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Selective Mutism: Evolution of the Concept and the Significance of the Psychoanalytic Approach

Abstract

This article opens a series of three publications dedicated to selective mutism. The article examines the evolution of concepts of selective mutism from early psychiatric descriptions to modern psychoanalytic models. Special attention is paid to the analysis of domestic and foreign publications, identifying gaps in theoretical and clinical approaches, as well as the significance of psychoanalytic understanding in working with this disorder.

Keywords: *selective mutism, psychoanalysis, psychodynamic therapy, anxiety, silence, child psychotherapy*.

Introduction

"Elective mutism," "selective mutism," "voluntary mutism," "relative mutism," "psychogenic mutism," "speech phobia," "voluntary silence," "logophobic mutism." Over the more than 100-year history of studying this phenomenon, it has been called by many different terms. And if at the beginning of creation there was "the word," then at the beginning of the history of studying this phenomenon, there was "silence."

The attention of psychiatrists was drawn to cases of silence in individuals who did not speak in selective circumstances, but could talk in others. In 1765, Cassian Osipovich **Yagelsky** (**Yagelsky**, 1765) in his dissertation "On Hysterical Disease" described hysterical mutism as one of the symptoms of hysteria. German therapist Adolf **Kussmaul** (**Kussmaul**, 1877) (1822–1902) also notes the mysterious silence of individuals who, in his opinion, possess the intellectual and physical abilities for verbal communication. The doctor first describes this condition in his book "Speech Disorders" in 1877. For A. Kussmaul, this was "aphasia voluntaria," in other words, volitional, voluntary silence. He even compares it to monastic vows of silence.

A few decades later, in 1905, **Sigmund Freud** described the case of his patient Dora in "Three Essays on the Theory of Sexuality" (**Freud**, 1990). Freud draws attention to the fact that Dora cannot speak in the presence of her secret lover. The psychoanalyst interprets her silence as "hysterical mutism."

In 1934, **M. Tramer** (**Tramer**, 1934) suggested that mutism could be selective and introduced the term "elective mutism." Scientists, primarily psychiatrists and neurologists, encountered the silence of their patients in a wide variety of situations. Over time, it became clear that there was heterogeneity in the manifestations of silence. Scientists faced an urgent need to comprehend and

attempt to classify all types of mutism encountered in their patients. However, until 1950, research on mutism was conducted extremely rarely and mainly by German-speaking scientists.

But in 1950, this phenomenon finally penetrated the English-speaking world. Thus, representatives of different approaches attempted to classify mutism and concluded that "elective" or "selective" mutism is a specific case of mutism with its own characteristics and diagnostic criteria. However, the diagnostic criteria have undergone changes and have not become definitive, and the causes of (elective) or (selective) mutism are so extensive and diverse that the etiology of this disorder still remains unclear.

In addition to psychiatrists and neurologists, psychologists, including those with a psychodynamic orientation, also conducted research on selective mutism. However, from the moment this phenomenon attracted attention to the present day, there have been very few such studies, and they largely consist of case reports or descriptions of research on small case series. Modern authors note that the fact that selective mutism is a relatively uncommon disorder (1%) negatively impacts research.

In his work "Children Who Are Anxious in Silence: A Review of Selective Mutism," **T.H. Ollendick** (**Ollendick**, 2013) notes that over 25 years, from 1990 onwards, only 37 studies were conducted, 5 of which were by psychodynamically oriented psychotherapists. And over the 10 years from 2005, all studies without exception were conducted within the framework of a cognitive-behavioral approach.

Thus, the modern view of selective mutism has been shaped by research conducted in fields such as psychiatry, neurology, and, for the most part, research within the cognitive-behavioral approach. It is believed that, despite the fact that the key symptom of "lack of speech" may diminish over time, it is evident that selective mutism negatively impacts a child's further development and life, considering that speech is a key communication function. All authors agree that the development of effective treatment for children with selective mutism plays an important role, which should be aimed at encouraging children to speak in situations where they previously did not. This can be achieved in two ways: through either psychosocial intervention or pharmacotherapy.

Sharon L. et al. (2006), in their comprehensive review of psychosocial intervention in children with SM(EM), concluded (and other authors agree with them) that, despite the significant limitations of the literature due to methodological shortcomings, the existing research provides arguments in favor of behavioral and cognitive-behavioral forms of intervention.

Based on the foregoing, it can be concluded that a view of SM(EM) has formed globally as a rarely occurring psychiatric condition that emerges between the ages of 3–5 years and creates significant obstacles for a child in their school and social functioning. It is a condition with an unclear etiology, resistant to any intervention, and requiring a multimodal approach that combines: psychosocial intervention (cognitive-behavioral approach is considered effective), psychiatry, neurology, and, if necessary, speech therapy and pharmacotherapy. The preference given to these types of interventions is quite understandable. This is because, from the first mention of mutism to the present day, research on SM(EM) has primarily been conducted in these areas.

The fact that SM(EM) is insufficiently studied by therapists of the psychodynamic orientation can be explained by the fact that, from a dynamic perspective, SM(EM) is a symptom whose disappearance may occur during the restoration of the normal course of personality development. In other words, treatment is directed not at the symptom itself, but at the specific personality or family system. In the course of psychodynamic psychotherapy, conflicts and deficits from various stages of the patient's psychic life can become the object of treatment, which leads to the impossibility of creating a precise algorithm for treating the symptom and complicates the formulation of a unified psychodynamic hypothesis. The scarcity of literary sources (only a few in Russian) and the diversity of theoretical approaches within the psychodynamic orientation create certain difficulties in describing and comprehending clinical cases of working with the SM(EM) symptom.

M.I. Buyanov (**Buyanov**, 1974) conducted research in 1974 involving 30 children and adolescents with various manifestations of a inhibited personality type combined with such forms of SM(EM) as: neurotic, pathochacterological (characterized by the fixation of a overvalued reaction of protest), and autochthonous (spontaneous, usually occurring in children with schizoid personality traits or with advanced formation of a pseudochizoid personality type). Typically, mutism in such children arose against the background of residual organic cerebral pathology, which most often manifested as organic mental changes, speech defects, and a cerebroasthenic (organic) psychosyndrome characterized by asthenia, headache, dizziness, increased fatigability, and memory peculiarities.

As of 1995, there was almost no information on SM(EM) in psychoanalytic sources. According to **Judith A. Yanoff**, this issue had only been addressed in three articles, and in two of them, SM(EM) was not presented as the primary focus. According to **Sharon L. et al.** (2006), as of 2005, only four articles had examined the psychodynamic perspective on the problem of SM(EM). Two of these used psychoanalysis. **L. Sharkey and F. McNicholas** in 2008 mention two more articles by psychoanalysts.

A. Muris and T. Ollendick (**Muris & Ollendick**, 2015), in their work dedicated to a review of selective mutism research, mention only thirty-seven publications on this topic between 1990 and 2005. Furthermore, only five of these publications examine psychodynamic treatment of SM. No such research has been conducted in our country. I found a single publication by **N.L. Vasilyeva**, released in 2013.

Throughout the history of mutism study, attempts have been made to classify it, including selective mutism (SM). In 1910, **Flourenville** divided mutism into "absolute," "relative," "voluntary," and "involuntary." **M. Tramer** (**Tramer**, 1934) in 1934 proposed replacing the term "voluntary mutism" with "elective", and "absolute" with "total." In 1936, **Watternick** and **Vedder** identified six categories of mutism:

- hysterical (most often occurring in adults);
- selective (most often occurring in children who do not speak to certain people and in certain circumstances);
- Heintz's mutism (as a reaction to changes in overly sensitive children);
- neurotic (as a manifestation of neurotic fear);
- acute (as an acute reaction to stress);

- ideogenic (as a fear of speech organ disease)

In 1963, **Reed** proposed two types of SM:

- SM reinforced by parental and teacher attention, in immature, manipulative children;

- SM as a speech phobia, maintained by the opportunity to avoid speech-related anxiety, in tense and anxious children.

Hayden in 1980 proposed the following classification:

- symbiotic mutism, characterized by symbiotic relationships with a caregiver and subordinate, but manipulative relationships with others;

- logophobic mutism, which manifests as a fear of the sound of one's own voice and the use of ritualized behavior;

- reactive mutism, associated with withdrawal and depression, seemingly caused by trauma.

- passive-aggressive mutism - silence is used hostilely, as a weapon.

M. I. Buyanov (**Buyanov**, 1974, 1995) identified the following variants of mutism: neurotic and pathochacterological, classifying them as SM:

- psychogenic mutism (within the framework of psychogenic psychosis – primarily hysterical);

- neurotic mutism: hysterical, logophobic, mixed;

- pathochacterological mutism;

- psychopathic mutism;

- endogenous-psychotic mutism: catatonic, hallucinatory, delusional, on the background of depression or mania, mixed.

Thus, it is evident that classifications of mutism were initiated by psychiatrists, and SM in these classifications is a specific case of a general psychiatric condition.

The prevalence rate of SM varies from 0.3 to 7 per 1000 children. It occurs more frequently in girls than in boys (ratio 2:1), and in immigrants – four times more often than in local residents. The average age of seeking help is 6.5–9 years, although symptoms can manifest as early as 3 years old.

S. Kagan (**Kagan**, 2017) (based on seminar materials, Moscow, 2017) explains the gap between the first signs and seeking professional help by the fact that relatives interpret the child's silence as shyness, stubbornness, or naughtiness and hope that it will pass "on its own." This delays treatment and worsens the prognosis.

The causes of SM remain unclear. It is hypothesized that they may have familial, genetic, and neurological origins. The literature mentions a case of identical twins and the presence of mutism

in three generations of a family. According to S. Kagan, 80% of children with increased amygdala activity by the age of 7 suffered from mutism or anxiety disorders.

Among psychological factors are trauma, attachment disorders, and family conflicts. SM children experience pronounced anxiety about the need to speak in public places. Often, this resembles an internal stupor, a block.

Contemporary literature interprets SM as an anxiety disorder. According to ICD-10 (F94.0), it is a specific form, and ICD-11 states:

"Selective mutism is a disorder that arises in childhood, in which a child demonstrates a marked inconsistency in speaking in social situations, despite speaking in other situations. The disturbance is associated with impaired social functioning and is not explained by insufficient knowledge of the language, speech disorders, or psychoses."

Despite the fact that the modern understanding of SM has been shaped primarily by medical and cognitive-behavioral research, the psychodynamic approach plays a key role in a deeper comprehension of the symptom of silence. As early as the beginning of the 20th century, **S. Freud** (**Freud**, 1990) in "Analysis of a Phobia in a Five-Year-Old Boy" and in the case of Dora, described silence as a manifestation of hysterical defense, linking it to repressed affective and sexual dynamics. Since then, silence has come to be viewed in psychoanalysis not only as a symptom but also as communication, a form of resistance, regression, reenactment, identification, or even aggression.

Contemporary psychoanalysts emphasize that silence can be:

- a form of expressing internal conflict (fear, aggression, guilt);
- a reaction to separation anxiety;
- a symbolic act of resistance to parental or social expectations;
- a reenactment of trauma or identification with a silent object.

Working with such a symptom requires a special therapeutic approach, focused not on removing the behavioral manifestation, but on exploring the unconscious dynamics that maintain silence as a defense. A particular complexity lies in the fact that silence itself blocks the primary means of communication between the patient and the therapist – speech. Psychoanalytic therapy relies on understanding transference-countertransference dynamics, as well as on the use of symbolic forms of expression (play, drawing, the body) as carriers of experience.

From 2015 to 2024, several significant psychodynamic publications have emerged, strengthening the position of psychoanalytic therapy in relation to selective mutism. For instance, the article by **Fernandez & Sugay** (2016) presents the case of a 9-year-old girl who underwent psychodynamic play therapy. Play in therapy served as a symbolic space where the child could express experiences related to anxiety, separation, and the fear of rejection. As the play progressed, the child began to show the first signs of verbalization.

The case of a 5.5-year-old girl, described by **Singhal & Mehrotra** (2014), reveals the dynamics of anxious attachment and ambivalent relationships with her mother. The non-directive play

therapy used allowed for a gradual reduction in anxiety levels and the restoration of the ability for spontaneous verbal interaction.

Ganem (2023) presents in their article a successful case of comprehensive treatment for a child with SM, where, alongside behavioral techniques, work was done with the family system and the unconscious messages of the symptom. The author emphasizes that the symptom of silence reflected not only the child's anxiety but also the fear of being heard in the context of parental conflict.

The study by **Ale et al.** (2013) describes two cases of early SM, in which the symptom was viewed as an expression of blocked aggression and fear of loss. In both cases, therapeutic work included attention to parental anxiety, family dynamics, and the child's ability to use silence as a means of anxiety regulation.

Thus, modern psychodynamic observations and clinical vignettes suggest that SM can be a symptom in which fear, protest, and unconscious messages merge. Psychoanalysis restores meaning to the symptom, which has been lost in behavioral reduction. It helps not only to overcome silence but also to hear it.

The presented clinical materials illustrate the key functions of the symptom. Below are the main directions in which psychoanalytic thinking allows us to reveal the deep structure of selective mutism and build individualized therapeutic work.

The psychoanalytic approach, despite its modest representation in empirical research on selective mutism, offers a unique opportunity to view the symptom not as an external behavioral disorder, but as a deep form of psychic expression. This is where its specific significance lies.

In the psychoanalytic perspective, the symptom of silence is understood as a multilayered act – simultaneously a defense, a message, and a form of existence in relationships. Silence becomes a language accessible to the child in situations where speech as a means of self-expression is blocked or traumatized. It is not simply a refusal to speak, but a refusal of symbolic mediation between the inner and outer world, between oneself and the other.

From a metapsychological point of view, silence can be the result of repression directed at affects of anxiety, guilt, and aggression. It often takes the form of regression to pre-linguistic stages of development, when ego functions are not yet capable of processing internal experience into symbolic form. In some cases, it is a form of omnipotent control – a refusal of communication as a way to maintain power over a situation where a child feels vulnerable. The symptom can be a way of suppressing aggression, identification with a silent object, or an expression of conflict within the family system, where emotional expression and autonomy have been repressed.

Psychoanalytic therapy in this context is not aimed at "eliciting speech." Its goal is to understand what blocks speech, what feelings, fantasies, and fears lie behind the silence. An important tool becomes not only observing the child but also analyzing countertransference reactions: boredom, anxiety, irritation, helplessness that arise in the therapist become a significant diagnostic source for understanding the patient's unconscious processes. Silence ceases to be a dead end; it transforms into a mode of communication.

A child can express themselves through bodily signals, drawing, play, and ritualistic actions. It is in these forms that the development of symbolization begins. As the described cases show, speech appears not as a result of external training but as a consequence of internal

transformation: only when the child feels safe and finds a container for their anxiety and affects does the beginning of verbalization become possible.

The family system, especially in cases where an anxious, ambivalent, or merging maternal figure is present, can unconsciously support the symptom by forbidding a child from being separate, speaking, or asserting themselves. Psychoanalysis allows for working not only with the individual symptom but also with its systemic function: as a form of loyalty, a way to preserve symbiotic closeness, a defense against object destruction. Under these conditions, the child's silence is not simply a refusal to speak; it is a form of love, resistance, and fear of rejection.

Following Bion, it can be argued that the emergence of speech becomes possible only in a space where there is containment – the therapist's psychic capacity to bear the feelings projected by the child, process them, and return them in an accessible, accepted form. This is the foundation for the formation of the symbolic function, the development of thinking, and the emergence of genuine speech. In this sense, the symptom is not a developmental error, but a result of the absence or lack of a containing object.

The psychoanalytic approach is important not only as a theory but also as an ethical stance. It proposes not to eliminate the symptom at all costs, but to understand it. This is particularly valuable when working with children who cannot (or dare not) speak directly. Silence becomes material for work, not something to be directly eliminated, but something that requires listening and accompaniment. Psychoanalytic therapy creates a space where silence can be translated into words, but only when internal conditions are met.

Thus, the significance of the psychoanalytic approach lies in its ability to:

– allow for a deeper understanding of the symptom's causes and functions;

– work not with behavior, but with the unconscious reality;

– create conditions where the development of symbolization and speech is possible;

– respect silence as a language deserving attention and careful translation.

The second article in the series will demonstrate how psychoanalytic models—from drive theory to the concept of the transitional object—enable the construction of a therapeutic hypothesis and the accompaniment of a child from silence to the capacity to speak.

Conclusion

Therefore, over more than a century of history, views on selective mutism have undergone a significant transformation: from its interpretation as a form of hysteria or willful silence to the recognition of SM as an independent anxiety disorder. Modern diagnostic systems, primarily ICD-11, have established selective mutism as a distinct clinical condition with its own criteria.

However, despite the expansion of research, a significant portion of the scientific literature still focuses on behavioral or psychopharmacological approaches. This narrows the understanding of the symptom's underlying causes and hinders work with its individual dynamics. Yet, it is precisely the unconscious basis of the symptom (its connection to anxiety, aggression, regression, and the inability to symbolize) that remains undeciphered outside the framework of a psychoanalytic perspective.

The psychoanalytic approach, although less represented quantitatively, offers a unique opportunity to conceptualize SM as a message, a form of regression, defense, or expression of internal conflict. It emphasizes not the elimination of the symptom, but the restoration of the child's capacity for symbolization, relationship building, affect processing, and psychic autonomy. Speech becomes not just a function to be activated, but an expression of the psychic work occurring within the therapeutic relationship.

Clinical cases presented in foreign publications of recent years confirm that therapeutic work with silence as a meaningful symptom leads not only to the disappearance of speech deficit but also to the transformation of the child's inner world. It is this transformation, not correction, that constitutes the essence of psychoanalytic therapy.

Despite the limited number of psychoanalytic publications on the topic, the existing materials already demonstrate the value of this approach, especially in cases where behavioral methods prove insufficient or inapplicable. Future research in this area should focus on expanding the empirical base, understanding the symbolic aspects of the symptom, and formalizing diagnostic and therapeutic methods for SM within a psychodynamic framework.

Psychoanalysis allows not just to eliminate silence but to hear in it what the child cannot express in words. It maintains respect for the symptom as an important element of the child's inner world, helps to uncover the affects and conflicts that lie behind the silence, and creates a space where their processing is possible. Thanks to this, the psychoanalytic approach becomes not only a method of therapy but also a way of ethical engagement with silence as a human expression.

The second article in the series will examine the theoretical foundations of the psychoanalytic approach (from drive theory to the concept of the transitional space) and demonstrate how these ideas help to gain a deeper understanding of the nature of selective mutism and to construct a therapeutic hypothesis based not on the symptom but on the internal logic of psychic development.

Bibliography

Buyanov, M.I. “Behavior Disorders in Children.” Moscow: Meditsina, 1974.

Vasilieva, N.L. “Psychoanalytic Therapy for Selective Mutism.” Journal of Psychoanalytic Psychotherapy, no. 2, pp. 45–56, 2013.

Gannam, N. “Selective Mutism: A Successful Case of Therapy.” International Physical Medicine & Rehabilitation Journal, no. 8, no. 3, pp. 1–3.

Kagan, S. “Selective Mutism: Theory and Practice.” Moscow: Based on Seminar Materials, 2017.

Kussmaul, A. “Speech Disorders.” Berlin, 1877.

Muris, P., Ollendick, T.H. “Children Who Are Anxious in Silence: A Review of Selective Mutism.” Clinical Child and Family Psychology Review. 2015. Vol. 18, No. 2, pp. 151–169.

Ollendick, T.H. “Children Who Are Anxious in Silence: A Review of Selective Mutism” // Child and Adolescent Psychiatric Clinics. 2013.

Reed. “Forms of Selective Mutism in Children” // J Child Psychol Psychiatry, 1963, N4, 99–107.

Singhal, M., Mehrotra, S. “Using Play for Diagnosis and Therapy: A Case of a Child with Selective Mutism” // International Journal of Play. 2014. Vol. 3, No. 1, pp. 1–12.

Tramer, M. “Elective Mutism in Children” // Zeitschrift für Kinderpsychiatrie. 1934.

Fernandez, K., Sugai, K.O. Psychodynamic Play Therapy: A Case of Selective Mutism // International Journal of Play Therapy. 2016. Vol. 25, No. 4, pp. 203–209.

Florenville. Classification of Mutism. — 1910. (historical mention, cited from: Tramer, M., 1934)

Freud, Z. The Case of Dora // Collected Works: in 5 volumes. Moscow: Nauka, 1990.

Sharkey, L., McNicholas, F. Review of Psychoanalytic Publications on SM // European Child & Adolescent Psychiatry, 2008, No. 17, pp. 255–263.

Yagelsky, K. O. On Hysterical Disease. St. Petersburg, 1765. Diss.

Yanoff, J. A. Review of Publications on Selective Mutism up to 1995. (cited from: Kokhan Sh., 2005)

Watternick, Vedder. Classification of Mutism in Children. 1936. (based on historical reviews)

Ale C., Mann A., Menzel J., Storch E.A., Lewin A.B. Two Cases of Early Childhood Selective Mutism: Variations and Treatment Complexities // Clinical Case Studies. 2013. Vol. 12, N 4, P. 278–290.

Ganem N. Selective Mutism: Report of a Successful Case // International Physical Medicine & Rehabilitation Journal. 2023. Vol. 8, N 3, P. 1–3.

Hayden T.L. (1980) The Classification of Elective Mutism. J Am Acad Child Adolesc Psychiatry, 1980, N19, P.118-133.

Sharon L., Cohan, Denise A. Chavira and Murray B. Stein Practitioner Review: Psychosocial interventions for children with selective mutism: a critical evaluation of the literature from 1990-2005. Journal of Child Psychology and Psychiatry, 2006, N47:11, 1085-1097.