgili destek alınması sorunun çözümüne fayda sağlayacaktır.
Anahtar kelimeler: Selektif mutizm; tedavi; ergen.

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Received / Geliş Tarihi : 24.03.2022
Accepted / Kabul Tarihi : 21.07.2022
Available Online /
Çevrimiçi Yayın Tarihi : 08.08.2022

INTRODUCTION

Selective mutism is a rare childhood anxiety disorder characterized by the inability to speak in certain social situations in which speech is expected, despite speaking fluently in other situations (1). The average age of onset for selective mutism is 2 to 5 years old, but symptoms may not be noticed until starting school. In general, selective mutism improves with age, while other mental disorders can be seen later (2). Social phobia and depression are common comorbidities. Traumatic events were suspected in the etiology in the past, while today genetic, psychological, and language-related factors have been assumed (3).

Its prevalence varies between 0.03% and 1% in various clinical and school samples (4). Selective mutism is 1.2 to 2 times more common in girls (5). In treatment, psychotherapies, psychosocial interventions, and selective serotonin reuptake inhibitors (SSRIs) are used (6).
In this case, we aimed to discuss the psychiatric and sociocultural functionality of an adolescent with selective mutism, who did not be treated for 12 years.

CASE REPORT

A 17-year-old female patient in her 2nd year of high school applied to our polyclinic with her father voluntarily because of "not talking to foreigners".
At the age of 5, the patient started not to talk to anyone except her parents. According to the family, she did not have any problems in speech-related developmental stages and she had no problem talking to strangers before the age of 5. No significant stressor was described. Despite all the efforts of her parents, the patient continued to suffer from this condition.
When she started primary school, she applied to child psychiatry twice with this complaint, and fluoxetine solution, an SSRI, was started. The dose of fluoxetine could not be learned. The drug was discontinued because the family thought it was ineffective. She has not received any psychotherapeutic support.
She could not go to primary school in her first year as she could not stay at school and run away. After that year, she was able to adapt to school. However, since then, she has been communicating with her teacher and friends with gestures and facial expressions or just nodding her head. Her academic performance was good.
Her family stated that she was a worried child, and her anxiety increased in the mornings of school days. It was learned that she checked her bag and receipts frequently, though it did not take most of her time during the day. According to her family, she is a curious child who is quick to learn. Her family does not think she is shy.
During the clinical examination, she was making effective eye contact and communicating by nodding. Her intelligence seemed to be normal. She had no problems with sleeping and appetite.
According to the mother, the prenatal and postnatal period was normal. She was delivered vaginally at 38 gestational weeks. Her first words were at the age of 9 months, she started to walk when she was 12 months, and completed toilet training when she was 2.5 years old. Her mother was the primary caregiver during her childhood. She always lives with her family and no traumatic experiences have been described. There was not any pathology in her medical and neurological examinations. There was no psychiatric disorder or speech-related disorder in her family history.
Our case cannot speak in social areas (eg. school), although she speaks in other situations (eg. at home with family). This impairs social communication, the duration lasts longer than one month, and the state of being unable to speak is not related to not knowing the language of the society or not being able to speak that language comfortably. She met the diagnostic criteria for selective mutism according to the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition (DSM-5), as she did not have a condition that was explained by autism spectrum disorder, communication disorder, or any psychotic disorders.
In the treatment, sertraline 50 mg/day and lorazepam 1 mg/day were started. She was seen biweekly. After one month, her anxiety decreased and she started going out with her friends, but there was no improvement in her verbal communication. At the end of the first month, lorazepam treatment was stopped and psychotherapy was recommended. It was observed that the patient started to talk to the teacher and close friends in the second month after the beginning of the treatment, although it was observed that there was an increase in her functionality, the expected recovery has not been fully achieved yet. The patient's follow-up continues.

DISCUSSION

Selective mutism was first defined in 1877 as "aphasia voluntaria" and was named "elective mutism" in the DSM. Its name was changed to "selective mutism" in 1990 (7). The clinical course of selective mutism is very variable, it may regress suddenly and completely, or it may show a slow regression. Continuation into adulthood is less common (3). While this diagnosis was under the title of "Other Disorders of Infancy, Childhood or Adolescence" in DSM-4-TR, it was included under the title of "Anxiety Disorders" of DSM-5 and entered the focus of adult psychiatry.
Selective mutism is a rare psychiatric disorder and it's difficult to treat. A multidisciplinary treatment approach is required. Today, cognitive behavioral therapies (8,9) and psychopharmacological agents are used (6,10).
In this case, selective mutism symptoms started at the age of 5 and continued till 17 years old. This is due to the lack of regular visits to a child psychiatrist, and so lack of regular follow-up and treatment.
Selective mutism impairs psychosocial and academic functioning (11), but in this case, the impairment seemed not to be important. This may be due to the low socioeconomic level and cultural structure of the family. Also, the reason for ignoring the deterioration in social functioning at school may be because of good academic achievement.
Studies have shown that 80% of cases with selective mutism are frequently accompanied by an additional diagnosis of anxiety disorder, especially social phobia (69%) (12,13). Untreated selective mutism can lead to impaired functioning and increase the risk of other psychiatric disorders (7).
The timely diagnosis and treatment of selective mutism with psychotherapeutic and psychopharmacological approaches can prevent comorbid conditions and deterioration in functionality.

CONCLUSION

Shy behaviors and limited speech, especially in girls, may be considered as appropriate and respectful behavior culturally and it may be difficult to treat the situation as a disorder. As a result of delays in diagnosis and treatment, it is inevitable for the disorder to become chronic. Although selective mutism is seen rarely with age, physicians other than psychiatrists are needed to be more aware and should refer the patients to psychiatry when suspected.

Informed Consent: Written informed consent was obtained from the patient for publication.

Conflict of Interest: None declared by the authors.

Financial Disclosure: None declared by the authors.

Acknowledgments: None declared by the authors.

Author Contributions: Idea/Concept: ŞB; Design: MAC; Data Collection/Processing: OG, SAS; Analysis/Interpretation: OG, SAS; Literature Review: OG, SAS, ŞB; Drafting/Writing: OG, SAS; Critical Review: OG, SAS, ŞB.

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