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Case Report

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Selective mutism: report of a successful case

Abstract

The present study reports a successful case of selective mutism in a four-year-old child. it goes according to the current literature that says that combined treatment (CBT + medication) and early intervention ensure a good prognosis.

Keywords: selective mutism, anxiety disorder, fluoxetine, comunication, behavior therapy

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Abbreviations: SM, selective mutism; CBT, comportamental behavior teraphy; ASD, autism spectrum disorder; SSRI, selective serotonin recaptation inhibitors

Introduction

Selective Mutism was described by the German physician Kussmaul in 1877, who referred to patients who did not speak in some situations, although they could, naming the problem "Voluntary Aphasia". In 1934, Tramet introduced the designation Elective Mutism to describe an inability to speak in situations where one would be expected to do so. This is still the nomenclature of this nosological entity in the ICD-10.

Carbone, Schmidt, Cunningham, McHolm, St Pierre & Boyle also found evidence that Selective Mutism is an anxiety disorder but with specific deficits in terms of social functioning. Until the DSM-4 TR, Selective Mutism was part of the chapter of disorders related to neurodevelopment, as well as Autism. This happened due to the tenuous age of onset of symptoms and the similarity with ASD. Only in 2013 in the DSM-5, this entity was categorized as an anxiety disorder very assertively due to its genesis and pathophysiology. Selective Mutism(SM) is an Anxiety Disorder that is characterized by a persistent inability to speak in specific situations, namely social ones.

It is a Disorder that affects a young age group, between 2 and 5 years old. The diagnosis usually takes place when starting school, when the child is repeatedly confronted with the challenge of speaking in front of others, and resistance to communicating is then perceived. MS is considered rare but it is increasingly noted that it is not a rare disorder but underdiagnosed. One in every hundred and forty children have selective mutism.

Case report

Female patient, 4 years old, comes to the psychiatrist's office with a diagnosis of Selective Mutism(SM) after regressing in psychotherapeutic treatment based on CBT with a focus on Selective Mutism. Since the age of 2, she communicates verbally only with her parents. When other family members present, mute. In the home context, she speaks normally with mastery of oral language, without behavioral restrictions and within the appropriate development for her age group. In the school context, she remains silent with children and adults and makes little non-verbal communication. She remains immobile, unable to ask for physiological needs such as urinating or drinking water, and she also does not eat in front of other child. She has school refusal and somatic complaints such as nausea and abdominal pain daily on the way to school. Also cannot use cell phone audio resources where your voice is in evidence.

In the first psychiatric evaluation, she remains silent, does not make eye contact, does not play with the ludic resources offered, does not use gestures to communicate. Other diagnoses such as autism and psychoses are ruled out by parents, school and psychologist reports. As there was a failure in the therapy in which the child was being treated and he could no longer progress due to the high intensity of anxiety, Fluoxetine was started until dose of 20mg/day.

In one month, the patient presents improvement of physical symptoms, but remains in the same staging in relation to mutism. In the second month, through gestures and whispers, she is already able to communicate with teachers for basic needs. The cildren already plays with her peers and smiles, but remains silent. In the fourth month, the psychiatrist is welcomed with "Hi, today I want to talk to you".

In six months of drug treatment and CBT focusing on the MS, the patient is able to communicate verbally in a broad way and in the most different places. Within this same period, the consolidation and generalization of speech is decreed and the child is discharged from psychology. Psychiatric medication is maintained for another 12 months to maintain gains and then weaned off.[1–8]

Discussion

The case exemplifies what the literature shows us. When the correct conduct is established beforehand, the faster the voice will return and the better the prognosis. Studies also point to a more satisfactory prognosis when medication and CBT focusing on Selective Mutism are available concomitantly. It is an election criterion for the use of medication in older children, with a long time of selective mutism, with comorbidities and when they stop progressing in psychotherapy. It is also necessary to exclude comorbidities such as ASD, sensory processing disorder, depression, and other anxiety disorders. In older children, the prevalence of social anxiety and Selective Mutism is around 70% of cases. The child reported in the case had a good prognosis and a quick discharge due to his tender age, correct psychotherapeutic technique and rapid implementation of SSRIs, the drug choice for these cases.[1]

Conclusion

The lack of knowledge about the disorder by professionals who deal with children and the fact that the child talks normally with the

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parents creates difficulty in the diagnosis and underreporting of cases. Delay in treatment implementation impairs the development of social skills and interferes with educational performance. If not properly treated, it becomes chronic and the perspective of speech becomes increasingly distant, as well as the acquisition of comorbidities. It is necessary to raise the awareness of health professionals and especially of education professionals, since teachers are the first look at this child.

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Conflicts of interest

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