Selective Mutism

Children who are physically healthy - and are thus able to speak - but do not do so, or do so only with selected persons, usually family members, are referred to as having selective mutism.

The World Health Organization (WHO) urgently suggests: If a child does not speak in social situations outside the family, for a period longer than 4 to 6 weeks, help must be sought.

A majority of children affected by selective mutism are girls (2:1). Children affected are described as shy, inhibited, insecure, withdrawn, too quiet, socially isolated, unsociable, anxious, and sometimes as having hidden aggression.

The onset usually occurs when the child begins preschool. It is evident in an absence of speaking, a lack of formation of social contacts, and non-compliance with requests.

Unavoidably, negative social impacts thus arise. If these persist for a period of years, they inevitably leave their mark on the personality. Moreover, consistent silence over months or years requires enormous psychological energy, which comes at the expense of other areas, such as learning. Speech is also missing as a means of acquiring knowledge. This often results in intellectual deficiencies, despite good potential.

Being silent is ***one*** strategy for problem solving - but not an optimal one.

Throughout Germany a lack of knowledge is discernible, even in professional circles; thus parents are often placated with statements such as, "Your child will grow out of it. Give the child time!" However, time is precisely what the children do not have.

The psychological stress underlying a selective mutism disorder is often unrecognised. If children with selective mutism are regarded as not requiring therapy, this means that they are left alone with their problems. Usually anxiety lies behind the refusal to speak. This anxiety constrains the child, depriving the child of the free will to speak (again).

Selective mutism is also sometimes confused with early childhood autism/Asperger's syndrome.

In the WHO International Classification of Diseases, **selective mutism** is therefore defined as a psychologically based **psychosocial disorder** (ICD-10, F 94.0).

An exclusively logopedic/speech therapy treatment is therefore contraindicated; it can even aggravate the symptoms (Professor R. Castell, University of Erlangen, Division of Child and Adolescent Psychiatry).

If no conspicuous progress has occurred within 6 months after the beginning of therapy, the therapy should be changed (Professor M. Doepfner, University of Cologne, Psychiatrist for Children and Adolescents).

When children are silent

Jana has exhibited anxious behaviour since birth. For the past two years she has attended preschool. Until now she has not spoken to the teachers or to the other children. In the room, Jana usually stands by the wall and does not play with others. Next year she is to start school. Despite the fact that she has normal intelligence, the professional personnel are talking of a special needs school. In her home environment Jana speaks aloud normally with her parents, whispers with her grandfather, and has never spoken to her grandmother.

Hannah, 8 years old, did not speak in preschool and does not speak in elementary school. She refuses to take part in physical education. She is an outsider in the class, without friends. She hides her face behind her long hair, and sometimes sucks her hair. When she comes out of school she is aggressive, loud, and speaks incessantly.

Behavioural characteristics

Examples

- does not speak in strange surroundings
- often displays a stiff, empty facial expression; avoids eye contact
- seems sad, depressed, withdrawn
- communicates with conspicuous facial expressions or gestures
- tends toward aggressive/auto-aggressive behaviour, usually within the family
- stands as if petrified in preschool or school
- bedwetting and/or soiling; development of tics/compulsions
- exhibits unusual eating/sleeping behaviour