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Selective Mutism vs Reactive Mutism

A Position Paper Advocating for Improved Terminology, Understanding and Support

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Selective Mutism vs Reactive Mutism

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Maggie's interest in selective mutism began in the seventies when she refused to believe that the young person referred to her was 'choosing not to speak'. She has been an advocate for those affected by selective mutism ever since, working closely with young people and their families to develop effective support strategies, calling on her professional body to recognise and address selective mutism, and supporting parent associations worldwide to challenge outdated and harmful therapeutic practice.

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If you have any feedback on this position paper, we would love to hear from you. You can share feedback using this link: https://forms.gle/FHF5ZtqEvkUzPxKr8

Why is this important?

In “autism circles”, when people are distressed/dysregulated/unable to speak as a result of a high level of stress, this is often labelled “situational mutism”.

In “selective mutism circles” where selective mutism is often described as a phobia of the expectation to speak, some people say it’s helpful to call it “situational” as people do not always understand the medical definition of “selective”, and do not like the fact that “selective” makes it sound like a choice when it is not.

As a result, the term situational mutism is currently being used to describe different things which is causing confusion.

If an autistic person is unable to speak, it can be a response to stressors or the environment[1], but it can also be a phobia of the expectation to speak[2]. Depending on the reason, different support and input is needed and importantly, the wrong support can have a negative impact:

If someone experiences mutism as a reaction to stressors or the environment, treating this as a phobia or irrational anxiety by using graded exposure (small steps) is likely to create extra stress for the person who is experiencing it.

Placing the onus on the individual, rather than modifying their environment, can lead to feelings of inadequacy, frustration, anger or failure. This has been linked to masking in the autistic population, which can be detrimental to their wellbeing[3] and leads to life changing experiences such as autistic burnout[4]. Recognising the role of external factors is vital when it comes to supporting people who experience this type of mutism.

If someone experiences a phobia of the expectation to speak and people assume it is a freeze response as a result of stress, no action will be taken to help them overcome the phobia.

Without appropriate support they will struggle with selective mutism for far longer than they should:

- People who experience selective mutism report that it is extremely distressing.
- The longer you experience selective mutism, the more difficult it is to overcome.

Early intervention and understanding are therefore vital when it comes to supporting people who have selective mutism.

We believe there are three issues:

1. The term situational mutism is currently used to describe different things

- and we believe that using different terms to describe these different things is essential to reduce confusion and ensure that people get the right support:

Selective mutism (SM)
- an anxiety disorder triggered by, according to diagnostic criteria, the expectation to speak[5]. Anxiety disorders occur when harmless objects or situations trigger fear, anxiety or avoidance behaviour - individuals develop an imaginary fear that is out of proportion to actual events[6].

Reactive mutism (RM)
- an umbrella term used to describe mutism that is an understandable reaction to an actual event. For example, an event could involve potential harm or threat, leaving the individual emotionally traumatised and mute or withdrawn in all settings. Or the event could involve environmental stressors which leave the individual overwhelmed and unable to deal with a bombardment of sensory information. Either way, with RM there is, or was, a real threat to the individual's well-being.

We believe that both SM and RM are more common in autistic people because they are likely to be "more sensitive" in nature, making them more prone to developing anxiety disorders, and/or they experience higher levels of stress than the general population.

2. RM (as per the definition above) is not well understood, as it is often conflated with SM. Individuals with RM are therefore not getting the help they need. We believe there needs to be more public information and signposting around this.

This document aims to be the start of this process, by sharing a clear description of what SM is, what RM is, and the key differences between the two.

3. SM is an official diagnostic term for a specific type of mutism[7], but due to lack of recognition of RM, both 'situational mutism' and 'selective mutism' are being used as umbrella terms to describe various types of mutism. Losing sight of the official diagnostic term 'selective mutism' is causing problems for individuals and families when it comes to seeking support.

Different types of mutism fall within the remit of different professionals, each with a skill set that is suited to dealing with particular underlying issues. For example, mental health professionals may be able to support clients who have experienced emotional trauma; autism specialists, specialist teachers and occupational therapists may provide support for sensory differences, masking and burnout; speech and language therapists and psychologists may also specialise in autism and be familiar with facilitating social interaction and working through communication hierarchies. It is important to get support from the right professional.

Some specialists have a broad range of knowledge and are able to give accurate advice and support based on the reasons behind mutism or identify when an alternative referral is needed. But many families report dissatisfaction in how they are supported and the impact this is having on both the young person and their family. We believe that more specific terminology and associated guidance would help individuals and families make better use of available services and get the right help in a more timely manner.

What is Selective Mutism?

Selective mutism (SM) is an anxiety disorder that can affect almost anyone, leaving them unable to speak at times. The term “selective” means “non-pervasive” or “specific”.

While autism is known as “pervasive” (meaning you are always autistic wherever you are), SM occurs in “select” situations, meaning that you are affected in some situations, but not others. The term “selective” does not mean it is a choice.

SM is defined in two international classification systems: the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Both systems recognise that SM may occur alongside other anxiety disorders and/or communication difficulties. The wording regarding dual diagnosis of SM and autism has been less clear but the ICD-11 gives the most recent definition and makes it clear that SM and autism should not be confused. It is possible to have both SM and autism if the diagnostic criteria for both conditions are met.

Within both classification systems, clinicians are invited to use their clinical judgement within the general policy that if the criteria are met for more than one diagnosis, then both diagnoses may be given. Recent evidence indicates that SM and autism should be regarded as separate, but frequently co-occurring conditions[8, 9, 10] and this is backed up by extensive clinical experience[11,12.]

Selective Mutism, ICD-11 CDDR (2024)[11]

“

- **A child demonstrates adequate language competence in specific social situations (typically at home) but consistently fails to speak in other specific social situations (typically at school).**
- **The duration of the disturbance is at least 1 month, not limited to the first month of school.**
- **The disturbance is not due to a lack of knowledge of, or comfort with, the spoken language demanded in the social situation.**
- **The symptoms are not better accounted for by another disorder (e.g. autism spectrum disorder or developmental language disorder).**
- **The failure to speak significantly interferes with educational achievement or with social communication, or other important areas of functioning.”**

Neither classification system attempts to explain the nature of SM but by classifying it as an anxiety disorder, they acknowledge that the mutism is caused by a disordered anxiety response to a situation, rather than the situation itself. As explained below, SM is best viewed as a phobia of the expectation to talk in specific social situations[13,14,15.] When you feel this expectation to talk - for example, a person you’ve never spoken to before asks you a question - you experience a “freeze” response, meaning you physically can’t speak even if you really want to.

As with any phobia, selective mutism can be overcome with the right support.

Why view selective mutism as a phobia?

- SM meets the diagnostic criteria for a phobia
- It is the only explanation that can account for every occurrence of SM
- Only phobias trigger such an instant (automatic) freeze reaction that is consistent rather than mood-dependent
- Phobias are not regarded as 'refusal' to act
- Avoidance is viewed objectively as a natural part of phobias rather than a causal factor
- It explains the complete lack of anxiety at times
- The onset of SM can be explained in the same way as the onset of phobias - an unfortunate combination of events that leads to 'fear-conditioning'
- As with all phobias, selective mutism appears to follow a set of "rules"
- SM responds to the same treatment as phobias
- It puts the focus on appropriate management rather than different types of SM

SM meets the diagnostic criteria for a phobia

Marked and excessive fear or anxiety that consistently occurs upon exposure or anticipation of exposure to a harmless situation (the expectation to speak). The phobic situation is actively avoided or else endured with intense fear or anxiety.

It is the only explanation that can account for every occurrence of SM

Researchers have tried to find the underlying cause of SM by looking at shared characteristics but have not found an answer; this is a heterogeneous group of people with as many differences as similarities. Viewing SM as a phobia allows for all these differences and provides a simple explanation - what the SM population has in common is their SM. All of them have a phobia and have come to associate the expectation to speak to people outside their existing talking circle with a sense of panic, dread or extreme anxiety.

Only phobias trigger such an instant (automatic) freeze reaction that is consistent rather than mood-dependent

If you have a phobia of dogs you do not have good days and bad - you experience the fight-flight-freeze reflex automatically, every time you are exposed to a dog. It is the same for SM. The pattern of failure to speak is consistent, predictable and automatic (outside the individual's control).

Phobias are not regarded as 'refusal' to act

The general public is not judgemental when it comes to phobias. People understand how a person with a phobia of flying would miss an important event rather than get on a plane. They do not view this as refusal to fly or a desire to manipulate the situation for personal gain - they are sympathetic and know the person wants to attend the event but is unable to face their fear. It is now accepted that SM is not 'refusal to speak' and embracing it as a phobia brings greater understanding and appropriate support.

Avoidance is viewed objectively as a natural part of phobias rather than a causal factor

Avoidance of social situations is a huge part of SM, hence the misconception that SM is a form of social anxiety or shyness. People with SM will naturally want to avoid settings where they might be put on the spot and expected to speak, but it is the need to talk that they dread - not the setting per se. We see this with other phobias - someone with a phobia of dogs may avoid parks. They do not have a fear of parks, only what they might find there.

Avoidance is how people with phobias try to keep their anxiety in check. Although this avoidance can make people with SM appear to be shy, the majority are not shy with their friends and families and are confident with others once they've overcome their SM. People who have phobias work very hard to avoid exposure to the trigger of their phobia. They will opt for a pet rabbit rather than a dog, take a ferry rather than fly - understandable substitutions that free them from phobic anxiety.

It is not so easy to avoid exposure to the need to talk. Every day can become a painful endurance test. Many children with SM do all they can to get out of going to school where they are frequently asked questions and encouraged to talk; actions which repeatedly trigger their phobia. But some - in many ways the lucky ones - recognise that they do not experience a phobic response when they make no attempt to talk. They therefore resolve not to talk in challenging environments such as school. A weight is then lifted and they are able to participate in activities without anxiety. This strategy is only effective for people who are able to disregard the social pressure to talk that surrounds us all. Opting for silence is secondary to their SM, not the reason for it; it is a coping strategy just like opting for a rabbit or the ferry.

It explains the complete lack of anxiety at times

Families frequently report that their children are 'two children rolled into one' - in some settings they are completely relaxed, talkative and noisy; in others they are quiet, tense and withdrawn. The same child may freeze with a blank expression when expected to talk to certain people, but quickly relax and have fun in the same setting when it is clear to them that there is no need or expectation for them to talk.

SM is an anxiety disorder so it can be hard to understand that people who have SM are often far from anxious. Indeed, seeing someone go from quiet and withdrawn one minute, to confident and even cheeky the next, can sometimes give the impression that the SM is all an act. Once SM is seen as a phobia rather than a product of general anxiety, this change in behaviour can be viewed more objectively.

When the trigger (the expectation to talk to certain people) is neither present nor anticipated, the individual can be their true self. Consequently, children and adults who have SM may surprise others by confidently performing in public in ways that seem to be much scarier than talking - activities such as photographic modelling, playing a musical instrument on stage and competitive gymnastics.

The onset of SM can be explained in the same way as the onset of phobias - an unfortunate combination of events that leads to 'fear-conditioning'

Although many families and individuals try to rationalise SM by linking it to a traumatic event such as moving house or a bereavement, just as many can find no rational explanation for the failure to speak. This is typical of phobias of harmless objects like buttons that are caused by a psychological process called 'transference'. The individual's initial panic is not caused by buttons - they simply happen to be holding or fiddling with a button while alarmed by something else. In this moment, the source of their panic is subconsciously transferred from the actual event to the button. Touching, possibly even looking at a button, subsequently triggers the same panic feeling as the original event.

The onset of SM can usually be explained in the same way - a well-meaning stranger or unfamiliar person tries to engage a child who is too alarmed or shocked by the situation they find themselves in to speak. Parents are rarely present which contributes to the child's anxiety. For example, the child is separated from parents when in hospital or when staying with relatives they hardly know and does not know what is happening to them or when they'll see their parents again. As the child's heart races, a stranger or unfamiliar person talks to them and tries to elicit a response. In this moment, the child's panic becomes associated with the expectation to speak to someone who is outside their existing talking circle.

Other explanations for phobias include 'modelling' (e.g. learning from a parent to be afraid of spiders) and 'direct association' (e.g. being bitten by a dog and believing that all dogs are dangerous). Both these explanations can also be found within the SM populations (e.g. learning from an older sibling to avoid talking outside the home; being mocked about speech difficulties and becoming afraid to talk).

As with all phobias, selective mutism appears to follow a set of "rules"

Owing to the nature of fear-conditioning and the unique set of circumstances in which phobias arise for each individual, phobias are highly specific in nature and the triggers vary from person to person. For example, a phobia of buttons may involve only buttons of a certain texture, material or appearance. Having no control over their response to certain triggers, it will seem to the individual that their reactions are governed by an internal set of 'rules' rather than their own choice.

So it is with SM. The pattern of failure to speak varies from one individual to another, particularly in terms of who they can and can't talk to, who they feel comfortable being overheard by, and how far they need to be from bystanders in order to talk.

Whatever the pattern, it will be highly consistent in line with a set of 'rules', and the individual will be unable to speak in certain situations in accordance with those rules. The rules reflect the individual's unique set of anxiety-triggers and are not of the individual's making in the first instance, but will become more conscious as the individual tries to understand and manage their SM.

Carl Sutton writes about his rule system in the book 'Selective Mutism In Our Own Words'. The final rule reflects the shame he experienced as a result of his SM, as much as his need to avoid any situation that might lead to an expectation to speak to someone for the first time. Keeping his speaking and non-speaking worlds apart was a constant struggle:

- I was compelled to be mute with certain people every time I encountered them.
- Those who had never heard me speak would never hear me speak.
- Anyone associated with anyone I could not speak to could not be spoken to.
- Those who only knew me as mute could not discover I could speak in other situations.
- Those who did not know I was mute in other situations could never find out about my muteness.

SM responds to the same treatment as phobias

Treatment involves exploring and understanding the onset and maintenance of the phobia to ensure a general reduction in anxiety, followed by gradual exposure to the feared object or event until the automatic fight-flight-freeze response has been eliminated. It is possible to completely overcome SM using this approach, while interventions that target social anxiety, confidence-building, social skills and language development are partially effective at best and detrimental at worst.

It puts the focus on appropriate management rather than different types of SM

It is recognised that no two individuals with SM behave in the sameway and this has led various researchers to attempt to classify SM into subtypes with a focus on the individual rather than the behaviour of adults in response to the individual's SM. Phobias are maintained by pressure and avoidance. Pressure increases anxiety and the negative feelings associated with the feared object or event, while avoidance provides temporary relief and reinforces the individual's belief that the feared object or event poses a threat.

Viewing SM as a phobia introduces an essential element to effective intervention. Adults around the individual are helped to identify and eliminate any maintaining factors by removing pressure to talk while helping individuals to participate in social situations at their own pace rather than avoiding them completely. When SM is recognised early, adjusting adult behaviour in this way may be all that young children need in order to overcome SM.

Additional points about selective mutism:

Selective mutism affects more than talking

Individuals who have SM rarely have difficulty only with talking, particularly if their SM is not being handled sympathetically or appropriately by those around them. This is seen in a number of ways.

Phobias are always managed through avoidance as this reduces the likelihood of the phobia being triggered. It is an instinctive reaction to try to avoid anything that could lead to an increased expectation to talk or interact with others, for example:

- Non-verbal communication using gestures, writing, drawing, etc.
- Making choices
- Being the centre of attention
- Meeting new people
- Initiating contact
- Earning praise
- School attendance

Having SM affects your ability to initiate conversation so you may be unable to meet essential needs such as:

- Accessing the toilet.
- Reporting illness and bullying.
- Asking for help to understand classwork and homework assignments.
- Using the canteen.
- Maintaining friendships.

The physical effects associated with SM include anxiety-induced nausea and muscular tension (freezing) which can interfere with routine activities such as:

- Eating.
- Walking, running, sports.
- Writing and keyboard skills.

Knowing that there are situations where you will freeze and be unable to speak can create enormous social anxiety if your difficulty is not acknowledged and accommodated by people around you. Concerns may include:

- What will people think of me when I don't say anything?
- How will I cope when I can't tell people what I need?
- Will I get told off/humiliated/ignored again?

- Will I be accepted the way I am?
- Why does no-one get that I'm not doing this deliberately?
- If I do manage to speak a little, will I be expected to talk all the time, before I'm ready?
- How will other people react to hearing me talk for the first time? Will I be able to deal with their comments/questions?

If SM is ignored or mishandled over a long period, this natural social anxiety can develop into one or more secondary psychological issues. These can take time and additional help to resolve and, in some cases, can persist even after the SM has been addressed. For example:

- Difficulties attending school
- Social anxiety disorder - a fear of being negatively evaluated which is extreme and out of proportion to actual events
- Depression
- Self-injury
- Isolation and dependence on carers.

It's common for people who are sensitive and susceptible to developing anxiety disorders to have a low tolerance to sensory input and to experience more than one anxiety disorder at the same or different times. They could also be experiencing developmental difficulties which impact on their general confidence and anxiety levels or ability to interact. It is therefore possible to experience one or more of the following in addition to SM:

- Sensory issues
- Separation anxiety
- Other fears or phobias
- Autism
- Specific learning difficulties
- Poor coordination, posture and balance
- Speech and language difficulties

Some of the additional difficulties and anxieties discussed in this section can be completely avoided through early recognition and sensitive handling of SM. Others occur independently of SM and require different but complementary support. Either way, it is important to be aware of the wider picture and potential impact of SM in order to address all concerns and provide support for any anxieties that may be influencing the individual's behaviour.

Selective mutism is not always perceived as a fear of talking

SM is commonly described as 'a fear of talking' which is less of a mouthful than 'a phobia of the expectation to talk' - but not all young people see it this way. They might feel too scared to go to school in case they have to talk, and they might dread being asked a question by people they've never spoken to, but they may reject the idea that they're too scared to talk. They would talk if they could; it's just that something stops them – so if anything, they're scared of not talking.

Phobias trigger the fight-flight-freeze reflex which is primarily a physical response - a state of panic characterised by a racing heart-beat, muscle tension and shortness of breath. When the trigger is something you can see, like a dog or spider, it's easier to link the feeling of panic to something concrete and identify with being scared of that object - your bodily sensations are then associated with the emotion of fear. But with SM there's nothing to see except things that might not be scary at all - a kind relative or teacher, for example, or an enjoyable activity.

Consequently, not all people who have SM associate the intense discomfort they feel when they try to talk with fear. This is particularly true of neurodivergent individuals who struggle with 'interoception' - the awareness and understanding of internal bodily sensations. Nonetheless, their fight-flight-freeze reflex is triggered when they respond to the expectation to speak and their automatic warning system tells them 'Danger, don't do it'; their muscles tense, their vocal cords freeze and talking is impossible. They don't know why this happens, they just know that they don't like it and don't want it to happen again.

People with a tendency to focus on the here and now rather than the overall picture, may focus only on the effect of trying to talk - a horrid sensation and their words getting stuck in their throat. They may therefore say - and genuinely believe - that they don't want to talk. They lose sight of the fact that they wanted to talk in the first place - that's in the past. They may be adamant that they're not scared of talking - they just don't want to do it - and may make no attempt to talk in certain settings as this enables them to avoid distress.

A 15 year old who has come to understand that her SM is a phobia and is well on the way to overcoming it says: 'Don't believe them when they say they don't want to talk. They do. They just don't want to be in a situation where it's hard for them to talk.' [16]

Nonetheless, it is very important to take on board each person's view and use that as a starting point for any conversation about SM. It is not helpful to describe SM as a fear of talking if that is not how they see it. And it is not surprising that they don't want to talk when they have found it so difficult in the past.

Low profile selective mutism is easily missed

There is a presentation of SM called “low profile selective mutism”, where people can speak a little to most people, but still meet the criteria for a diagnosis of selective mutism. This often goes under the radar as it’s easy to assume they are just shy or rather quiet.

People with low profile selective mutism have the same fear of talking as any other person with SM, but it is outweighed by fear of what will happen if they do not speak.

People with a low profile presentation of SM can often be recognised by the strain or distortion in their voice when talking outside the comfort of their home or friendship group. They can manage the minimum of speech when they are trying hard to fit in. They are therefore able to respond to others if this can be done in a few words, but are unable to initiate vocal interaction, give long explanations or talk about tricky subjects such as their true feelings or emotions - exchanges that are unpredictable or require more words. Consequently, there are many social situations where they find themselves unable to talk.

Young people with low profile selective mutism often seem “fine” at school because they manage to answer questions and passively comply with instructions, but they can have meltdowns and struggle when they get home. Like all young people who have SM, they may be unable to let staff know how they feel during the day, so their discomfort and frustration builds until they are home and able to release it.

What is Reactive Mutism?

RM is a term first used by Torey Hayden in a paper published in 1980[17]. It described mutism that occurred as a reaction to a single or a series of traumatic events. Recognising that mutism is sometimes the body's response to distressing circumstances is important, not least because the emphasis is then firmly placed on directly addressing and alleviating that distress. We have therefore expanded the term to refer to mutism that arises as a reaction to any form of stress or trauma.

RM is where someone is physically unable to speak due to the stress/anxiety/overwhelm they experience in response to an actual event or situation. This may be something that happened to them in the past (e.g. an emotionally traumatic incident), something that is happening to them in the present (e.g. a conversation about an emotive subject, or sensory overload caused by a stressful classroom environment that is too loud, too bright and operating at too fast a pace) or something they have come to anticipate (e.g. a struggle to get through the day with a lack of understanding and support from teaching staff or being in an environment that isn't suited to their sensory needs). RM is therefore a sign of distress, rather than an anxiety disorder, similar to not speaking when in a state of shock.

When RM occurs in response to an emotionally traumatic event, it has also been described as 'traumatic mutism'. This may be total (the affected person stops talking completely) or partial (the person becomes withdrawn and says much less than usual). Traumatic mutism may persist for days, weeks or months after the event and, unlike selective mutism, can be observed in all settings[11,18].

RM can affect anyone, but is particularly prominent in the autistic population, due to:

- Sensory differences, resulting in autistic people being more likely to experience sensory overload.
- Difficulties perceiving, recognising or modulating their body's internal state can lead to autistic people feeling emotions extremely intensely or experiencing confusing sensations which contribute to their overload.
- Struggle with emotional regulation makes it harder for some autistic people to stay calm in stressful situations.
- Autistic people are likely to experience high levels of anxiety around any situation involving uncertainty (Jenkinson et al., 2020), e.g classroom instruction, unexpected timetable changes, meeting new people.
- Autistic people on average experience higher levels of stress than the general population, meaning they are more susceptible to a build-up of stress from different sources. This means that sometimes it may only take a small thing to raise their stress to an intolerable level.

Reactive mutism can sometimes look like selective mutism

RM be caused by being in an environment that is not suited to your needs. If an environment causes consistent levels of stress (e.g. if it is too busy, too loud or you are anxious due to being picked on by others), this can put you into a permanent state of anxiety in that environment, which can result in a 'selective mutism presentation' (i.e. a young person speaking freely at home but not being able to speak at school). If the environment was less stressful for the person, speaking would be easier.

Unfortunately, some young people become so stressed at school that they associate the setting with stress and shut down on arrival. When this happens, they are unable to talk there, even when the environment has been adapted to their needs.

People can have both selective mutism and reactive mutism

Someone may have a phobia of the expectation to speak in certain situations, AND be unable to speak when anxious/stressed/overwhelmed. SM and RM are not exclusive. For example:

- Mia had a low-profile presentation of SM until she was 16. She was then traumatised by being shouted at publicly at school and stopped talking completely (RM). Two years later she started talking again to her immediate family and gradually added other adults to her talking circle (SM). She continues to be deeply affected by conflict and negative judgment, and may talk to no-one for days at a time (RM).
- Sam can talk to his best friend at school but no other peers (SM). When overwhelmed by classroom noise or confusing instructions he doesn't talk to his friend either (RM).

It sometimes helps to remember that people who have SM are consistent in their pattern of NOT talking, rather than their pattern of talking. If their usual pattern of talking is disrupted, this could be due to RM or reluctance to talk (see Footnote).

Is it selective mutism or reactive mutism or both?

The following comparison may be helpful when making a diagnosis. It should not be necessary to spend a long time trying to decide if a person is experiencing SM or RM. If they are displaying signs of both, they are most probably experiencing both.

Aspect	Selective mutism (SM)	Reactive mutism (RM)
Link with anxiety	SM is an anxiety disorder - the individual experiences a disproportionate panic reaction in response to a harmless trigger (the need to talk). The anticipation of being unable to talk makes the person stressed/anxious.	RM is a response to being overwhelmed/stressed/ traumatised. The individual's response is to be expected given their circumstances. Being stressed/anxious makes the person unable to talk.
Pattern of mutism	SM is a consistent inability to speak in certain social situations where speaking is expected. The pattern is therefore person dependent. A fairly limited range of people can be identified with whom the person behaves naturally and talks to easily provided no-one else is present. The person does not talk to, or often in front of, anyone else. The person often acts differently and behaves in a more inhibited manner with the second group of people but can be relaxed and outgoing when confident there's no need to talk. This pattern does not change from day to day and can persist for months or years, but with the right support, the number of people that the person talks to will gradually increase.	The pattern of talking relates to the person's stress level and whatever has caused that stress, be it a particular memory, location, person, intrusive thoughts or overwhelming environment. In contrast with SM, no-one is exempt from the effects of RM - when stressed or overloaded, the person can't speak to anyone and when traumatised after experiencing or witnessing a threatening event, the person is less communicative with everyone. There is also less consistency - for example, the person talks to others on a fluctuating basis depending on their level of stress. RM reduces as the individual's stress level subsides.

Aspect	Selective mutism (SM)	Reactive mutism (RM)
Trigger	SM is triggered by the expectation to talk to people outside your existing talking circle. It is rarely confined to a single setting like school and can be observed in other settings as a dislike or wariness of being overheard by people who know you as mute or people you have never spoken to.	RM is a loss of speech triggered by stress or trauma. Sometimes there is a gradual build-up of stress and after talking with no difficulty, the person shuts down and is unable to speak. RM can also be centred around a single setting that the person always finds stressful and may persist for some time after leaving that setting while the person takes time to decompress.
History of talking	Children typically develop speech in the usual way with close family and regular visitors to their home. After SM develops, the person continues talking to people they talk to regularly, but does not talk to new or unfamiliar people. Consequently, there will be many people who have never heard the person's voice.	When mutism is due to trauma, there are typically no concerns about the person's talking prior to the trauma. After the trauma, the person stops talking to people they previously spoke to.Similarly, when mutism is due to environmental stress or sensory/emotional overload, the person is unable to talk to people they could talk to before.
Talking in front of other people	The person could be talking happily to someone (e.g. a friend or parent) but will suddenly tense and stop talking or whisper when they notice someone from outside their talking circle (e.g. teacher, strangers, extended family). This is because, often subconsciously, they associate being overheard with an increased expectation to talk.	When relaxed and talking easily, person with RM do not usually stop talking when aware that other people are in earshot. Being overheard does not increase their stress unless they associate the bystander(s) with stressful circumstances or don't want them to hear WHAT they are saying (as opposed to revealing that they can talk).
Reason for not talking	Until SM is explained as a phobia or as words getting stuck in their throat, the person doesn't know why they don't talk - they simply find they can't do it. However, when repeatedly asked why they don't talk they may come up with a reason that doesn't always make good sense, e.g I hate my voice; I don't want to spread germs.	The person sometimes know why they can't talk. They may be aware that their environment is stressful, that they feel acutely uncomfortable with certain people or the topic of conversation, that they can't talk when they get angry or upset or it just feels like everything is too much.

Aspect	Selective mutism (SM)	Reactive mutism (RM)
Reason for not talking (cont.)	As they get older, their reasons often reflect increased social anxiety, e.g. I don't want to say the wrong thing; I don't want to draw attention to myself; people will think it's weird if I start talking now. Adults are often baffled by the person's lack of speech and see no reason for it.	Adults are sometimes able to see signs of stress, e.g. increased irritability; hands over ears; eyes shut. It may also be possible to identify an event that triggered a trauma response and subsequent reduction of speech, e.g. an incident of bullying or being restrained.
How it feels	Individuals who have SM may be aware of the physical effects of the fight-flight-freeze response as they try to speak - for example, racing heart, tingling hands, tight chest or shortness of breath. But in addition, they report or identify with a sensation that their words get stuck in their throat and won't come out. If the person is unable to explain to parents or trusted adults how it feels when they try to talk, they can be given a list of statements to choose from. The person with SM selects a statement such as 'I want to talk but I can't get the words out – my throat feels blocked.'[19]	People with RM also report feeling stuck but it tends to be more general than words getting stuck in their throat. For example, they may report feeling overwhelmed, suffocated, helpless, unable to process what is going on around them, drowning in their emotions, or unable to move, speak, act or escape.
Visual signs	When talking in public places to friends or relatives, person with SM does various things to reduce the risk of people outside their talking circle seeing them talk: they may cover their mouth with their hands, move their lips as little as possible, whisper in their parents' ears, or all three. They tend to keep their lips firmly together in settings where they fear people may expect them to talk, and rarely smile in school photos.	Depending on the source of their stress, person with RM may do the same things as a person with SM. They may also try to shut out stressors by e.g. covering their ears, shutting their eyes, putting their heads on their desks or walking away.
Effect of removing expectation to speak	When reassured there's no expectation to speak and finding that this is indeed the case (adults are doing all the talking, asking no questions and conveying approval), the person who experiences SM visibly relaxes and is able to participate in activities.	When the person is experiencing RM, telling them there's no need to talk is rarely enough to offset their stress levels and facilitate relaxed non-verbal participation - RM is part of a more general stress response.

Aspect	Selective mutism (SM)	Reactive mutism (RM)
Effect of environmental stresses	The person with SM is unable to speak to certain people, regardless of environmental factors such as noise-level, flickering lights, visual distractions or spoken language overload. Removing these factors or moving to a less stressful environment does not help. But moving away from other people allows the person with SM to start responding to a trusted adult on a one-to-one basis. Some people with SM do better with background noise as they are able to talk quietly to their friends without fear of other people overhearing.	When mutism is due to an inability to cope with factors in the immediate environment, adjusting the environment can reduce stress and make it possible to speak again. Sometimes person are not able to destress until they have actually left the setting they are in, but once in an environment without stressors, they will be able to decompress and talk in time. When mutism is a reaction to trauma and its associated memories, thoughts and feelings of being unsafe, person need emotional support to feel safe again. This can be a lengthy process.
Effect of graded exposure	The person with SM usually responds rapidly to: i) Having their difficulty talking spoken about openly with reassurance that it's not their fault and talking will get easier ii) Removing all pressure to speak - person is told there's no rush and they can talk when they feel ready/when it feels easier iii) Graded exposure to the expectation to talk via simple modifications that parents and staff build into natural conversation (e.g. commentary-style talk; graded questioning; using friends/ parents as go-betweens) iv) If necessary, graded exposure to the expectation to talk via a small-steps programme in addition to the above.	Person with RM will not be helped by a small-steps programme of graded exposure to the expectation to speak, this may even add to their stress. However, i) - iii) in the opposite column could give them time to build trust in adults if that's what's needed - the techniques used in iii) are completely non-invasive and used at the person's pace. But if it's modification of environmental stressors that's needed, i)-iii) will have no effect.

Footnote: Reluctance to talk

Just like anyone else, people who experience SM and/or RM may be reluctant/unwilling to talk at times in case this has negative consequences. Unlike SM and RM, reluctance to talk is a conscious decision not to talk which may be associated with some anxiety but does not trigger a panic reaction or shutdown beyond the person's control.

Reasons for preferring not to talk include:

- Fear of making a mistake or being corrected
- Fear of being laughed at, teased or disrespected by others
- Fear of not being heard or understood
- Not wanting to upset another person or talk to a person who has upset you
- Not wishing to be drawn into a topic that is uncomfortable, uninteresting or time-consuming
- Not wanting other people to overhear a private conversation.

Reluctance to talk does not have the consistency of SM - the person talks freely when not concerned about the consequences of talking. Nor does it have the wide-reaching and lasting effects of RM - the person does not need time to destress before moving on to other things. However, one can lead to the other.
If encouraged to talk when already feeling uncomfortable, this pressure can lead to a complete shutdown and inability to talk (RM). And repeated incidents of this type or insensitive handling can lead to consistent and more generalised inability to talk (SM).

References:

- 1. DSM-5, page 57, and ICD-11 CDDR, page 129, list 'sensory sensitivities' as an additional feature of autism. NAS website states that sensory overload in autism can result in withdrawal, distressed behaviour, meltdowns or not responding.
  - Diagnostic and statistical manual of mental disorders (5th ed.), (2013). Arlington, VA: American Psychiatric Association
  - Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders (2024), World Health Organisation, Geneva.
  - National Autistic Society, https://www.autism.org.uk/
- 2. DSM-5, page 58, states that autism and anxiety disorders can co-occur. ICD-11 lists autism as an exclusion to SM, i.e. a different/separate disorder, and ICD-11 CDDR explains on page 23 that both conditions may be diagnosed at the same time.
- 3. Cage and Troxell Whitman (2019). 'Understanding the Reasons, Contexts and Costs of Camouflaging for Autistic Adults'. Journal of Autism and Developmental Disorders 49(10)
  - DOI: 10.1007/s10803-018-03878-x
- 4. Raymaker et al. (2020). 'Having All of Your Internal Resources Exhausted Beyond Measure and Being Left with No Clean-Up Crew: Defining Autistic Burnout'. Autism in Adulthood 2(2):132-143. DOI: 10.1089/aut.2019.0079
- 5. DSM-5, page 189, describes SM as a failure to speak when speaking is expected while ICD-11 refers to situations requiring speech.
- 6. DSM-5, page 189, explains that anxiety disorders are only diagnosed when there is no other explanation for the symptoms. Individuals with anxiety disorders overestimate the danger in situations they fear or avoid, i.e. the threat is imagined.
- 7. Selective mutism is a highly consistent failure to talk in certain social situations which is categorised under Anxiety Disorders in DSM-5 and ICD-11 - meaning that there is nothing that the mutism can be attributed to, other than an imagined threat. Identifiable stressors such as environmental stress and emotional trauma are covered elsewhere: DSM-5, p.50, autism, 'hyper-reactivity/adverse reaction to sensory input'; ICD-11, autism, 'excessive and persistent hypersensitivity to sensory stimuli'; DSM-5, p.265, Trauma and stressor-related disorders; ICD-11, 6B4 Disorders specifically associated with stress and QE84, Acute stress reaction.
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- 14. Johnson, M., & Wintgens, A. (2015). 'Viewing selective mutism as a phobia of talking: The importance of accurate conceptualisation for effective clinical and parental management'. In C.A. Essau & J.L. Allen (Eds.), Making parenting work for children's mental health (ACAMH Occasional Paper 33, pp. 61–71). Association of Child and Adolescent Mental Health. https://www.researchgate.net/publication/316929020
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- 16. 'Silent children - approaches to selective mutism', a film made by SMIRA in conjunction with the University of Leicester, 2004. https://www.selectivemutism.org.uk/videos/
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- 19. Form 9, 'Worrying Thoughts', in The Selective Mutism Resource Manual by M Johnson and A Wintgens (2016), Routledge.

Summary:

	Selective mutism (SM)	Reactive mutism (RM)
DEFINITION	An anxiety disorder - a phobia of the expectation to speak in certain social situations, creating an inability to speak. This is often mislabelled as “choosing” not to speak.	A temporary loss of speech in reaction to stress or trauma, lasting from minutes to weeks.
TRIGGER	The expectation or pressure to speak.	Stressors like sensory/emotional overwhelm, an environment that feels uncomfortable or threatening or trauma.
NATURE	The fear or sense of dread is a phobic response which is out of proportion to the actual situation.Consistently occurs in specific situations, such as talking to teachers at school, but not in others such as talking to parents at home.The person can feel completely safe and comfortable, but still be unable to speak when expected to.If mistaken for RM, delaying proper intervention can strengthen the SM.	Mutism is a direct reaction to real or perceived stress or danger. Can occur across all environments, depending on the person’s level of stress.If mistaken for SM, exposure therapy for phobias can lead to increased stress.
DIAGNOSTIC STATUS	Classified as an anxiety disorder in the DSM and ICD.	Not a standalone diagnosis but nonetheless, a sign of acute distress which requires targeted intervention over and above any other prevailing diagnosis.
ASSOCIATED POPULATION	Can affect anyone with a sensitive disposition. More common in people who experience higher levels of stress than the general population, including autistic individuals.	Can affect anyone, but most common amongst autistic individuals.
ULTIMATE AIM OF INTERVENTION	To extinguish the brain’s disordered response to a harmless trigger - the expectation to speak - while ensuring that the person feels safe and well-supported.	To remove the source of stress via environmental modification and/or support to understand and process emotional trauma.