International Journal of Interdisciplinary Medical Sciences

VOL. 2 • ISSUE 1 • JUNE - JULY 2026

International Journal of Interdisciplinary Medical Sciences (IJIMS)

eISSN: 3139-3071

ORIGINAL RESEARCH ARTICLE

Received : 2 Oct 2026

Revised : 20 Oct 2026

Accepted : 10 Nov 2026

Published : 14 Nov 2026

MANAGEMENT OF ADULT-ONSET SELECTIVE MUTISM WITH AYURVEDA: A CASE REPORT

Dr. Punith P [1], Dr. Priyadarshini [2]

1. *Assistant Professor, Department of PG Studies in Manovijnana Evum Manasaroga, Shri Dharmasthala Manjunatheshwara College of Ayurveda, Hospital and Research Centre, Udupi, Karnataka*
2. *PG Scholar, Department of PG Studies in Manovijnana Evum Manasaroga, Shri Dharmasthala Manjunatheshwara College of Ayurveda, Hospital and Research Centre, Udupi, Karnataka*

ABSTRACT

Selective Mutism (SM) is a childhood-onset anxiety disorder characterised by persistent failure to speak in specific social settings despite normal language ability and comprehension, with a prevalence of approximately 1 in 140 children; presentation in adulthood is rare.[1] Neurobiological studies implicate dysregulation of the amygdala-driven fear response in the inability to initiate speech in select contexts.[2]

This case report describes the clinical presentation, differential diagnosis, and integrative Ayurvedic management of a 37-year-old male with adult-onset selective mutism precipitated by interpersonal trauma and compounded by subsequent bereavement. The patient had no prior history of speech or social-communication difficulty and remained undiagnosed and untreated for an extended period before presentation.

Management combined Ayurvedic psychopharmacological intervention (Dosha-pratyanika and Vyadhi-pratyanika Chikitsa), Panchakarma procedures, and psychotherapeutic support through Sattvavajaya Chikitsa, delivered across three inpatient admissions and regular outpatient follow-up over approximately ten months. Serial Hamilton Anxiety Rating Scale (HAM-A) assessments showed a reduction in total score from 36 (first admission) to 12 (most recent follow-up), a 66.7% reduction, corresponding with clinically observed resumption of verbal communication across multiple contexts, improved social participation, and return to stable occupational functioning.

This case highlights the need for systematic differential diagnosis when selective mutism presents atypically in adulthood, and illustrates a structured, multimodal Ayurvedic approach to its management.

Corresponding Author

Name: Dr. Punith P. [1], Assistant Professor, Department of PG Studies in Manovijnana Evum Manasaroga

Institution: Shri Dharmasthala Manjunatheshwara College of Ayurveda, Hospital and Research Centre, Udupi, Karnataka

punith.p36@sdmayurvedacollegeudupi.in

Phone: 8310726683

KEYWORDS - Selective mutism, Mukatvam, Adult-onset, Ayurveda management, Hamilton Anxiety Rating Scale

INTRODUCTION

Selective Mutism (SM) was first described by German physician Kussmaul in 1877 as "Voluntary Aphasia," referring to individuals who could speak but remained silent in specific situations.[3] In 1934, Tramer introduced the term "Elective Mutism," which remains in the ICD-10 classification. Subsequent research by Carbone et al. established SM as an anxiety disorder with distinct social deficits.[3]

SM was previously classified under neurodevelopmental disorders owing to symptom overlap with Autism Spectrum Disorder (ASD). It was later reclassified as an anxiety disorder in DSM-5 (2013), reflecting its underlying pathophysiology. It typically manifests as a persistent inability to speak in select social contexts, emerging between ages 2 and 5. Though considered rare, SM is increasingly recognised as underdiagnosed, affecting approximately 1 in 1000 individuals.[4]

Although SM typically emerges in early childhood, isolated reports describe new-onset or re-emergent mutism in adults following acute psychological trauma, severe bereavement, or profound anxiety exposure, in the absence of a childhood history of the disorder. The present case is one such presentation: the patient had no documented history of speech or social-communication difficulty prior to 2016 and had functioned normally in occupational and interpersonal domains until a discrete anxiety-provoking event precipitated progressive withdrawal and mutism. This trajectory -- new-onset mutism in a previously asymptomatic adult, temporally linked to identifiable psychosocial stressors -- distinguishes the case from developmental SM and is examined further under Differential Diagnosis and Discussion.

Because this report describes a multimodal treatment protocol delivered concurrently, it emphasises descriptive, quantifiable outcome measures (HAM-A scores and documented functional milestones) rather than attributing improvement to any single intervention; this constraint is discussed further under Limitations.

CASE REPORT

Patient Information

The subject of this case report is a 37-year-old male who exhibited a gradual and progressive decline in verbal communication and daily functioning. Initially, the patient ceased communication with his immediate family members, followed by withdrawal from all social interactions. Over time, he reduced his food intake, remained inactive and confined to bed for extended periods, and eventually developed pressure sores. A weight loss of approximately 10--15 kilograms was observed over one year, bringing his body weight down from 57 to 42 kilograms.

According to the primary informant (a close family member) who provided the history owing to the patient's inability to communicate, the onset of his psychological disturbance began in 2016, during which time he was employed and functioning well in daily life. That year, he experienced a distressing encounter with law-enforcement authorities that left him visibly shaken and appeared to initiate a persistent fear response, particularly toward authority figures and public spaces, which gradually contributed to his social withdrawal.

Around the same period, an interpersonal conflict added to his sense of threat and further deepened his withdrawal from social interaction. Since then, he has reportedly demonstrated heightened anxiety, avoidance behavior, and an unwillingness to communicate with anyone outside his immediate environment.

His condition further deteriorated following the death of his father in March 2024, with whom he shared a close emotional bond. A concurrent family health crisis added to his emotional burden. These life stressors appear to have contributed to a gradual decline in his psychological functioning.

Despite the chronicity of his condition, comprehensive medical evaluation including brain imaging (MRI) revealed no neurological abnormalities, ruling out organic mental disorders. The patient continued to demonstrate severe depressive symptoms, profound social withdrawal, and selective mutism.

Based on the clinical presentation and detailed history provided by the informant, a diagnosis of selective mutism with unresolved psychological trauma and secondary depressive features, situated within the anxiety-spectrum disorders, was considered (see Differential Diagnosis).

The patient approached us in mid-2024, approximately three months after the death of his father. An integrative treatment approach was initiated, comprising Ayurvedic psychopharmacological interventions -- specifically Dosha-pratyanika and Vyadhi-pratyanika Chikitsa -- in combination with structured psychotherapeutic support through Sattvavajaya Chikitsa. Treatment aimed to address his mutism, anxiety, and depressive symptomatology within a holistic framework.

CLINICAL FINDINGS

A detailed psychiatric assessment was conducted based on information from both the patient and caregiver. He exhibited markedly reduced eye contact, absence of social smile, and minimal non-verbal communication. Throughout the assessment, he remained silent, showed limited spontaneous movement, and did not engage with the examiner or surroundings. His affect was blunted, facial expression flat, and there were no signs of overt psychosis, catatonia, or neurological deficit. A Mini-Mental Status Examination (MMSE) was administered, yielding a total score of 18/30, indicative of moderate cognitive and psychological impairment at presentation (see Limitations regarding interpretation). In conjunction with his behavioural presentation, the overall clinical picture was suggestive of severe social withdrawal, consistent with a diagnosis of selective mutism likely situated within the spectrum of anxiety- or trauma-related disorders.

MENTAL STATUS EXAMINATION [5]

General Appearance and Behavior: The patient appeared lean with minimal self-care; fearful and less cooperative with the examiner, showing grade-5 comprehension and insight. Gait and posture were normal and motor activity within normal limits. Social interaction was completely impaired and rapport with the examiner was less casual, appearing stupors.

Speech: Rate and quantity of speech were minimal (absence of speech i.e mutism); volume and tone were decreased.

Mood and Affect: The patient exhibited a sad mood (melancholy).

Thought: Could not be elicited due to mutism and stupor, though stream and form of thought appeared disturbed, as the patient exhibited fear.

Perception: Could not be elicited due to mutism.

Cognition: Consciousness was clouded but orientation to time, place and person remained intact. Attention was poor, concentration reduced, and memory partially impaired.

Insight: Present.

Judgment: Impaired.

MANA PARIKSHA [6] -- VARIANTS OF ASHTAVIBRAMA

Manas -- Atichinthana (excessive thinking): excessive or obsessive thinking leading to mental confusion, anxiety, and inability to focus on the present moment.

Buddhi -- Nishchayathmikatwa affected (uncertainty): difficulty in making decisions.

Samjna jnana -- confused or distorted perception, making it difficult to distinguish reality from imagination.

Smruthi -- Ayathavatha smarathi (negative thoughts): could not be elicited due to mutism.

Bhakti -- Anichha (loss of desire in previous pleasures): loss of interest in activities.

Sheela -- change in basic daily routine, hygiene, eating and sleeping pattern.

Cheshta -- decreased psychomotor activity; slowed movement.

Achara -- loss of interest in cultural and spiritual practices.

DIFFERENTIAL DIAGNOSIS

Given the atypical adult presentation, selective mutism was differentiated from the following conditions, using the findings above:

Major Depressive Disorder (MDD). The patient exhibited sad mood, anhedonia (Bhakti--Anichha), psychomotor slowing (Cheshta), and significant weight loss -- features that overlap with MDD. However, mutism was the earliest and most dominant presenting feature, and the patient initially retained non-verbal engagement with family before global withdrawal occurred, a pattern more consistent with an anxiety-mutism spectrum presentation than with primary MDD-related psychomotor retardation. Depressive features were therefore considered secondary to, rather than the primary driver of, the clinical picture.

Social Anxiety Disorder (SAD). Marked fear of social and evaluative situations was present and is a recognised core feature shared with SM; up to 97--100% of SM cases co-occur with social anxiety, with comorbid anxiety reported in as many as 80% of adults with SM. Because mutism was near-total across virtually all social contexts rather than confined to performance- or evaluation-based situations, a primary diagnosis of SM with comorbid social anxiety was favoured over SAD alone.

Trauma- and stressor-related disorders (e.g. PTSD, Adjustment Disorder). The temporal relationship between an identifiable distressing event, subsequent bereavement, and symptom onset raised the possibility of a trauma-related aetiology. Core re-experiencing symptoms (intrusive memories, flashbacks, and nightmares) could not be positively elicited because of the patient's mutism, and no collateral history confirmed them. This is acknowledged as an assessment limitation rather than a confirmed exclusion, and a trauma-related contribution cannot be fully ruled out.

Psychotic disorder. This was considered given the profound withdrawal and reduced responsiveness, and differentiated on the basis of intact orientation to time, place and person; absence of catatonic signs (normal gait, posture and motor activity); absence of observed bizarre behavior; and an informant-reported history of a clear psychosocial precipitant with a progressive rather than acute-psychotic course. Formal thought content (delusions, hallucinations) could not be directly elicited due to mutism; this is likewise acknowledged as an assessment limitation rather than definitive evidence against a psychotic process.

On balance, the clinical picture -- progressive, context-spanning mutism precipitated by discrete psychosocial trauma and bereavement, with preserved insight, intact sensorium, and absence of psychotic or catatonic signs -- was considered most consistent with selective mutism within the anxiety-spectrum, with secondary depressive features.

DIAGNOSTIC ASSESSMENT

The Hamilton Anxiety Rating Scale (HAM-A), Mental Status Examination, and Mana Pariksha assessment revealed significant derangement across cognitive, emotional and behavioural domains. The Hamilton scale was used given that selective mutism is categorised under anxiety disorders, providing a relevant measure of anxiety severity.[7] Scores were recorded at the first inpatient admission (01/05/2024) as the initial assessment, and repeated at the most recent structured follow-up (07/03/2025).

Sl. No.	Component	Initial assessment (01/05/2024)	Follow-up assessment (07/03/2025)
1	Anxious mood	4	1
2	Tension	3	1
3	Fear	5	2
4	Insomnia	3	0
5	Difficulty in concentration and memory	4	2
6	Depressed mood	5	2
7	General somatic symptoms (Muscular)	3	1
8	General somatic symptoms (Sensory)	3	1

9	Cardiovascular symptoms	1	0
10	Respiratory symptoms	0	0
11	Gastro-intestinal symptoms	2	1
12	Genito-urinary symptoms	0	0
13	Other autonomic symptoms	1	0
14	Behaviour during interview	2	1

Sl. No.	**Component**	**Initial assessment (01/05/2024)**	**Follow-up assessment (07/03/2025)**
	Total score	36	12

Total HAM-A score reduced from 36 to 12 - a 66.7% reduction - providing objective, data-based support for the degree of clinical improvement described in this report.

TIMELINE

Date	Event
2016	Onset of psychosocial stressor; gradual withdrawal and reduction in communication begins
2016 onward	Progressive decline in food intake, mobility and self-care; development of pressure sores
Mar 2024	Death of father; further clinical deterioration
Mid-2024	Presentation for Ayurvedic evaluation; integrative treatment initiated
01/05/2024 - 21/05/2024	1st IPD admission - initial MSE, MMSE and HAM-A assessment; Panchakarma and Shamanoushadhi initiated
June 2024 - Jan 2025	Regular OPD follow-up with titration of oral medication
~2 months post 1st admission	Early psychosocial engagement - social smile, intermittent eye contact, minimal verbal response to treating physician
09/09/2024 - 16/09/2024	2nd IPD admission
~ 6 months post 1st admission	Gradual speech with therapist and family begins; reduced fear/anxiety reported
~ 8 months post 1st admission (~Jan 2025)	Marked improvement - cooperative, communicative, engaged with postgraduate students during history-taking

Date	Event
07/03/2025 - 14/03/2025	3rd IPD admission - Vaitarana and Hapushadi Yapana Basti, Seka, Takradhara, and Tibetan-music-assisted relaxation
Final follow-up (~3 months prior to report)	Stable local employment; sustained verbal communication across settings; HAM-A total score 12

THERAPEUTIC INTERVENTION

Treatment combined Panchakarma procedures, oral Shamanoushadhi (pacifying medication), and Sattvavajaya Chikitsa (supportive psychotherapy and relaxation techniques), delivered across three inpatient admissions and interim outpatient visits. Exact per-session duration, number of sittings, and post-procedure (Paschat Karma) schedules for each Panchakarma procedure are not fully itemised in the case records reviewed for this report and are noted as a reporting gap under Limitations; treating physicians are advised to document these parameters in full for future case reports.

PANCHAKARMA AND ADJUNCT PROCEDURES BY ADMISSION

1st Admission (01/05/24 -21/05/24)	2nd Admission (09/09/24 - 16/09/24)	3rd Admission (07/03/25 - 14/03/25)
Vaitarana Basti Shirodhara with Yashtimadhu Kwatha Takradhara Sarvanga Abhyanga with Mahanarayana Taila Taladhara with Kachuradi churna + Himasagara taila Hapushadi Rajayapana Basti	Sarvanga Abhyanga with Mahanarayana Taila Hapushadi Rajayapana Basti Takradhara	Hapushadi Yapana Basti Seka with Yashtimadhu + Haridra Takradhara Guided relaxation with Tibetan music (morning and evening)

PROCEDURE RATIONALE

Hapushadi Yapana Basti is a nourishing medicated enema indicated for vata-predominant conditions; it promotes buddhi, medha, agni and bala, supporting cognitive function, digestion, vitality, and balancing vata while rejuvenating systemic strength.[9]

Vaitarana Basti was administered using Gomutra, Ardraka, Saindhava and Taila. Since manas functions under the influence of Raja and Vata Dosha, Vaitarana Basti, with its tikshna, ushna and vatanulomana properties, pacifies deranged vata and its aggravation, helping normalise manasika vikara. Modern studies on the gut-brain axis support this mechanism, aligning with koshta shuddhi and srotoshodhana indirectly reducing toxic burden on the nervous system.[10] Sarvangabhyanga employed medicated oils such as Mahanarayana taila for systemic vata alleviation. Shirodhara was performed with Yashtimadhu Kwatha for calming the mind and stabilising manas. Taladhara used Kachuradi churna and Himasagara taila for cooling and enhancing sensory balance.

ADJUNCT RELAXATION THERAPY

Guided relaxation sessions using Tibetan singing-bowl music were incorporated during the third admission, administered in the morning and evening as an adjunct to Ayurvedic psychopharmacotherapy and Sattvavajaya Chikitsa. Through harmonic overtones and meditative rhythms, such music-based interventions have been shown in observational studies to reduce tension and enhance well-being,[8] and were used here to support autonomic balance and anxiety reduction alongside the primary Ayurvedic protocol.

ORAL MEDICATION (SHAMANOUSHADHI) - 1ST ADMISSION

Medicine	Dosage
Tab. Tagara	0-0-2
Saraswatarishta	15ml-15ml-15ml
Ashwagandharishta	10ml-10ml-10ml
Sarpagandha Vati	1/2-1/2-1/2
Apatantraka Vati	1-1-1

Medicine	Dosage
Panchakola Phanta + Yashtimadhu Kwatha + Ashwagandha Kwatha	30ml-30ml-30ml
Kalyanataka Gritha + Hingwachadi churna	5ml + 1 pinch respectively
Shankhapushpi Syrup	10ml-10ml-10ml

OPD VISITS, 07/06/2024 -- 30/01/2025 (MEDICATION TITRATION SUMMARY)

Visit date	Medicines (dosage)
7/6/2024	Tab. Tagara (0-0-2); Saraswatarishta (10-10-10ml); Manasamitra Vati (1-0-1); Brahmi Ghritha (5ml at 9am & 6pm); Shankhapushpi Syrup (10-10-10ml)
21/06/2024	Manasamitra Vati (1-1-1); Kalyanaka Ghritha (5ml at 6am & 6pm); Ashwagandharishta (10-10-10ml)
13/07/2024	Manasamitra Vati (1-1-1); Kalyanaka Ghritha (5ml at 6am & 6pm); Ashwagandharishta (10-10-10ml); Shankhapushpi Syrup (10-10-10ml); Tab. Tagara (0-0-
30/07/2024	As above, plus Himasagara taila for external scalp application
7/8/2024	As above, plus Panchakola Phanta (15ml at 6am & 6pm)
23/10/2024	Manasamitra Vati (1-0-1); Shankhapushpi Syrup (10-0-10ml); Kalyanaka Ghritha (5ml at 6am & 6pm); Panchakola Phanta (15ml at 6am & 6pm); Balarishta
27/11/2024	Kaishora Guggulu (2-2-2); Shankhapushpi Syrup (10-10-10ml); Kalyanaka Ghritha (5ml at 6am & 6pm); Panchakola Phanta (15ml at 6am & 6pm); Balarishta
31/12/2024	Shankhapushpi Syrup (10-10-10ml); Tab. Tagara (0-0-1)
30/01/2025	Shankhapushpi Syrup (10-10-10ml); Tab. Tagara (0-0-1); Ashwagandharishta (10-0-10ml)

ORAL MEDICATION (SHAMANOUSHADHI) -- 2ND ADMISSION (09/09/2024--16/09/2024)

Medicine	Dosage
Manasamitra Vati	1-0-1
Saraswatarishta	0-0-20ml
Brahmi Ghritha with 1 pinch Hingwachadi churna	10ml at 9am & 6pm
Shankhapushpi Syrup	10-10-10ml

MEDICINES ADVISED ON DISCHARGE (2ND ADMISSION)

Medicine	Dosage
Tab. Tagara	0-0-1
Saraswatarishta	0-0-20ml
Shankhapushpi Syrup	10-10-10ml
Manasamitra Vati	1-0-1
Panchakola Phanta (freshly prepared)	50ml at 6am & 6pm
Mahapaishachika Ghritha with Hingwachadi churna	10ml at 6am & 6pm
Freshly prepared kashaya of Jatamansi churna (20g) + Ashwagandha churna (20g) + Vacha churna (10g) + Brahmi churna (25g) + Shunti churna (10g) + Yashtimadhu churna (15g)	30ml at 6am & 6pm

RESULT

At initial admission, the patient exhibited severe social withdrawal, mutism, significant weight loss, and physical complications including pressure sores. He was started on Ayurvedic psychopharmacological treatment, supportive psychotherapy, and relaxation techniques. During the first phase of treatment, although there was no significant improvement in verbal communication, the patient showed mild progress in his overall condition: physical symptoms improved, appetite slightly increased, and he began responding to basic non-verbal cues, though mutism persisted.

At the two-month follow-up, early signs of psychosocial engagement were observed: a social smile, intermittent eye contact, and minimal communication with the treating physician, indicating the beginning of emotional responsiveness and a reduction in previously rigid withdrawal.

Over the next six months, with continued medication, individual counselling, and family therapy, the patient began to speak gradually with the therapist and family, and reported reduced fear and anxiety. Although residual feelings of hopelessness were reported, he showed increased interest in daily activities, particularly computer-based work and typing-related tasks.

In 2025, approximately eight months after the initial admission, the patient was readmitted for follow-up treatment. At this stage, marked improvement was observed: he was cooperative, communicative, and engaged actively with postgraduate students during history-taking, demonstrating improved social interaction, initiating conversations, and participating in family and community gatherings.

At the most recent follow-up, three months prior to completion of this report, the patient had secured stable local employment.

He had resumed regular daily functioning, continued engaging in social and occupational activities, and maintained verbal communication across various settings. Though minor elements of emotional vulnerability remained, the overall progress indicated substantial recovery and reintegration into functional life.

DISCUSSION

This case illustrates an exceptionally rare presentation: a 37-year-old adult male with late, persistent selective mutism (SM), precipitated by interpersonal trauma and compounded by grief and environmental stressors. Despite the classic onset of SM in early childhood (typically ages 2--5), our patient first displayed full clinical features in adulthood, having received no prior intervention for the condition. This aligns with emerging literature showing that undiagnosed or unresolved SM can persist into, or newly develop in, adulthood following trauma, life transitions, or severe anxiety exposure. Population estimates place lifetime SM prevalence between 0.2% and 1%, with most data focused on children.

Since DSM-5 formally reclassified SM under Anxiety Disorders, following evidence that it shares core neurobehavioural features with social anxiety and avoidance behaviour, this patient's presentation -- heightened amygdala-driven fear, social withdrawal, and mutism across nearly all contexts -- reinforces the current nosology, and is consistent with the differential-diagnostic reasoning set out above. Up to 97--100% of SM cases co-occur with social anxiety, and comorbid anxiety as high as 80% has been reported in adults with SM. This condition in Ayurveda can be correlated with Mukatvam (Mandavachanam), meaning diminished speech or speechlessness.[11]Mukatva has been described in classical texts in diverse terms, including Vakrahitha,[12] Vachanarahitha or Avachana,[13] and Avaktvam.[14]

LIMITATIONS

This report has several limitations that should inform interpretation of the outcome. First, the patient received multiple concurrent Ayurvedic interventions -- psychopharmacological formulations, Panchakarma procedures, and Sattvavajaya-based psychotherapy -- throughout treatment. As with most integrative case reports, this design does not allow the effect of any single intervention to be isolated; observed improvement should be attributed to the combined protocol rather than to any one therapy.

Second, a repeat Mini-Mental Status Examination was not performed at follow-up. The initial score of 18/30 may reflect a combination of impaired attention and concentration secondary to severe anxiety and depressive stupor rather than a primary cognitive disorder; this could not be confirmed without serial cognitive assessment, which is recommended in future case documentation.

Third, several diagnostic considerations (intrusive trauma symptoms, formal thought content) could not be directly elicited because of the patient's mutism, and were assessed indirectly through caregiver history and behavioural observation; this is an inherent constraint of evaluating a mute patient rather than a methodological oversight, but it limits certainty in excluding trauma-related and psychotic differentials.

Fourth, reported functional and occupational recovery, while substantial and corroborated by the quantitative reduction in HAM-A score, was assessed clinically rather than through standardised quality-of-life or functional-outcome instruments. Given these limitations and the inherent constraints of a single case report, the findings should be regarded as hypothesis-generating rather than confirmatory of causal efficacy, and future studies should validate this integrative model using standardised speech, anxiety, and quality-of-life metrics, compared against conventional pharmacotherapy or standard psychotherapeutic approaches.

PATIENT PERSPECTIVE

Owing to the severity of his mutism at presentation, the patient was unable to provide a first-person account of his experience during the early phase of treatment, and history was obtained through his caregiver. As verbal communication gradually returned, he reported reduced fear and anxiety and described renewed interest in daily and occupational activities; residual feelings of emotional vulnerability were also acknowledged by the patient at follow-up.

INFORMED CONSENT

Written informed consent was obtained from the patient for publication of this case report and the accompanying clinical details, once he had regained the capacity to communicate and understand the nature of the disclosure; consent for the earlier period of illness, during which he was unable to communicate, was obtained from his legal representative. Identifying details not essential to the clinical narrative (including specific incident details, place of employment, and details of family members' health) have been omitted or generalized to protect patient confidentiality.

CONCLUSION

Adult-onset selective mutism (SM), though rare, may emerge following trauma, grief, or overwhelming anxiety even after decades of verbal fluency. At admission, the patient presented with severe social withdrawal, mutism, significant weight loss, and complications from immobility including pressure sores. By the two-month follow-up, he showed modest physical recovery and emerging non-verbal responsiveness. In this case, integrative therapy -- combining Ayurvedic psychopharmacology (medhya rasayanas such as Brahmi and Ashwagandharishta, among others), supportive psychotherapy including relaxation techniques, and family counselling -- was associated with a phased transformation: within two months, the patient regained appetite and non-verbal engagement; over six months he began speaking with family and therapists; and by eight months he showed substantial social integration, including participation in family and community gatherings, stable local employment, and sustained verbal interaction, corroborated by a 66.7% reduction in total HAM-A score. Minimal residual vulnerability remained.

This progression, and the differential-diagnostic reasoning set out above, underscore that structured, culturally congruent integrative care -- emphasizing anxiety regulation before graded exposure -- can be associated with substantial functional and occupational recovery in adult SM. Given the limitations discussed, future studies should validate this model using standardized speech, anxiety, and quality-of-life metrics, and compare it with conventional psychotherapy or pharmacotherapy.

Acknowledgements -- None

Conflict of Interest -- None declared

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