

Assessment Of Dangerousness Complicated By Mutism Associated With Psychosis

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Citation

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Abstract

Mutism, or the absence of speech, is known to have a wide range of etiologies in medicine, neurology and psychiatry. More narrowly defined as “organic or functional absence of the faculty of speech” (1), mutism has been described as a presenting symptom in psychiatric disorders such as Major Depressive Disorder, catatonic states, Conversion Disorder, Anxiety disorders, Acute Adjustment disorders, and some personality disorders (1,2). We present a case in which mutism was a complicating factor in the assessment and treatment of a patient with psychosis, for whom the assessment of dangerousness was especially important but difficult to complete with confidence.

INTRODUCTION

Mutism, or the absence of speech, is known to have a wide range of etiologies in medicine, neurology and psychiatry. More narrowly defined as “organic or functional absence of the faculty of speech” (1), mutism has been described as a presenting symptom in psychiatric disorders such as Major Depressive Disorder, catatonic states, Conversion Disorder, Anxiety disorders, Acute Adjustment disorders, and some personality disorders (1,2). We present a case in which mutism was a complicating factor in the assessment and treatment of a patient with psychosis, for whom the assessment of dangerousness was especially important but difficult to complete with confidence.

CASE

A 35 year old white male was found by the police under a bridge acting suspiciously. On questioning, the patient did not speak but wrote that he was being followed, was receiving subliminal messages in newspapers and that he was concerned about intent by “others” to keep bombs in the holes in the train tracks. He reported, again in writing, that he was born in Russia, was mute since birth due to an unspecified defect, that he had no psychiatric history and no local contacts. His medical workup, including urine toxicology, was unremarkable. A CT scan of the brain was normal. An ENT consult noted intact vocal cords. There was no history to suggest seizures, substance abuse or a mood disorder. The patient on admission was prescribed risperidone 2mg/day for 3 days after which he refused

medications. One week after hospitalization, he requested to be discharged. An administrative hearing was convened to ascertain the patient’s dangerousness, given his apparent preoccupation with bombs under the train track. It was determined that he was not an acute danger to himself or others. The patient was discharged to a shelter and given a follow-up out-patient appointment.

One week later, the patient was re-admitted to another psychiatric hospital under a different name. He was initially brought to the second ER after cutting his wrist. While awaiting his evaluation he eloped from the ER by climbing a fence and heading into heavy traffic on an adjacent highway. He was pursued by hospital security and was safely returned to the hospital for inpatient admission. By chance, the patient was recognized by the psychiatrist who had treated the patient during the previous hospital admission. He again indicated that he could not speak. He was evaluated by a sign language interpreter who determined that the patient could not understand American Sign Language. His writings revealed that he was profoundly thought disordered and had a number of delusional beliefs. He was prescribed antipsychotic medication which he refused. He was taken to court, where his retention was upheld and he was ordered to receive involuntary medication. He was then given a trial of risperidone 4 mg/day for 2 weeks with partial clinical response evidenced by a decrease in thought disorder and delusional beliefs in his writings. To improve response the patient was switched to aripiprazole, titrated to 30 mg/day.

One week later the patient began to speak. Subsequent interviews revealed a long psychiatric history which included treatment with lithium carbonate and aripiprazole, jumping off a bridge, multiple hospital admissions, paranoia, wandering, racing thoughts, grandiosity, and delusions of persecution, with impaired insight, judgment and poor adherence. The patient was later transferred to a State hospital for

DISCUSSION

The decision to civilly commit a patient is based on a “dangerousness” standard in almost every state (3). This is important in protecting patients’ rights. However, there has been increased focus on the often countervailing need of a patient to be expeditiously treated and, indeed, the American Psychiatric Association has proposed moving away from the “dangerousness” standard to a “need-for-treatment-based” standard (3). In everyday practice, doctors in emergency departments must make the initial decision as to whether or not to involuntarily commit a patient, balancing dangerousness, need for treatment and upholding patients’ rights (3). In making this decision, they are best guided by their assessment of the immediacy of dangerousness based on the presenting complaints, examination, past history, and collateral information.

In the case presented here, the clinicians’ ability to fully assess the immediacy of dangerousness was complicated by the patient’s mutism. Based on the clinical information available at the first hospitalization, the clinician assessed

the patient as not imminently dangerous. As the patient’s condition deteriorated from the first hospitalization to the second, dangerousness, in this case manifested as self harm, was able to be observed in the patient’s behavior. Had the patient been able to speak at the time of the first hospitalization, it is likely that a more complete and accurate assessment could have been made. Some authors have reported mutism present in psychotic decompensation (4,5). Clinicians in acute care psychiatric settings should consider psychosis as a possible etiology of mutism, when no organic explanation can be found. Increased awareness of this presentation may facilitate better clinical and legal assessments and prompt treatment, reducing patient suffering and risk of dangerous behavior.

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