ANXIETY DISORDERS

Selective Mutism

SM

DSM-5-TR 313.23 | ICD-10-CM F94.0

Consistent failure to speak in specific social settings despite speaking normally elsewhere, driven by anxiety rather than by defiance.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~0.7-1% of children	Ages 2-5; seen at school	Slight female predominance	Speech improves; anxiety stays

CLINICAL PICTURE

- The child speaks freely at home with immediate family but is entirely silent at school, in public, or with extended relatives and visitors.
- Silence comes with a frozen facial expression, averted gaze, stiff posture, and reliance on nodding, pointing, or a whispered proxy speaker.
- Teachers describe a child who never asks for help, will not use the school bathroom, and cannot read aloud or participate in group work.
- Parents often see a talkative and even bossy child at home, which leads schools to misread the classroom silence as oppositional behavior.
- Onset clusters at school entry when speaking demands rise sharply, and the average delay from onset to diagnosis exceeds several years.
- Academic performance and peer relationships suffer even when the child knows the material, because assessment depends on spoken output.

DIAGNOSTIC CRITERIA AT A GLANCE

- Consistent failure to speak in specific social situations where speaking is expected, despite speaking normally in other situations.
- The disturbance interferes with educational or occupational achievement or with ordinary social communication with peers and adults.
- Duration must be at least 1 month, and the first month of school does not count, since transient silence at school entry is common.
- The failure to speak is not attributable to lack of knowledge of, or comfort with, the spoken language required in that situation.
- Not better explained by a communication disorder, and it does not occur exclusively during autism spectrum disorder or a psychotic disorder.

NEUROBIOLOGY & PHYSIOLOGY

- Behavioral inhibition to the unfamiliar, a temperament trait with substantial heritability, is the strongest known predisposing factor.
- Amygdala hyperreactivity to unfamiliar faces and voices parallels the pattern documented in social anxiety disorder across the lifespan.
- Family aggregation is strong, with elevated rates of social anxiety disorder and selective mutism among first-degree relatives.
- Candidate variants such as CNTNAP2 linking language and anxiety phenotypes have been reported but not consistently replicated.
- Auditory processing differences during vocalization, including reduced efferent auditory pathway activity, have been described in affected children.
- Subtle expressive language weaknesses and speech articulation problems are present in roughly a third of children carrying the diagnosis.

PSYCHOLOGICAL MECHANISMS

- Silence functions as avoidance: it terminates the anticipated evaluation, is negatively reinforced, and strengthens with each successful escape.
- Adults inadvertently maintain it by answering for the child, accepting nonverbal responses, and quietly removing all speaking demands.
- The child fears their own voice being heard and judged, which is why whispering typically precedes audible conversational speech.
- Anxious or overprotective parenting and family social reticence correlate with severity but are not sufficient causes on their own.
- Immigrant and bilingual children face elevated risk during the silent period of second-language learning, which must not be pathologized.

DIFFERENTIAL & COMORBIDITY

- Normative silent periods in second-language learners resolve within months and never extend to speech in the child's first language.
- Autism spectrum disorder, language disorder, and intellectual disability impair speech across all settings rather than selectively.
- Social anxiety disorder co-occurs in the large majority of cases and is the most useful conceptual frame for planning treatment.
- Separation anxiety, specific phobia, enuresis or encopresis, and oppositional behavior at home are frequent additional comorbidities.
- Untreated selective mutism predicts persistent social anxiety and phobic disorders into adulthood even after speech itself normalizes.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- Behavioral therapy is first-line, and medication is added when the child is too anxious to engage in exposure or when progress stalls.
- **Fluoxetine 10-40 mg/day** has the most evidence, including a small placebo-controlled trial, and requires 8 to 12 weeks for full effect.
- **Sertraline 25-200 mg/day** and other **SSRIs** are used interchangeably following standard pediatric anxiety dosing and titration practice.
- Monitor for activation, behavioral disinhibition, and suicidality per the FDA boxed warning, with contact every 1 to 2 weeks early on.
- Benzodiazepines and antipsychotics have no role here, since sedation degrades the child's capacity to practice speaking in session.

PSYCHOTHERAPY

- **Integrated Behavior Therapy for Selective Mutism** across roughly 20 sessions produced significant speech gains in a randomized pilot trial.
- **Stimulus fading** gradually brings new listeners into a setting where the child already speaks, one person and one small step at a time.
- **Shaping** rewards successive approximations: mouthing, whispering, a single word, a phrase, and finally full-volume conversational speech.
- **Defocused communication** removes direct questions and eye pressure and improved outcomes in a Norwegian randomized school-based trial.
- **Parent-child interaction therapy** adapted for mutism coaches caregivers in labeled praise and in not speaking on the child's behalf.

ADJUNCT & SUPPORTIVE

- School collaboration is essential: a 504 plan or IEP with speaking accommodations, a designated warm-up adult, and graded participation goals.
- Coach every adult to wait at least 5 seconds after asking a question and never to answer on the child's behalf to relieve the tension.
- Track progress with the **Selective Mutism Questionnaire** and a setting-by-setting speaking map covering home, school, and community.
- Intensive group programs and specialized summer camps deliver massed exposure practice with staff trained in fading and shaping.
- Treat early, since intervention before roughly age 8 to 10 predicts substantially better outcomes than starting in adolescence.

CLINICAL PEARLS

- Talkative at home, silent at school: that is anxiety, not oppositionality.
- Never answer for the child; the rescue is exactly what maintains the silence.
- Fluoxetine helps when anxiety blocks exposure work, but behavior therapy leads.

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NOTE

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