

# “When the Words Just Won’t Come Out”

## Understanding Selective Mutism

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### Definition

Selective Mutism (SM) is a complex **childhood anxiety disorder** characterized by a child’s inability to speak in select social settings, such as school. These children are able to talk normally in settings where they are comfortable, secure, and relaxed.

According to studies, approximately 90% of children with SM suffer from social phobia. Social phobia is a persistent fear of social or performance situations and is quite debilitating and painful to the child. This is evident by their uncomfortable body language when any attention is brought to them.

Children and adolescents with SM have an actual fear of speaking and interacting socially where there is an expectation to talk. In these situations, they often stand motionless with fear. These children are so anxious they literally freeze, become expressionless, appear unemotional, and often become socially isolated. This can be quite heart-wrenching to observe.

### How Do Children Develop SM?

The majority of children with SM have a genetic predisposition to anxiety. In other words, they have inherited anxiety from various family members. Very often, from infancy on, these children show signs of severe anxiety such as separation anxiety, frequent tantrums and crying, moodiness, inflexibility, sleep problems, parental separation issues, and extreme shyness. Because most of these children have a persistent fear of performance or social interaction, they manifest symptoms such as freezing, lack of smiling, expressionless face, and mutism as a direct response to fear and anxiety.

**SM is  
Inherited**

When compared to the typically shy and timid child, children with SM are at the extreme end of the spectrum. So much so, that the severity of the child’s behavioral inhibition enables a pathological reaction in response to various social stressors. Most of the distinctive behavioral characteristics that children with SM portray can be explained by the studied hypothesis that children with inhibited temperaments have a decreased threshold of excitability in the almond-shaped area of the brain called the amygdala.

According to studies, when confronted with a fearful scenario, the amygdala receives signals of potential danger (from the sympathetic nervous system) and begins to set off a series of reactions that will help individuals protect themselves. In the case of children with SM, the fearful scenarios are social settings such as school, birthday parties, social gatherings, etc.

Approximately 20-30% of children with SM have subtle speech and language abnormalities, for example expressive language disorders. However, these children still have anxiety as the underlying cause for their mutism. Etiologies for speech and language abnormalities can vary between immature speech and language development to mild speech impediments. More studies are necessary to fully assess speech and language abnormalities and SM.

There is a percentage of children with SM who come from bilingual families, have spent time in a foreign country, or have been exposed to another language during formative language development (ages 2-4 years old). These children are usually innately temperamentally inhibited (prone to shyness and anxiety), but the additional stress of speaking another language and being insecure with their skills is enough to cause an increase in anxiety and mutism.

**There is no evidence that the cause of SM is related to abuse, neglect, or trauma.**

## **Behavior**

It is important to realize that the majority of children with SM are as normal and appropriate as any other child when in a comfortable environment. Parents will often comment how boisterous, social, funny, inquisitive, extremely verbal, and even bossy and stubborn these children are at home! However, what differentiates children with SM is their severe behavioral inhibition and inability to speak in most social settings. These children feel as though they are “on stage” every minute of the day! This can be quite devastating for both the child and parents involved. Often, these children show signs of anxiety before and during most social events. Tummy-aches, nausea, vomiting, diarrhea, headaches, and an array of other physical complaints are common before school or social outings.

When in school, most children with SM stand motionless and expressionless and most demonstrate awkward or stiff body language. Some children turn their heads, chew or twirl their hair, avoid eye contact, or withdraw into a corner. Over time, these children learn to cope in order to participate in certain social settings. However, they only perform nonverbally or by talking quietly to a select few. Social relationships are very difficult for the child with SM.

Children with SM have tremendous difficulty initiating any form of communication and are slow to respond even when it comes to nonverbal communication. This can be quite frustrating to the child as time goes by. A child with SM will exist nonverbally in various social settings, sometimes for many years, unless they are properly diagnosed and treated.

## **Characteristics**

The following are various personality characteristics of children with SM.

- Mutism
- Blank facial expressions (when anxious)
- Lack of smiling (when anxious)
- Staring into space (when anxious)
- Difficulty with eye contact (when anxious)
- Frozen appearance (when anxious)
- Awkward and stiff body language (when anxious)
- Difficulty initiating play
- Difficulty saying or indicating thank-you, hello, or goodbye
- Slowness to respond (i.e., when asked a question, will take longer than the average child to respond either verbally or nonverbally. This is one reason why standardized testing is often difficult and yields inaccurate results)
- Heightened sensitivity to surroundings such as noise, crowds, and touch
- Excessive tendency to worry and have fears (often manifested in children older than 6 years of age)
- Behavioral manifestations at home such as: moodiness, assertiveness, inflexibility, procrastination, crying easily, need for control, bossiness, domination, extreme talkativeness, and expressiveness
- Intelligent, perceptive, and inquisitive
- Introspective and sensitive (seems to understand the world around them more thoroughly than other children the same age, and portrays an increased sensitivity to feelings and thoughts, although often have difficulty expressing feelings)
- Manifests artistic interests

As one can clearly see, mutism is just one of the many characteristics that children with SM portray.

## **Why Such Scarcity in Awareness of SM**

So few understand SM including teachers, therapists, and physicians. This can be attributed to the limited studies and research available on the topic of SM. Most research results are based on subjective findings on a limited number of children. In addition, textbook descriptions are often nonexistent, limited, or information is inaccurate and misleading.

As a result, few people truly understand SM. Professionals and teachers will often tell a parent that the child is just shy or that they will outgrow their silence. Others interpret mutism as a means of being oppositional and defiant; where mutism is a means of manipulating and controlling a situation. Some professionals view SM as a variant of autism or an indication of severe learning disabilities. For the child truly affected by SM, these assumptions are incorrect, inappropriate, and dangerous!

As a result of the scarcity and often inaccuracy of the information within the literature, children with SM may be misdiagnosed and mismanaged. In many circumstances, parents will wait and hope their child outgrows the mutism. However, without proper recognition and treatment, most of these children do not outgrow SM and end up going through years without speaking, interacting normally, or developing proper social skills.

## Evaluation

A trained professional familiar with SM will request a preliminary interview with the parents or guardians of the child suspected of having SM. Emphasis will be on social interaction and developmental history, as well as behavioral characteristics (including any delays in hearing, speech, and language), family history (history of family members with anxiety and/or depression is common), behavioral characteristics (shy temperament), a description of the child and family's home life, (family stress, divorce, death, etc.) and medical history.

The professional will often then ask that the child attend a session. Although most children with SM do not speak to the diagnosing professional, the professional can spend time with the child and attempt to build trust.

Because 20-30% of children with SM have a subtle abnormality with speech and language, a thorough speech and language evaluation is often ordered. In addition, a complete physical exam (including hearing), standardized testing, psychological assessments, as well as a thorough developmental screen are often recommended if the diagnosis is not clear.

## Diagnoses

The average age of diagnosis is between 3 and 8 years old; however, these children were most likely temperamentally inhibited and severely anxious in social settings as infants and toddlers. Early on, parents may notice that their child is not speaking to most individuals outside the home, but may have thought their children were just "very shy."

SM usually does not become noticed until the child enters school where there is an expectation to perform, interact, and speak. It is then that SM becomes apparent and teachers are generally the first to identify a problem. The teacher may become concerned and will tell parents that the child is not talking or interacting with other children. This can sometimes be confused with normal and acceptable behavior since most children have a history of separation anxiety and have been "slow to warm up." However, ***if mutism persists for more than a month, a parent should seek a help from their physician or pediatrician and/or a psychiatrist or therapist who has experience with SM.***

## Importance of Early Diagnoses

Findings indicate that the earlier a child is treated for SM, the quicker the response to treatment, and the better the overall prognosis. If a child remains mute for many years, his or her behavior can become a conditioned response where the child literally becomes accustomed to nonverbalization as a way of life. In other words, SM can become a difficult habit to break!

The U.S. Surgeon General recently stated that our country is in a state of emergency as far as children's mental health is concerned. **Anxiety disorders are the #1 mental illness among children and adolescents.**

Evidence shows that 10% of children suffer from mental disorders, but less than 5% of these children are actually receiving treatment.

**Because SM is an anxiety disorder, if left untreated, it can cripple a child for life and may curb the way for an array of academic, social, and emotional repercussions such as:**

- Development of worsening anxiety
- Development of depression and manifestations of other anxiety disorders
- Social isolation and withdrawal
- Poor self-esteem and self-confidence
- Poor academic performance, school expulsion, or school drop out
- Underachievement academically and in the work place
- Self-medication with drugs and/or alcohol
- Crime and involvement with the juvenile justice system
- Suicidal thoughts and possible suicide

These potential consequences of no or incorrect diagnoses and/or treatment methods demonstrate the importance that the main objective should be to diagnose our children early so they can receive proper treatment at an early age. This will enable them to develop proper coping skills and overcome anxiety.

**Diagnostic Criteria** The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, published by the American Psychiatric Association, outlines the following criteria for diagnosing SM.

1. Child does not speak in certain places such as school.
2. But, can speak normally in other settings where he/she is comfortable and relaxed (often at home).
3. Child's inability to speak interferes with ability to function in educational and/or social settings.
4. Mutism has persisted for at least 1 month.
5. Mutism is not part of a communication disorder such as stuttering, and is not due to other conditions such as autistic spectrum disorders.

## Parental Role

Parents should remove all pressure and expectations for the child to speak. They should convey to their child that they understand that he or she is "scared" to speak and that they will help their child through this difficult time. Praise should be given for the child's accomplishments and efforts, and support and acknowledgment should be given for their difficulties and frustrations.

Parents should do their homework and are encouraged to read as much information as they can about SM. The Selective Mutism Group Childhood Anxiety Network (SMG~CAN) website is a great resource, with thousands of pages of information to read and print out to educate others. Membership in the SMG~CAN community also offers lots of opportunities for support and interaction with experts and experienced parents and teachers. It is the largest, most comprehensive organization in the world dedicated to SM. (Visit [www.selectivemutism.org](http://www.selectivemutism.org))

Parents should go with their instincts and speak with their family physician or pediatrician and/or seek out a psychiatrist or a therapist who has experience with SM. They should ask the treating specialist his or her views on SM as inappropriate treatment methods will only heighten a child's anxiety.

## Treatment

The main goal with treatment is to **lower anxiety, increase self-esteem and increase confidence in social settings**. Emphasis should never be on "getting a child to talk." All expectations for verbalization should be removed. With lowered anxiety levels and confidence, verbalization will eventually follow. A professional should devise an "individualized treatment plan" for each child.

Treatment usually focuses on a combination of the following.

**(1) Behavioral Approach:** Positive reinforcement and desensitization as well as removing all pressure to speak techniques are the primary behavior treatments for SM. Emphasis should be on understanding the child and acknowledging their anxiety. Introducing the child to social environments in subtle and non-threatening ways is an excellent way to help the child feel more comfortable. A sample step-by-step "behavioral approach" plan follows:

1. With few people present at the school, the parent and child "practice speaking" in the school environment.
2. During a time when other children are not present, one or two friends may accompany the child at the school's playground to play.
3. During a time when other children are not present, a small group of familiar friends may accompany the child at the school's playground to play.
4. Parent(s) will spend time with their child in the classroom.
5. When the child is speaking quite normally, first the teachers, then the students, are gradually introduced into a group setting.
6. Only when anxiety is lowered and the child feels comfortable and is obviously ready for some subtle encouragement, positive reinforcement for verbalization is introduced.

**(2) Psychological Approach:** Play therapy, psychotherapy, and other psychological approaches to treatment can be effective if all pressure for verbalization is removed and emphasis is on helping the child relax and open up. Confronting mutism in a nonthreatening way is important. Children with SM are scared; therefore, the focus should be to help the child identify with the intensity level of fear in a particular situation. Helping them to realize that they are understood and are being helped relieves tremendous pressure.

**(3) Cognitive Behavioral Therapy Approach:** Cognitive Behavioral Therapy Approach (CBT) helps the child modify their behavior by helping them redirect their anxious fears and worries into positive thoughts. CBT requires the incorporation of awareness and acknowledgement of anxiety and mutism. Most children with SM worry about others hearing their voice, being asked questions about why they do not talk, or being forced to speak. Focus should be on emphasizing the child's positive attributes, building confidence in social settings, and lowering overall anxiety and worries.

**(4) Medication:** Studies clearly indicate that the best approach to therapy is a combination of behavioral techniques and medication. Because most parents are reluctant to start medication immediately, behavioral techniques are often utilized as a first step in the treatment plan. Duration and success of behavioral treatments alone vary from child to child. However, if a child does not make adequate progress, medication is often recommended.

Medication in the form of serotonin reuptake inhibitors (SSRIs) such as Prozac, Paxil, Celexa, Luvox, and Zoloft are very successful in the treatment of anxiety disorders. Similar to the SSRIs, there are other drugs that affect one or more neurotransmitters that are also proven to be effective. These drugs include serotonin, norepinephrine, GABA, and dopamine. Examples are Effexor XR, Serzone, Buspar, and Remeron.

Both classes of drugs work well in children that have a true biochemical imbalance. This seems to be the case in the majority of children with SM. Very often, positive effects have been seen in as little as a week! Medication is used as a "jump start" with the hope that, as anxiety is lowered via medication; behavioral techniques can be implemented more easily and successfully!

**(5) Self-Esteem Boosters:** Parents should emphasize their child's positive attributes. For example, if a child is artistic, then by all means, show off their artwork! Utilize a special wall to display the child's masterpieces; perhaps they can even have a special exhibit. They can be given the opportunity to "explain" their artwork to family members and close friends. This promotes more verbalization practice, as well as helping with confidence.

**(6) Frequent Socialization:** Socialization should be encouraged as much as possible without pushing the child. Frequent play dates should be arranged with classmates or a small group interaction with individuals the child knows best. The goal should be that the child feels comfortable enough with their classmates so that verbalization will occur. Most children with SM will talk to friends in their own home. As the child gets increasingly comfortable speaking to one child, another child could be included. The group could increase to two or three children at a time. As a child gets more comfortable with friends, they will hopefully speak to them at school.

**(7) School Involvement:** It is necessary for parents to educate teachers and school personnel about SM. It is imperative that the school understands that children with SM are not being defiant or stubborn by not speaking, that they truly cannot speak. The teacher should understand that it is crucial for a child with SM to feel assured that they will not be expected to speak. Furthermore, nonverbal communication is

acceptable in the beginning and should be encouraged. Teachers should also be involved in the treatment plan. As the child progresses in his or her treatment, the teacher should encourage verbalization in subtle, nonthreatening ways.

**(8) Family Involvement and Parental Acceptance:** A parent's acceptance and understanding is crucial for the child with SM. In addition, family members must be involved in the entire treatment process. Very often changes in parenting styles and expectations are necessary to accommodate the needs of the child with SM. The child should never be pressured or forced to speak, this will only cause more anxiety. The child should feel that parents are there for them and they should receive special one-on-one time with the parent(s). Ideally, this time should be spent at home in the evenings, when all pressure is off, and they feel most comfortable. The parent can help the child relieve stress by becoming engaged in discussions about their feelings and allowing them to "open up."

***It is important to realize that with proper diagnosis and treatment, the prognosis for overcoming SM is excellent!***

#### **Contact Information**

Contact the SMG-CAN for further information. Visit [www.selectivemutism.org](http://www.selectivemutism.org).

The SMG~CAN is a division of the nonprofit, 501(c) 3 organization, the Childhood Anxiety Network [www.childhoodanxietynetwork.org](http://www.childhoodanxietynetwork.org).