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14-YEAR-OLD MALE WITH SELECTIVE MUTISM – CASE REPORT

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ABSTRACT

Selective mutism is a rare anxiety disorder characterized by an individual's persistent inability to speak in particular social environments, such as at school or in public places, while being able to communicate effectively and comfortably in other environments, like at home or with close family and friends.¹ Selective mutism commonly manifests during early childhood, affecting approximately 0.2% to 0.8% of children, with a higher prevalence observed in preschool environments.² This disorder can profoundly disrupt a child's developmental trajectory, potentially leading to significant social and academic impairments if not addressed promptly.³ This case report explores the developmental and communication challenges faced by a 14-year-old teenage boy presenting with significant delays in social communication skills. Referred to a developmental facility due to concerns about his social interaction and communication abilities. Patient's symptoms and behaviors align with a diagnosis of Selective Mutism as defined by the DSM-V criteria. This study provides a detailed account of how parents facing difficulty in obtaining an accurate diagnosis, which ultimately impacts the appropriate management and treatment. Limitations in speaking in public are often interpreted as part of a child's shy and quiet personality. As a result, this can lead to delays in diagnosis and eventually affect his language skills. Good awareness from parents and professionals is needed for early detection. As a professional, the ability to make an accurate diagnosis is essential to provide appropriate interventions for better prognosis and prevent further complications.

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- Selective mutism
- 14 years old child
- Diagnosis

1. INTRODUCTION

Selective mutism is a relatively rare but significant anxiety disorder that primarily affects children. It is characterized by a child's inability to speak in certain social situations despite being able to speak in other settings, such as at home.¹ Selective mutism affects approximately 1% of children. The disorder typically manifests between the ages of 2 and 5 years old, with symptoms often becoming noticeable when a child starts school or enters new social settings. Selective mutism is somewhat more common in females than males. Studies suggest that the ratio of girls to boys affected by selective mutism is approximately 2:1.²⁻⁶ There is evidence that selective mutism may run in families, indicating a possible genetic component or familial pattern.⁷⁻⁸ Children who have selective mutism frequently experience additional issues like social anxiety disorder, speech and language difficulties, or developmental disorders. About half of these children also meet the criteria for social anxiety disorder.⁹⁻¹²¹⁸ There is limited evidence suggesting that selective mutism might be more frequently identified in children from higher socioeconomic backgrounds due to increased access to healthcare services and early educational settings.^{4-5,9-10}

Despite being recognized in the psychiatry community for over a century, selective mutism is still a poorly understood condition that has not been extensively investigated. In this case, we see that the complaints exhibited by this teenage boy could be misleading to a different diagnosis and eventually lead to inappropriate interventions, which will ultimately affect the child's development, particularly in the area of communication skills. In this case report, we aim to discuss the development of a teenage male with selective mutism who was not diagnosed and treated until the age of 14. This case report examines his developmental history, clinical observations, and assessment outcomes to better understand his condition.

2. CASE REPORT

A 14 year-old male applied to our facility accompanied with his parents with concerns limitation in social communication based on teacher's report. He tends to be very quiet and shy at school and his behaviors impacted his academic and social performance at present¹⁷. Based on parent's report, he exhibited normal verbal communication at home but was almost non-verbal in school and social settings outside his immediate family. At home, he looked more comfortable talking to his parents and siblings.

Patient was born full-term through C-section delivery, weighing 3700 gram. Prenatal and postnatal period was normal. He has history of seizures and ear infection but no complication was reported. There was no history of head trauma or allergies. No history of long-term medication. His hearing test was reported to be within normal limits.

He was the second child in the family and has two other siblings who are 15 years old and 2.5 years old. Patient always lives with his family and no traumatic experiences have been described. In family. There was not any pathology in his medical and neurological examination. There was no psychiatric disorder or speech-related disorder in his family history.

In term of his developmental history, he demonstrated typical motor development but significant delays in speech development. His first word emerged at the age of 2 years. By the age of 2, his parents started to feel that his speech development was delayed compared to other children his age. There was no history of problem in oromotor development as well as sensory processing development.

Due to parent's concern in the area of speech delay, he was first evaluated by pediatrician, who recommended providing him with stimulation. His parents then enrolled him in speech therapy and then discontinued after six months because patient had shown good progress. After that, no intervention was provided, and the patient was simply recognized as a shy child. At present, patient tends to speak only in short sentences, and instructions need to be given repeatedly in order to make him to speak especially in social settings.

Behaviorally, his parents report that patient tends to take a long time to adapt and seems shy. He is also reported to be reluctant to share his property with others. During the pandemic, he spent much time playing on devices.

Patient began his education at one of the private school and have been struggled academically since then. He was put into Individualized Learning Program when he was in junior high due to the ongoing academic and social interaction difficulties. His mother hired a private tutor, but communication issues persisted. An intelligence test was conducted and indicated a below-average intelligence with a significant discrepancy between verbal IQ (58) with performance IQ (82).

The examination conducted in our facility consists of clinical observation and psychometric evaluation. We also ask parents to send a video containing interactions between the child and parents.

Clinical observations revealed slow response times, and reluctance to engage with questions. He preferred simple tasks and exhibited anxiety and discomfort with new situations and new people. Despite appearing cooperative, He did not initiate conversation and tends to avoid eye contact. He only responded with nods or head shakes, or with very quiet verbal responses. Patient also appeared more unwilling to respond when there was more than one examiner in the observation room. In subtests that did not require a verbal response, he was more cooperative and followed instructions. However, during subtests that required patient to answer, he appeared to struggle, tended to rock his legs, or stared at the table for an extended period. When he struggled with verbal responses during the language test, the examiner adapted it by allowing him to circle answers instead.

Aside from our clinical observation, we also asked parents to record patient's activities at home. The video was recorded in a home setting where patient appears to be watching television with his sibling. In the video, he looks relaxed and not anxious at all. He is able to interact and communicate verbally with his sibling and father. He also answers questions posed by his father, although his responses are fairly brief (in the form of phrases). His way of responding is also considered quite natural, with appropriate intonation. We saw a notable discrepancy between his home and external behavior. During our observation, we did not find any repetitive behaviors typically associated with Autism Spectrum Disorder, nor did we observe any psychotic behaviors. In addition to the observation results, we also conducted a series of psychometric evaluations, including both questionnaire completion and standardized test such as language test, social skill test and cognitive test. Instruments used in this case were Clinical Evaluation of Language Fundamentals-5th Edition, Oral and Written Language Scale-2nd Edition, Screening for Bahasa Indonesia, Social Skills Improvement System-Social Emotional Learning Edition and Weschler Intelligence Scale for Children-4th Edition.

The result from the psychometric evaluation showed that his language test results indicate a significant difference between his receptive and expressive abilities, understanding verbal information better than he can express himself. When subtests were administered in Indonesian, he performed better, suggesting he has a stronger command of that language. However, the overall score patterns were similar in both languages, with many scores still in the very low range. This highlights that patient's language difficulties persist regardless of the language used. Additionally, his lack of verbal responses in expressive tasks means his expressive language scores are not currently reflective of his true abilities.

The completion of the SSIS-SEL questionnaire by parents and teachers indicates that his scores fall in the below-average category compared to other children his age. Scores in this category suggest problems with overall social-emotional skills, particularly in the area of relationship skills. However, patient's self-assessment shows that his scores fall in the average category compared to his peers, indicating that he perceives his overall social-emotional skills as good. Nonetheless, he also feels that he struggles in the area of relationship skills.

Patient's overall cognitive abilities, as assessed by the WISC-IV, cannot be summarized by a single score due to his significantly better nonverbal reasoning compared to verbal reasoning. His verbal reasoning is in the Very Low range (VCI = 45), while his nonverbal reasoning is Average (PRI = 90). Both his working memory (WMI = 62) and processing speed (PSI = 50) are also in the Very Low range, indicating weaknesses in attention, concentration, and quick visual processing.

In summary, considering the developmental history, clinical observations, and psychometric assessments, we currently see that patient exhibits behaviors consistent with the characteristics of Social Anxiety Disorder, manifested in the form of Selective Mutism. The results of the assessment also indicate a possible Language Disorder. Given patient's limitations in responding to expressive tasks, further examination (after improvement in the condition of Selective Mutism) is necessary to obtain a clearer picture of his expressive language abilities and cognitive profile, particularly in the area of Verbal Comprehension.

3. DISCUSSION

Patient's symptoms and behaviors align with a diagnosis of Selective Mutism as defined by the DSM-V criteria, which describes a consistent failure to speak in specific social situations despite speaking in other contexts. The disturbance interferes with educational or occupational achievement or with social communication. The duration of disturbance is at least 1 month and the failure of speak is not attributable to lack of knowledge of, or comfort with, spoken language required in the social situation. The disturbance is not better explained by a communication disorder and does not occur exclusively during the course of Autism Spectrum Disorder, Schizophrenia, or another psychotic disorder.

In our patient, his reluctance to speak in clinical settings compared to his more interactive behavior at home highlights the influence of environmental context on his communication. This condition has been observed for years, since he was in elementary school. The clinical observations of patient being tense, anxious and unresponsive, contrasted with his more relaxed behavior at home. No sign of repetitive behaviors typically associated with Autism Spectrum Disorder, nor did we

observe any psychotic behaviors. Psychometric evaluation suggest problems with overall social-emotional skills, particularly in the area of relationship skills. Language test shows a significant difference between his receptive and expressive abilities, understanding verbal information better than he can express himself. Cognitive test indicating that his significantly better nonverbal reasoning compared to verbal reasoning. In summary, this patient met the diagnostic criteria for selective mutism according to the Diagnosis and Statistical Manual of Mental Disorder (DSM) fifth edition.

Regarding his language ability at present, we found that the patient's language skills fall below average when compared to other children his age. Based on a review by Viana et al, the study conclude that receptive and expressive language skills may vary in children with selective mutism. Its also stated that expressive–receptive and receptive language disorders may coexist with selective mutism.¹³Some children with selective mutism with average receptive language abilities may demonstrate shorter, less detailed, and more linguistically simplistic narratives.¹⁴ These subtle deficits in expressive language are theorized to be a compilation of anxiety, mild language deficits, and lack of experience with high-level language skills. Study by Steinhausen et.al suggests that many children with selective mutism have premorbid speech and language problems (38%).¹⁵

In this case, there are several factors that may underlie the results. The first is the patient's reluctance to provide verbal responses, which can indirectly affect the test outcomes. A child with selective mutism might not be able to participate in formal evaluation activities, and they may lack verbal responses and use nonverbal responses (e.g., pointing or gesturing). This finding is exactly found in this case. The underlying cause is a lack of language development in line with age progression, due to the patient's tendency to refuse communication with people he perceives as unfamiliar. Without an accurate diagnosis, the patient has not received appropriate therapy, which will eventually impact his language development.

In this case, over the past 14 years, no diagnosis was established, and the parents were only advised to provide stimulation. The patient was merely perceived as a shy child when asked to speak in social settings. The cognitive test results, showing that his non-verbal development is significantly better than his verbal reasoning development, indicate that this communication difficulty is not due to an intellectual disability. However, the results also show that his language-related reasoning skills have not developed as expected. Untreated selective mutism can lead to impaired functioning and increase the risk of other psychiatric disorder.¹⁶

The prognosis for a child with selective mutism is generally positive, especially with early intervention. Many children can overcome selective mutism with appropriate treatment, which often includes behavioral therapy, such as cognitive-behavioral therapy (CBT).

Factors that can influence the prognosis include the child's age, the duration and severity of the mutism, the presence of comorbid conditions (like anxiety disorders), and the support available from parents and teachers. With effective treatment and support, many children gradually become more comfortable speaking in various social situations. This case has a good prognosis because the child was detected at an early age and there is positive support from the parents.

Cognitive Behavioral Therapy (CBT) is recommended to address patient selective mutism through gradual exposure and positive reinforcement. Involvement of family members in therapy is crucial to support patient progress. Educational recommendations include considering a homeschooling approach with a focus on cognitive and problem-solving skills, or enrolling in a mainstream school with small class sizes and individualized support. A structured learning environment, predictable routines, and accommodations for non-verbal communication are advised to help patient adjust and succeed. Parental guidance emphasizes creating a supportive, pressure-free environment, while teachers are encouraged to build warm, supportive relationships and use low-pressure interaction techniques to facilitate patient participation and communication.

Medication for a child with selective mutism is usually considered when the condition greatly impacts their functioning and other treatments, such as behavioral therapy, have not worked. Since selective mutism is frequently linked to anxiety, selective serotonin reuptake inhibitors (SSRIs) may be prescribed to help alleviate anxiety symptoms. However, medication is usually seen as a secondary option, and the first-line treatment is often cognitive-behavioral therapy (CBT) or other therapeutic approaches. A thorough assessment by a mental health professional is essential to determine the best course of action tailored to the child's specific needs.

4. SUMMARY

Shyness and limited speaking ability, particularly with unfamiliar people, can indicate a specific developmental disorder like Selective Mutism. In this case, the diagnosis was made only when the child turned 14, despite the parents noticing developmental issues from an early age. This delay hindered the timely treatment that could have been beneficial. The case illustrates that delay diagnosis and treatment can lead to chronic difficulties, such as underdeveloped language skills. Although Selective Mutism is uncommon, it's essential for physicians to be vigilant in identifying it to ensure timely intervention and prevent complications associated with late treatment.

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14-YEAR-OLD MALE WITH SELECTIVE MUTISM – CASE REPORT

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14-YEAR-OLD MALE WITH SELECTIVE MUTISM – CASE REPORT

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ABSTRACT

Selective mutism is a rare anxiety disorder characterized by an individual's persistent inability to speak in particular social environments, such as at school or in public places, while being able to communicate effectively and comfortably in other environments, like at home or with close family and friends.¹ Selective mutism commonly manifests during early childhood, affecting approximately 0.2% to 0.8% of children, with a higher prevalence observed in preschool environments.² This disorder can profoundly disrupt a child's developmental trajectory, potentially leading to significant social and academic impairments if not addressed promptly.³ This case report explores the developmental and communication challenges faced by a 14-year-old teenage boy presenting with significant delays in social communication skills. Referred to a developmental facility due to concerns about his social interaction and communication abilities. Patient's symptoms and behaviors align with a diagnosis of Selective Mutism as defined by the DSM-V criteria. This study provides a detailed account of how parents facing difficulty in obtaining an accurate diagnosis, which ultimately impacts the appropriate management and treatment. Limitations in speaking in public are often interpreted as part of a child's shy and quiet personality. As a result, this can lead to delays in diagnosis and eventually affect his language skills. Good awareness from parents and professionals is needed for early detection. As a professional, the ability to make an accurate diagnosis is essential to provide appropriate interventions for better prognosis and prevent further complications.

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KATA KUNCI

- Selective mutism
- 14 years old child
- Diagnosis

1. INTRODUCTION

Selective mutism is a relatively rare but significant anxiety disorder that primarily affects children. It is characterized by a child's inability to speak in certain social situations despite being able to speak in other settings, such as at home.¹ Selective mutism affects approximately 1% of children.

The disorder typically manifests between the ages of 2 and 5 years old, with symptoms often becoming noticeable when a child starts school or enters new social settings. Selective mutism is somewhat more common in females than males. Studies suggest that the ratio of girls to boys affected by selective mutism is approximately 2:1.²⁻⁶ There is evidence that selective mutism may run in families, indicating a possible genetic component or familial pattern.⁷⁻⁸ Children who have selective mutism frequently experience additional issues like social anxiety disorder, speech and language difficulties, or developmental disorders. About half of these children also meet the criteria for social anxiety disorder.^{9-12,18} There is limited evidence suggesting that selective mutism might be more frequently identified in children from higher socioeconomic backgrounds due to increased access to healthcare services and early educational settings.^{4-5,9-10}

Despite being recognized in the psychiatry community for over a century, selective mutism is still a poorly understood condition that has not been extensively investigated. In this case, we see that the complaints exhibited by this teenage boy could be misleading to a different diagnosis and eventually lead to inappropriate interventions, which will ultimately affect the child's development, particularly in the area of communication skills. In this case report, we aim to discuss the development of a teenage male with selective mutism who was not diagnosed and treated until the age of 14. This case report examines his developmental history, clinical observations, and assessment outcomes to better understand his condition.

2. CASE REPORT

A 14 year-old male applied to our facility accompanied with his parents with concerns limitation in social communication based on teacher's report. He tends to be very quiet and shy at school and his behaviors impacted his academic and social performance at present¹⁷. Based on parent's report, he exhibited normal verbal communication at home but was almost non-verbal in school and social settings outside his immediate family. At home, he looked more comfortable talking to his parents and siblings.

Patient was born full-term through C-section delivery, weighing 3700 gram. Prenatal and postnatal period was normal. He has history of seizures and ear infection but no complication was reported. ¹¹ There was no history of head trauma or allergies. No history of long-term medication. His hearing test was reported to be within normal limits.

He was the second child in the family and has two other siblings who are 15 years old and 2.5 years old. ⁴ Patient always lives with his family and no traumatic experiences have been described. In family. There was not any pathology in his medical and neurological examination. There was no psychiatric disorder or speech-related disorder in his family history.

In term of his developmental history, he demonstrated typical motor development but significant delays in speech development. His first word emerged at the age of 2 years. By the age of 2, his parents started to feel that his speech development was delayed compared to other children his age. There was no history of problem in oromotor development as well as sensory processing development.

Due to parent's concern in the area of speech delay, he was first evaluated by pediatrician, who recommended providing him with stimulation. His parents then enrolled him in speech therapy and then discontinued after six months because patient had shown good progress. After that, no intervention was provided, and the patient was simply recognized as a shy child. At present, patient tends to speak only in short sentences, and instructions need to be given repeatedly in order to make him to speak especially in social settings.

Behaviorally, his parents report that patients tends to take a long time to adapt and seems shy. He is also reported to be reluctant to share his property with others. During the pandemic, he spent much time playing on devices.

Patient began his education at one of the private school and have been struggled academically since then. He was put into Individualized Learning Program when he was in junior high due to the ongoing academic and social interaction difficulties. His mother hired a private tutor, but communication issues persisted. An intelligence test was conducted and indicated a below-average intelligence with a significant discrepancy between verbal IQ (58) with performance IQ (82).

The examination conducted in our facility consists of clinical observation and psychometric evaluation. We also ask parents to send a video containing interactions between the child and parents.

Clinical observations revealed slow response times, and reluctance to engage with questions. He preferred simple tasks and exhibited anxiety and discomfort with new situations and new people. Despite appearing cooperative, He did not initiate conversation and tends to avoid eye contact. He only responded with nods or head shakes, or with very quiet verbal responses. Patient also appeared more unwilling to respond when there was more than one examiner in the observation room. In subtests that did not require a verbal response, he was more cooperative and followed instructions. However, during subtests that required patient to answer, he appeared to struggle, tended to rock his legs, or stared at the table for an extended period. When he struggled with verbal responses during the language test, the examiner adapted it by allowing him to circle answers instead.

Aside from our clinical observation, we also asked parents to record patient's activities at home. The video was recorded in a home setting where patient appears to be watching television with his sibling. In the video, he looks relaxed and not anxious at all. He is able to interact and communicate verbally with his sibling and father. He also answers questions posed by his father, although his responses are fairly brief (in the form of phrases). His way of responding is also considered quite natural, with appropriate intonation. We saw a notable discrepancy between his home and external behavior. During our observation, we did not find any repetitive behaviors typically associated with Autism Spectrum Disorder, nor did we observe any psychotic behaviors. In addition to the observation results, we also conducted a series of psychometric evaluations, including both questionnaire completion and standardized test such as language test, social skill test and cognitive test. Instruments used in this case were ¹⁰ Clinical Evaluation of Language Fundamentals-5th Edition, Oral and Written Language Scale-2nd Edition, Screening for Bahasa Indonesia, Social Skills Improvement System-Social Emotional Learning Edition and Weschler Intelligence Scale for Children-4th Edition.

The result from the psychometric evaluation showed that his language test results indicate a significant difference between his receptive and expressive abilities, understanding verbal information better than he can express himself. When subtests were administered in Indonesian, he performed better, suggesting he has a stronger command of that language. However, the overall score patterns were similar in both languages, with many scores still in the very low range. This highlights that patient's language difficulties persist regardless of the language used. Additionally, his lack of verbal responses in expressive tasks means his expressive language scores are not currently reflective of his true abilities.

The completion of the SSIS-SEL questionnaire by parents and teachers indicates that his scores fall in the below-average category compared to other children his age. Scores in this category suggest problems with overall social-emotional skills, particularly in the area of relationship skills. However, patient's self-assessment shows that his scores fall in the average category compared to his peers, indicating that he perceives his overall social-emotional skills as good. Nonetheless, he also feels that he struggles in the area of relationship skills.

Patient's overall cognitive abilities, as assessed by the WISC-IV, cannot be summarized by a single score due to his significantly better nonverbal reasoning compared to verbal reasoning. His verbal reasoning is in the Very Low range (VCI = 45), while his nonverbal reasoning is Average (PRI = 90). Both his working memory (WMI = 62) and processing speed (PSI = 50) are also in the Very Low range, indicating weaknesses in attention, concentration, and quick visual processing.

In summary, considering the developmental history, clinical observations, and psychometric assessments, we currently see that patient exhibits behaviors consistent with the characteristics of Social Anxiety Disorder, manifested in the form of Selective Mutism. The results of the assessment also indicate a possible Language Disorder. Given patient's limitations in responding to expressive tasks, further examination (after improvement in the condition of Selective Mutism) is necessary to obtain a clearer picture of his expressive language abilities and cognitive profile, particularly in the area of Verbal Comprehension.

3. DISCUSSION

Patient's symptoms and behaviors align with a diagnosis of Selective Mutism as defined by the DSM-V criteria, which describes a ³ consistent failure to speak in specific social situations despite speaking in other contexts. The disturbance interferes with educational or occupational achievement or with social communication. The duration of disturbance is at least 1 month and the failure of speak is not attributable to lack of knowledge of, or comfort with, spoken language required in the social situation. The disturbance is not better explained by a communication disorder and does not occur exclusively during the course of Autism Spectrum Disorder, Schizophrenia, or another psychotic disorder.

In our patient, his reluctance to speak in clinical settings compared to his more interactive behavior at home highlights the influence of environmental context on his communication. This condition has been observed for years, since he was in elementary school. The clinical observations of patient being tense, anxious and unresponsive, contrasted with his more relaxed behavior at home. No sign of repetitive behaviors typically associated with Autism Spectrum Disorder, nor did we

observe any psychotic behaviors. Psychometric evaluation suggest problems with overall social-emotional skills, particularly in the area of relationship skills. Language test shows a significant difference between his receptive and expressive abilities, understanding verbal information better than he can express himself. Cognitive test indicating that his significantly better nonverbal reasoning compared to verbal reasoning. In summary, this patient ⁴met the diagnostic criteria for selective mutism according to the Diagnosis and Statistical Manual of Mental Disorder (DSM) fifth edition.

Regarding his language ability at present, we found that the patient's language skills fall below average when compared to other children his age. Based on a review by Viana et al, the study conclude that ²receptive and expressive language skills may vary in children with selective mutism. Its also stated that ²expressive–receptive and receptive language disorders may coexist with selective mutism.¹³ Some children with selective mutism with average receptive language abilities may demonstrate shorter, less detailed, and more linguistically simplistic narratives.¹⁴ ²These subtle deficits in expressive language are theorized to be a compilation of anxiety, mild language deficits, and lack of experience with high-level language skills. Study by Steinhausen et.al ⁸suggests that many children with selective mutism have premorbid speech and language problems (38%).¹⁵

In ²this case, there are several factors that may underlie the results. The first is the patient's reluctance to provide verbal responses, which can indirectly affect the test outcomes. ²A child with selective mutism might not be able to participate in formal evaluation activities, and they may lack verbal responses and use nonverbal responses (e.g., pointing or gesturing). This finding is exactly found in this case. The underlying cause is a lack of language development in line with age progression, due to the patient's tendency to refuse communication with people he perceives as unfamiliar. Without an accurate diagnosis, the patient has not received appropriate therapy, which will eventually impact his language development.

In this case, over the past 14 years, no diagnosis was established, and the parents were only advised to provide stimulation. The patient was merely perceived as a shy child when asked to speak in social settings. The cognitive test results, showing that his non-verbal development is significantly better than his verbal reasoning development, indicate that this communication difficulty is not due to an intellectual disability. However, the results also show that his language-related reasoning skills have not developed as expected. Untreated selective mutism can lead to impaired functioning and increase the risk of other psychiatric disorder.¹⁶

The prognosis for a child with selective mutism is generally positive, especially with early intervention. Many children can overcome selective mutism with appropriate treatment, which often includes behavioral therapy, such as cognitive-behavioral therapy (CBT).

Factors that can influence the prognosis include the child's age, the duration and severity of the mutism, the presence of comorbid conditions (like anxiety disorders), and the support available from parents and teachers. With effective treatment and support, many children gradually become more comfortable speaking in various social situations. This case has a good prognosis because the child was detected at an early age and there is positive support from the parents.

Cognitive Behavioral Therapy (CBT) is recommended to address patient selective mutism through gradual exposure and positive reinforcement. Involvement of family members in therapy is crucial to support patient progress. Educational recommendations include considering a homeschooling approach with a focus on cognitive and problem-solving skills, or enrolling in a mainstream school with small class sizes and individualized support. A structured learning environment, predictable routines, and accommodations for non-verbal communication are advised to help patient adjust and succeed. Parental guidance emphasizes creating a supportive, pressure-free environment, while teachers are encouraged to build warm, supportive relationships and use low-pressure interaction techniques to facilitate patient participation and communication.

Medication for a child with selective mutism is usually considered when the condition greatly impacts their functioning and other treatments, such as behavioral therapy, have not worked. Since selective mutism is frequently linked to anxiety, ⁷selective serotonin reuptake inhibitors (SSRIs) may be prescribed to help alleviate anxiety symptoms. However, medication is usually seen as a secondary option, and the first-line treatment is often cognitive-behavioral therapy (CBT) or other therapeutic approaches. A thorough assessment by a mental health professional is essential to determine the best course of action tailored to the child's specific needs.

4. SUMMARY

Shyness and limited speaking ability, particularly with unfamiliar people, can indicate a specific developmental disorder like Selective Mutism. In this case, the diagnosis was made only when the child turned 14, despite the parents noticing developmental issues from an early age. This delay hindered the timely treatment that could have been beneficial. The case illustrates that delay diagnosis and treatment can lead to chronic difficulties, such as underdeveloped language skills. Although Selective Mutism is uncommon, it's essential for physicians to be vigilant in identifying it to ensure timely intervention and prevent complications associated with late treatment.

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