

Introduction - Selective mutism (SM), as defined by NHS (2026), is an anxiety-based condition in which a child consistently struggles to speak in social settings despite being able to communicate comfortably in others, most often at home. It is commonly identified in early childhood and is frequently first noticed when a child begins nursery or primary school. In the United Kingdom, selective mutism is recognised as an additional learning need because the condition can significantly affect educational participation, communication, emotional wellbeing, and social development. Although some children may appear shy or quiet, selective mutism extends beyond typical shyness. The inability to speak in certain environments is not a behavioural choice or refusal. Instead, it is linked to severe social anxiety and a physiological freeze response. This misunderstanding often leads to delayed intervention, increasing the risk of long-term academic and psychological difficulties.

Identification and Diagnosis of Selective Mutism - Cleveland Clinic (2023) states that Selective mutism is usually first identified by teachers, nursery practitioners, speech and language therapists, or parents who notice a pattern of communication differences across environments. A child with selective mutism may speak freely with close family members but remain silent in school, around unfamiliar adults, or in public settings. Early signs can include inability to answer direct questions in class, reliance on gestures, nodding, or pointing, avoidance of eye contact, freezing when expected to speak, withdrawal from group activities, visible distress during social interaction. Diagnosis is generally based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders. Stated by Kashyap (2026), a diagnosis requires the following: consistent failure to speak in specific social situations where speaking is expected, normal speech in other settings, symptoms lasting at least one month beyond school adjustment periods, interference with educational or social functioning, symptoms not better explained by another communication disorder or autism spectrum condition alone. A multidisciplinary assessment is often recommended. This may involve educational psychologists, speech and language therapists, paediatricians, teachers, and family members. Assessment usually includes behavioural observation, developmental history, school reports, and exclusion of hearing impairment or language disorder. One challenge in diagnosis is that selective mutism can be confused with autism spectrum disorder, speech delay, trauma responses, or English as an additional language. A child learning English may naturally experience a silent period, but this differs from selective mutism because the anxiety pattern is less persistent and communication gradually increases. Delayed diagnosis remains common because adults may assume the child is simply shy, stubborn, or lacking confidence. This misunderstanding can unintentionally reinforce anxiety by placing pressure on the child to speak before they feel safe.

Impact of Barriers on Children with Selective Mutism - Children with selective mutism experience several barriers that affect learning and inclusion. Classroom participation is heavily reliant on verbal communication. Muller (2020) states that pupils may struggle to answer register questions, participate in discussions, ask for help, or demonstrate understanding verbally. This can result in teachers underestimating cognitive ability or academic knowledge. Assessment practices can also disadvantage these children. Oral presentations, reading aloud, and group tasks may create intense anxiety, causing pupils to avoid tasks or disengage completely. A lack of understanding from staff can worsen outcomes. If adults interpret silence as defiance or poor behaviour, children may experience increased shame and anxiety. Peer relationships are often impacted because communication is central to friendship formation. Nathanson (2026) states that children with selective mutism may want social interaction but feel unable to initiate or respond. This can lead to social isolation, peer misunderstanding, exclusion from play and dependency on one familiar peer or adult. Without support, children may become increasingly withdrawn, affecting emotional wellbeing and confidence.

Emotional and psychological barriers - Wong (2010) believes that Selective mutism is closely linked to social anxiety. The repeated experience of wanting to speak but being unable to, can create frustration, embarrassment, and low self-esteem. Children may internalise beliefs such as: “Something is wrong with me”, “People think I am rude”, “I will get it wrong if I speak” Over time, untreated selective mutism may contribute to generalised anxiety, school avoidance, depression, or persistent communication difficulties into adolescence. Family stress can also increase, as parents may feel guilt, confusion, or pressure from professionals to “make” their child speak.

Support Strategies - One of the most effective support strategies for selective mutism, according to SMA (2026), is graded exposure, often used alongside cognitive behavioural principles. Graded exposure involves gradually reducing anxiety by introducing communication demands in small, manageable steps. Rather than expecting immediate speech, adults support progress through low-pressure communication opportunities. An Example of progression is this - child communicates non-verbally with trusted adult, child whispers to parent in school. child whispers to trusted adult with parent present. child speaks softly to adult in low-pressure environment. speech generalises to classroom and peers This strategy is effective because it targets anxiety rather than focusing solely on speech output. Adults should avoid, pressuring the child to speak, praising speech in a way that increases self-consciousness, speaking on behalf of the child excessively, forcing participation in verbal tasks unexpectedly. Instead, supportive practice includes establishing predictable routines, allowing alternative communication methods, using visual supports, building trusted adult relationships and creating low-demand speaking opportunities Collaboration between home and school is essential. Consistency helps the child feel safe and reduces mixed expectations. Speech and language therapists may also support intervention by assessing communication skills and advising staff. The graduated approach aligns with inclusive education because it prioritises accessibility, emotional safety, and participation.

Conclusion - Selective mutism is a significant anxiety disorder that can create serious barriers to education, communication, and emotional wellbeing. Although children with selective mutism may be misunderstood as shy or oppositional, the condition reflects severe anxiety rather than behavioural refusal. Early identification is essential and should involve observation across settings, multidisciplinary assessment, and awareness of differential diagnoses. Delayed recognition can intensify barriers and negatively affect both academic progress and social development. Graded exposure offers an evidence-informed support strategy that promotes communication development through small, achievable steps. When combined with collaborative working between families, educators, and professionals, children with selective mutism can experience improved confidence, participation, and inclusion. A strengths-based approach is therefore essential in ensuring that children with selective mutism are supported effectively within educational settings.

References

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