

# Decision-Making Capacity in an Adult Patient Exhibiting Signs of Selective Mutism: A Case Report

Tabachnik A\*, Ullo M, Tennenbaum D and Tobia A

*Department of Psychiatry, Rutgers Robert Wood Johnson Medical School, 675 Hoes Lane West Piscataway, New Jersey*

**\*Corresponding author:** Tabachnik A, Department of Psychiatry, Rutgers Robert Wood Johnson Medical School, 675 Hoes Lane West, Piscataway, New Jersey 08854, United States, Tel: 732235-4403, E-mail: tabachar@rwjms.rutgers.edu

**Citation:** Tabachnik A, Ullo M, Tennenbaum D, Tobia A (2019) Decision-Making Capacity in an Adult Patient Exhibiting Signs of Selective Mutism: A Case Report. SAJ Case Report 6: 202

**Article history:** Received: 22 December 2018, Accepted: 07 June 2019, Published: 12 June 2019

## Abstract

Selective mutism is a psychiatric disorder characterized by a failure to speak in social circumstances in which there are expectations to speak. The affected individual has the ability to speak and speaks in other situations. A rare diagnosis in adulthood, selective mutism presents unique ethical dilemmas for medical professionals. The Consultation Liaison Psychiatry service at our institution evaluated the decision-making capacity of a 46-year-old female with selective mutism. Selective mutism, whether as a primary diagnosis or a sign secondary to other underlying psychopathology, has an interesting impact on the care of adult patients and warrants future discussion about the biopsychosocial management of the disorder.

**Keywords:** Anxiety; Consultation Liaison Psychiatry; Ethical Issues; Mental Health; Selective Mutism; Stress

## Introduction

Selective mutism is characterized by a consistent failure to speak in social situations in which there are expectations to talk (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication [1]. Selective mutism (SM) was previously classified (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition) in the section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence,” but is now classified in the DSM-5 as an Anxiety disorder, given that a large majority of children with selective mutism are anxious [2]. The criteria for diagnosis are essentially unchanged in the current DSM from previous versions. The duration of symptoms must last at least one month to qualify as SM. The lack of speech must also not be attributable to lack of knowledge or comfort with the spoken language, as well as not be better explained by a communication disorder or another psychiatric disorder.

Selective mutism is a psychiatric disorder of childhood with a prevalence of 0.7-0.8%, with a slightly greater frequency in females [3]. There is little to no documentation of SM in the adult population. There has been increased understanding that SM generally co-occurs with other anxiety disorders as well as with other neurodevelopmental disorders [4,5]. While SM does seem to run in families, its clinical course tends to remit in adulthood [6].

The onset of selective mutism in the adult population, more frequently as a symptom secondary to another psychopathology, presents as a unique clinical entity with a myriad of ethical implications. Of interest is the approach towards determining mental capacity to make medical decisions in the face of medical necessity. Unlike in the pediatric setting, an adult presenting with SM is usually expected, as the patient, to make his or her own decisions, unless otherwise specified. This concept, mental capacity, is distinctly different from competence, a legal term [7], and refers to the ability to consent to or refuse care. Capacity can be constantly fluctuating, depending on the presenting symptoms, impairments, and disturbances of the patient [8]. Of note, there are four unique elements related to decisional capacity (Table 1) [9]. The psychiatrist must determine not only what the patient can do, but also what the patient should be able to do when confronted with a situation that requires a decision [10]. Capacity is decision-specific and can fluctuate based on a patient's determined level. Depending on the complexity of the circumstance, one's level of capacity may or may not allow for resolution of the situation at hand. When a patient is determined to not have capacity, decision-making is then yielded to legal guardians, durable power of attorney, or family members of the patient.

1	The ability to communicate a choice
2	The ability to understand the relevant information
3	The ability to appreciate a situation and its consequences
4	The ability to reason rationally

**Table 1:** Elements of Decisional Capacity [9]

## Case Presentation

The consultation-liaison (C/L) Psychiatry service at Rutgers Robert Wood Johnson Medical School was asked to determine decision-making capacity of a 46-year-old female with a right ovarian mass. The patient presented to the Emergency Department at our institution following a syncopal episode with associated abdominal pain and was admitted for further evaluation. The Gynecology Oncology service discussed the risks and benefits of surgical intervention with the patient to rule out malignancy. However, questions remained regarding her understanding of the procedure.

Upon psychiatric evaluation, the patient was mute, and did not verbally contribute to the discussion. Her husband was present for the interview and provided the consultation service with comprehensive information regarding his wife's medical and social history. Of note, the patient would interact and verbally communicate with her husband when they were alone but was mute in other witnessed social situations.

Per the husband's report, the patient's psychiatric history began six years prior, when she developed suspicions about her husband's fidelity and began to socially withdraw. At that time, their daughters were roughly the same age as the patient had been when a family member sexually abused her. The husband was unable to provide additional details about the sexual abuse because his wife would not discuss it. Due to growing concerns about the patient's behavior, she was admitted to multiple psychiatric hospitals for a three-month period of time. She was treated with 5 mg aripiprazole and intense psychotherapy with recommendations for outpatient electroconvulsive therapy. Following discharge, the patient discontinued use of antipsychotic medication and returned to her state of isolation and paranoia. Three years later, the patient lost two close relatives in a short period of time and began to decompensate. Specifically, she gradually developed complete vegetative/affective cluster with increasing paranoid ideations. The patient began to believe people were attempting to poison her family and at times would refuse to consume any food or beverages. Her behavior became increasingly worrisome and within the year she became selectively mute. Since then, she has remained selectively mute and will only speak with her husband and a therapist who has since retired.

On mental status exam, the patient was interviewed while sitting upright in her hospital bed, in no acute distress. She was awake, alert, and oriented to month by use of a note pad. A formal cognitive assessment could not be undertaken due to her mutism. Grossly, she demonstrated mild-moderate deficits in concentration and attention, without evidence of agnosia. The patient was unable to communicate information regarding the proposed surgical intervention for her ovarian mass. The husband attempted to mediate the risks and benefits with the patient, but she would only shrug her shoulders in response. Therefore, the C/L service deemed that the patient did not possess the capacity to provide informed consent/refusal for her procedure. We believe that this patient's selective mutism is one of the later manifestations of her paranoid psychosis. While the remote history of sexual abuse likely contributed to her later development of paranoid psychosis, the more recent stressor of two family member deaths may have served as an etiology of selective mutism. Recommendations were made for the patient to receive 0.5 mg haloperidol every 12 hours, in addition to social work consultation to delegate a healthcare proxy.

Three days following initial consult from psychiatry, the patient was discharged from the hospital. As her proxy, her husband provided informed refusal for all antipsychotic medications in addition to surgical intervention for the ovarian mass. At the time of writing, the patient was lost to follow-up.

## Discussion

Selective mutism is a unique clinical entity rarely observed in the adult population. In the case presented, this patient's selective mutism is likely secondary to her development of paranoid psychosis and is an extreme manifestation of the poor communication observed in psychotic disorders. Her condition may have been precipitated by intrusive thoughts or flashbacks to childhood sexual trauma, given her daughters' current ages and the relatively recent onset of her symptoms. The deaths of two family members may have served as additional precipitants of her condition, given the timeline of this patient's symptoms. The implications of such a condition in an adult are numerous. For instance, this case highlights the medical and ethical complications of SM in the hospitalized patient. Refusal of a patient with SM to communicate with medical personnel poses many risks to both the patient and healthcare provider. In the case presented, it is unclear if the patient cognitively understood the associated risks and benefits of treatment (or alternatives) for her ovarian mass. It must be noted that this patient may lack decision-making capacity based on her diagnosis of paranoid psychosis alone, even if she were not selectively mute; however, the extreme symptom of selective mutism adds another layer of complexity in that she was unable to communicate any of the four elements that contribute to decisional capacity (Table 1). It is likely that in this patient, her SM would have remitted with adequate antipsychotic treatment. The provided dose of haloperidol 0.5 mg BID was likely insufficient even as an initial treatment, given the severity of her symptoms; adequate dosing for treatment of psychosis, per current recommendations, begins at 2 mg haloperidol daily, and can range to as much as 20

mg haloperidol daily in severe cases [11]. When treating a patient exhibiting SM, it is important to identify a proxy who can provide reliable insight regarding the patient's core values and goals of care. This patient's decision-making capacity must be re-evaluated after adequate treatment, which was not provided or consented to by her proxy.

Existing research on adults exhibiting SM is limited, as this is typically a diagnosis of childhood that is poorly understood. Intensive treatment during the onset of SM is likely pivotal in preventing the disorder from affecting the patient later on in life. Increased awareness of this condition may help bring patients to medical attention before a patient's mutism becomes reinforced over time. Future research should explore the role of anxiolytic medication and cognitive behavioral therapy in the management of patients exhibiting signs of selective mutism in the adult population, whether as a primary diagnosis or secondary to another psychopathology.

## Disclosures

The authors report no proprietary or commercial interest in any product mentioned or concept discussed in this article.

## References

1. Arlington VA (2013) Diagnostic and Statistical Manual of Mental Disorders, (Fifth Edition). American Psychiatric Association.
2. American Psychiatric Association. Highlights of Changes from DSM-IV-TR to DSM-5.
3. Bergman R, Piacentini J, McCracken J (2002) Prevalence and Description of Selective Mutism in a School-Based Sample. *J Am Acad Child Adolesc Psychiatry* 41: 938-46.
4. Steinhausen HC, Juzi C (1996) Elective mutism: An analysis of 100 cases. *J Am Acad Child Adolesc Psychiatry* 35: 606-14.
5. Kristensen H (2000) Selective Mutism and Comorbidity with Developmental Disorder/Delay, Anxiety Disorder, and Elimination Disorder. *J Am Acad Child Adolesc Psychiatry* 39: 249-56.
6. Steinhausen H, Adamek R (1997) The family history of children with elective mutism: A research report. *Eur Child Adolesc Psychiatry* 6: 107-11.
7. Buchanan A (2004) Mental capacity, legal competence and consent to treatment. *J R Soc Med* 97: 415-20.
8. Church M, Watts S (2007) Assessment of mental capacity: A flow chart guide. *Psychiatr Bull* 31: 304-7.
9. Appelbaum PS, Grisso T (1988) Assessing Patients' Capacities to Consent to Treatment. *N Engl J Med* 319: 1635-8.
10. Howe E (2009) Ethical Aspects of Evaluating a Patient's Mental Capacity. *Psychiatry (1550-5952)* 6: 15.
11. Lieberman JA, Stroup TS, McEvoy JP (2005) Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *N Engl J Med* 353: 1209-23.