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The prevalence of selective mutism varies with age, with younger children at increased risk for the disorder. According to the DSM-5, the point prevalence of selective mutism using clinic or school samples has been found to range between 0.03 percent and 1 percent, depending on whether a clinical or community sample is studied. A large epidemiologic survey in the United Kingdom reported a prevalence rate of selective mutism to be 0.69 percent in children 4 to 5 years of age, which dropped to 0.8 percent near the end of the same academic year. Another survey in the United Kingdom identified 0.06 percent of 7-year-olds as having selective mutism. Young children are more vulnerable to the disorder than older ones. Selective mutism appears to be more common in girls than in boys. Clinical reports suggest that many young children spontaneously "outgrow" this disorder as they get older; the longitudinal course of the disorder remains to be studied. ETIOLOGY Genetic Contribution Selective mutism may have many of the same etiologic factors leading to the emergence of social anxiety disorder. In contrast to other childhood anxiety disorders, however, children with selective mutism are at greater risk for delayed onset of speech or speech abnormalities that may be contributory. However, in addition to the speech and language factor, one survey found that 90 percent of children with selective mutism met diagnostic criteria for social phobia. These children showed high levels of social anxiety without notable psychopathology in other areas, according to parent and teacher ratings. Thus, selective mutism may not represent a distinct disorder, but may be better conceptualized as a subtype of social phobia. Maternal anxiety, depression, and heightened dependence needs are often noted in families of children with selective mutism, similar to families with children who exhibit other anxiety disorders. Parental Interactions Maternal overprotection and anxiety disorders in parents may exacerbate interactions that unwittingly reinforce selective mutism behaviors. Children with selective mutism usually speak freely at home, and only exhibit symptoms when under social pressure either in school or other social situations. Some children seem predisposed to selective mutism after early emotional or physical trauma; thus, some clinicians refer to the phenomenon as traumatic mutism rather than selective mutism. Speech and Language Factors Selective mutism is conceptualized as an anxiety-based refusal to speak; however, a higher than expected proportion of children with the disorder have a history of speech delay. An interesting finding suggests that children with selective mutism are at higher risk for a disturbance in auditory processing, which may interfere with efficient

processing of incoming sounds. For the most part, however, speech and language problems in children with selective mutism are subtle and cannot account for the diagnosis of selective mutism. DIAGNOSIS AND CLINICAL FEATURES The diagnosis of selective mutism is not difficult to make after it is clear that a child has adequate language skills in some environments but not in others. The mutism may have developed gradually or suddenly after a disturbing experience. The age of onset can range from 4 to 8 years. Mute periods are most commonly manifested in school or outside the home; in rare cases, a child is mute at home but not in school. Children who exhibit selective mutism may also have symptoms of separation anxiety disorder, school refusal, and delayed language acquisition. Because social anxiety is almost always present in children with selective mutism, behavioral disturbances, such as temper tantrums and oppositional behaviors, may also occur in the home. Compared to children with other anxiety disorders, except social anxiety disorder, children with selective mutism tend to have less social competence and more social anxiety. Janine is a 6-year-old Chinese-American first-grade girl who lives with her biological mother, father, and siblings. Janine's parents reported a 2-year history of not speaking at school, beginning in kindergarten, or to any children or adults outside of her family, despite speaking

normally at home. At home, she reportedly is animated and quite talkative with her immediate family and a few young cousins as well. Although she speaks to adult relatives outside of her immediate family, her communication is often limited to one-word responses to their questions. By her parents' report, Janine also exhibits extreme social anxiety, to the point of "freezing" in certain situations when attention is focused on her. At the time of her evaluation, Janine had not received prior treatment. Janine speaks fluent English, as well as Mandarin, and, according to her parents, met all developmental milestones on time and appears to have above-average intelligence. They also reported that Janine enjoys dancing, singing, and imaginative play with her sisters. During initial evaluation, Janine failed to make eye contact or respond verbally to the intake clinician. Janine's parents reported that this behavior is typical of her when in a new situation but that she communicates nonverbally and makes eye contact with most people once she "gets to know them." On request, Janine's parents provided a videotaped recording of Janine playing at home with her sisters. In the video, Janine was animated and was speaking spontaneously and fluently without obvious impairment. Janine received diagnoses of selective mutism and social anxiety disorder. CBT was recommended at this time. CBT was initiated and the therapist instructed Janine and her mother to come up with lists of easy, medium, and most difficult "speaking" situations and lists of small, medium, and large rewards. These lists then became the basis for assignments for

exposures and reinforcement for speaking tasks that gradually increased in difficulty. BT sessions included time with Janine and her mother together to review past and future assignments and time with Janine and the therapist alone. When treatment began, Janine did not communicate at all verbally or nonverbally with the therapist. The therapist gradually developed a rapport with Janine utilizing less stressful tasks such as whispering to her mother with the therapist in the corner, then nodding yes or no, pointing, whispering to a stuffed animal, whispering to her mother while facing the therapist, and eventually responding to the therapist directly. The therapist used animal puppets to enable Janine to "warm up" without talking directly to the therapist. After three sessions, Janine began to speak to the therapist in a quiet whisper. Janine received stickers for completing each speaking assignment, and, after filling up the sticker charts, she received rewards (a small toy or treat from reward list). Janine was also given assignments that involved her teacher and classmates. These were implemented in gradual fashion and included waving to the teacher, playing an audiotape of her saying "hello" to the teacher, whispering "hello" to the teacher, speaking "hello" to the teacher in a regular voice, and so on. After approximately 14 sessions, Janine succeeded in speaking a complete sentence in front of the class when called on and spoke to her teacher in front of several other students. During the last few sessions, Janine's mother took an increasingly active role in assigning and following up on speaking assignments. When Janine entered the 2nd grade it took only a few days for her to speak to her teacher and to most peers in class. After completion of therapy, Janine's mother continued to monitor Janine's speaking behaviors and to promote speaking in new situations by encouraging (and rewarding) Janine's gradual successes with novel people and situations. (Adapted from case material from. Lindsey Bergman, Ph.D. and John Piacentini, Ph.D.) Pathology and Laboratory Examination No specific laboratory measures are useful in the diagnosis or treatment of selective mutism. DIFFERENTIAL DIAGNOSIS Differential diagnosis of children who are silent in social situations emphasizes ruling out communications disorder, autism spectrum disorder, and social anxiety disorder, which may be diagnosed comorbidly. Once it is confirmed that the child is fully capable of speaking in certain situations, which are comfortable, but not in school and other social situations, an anxiety-related disorder comes to mind. Shy children may exhibit a transient muteness in new, anxiety-provoking

situations. These children often have histories of not speaking in the presence of strangers and of clinging to their mothers. Most children who are mute on entering school improve spontaneously and may be described as having transient adaptation shyness. Selective mutism must also be

distinguished from mental retardation, pervasive developmental disorders, and expressive language disorder. In these disorders, the symptoms are widespread, and no one situation exists in which the child communicates normally; the child may have an inability, rather than a refusal, to speak. In mutism secondary to conversion disorder, the mutism is pervasive. Children introduced into an environment in which a different language is spoken may be reticent to begin using the new language. Selective mutism should be diagnosed only when children also refuse to converse in their native language and when they have gained communicative competence in the new language but refuse to speak it. COURSE AND PROGNOSIS Children with selective mutism are often excessively shy during preschool years, but the onset of the full disorder is usually not evident until age 5 or 6 years. Many very young children with early symptoms of selective mutism in a transitional period when entering preschool have a spontaneous improvement over a number of months and never fulfill criteria for the disorder. A common pattern for a child with selective mutism is to speak almost exclusively at home with the nuclear family but not elsewhere, especially not at school. Consequently, a child with selective mutism may have academic difficulties, or even failure due to a lack of participation. Children with selective mutism are typically shy, anxious, and at increased risk for a depressive disorder. Many children with early onset selective mutism remit with or without treatment. Recent data suggest that fluoxetine (Prozac) may influence the course of selective mutism, and treatment enhances recovery. Children in whom the disorder persists often have difficulty forming social relationships. Teasing and scapegoating by peers may cause them to refuse to go to school. Some children with any form of severe social anxiety are characterized by rigidity, compulsive traits, negativism, temper tantrums, and oppositional and aggressive behavior at home. Other children with the disorder tolerate the feared situation by communicating with gestures, such as nodding, shaking the head, and saying “Uh-huh” or “No.” In one follow-up study, about one half of children with selective mutism improved within 5 to 10 years. Children who do not improve by age 10 years appear to have a long-term course and a worse prognosis. As many as one third of children with selective mutism, with or without treatment, may develop other psychiatric disorders, particularly other anxiety disorders and depression. TREATMENT A multimodal approach using psychoeducation for the family, CBT, and SSRIs as needed is recommended. Preschool children may also benefit from a therapeutic nursery. For school-age children, individual CBT is recommended as a first-line treatment. Family education and cooperation are beneficial. Published data on the successful treatment of children with selective mutism is scant, yet solid evidence indicates that children with social anxiety disorder respond to various SSRIs and, currently, CBT treatments are under investigation in a multisite, randomized placebo-controlled trial of children with

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