

# Selective Mutism

Authored by  
**mohammad looti**

October 6, 2025

## RECOMMENDED CITATION

mohammad looti (2025). *Selective Mutism*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=34936>

## Selective Mutism

**Primary Disciplinary Field(s):** Clinical Psychology, Child Psychiatry, Developmental Pediatrics

### 1. Core Definition

Selective Mutism (SM) is a complex, childhood-onset anxiety disorder characterized by a consistent failure to speak in specific social situations where speaking is expected (such as school, or in front of strangers), despite speaking normally in other situations (typically at home or with immediate family members). As defined in the provided source content, it was formerly known as **elective mutism**, a term which has been retired because it erroneously suggested that the individual was actively choosing not to speak. The condition is now understood to be driven by significant **anxiety** and phobic avoidance rather than wilful defiance.

The onset of Selective Mutism is generally observed before five years of age, often coinciding with entry into formalized schooling or childcare settings where social demands increase. Crucially, the failure to speak is not attributable to a lack of knowledge or comfort with the required language, nor is it due to a primary speech or hearing disorder. The child possesses the linguistic capacity to speak, demonstrating this skill fluently in environments where they feel safe and comfortable. The defining characteristic is the stark dichotomy between verbal fluency in one setting and complete non-verbal shutdown in another. The experience of the child is typically one of being physically or emotionally paralyzed by fear, rendering speech impossible in the specified environments.

### 2. Etymology and Historical Development

The concept of a specific situational inhibition of speech has been recognized clinically for over a century. The term *aphasia voluntaria* was used in 1877 by Adolph Kussmaul to describe individuals who chose not to speak. However, the disorder was formally introduced into psychiatric literature in 1934 by Dr. Moritz Tramer, who coined the problematic term **elective mutism**. Tramer noted the phenomenon primarily in children who maintained silence in school settings while remaining verbally fluent at home. The implication embedded within the term "elective" was that the child possessed a degree of control or choice over their silence, often leading to misinterpretation of the condition as oppositionality or stubbornness rather than a manifestation of severe social anxiety.

Significant reform occurred with the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). In the DSM-IV (1994), the term was officially changed to **Selective Mutism** to more accurately reflect the involuntary, anxiety-driven nature of the condition. This shift was critical for diagnostic accuracy and treatment planning, emphasizing that the inability to speak is rooted in a phobic response to social performance expectations. The inclusion of SM in the DSM-5 solidified its categorization as an anxiety disorder, linking it closely to social anxiety disorder (SAD), with

which it shares high rates of comorbidity and underlying biological vulnerability. This historical evolution underscores the progression of clinical understanding from a behavioral or oppositional problem to a genuine mental health condition requiring specialized intervention.

### 3. Diagnostic Criteria (DSM-5)

For a diagnosis of Selective Mutism to be conferred, the criteria outlined in the DSM-5 must be met. These criteria ensure that the symptoms are consistent, persistent, and not better explained by another condition. A crucial component of diagnosis involves observing the persistence of the symptoms across time, ruling out temporary shyness or adjustment difficulties.

The individual consistently fails to speak in specific social situations in which there is an expectation for speaking (e.g., at school), despite speaking in other situations.

The disturbance interferes significantly with educational or occupational achievement or with social communication. This requirement highlights the functional impairment caused by the disorder, distinguishing clinical severity from mere shyness.

The duration of the disturbance is at least one month (and is not limited to the first month of school). This timeframe is necessary to differentiate SM from the normal initial adjustment period experienced by many children entering a new environment.

The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation (e.g., a language barrier).

The disturbance is not better explained by a communication disorder (e.g., Childhood-Onset Fluency Disorder) and does not occur exclusively during the course of Autism Spectrum Disorder, Schizophrenia, or another psychotic disorder.

### 4. Etiology and Risk Factors

The etiology of Selective Mutism is considered multifactorial, involving a complex interplay of genetic, neurobiological, temperamental, and environmental factors. It is widely accepted that SM is primarily an anxiety disorder, suggesting a strong genetic loading for anxiety conditions. Studies indicate that children with SM frequently have first-degree relatives who exhibit high levels of social anxiety or other anxiety disorders, supporting a strong hereditary component. Neurobiologically, research often focuses on the potential over-activation of the amygdala, the brain structure responsible for processing fear and emotional responses, leading to an exaggerated "fight or flight" response in social situations that require verbal output.

A key risk factor is inhibitory temperament, sometimes referred to as behavioral inhibition. This temperamental style is characterized by a tendency to withdraw from or show fear in unfamiliar

situations or when interacting with unfamiliar people. Children with this temperament are highly sensitive to novelty and potential threat, predisposing them to develop conditions like SM and Social Anxiety Disorder. Additionally, environmental factors, such as parental modeling of avoidance behaviors, overprotective parenting styles, or difficult early social experiences, can exacerbate the predisposition. However, it is crucial to understand that SM is not caused by trauma, abuse, or neglect, although these adverse experiences can certainly complicate the presentation of the disorder.

## 5. Key Characteristics and Comorbidity

Selective Mutism manifests through several distinct behavioral and emotional characteristics beyond the absence of speech. Children with SM often rely heavily on nonverbal communication, such as pointing, nodding, shaking their head, or communicating through whispering, particularly when interacting with familiar peers or trusted adults in the settings where they are mute. However, in high-stress situations, even these nonverbal cues may cease, resulting in a frozen, blank, or unresponsive demeanor. The source content notes that this condition often occurs along with **anxiety disorder**, **extreme shyness**, and **social withdrawal**, which are defining comorbid features.

The rate of comorbidity between Selective Mutism and Social Anxiety Disorder (Social Phobia) is exceptionally high, with some studies suggesting up to 90% of children with SM also meet the criteria for SAD. This overlap reinforces the classification of SM as an anxiety disorder, focusing specifically on the intense fear of negative evaluation inherent in performance situations, such as speaking aloud. Other common comorbid conditions include generalized anxiety disorder, separation anxiety, and specific phobias. If untreated, the avoidance patterns established in childhood can solidify, leading to significant long-term difficulties in academic achievement, interpersonal relationships, and professional functioning.

## 6. Assessment and Differential Diagnosis

Accurate assessment of Selective Mutism typically involves a comprehensive evaluation conducted by a clinical psychologist or child psychiatrist. The process relies heavily on obtaining detailed information from multiple informants, including parents, teachers, and other caregivers, since the child's behavior differs markedly across settings. Assessment tools may include standardized questionnaires, structured interviews (e.g., the Selective Mutism Questionnaire), and direct observation in both comfortable and anxiety-provoking settings (if possible). A critical part of the assessment is determining the situations in which the child *is* speaking fluently versus those in which they are mute, thereby confirming the "selective" nature of the mutism.

Differential diagnosis requires ruling out several conditions that might mimic the core features of

SM. These include developmental language disorders, where the child's mutism is due to an underlying inability to produce speech rather than anxiety; transient shyness, which is less pervasive and resolves quickly; and symptoms related to Autism Spectrum Disorder (ASD). While children with ASD may exhibit limited verbal interaction, this is typically due to deficits in social reciprocity and communication skills rather than situational anxiety and phobic avoidance. Furthermore, hearing impairment must be ruled out, as auditory deficits can lead to difficulty with verbal participation.

## 7. Treatment Modalities

Treatment for Selective Mutism is most effective when initiated early and typically involves behavioral intervention, often drawing heavily on principles from Cognitive Behavioral Therapy (CBT). Because the core issue is anxiety driving avoidance behavior, the goal of treatment is to reduce anxiety and systematically increase verbal participation using techniques that encourage desensitization. Medication, primarily Selective Serotonin Reuptake Inhibitors (SSRIs), may be used in conjunction with behavioral therapy for older children or those with severe, pervasive anxiety.

The most successful behavioral techniques focus on gradually fading the child into verbal interactions. Key strategies include:

**Stimulus Fading:** A technique where the child speaks comfortably with a trusted person (e.g., parent) while a non-threatening third party (e.g., teacher) is gradually introduced into the setting. The parent then slowly fades their presence, leaving the child alone with the new adult.

**Shaping:** Rewarding approximations of speech, starting with nonverbal communication (waving, nodding), moving to whispering, then soft sounds, and finally, normal speech volume. **Positive reinforcement** is crucial at every step.

**Sliding In:** Gradually transitioning the child from speaking privately with a parent to speaking with a therapist or teacher, often using technological aids like walkie-talkies or audio recordings initially.

Consistency across home and school environments is essential for treatment success, requiring close collaboration between clinicians, parents, and educators to manage anxiety triggers and reinforce speech attempts.

## 8. Further Reading

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

[Selective Mutism Association \(SMA\)](#)

[American Academy of Child & Adolescent Psychiatry \(AACAP\) on Selective Mutism](#)