

Selective mutism

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Selective Mutism (SM)

Primary Disciplinary Field(s): Clinical Psychology; Child Psychiatry; Speech-Language Pathology

1. Core Definition and Diagnostic Criteria

Selective Mutism (SM) is a childhood anxiety disorder characterized by a consistent failure to speak in specific social situations where there is an expectation for speech (e.g., school, public), despite speaking comfortably and fluently in other settings (e.g., at home with immediate family). This behavior is not due to willful defiance, but rather an inability driven by intense social anxiety associated with the pressure to communicate verbally. Historically, SM was sometimes mistakenly referred to as "elective mutism," a term that inaccurately implied choice or oppositional behavior.

The formal diagnosis of SM is outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). The key criteria emphasize the situational specificity of the failure to speak and the resulting functional impairment. Crucially, the disorder must persist for at least one month beyond the initial adjustment period (e.g., the first month of school) and cannot be better explained by a lack of knowledge of the spoken language or by a primary communication disorder.

2. Prevalence and Epidemiology

Selective Mutism is considered a relatively rare disorder, although rates have been revised upwards in recent decades due to improved awareness and standardized diagnostic methods. Early estimates were often below 0.1%, but contemporary epidemiological studies utilizing community samples suggest a point prevalence ranging from 0.7% to 0.8% in young children. These figures may still represent an underestimate, as the non-disruptive nature of the disorder often leads to delayed identification.

Onset typically occurs in early childhood, most commonly identified between the ages of 3 and 5 years, when children transition into social settings like preschool or kindergarten where speaking demands are increased. Diagnosis, however, is frequently delayed by several years, often because parents or educators initially attribute the silence to extreme shyness, assuming the child will "grow out of it." Regarding demographics, many studies report a slightly higher prevalence in females than males, with ratios often cited around 1.5-2:1.

Cultural and linguistic factors are also important considerations. Research suggests that SM may be more prevalent in children from immigrant or bilingual backgrounds. While clinicians must differentiate SM from temporary silence related to acculturation stress or the normal phase of acquiring a second language, the increased social and linguistic demands inherent in these

situations can serve as risk factors, exacerbating underlying anxious predispositions in vulnerable children.

3. Etiology: The Roots of Silence

SM is understood through a multifactorial etiological model, resulting from a complex interplay of inherent vulnerabilities and environmental factors. The predominant conceptualization places SM firmly within the spectrum of anxiety disorders, with a strong link to social anxiety.

Temperamental Factors

The most robust temperamental predictor for SM is **behavioral inhibition (BI)**. BI is a constitutionally based trait characterized by a tendency to react to novel or unfamiliar people and situations with withdrawal, wariness, and fear. Children high in BI are naturally shy, cautious, and sensitive to social evaluation. This inherent vulnerability makes them highly susceptible to developing significant anxiety in social-evaluative contexts, which manifests as the inability to speak when expected.

Genetic and Biological Factors

Genetic studies confirm a hereditary component to SM and related anxiety. Family aggregation research consistently shows higher rates of anxiety disorders, particularly **Social Anxiety Disorder (SAD)**, among the first-degree relatives of children with SM. This suggests a shared genetic diathesis for anxiety-related traits. Neurobiological research implicates the **amygdala**, the brain region central to threat detection and fear processing. It is hypothesized that children with SM exhibit heightened amygdala reactivity to social stimuli that involve speaking expectations, thereby triggering an overwhelming anxiety response that results in physical freezing and mutism.

Environmental Factors

While constitutional factors create the predisposition, environmental influences play a crucial role in maintaining the behavior. The mechanism of **negative reinforcement** is central: when a child remains silent in an anxiety-provoking situation (e.g., being asked a question by the teacher), they successfully escape the anxiety, reinforcing the silence. Furthermore, parents or teachers who inadvertently "rescue" the child by answering for them or reducing verbal demands, while well-intentioned, can perpetuate this avoidance cycle. Overprotective parenting, high parental anxiety, and stressful life events (such as immigration) can also contribute to the onset or exacerbation of SM.

4. Comorbidity and Differential Diagnosis

Selective Mutism rarely occurs in isolation, and comprehensive assessment requires evaluating common co-occurring conditions and meticulously differentiating SM from other disorders involving reduced speech.

Comorbidity

The relationship between SM and SAD is profound, with comorbidity rates often cited between 70% and 100%. SM is often conceptualized as a severe presentation of SAD in childhood where the anxiety is so overwhelming that it results in complete speech inhibition in specific settings. Other common comorbid anxiety conditions include Separation Anxiety Disorder and Generalized Anxiety Disorder (GAD). Subtle **communication difficulties** (e.g., subtle articulation errors or language processing difficulties) are also observed in a subset of children with SM, which may increase self-consciousness about speaking.

Differential Diagnosis

Typical Shyness: SM is distinguished by its consistency, duration (over one month, excluding initial adjustment), and significant functional impairment. Shy children eventually warm up and speak; children with SM remain consistently mute in the specific feared context.

Autism Spectrum Disorder (ASD): While both involve social communication deficits, children with SM display age-appropriate social skills and fluent speech in comfortable settings (usually home). ASD involves pervasive deficits in social-emotional reciprocity and communication across all settings, regardless of anxiety level.

Communication Disorders: If the inability to speak is solely due to a severe expressive language deficit or stuttering that impacts speech in all settings, SM is ruled out. If a subtle communication deficit co-exists but does not account for the selectivity of the mutism, both diagnoses may be given.

Oppositional Defiant Disorder (ODD): The mutism in SM is anxiety-driven and involuntary, not willful defiance. Careful observation distinguishes anxiety-based freezing from active refusal to comply.

5. Evidence-Based Treatment Approaches

Effective treatment for SM is highly active, directive, and collaborative, relying overwhelmingly on behavioral and **cognitive-behavioral therapy (CBT)** principles to systematically reduce anxiety and reinforce verbal communication.

Core Behavioral Interventions

Stimulus Fading: This technique involves establishing comfortable speaking behavior in a low-anxiety setting (e.g., child speaking with a parent) and then gradually introducing the feared stimulus (e.g., the therapist or teacher) into the setting. The comfortable person then slowly withdraws until the child is communicating directly with the previously feared person.

Shaping / Graded Exposure: The child is exposed to speaking tasks arranged in a fear hierarchy, starting with minimal demands (e.g., mouthing words, whispering one sound) and reinforcing successive approximations of normal speech. This is often implemented through structured games designed to elicit communication without excessive pressure.

Contingency Management: Positive reinforcement (e.g., verbal praise, rewards) is systematically used to immediately reward communication attempts. Simultaneously, avoidance of negative reinforcement (i.e., allowing the child to escape speaking demands by remaining silent) is crucial; adults are coached to wait patiently for a response and avoid answering for the child.

Adjunct Treatment Modalities

Successful treatment requires close collaboration. Parent training is essential, focusing on teaching behavioral techniques and minimizing inadvertent reinforcement of silence. School collaboration involves educating teachers and implementing consistent behavioral plans (e.g., fading protocols, reinforcement systems) in the classroom setting. For children with severe, pervasive underlying anxiety, **pharmacotherapy**, typically Selective Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine, may be used as an adjunct to behavioral therapy to lower the overall anxiety threshold and increase the child's responsiveness to behavioral interventions.

6. Prognosis and Long-Term Outcomes

With early and appropriate intervention, the prognosis for overcoming the overt mutism is generally favorable. Factors associated with better outcomes include an earlier age of intervention (before patterns become entrenched), lower severity of mutism, and strong, consistent support from both family and school environments.

Longitudinal follow-up studies indicate that while the mutism itself often resolves by adolescence or early adulthood, the underlying vulnerability to anxiety frequently persists. A substantial proportion of formerly mute individuals continue to meet criteria for other anxiety disorders, most commonly SAD, and may experience difficulties with social functioning and confidence into adulthood. If left untreated, SM can lead to significant long-term academic underachievement, severe social isolation, and heightened risk for developing comorbid depression, underscoring the critical need for early and comprehensive intervention that addresses both the behavioral silence and the

underlying social anxiety.

Further Reading

[Selective Mutism \(Wikipedia\)](#)

[Social Anxiety Disorder \(Wikipedia\)](#)

[Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision \(DSM-5-TR\)](#)

[Boggs, Buss, & Kujawa \(2019\): Selective mutism as a social anxiety-related disorder](#)

[Oerbeck et al. \(2014\): A randomized controlled trial of behavioral intervention and SSRI medication for selective mutism](#)

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