„Logopedia Silesiana", t. 14, nr 1,
ISSN 2391-4297
https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02
pp. 1–10: English language version

Monika Kij
Poland
https://orcid.org/0000-0002-9211-1677

Agnieszka Leśniak-Stępień
Psychological and Pedagogical Counseling Center in Brzozów
Poland
https://orcid.org/0009-0007-5798-7829

When Words Fall Silent – A Case Study of a Boy with Suspected Selective Mutism

Abstract: Communication forms the foundation of social relationships and largely determines how a person functions within a group. This article focuses on mutism, understood as a specific form of communication disorder. It presents basic information about this phenomenon. The theoretical section is complemented by an analysis of a case study of a five-year-old boy with suspected selective mutism. The conclusions drawn from the case description serve as a basis for considering possible determinants and factors that may contribute to the development of mutism.

Keywords: communication, development, selective mutism.

Gdy milkną słowa – studium przypadku chłopca z podejrzeniem mutyzmu wybiórczego

Streszczenie: Komunikacja stanowi fundament relacji społecznych i w dużej mierze decyduje o sposobie funkcjonowania człowieka w grupie. Artykuł koncentruje się na mutyzmie, ujmowanym jako szczególna postać zaburzeń komunikacji. Przedstawiono w nim podstawowe informacje dotyczące tego zjawiska. Część teoretyczna została uzupełniona analizą studium przypadku pięcioletniego chłopca z podejrzeniem mutyzmu wybiórczego. Zebrane wnioski z opisu przypadku posłużą do rozważenia możliwych uwarunkowań i czynników sprzyjających pojawieniu się mutyzmu.

Słowa kluczowe: komunikacja, rozwój, mutyzm wybiórczy.

Introduction

In contemporary society, effective linguistic communication is fundamental to human functioning. It enables individuals not only to initiate and maintain relationships, but also to convey needs, emotions, and intentions, and to participate in family, school, and peer life.

Basil Bernstein notes that, in the course of socialisation, a child acquires linguistic codes through which they learn to speak and respond in a socially accepted manner (Bernstein, 1980, p. 91; cf. Piekot, 2008, p. 12). However, this process does not always proceed without disruption – certain experiences and conditions may hinder the development of communicative competence and interfere with the child's everyday communication.

This article is a case study of a five-year-old boy with suspected selective mutism. As part of the diagnostic procedure, a speech and language assessment and a psychological assessment were conducted. Data were also collected from an interview with the mother, and documentation relating to the child's functioning was analysed.

Selective mutism

Selective mutism (formerly known as elective mutism) is an anxiety-based disorder in which a child speaks freely and demonstrates age-appropriate language competence in certain social situations – most often at home – while in other contexts, for example in kindergarten or when interacting with unfamiliar people, the child consistently does not speak (Ołdakowska-Żyłka & Grąbczewska-Różycka, 2017, p. 13). Anna Herzyk defined mutism as the absence of speech, or a marked restriction of speech, with preserved speech comprehension. This approach also emphasises that mutism may occur in individuals whose speech apparatus functions normally at both central and peripheral levels (Herzyk, 1992, p. 56).

Adolf Kussmaul, a German neurologist, is regarded as the author of the earliest references to silent individuals; in 1877 he was the first to use the term aphasia voluntaria ('voluntary aphasia'). This label misleadingly suggested that people with mutism remain silent by choice, making a conscious decision not to speak. Many years later, in 1934, the child psychiatrist M. Tramer described silence as an intentional phenomenon, introducing the term elective mutism. In his account, the anxiety-related basis of the difficulty was still not foregrounded; instead, emphasis was placed on an intentional choice to refrain from speaking in specific situations (Panasiuk, 2019, pp. 316–317; cf. Ołdakowska-Żyłka & Grąbczewska-Różycka, 2017, p. 13).

In speech and language therapy, mutism has been conceptualised in various ways. In Leon Kaczmarek's classic symptom-based typology (1975), it was described as an ailment of speech substance encompassing both suprasegmental and segmental levels. By contrast, in Irena Styczek's causal classification (1983, p. 422), mutism was treated as an endogenous speech disorder classified among

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

neuroses. Adopting an aetiological criterion provided the basis for distinguishing two forms of mutism: organic (akinetic, hyperkinetic) and functional (psychogenic) (Panasiuk, 2019, p. 318).

In 1994, the term selective mutism was introduced in the DSM-IV classification and has been in continuous use in the literature ever since. This terminological change reflected a shift in how the phenomenon was understood: it began to be conceptualised as a difficulty or inability to speak in specific situations, rather than as a conscious decision to remain silent. It was then, that anxiety was identified as an important background factor. However, it was only in DSM-5 that selective mutism was formally classified among anxiety disorders (Ołdakowska-Żyłka, Grąbczewska-Różycka, 2017, p.13; cf. Cabała et al., 2019, p. 9; Bala et al., 2022, pp. 19–20).

Selective mutism has a complex, multifactorial aetiology. The literature highlights the role of biological predispositions, including genetic vulnerability, as well as possible co-occurring neurodevelopmental and neurological difficulties. Family-related factors and broader environmental influences may also be relevant. In connection with rising migration, the consequences of a change in environment and the child's functioning in bi- or multilingual conditions are increasingly taken into account (Cabała et al., 2019, p. 12). According to Maggie Johnson and Alison Wintgens, selective mutism may develop when a child begins to associate situations that require speaking with intense anxiety. This anxiety may be triggered, among other things, by a new and unfamiliar environment, separation from parents, and pressure stemming from the need to speak in public (Johnson, Wintgens, 2021, p. 60).

As Maria Bystrzanowska (2017, p. 154) notes, in Poland there is a deficiency of research on the prevalence of selective mutism and of analyses describing disorders co-occurring with this diagnosis.

Selective mutism is diagnosed when the difficulty in speaking persists for at least one month, excluding the first four weeks of the child's attendance at an educational setting. In addition, the diagnostic process should take into account whether the child understands speech, and whether the absence of speech occurs in specific social situations in which verbal responses are expected, with confirmed speaking in other circumstances. Another important criterion is whether the lack of speech has lasted longer than four weeks, and whether other developmental disorders that could explain the child's observed communication difficulties have been excluded (Kozłowska, Famuła-Jurczak, Hryniewicz, 2018, p. 205; c.f. Herzyk, 1992).

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

Characteristics of the Child[1]

Aleksander is a five-year-old boy. The pregnancy was uncomplicated. Initially, the mother took Duphaston (a miscarriage-preventing medication) as a prophylactic measure. At one stage of the pregnancy, the doctor diagnosed foetal hypotrophy (intrauterine growth restriction). Aleksander was born at term. He was delivered vaginally and had an Apgar score of 10.

According to his mother, the boy began babbling at 6 months. He produced his first words at 12 months and began using sentences at around 24 months. He started crawling at 9 months and began walking at 12 months. Overall, his development was age-appropriate.

The boy was breastfed until 8 months of age and was bottle-fed until three. At the expected age, he began drinking from an open cup and using cutlery independently. He chews solid foods; however, his parents have noticed increasing food selectivity.

The mother took her son for a routine check-up due to his lack of verbal communication in kindergarten. It was established that the difficulty also occurred on other occasions whenever the boy felt uneasy (for example, in the presence of strangers or long-unseen relatives).

According to his kindergarten teacher, the boy experienced adjustment difficulties. He would refuse to separate from his mother and sometimes cried. However, once he entered the classroom, the teacher was able to calm him down. He consistently chose a seat by the door, close to the teacher's desk. He would look around the room, watch the other children playing, and then stop crying. At present, Aleksander takes part in group-based activities. He readily follows the teacher's instructions and works on activity sheets. He enjoys drawing, and his artwork is neatly done. He is active and shows good engagement in physical activities, which he clearly enjoys. The boy also participates in team games. He likes the songs sung in kindergarten; however, he does not sing himself. He does not speak in group settings either. When asked a question, he makes eye contact with the teacher and nods or shakes his head. Aleksander has a close friend with whom he enjoys chasing a toy car around the tables or playing under a table. The boys play amicably, but without verbal interaction. After leaving the kindergarten, and at home, Aleksander gives a detailed account of his day; however, while at kindergarten he remains silent.

[1] The information about the child was obtained from his legal guardian (his mother, who accompanied Aleksander to the assessment) and from the documentation collected at Poradnia Psychologiczno-Pedagogiczna w Brzozowie (the Psychological and Pedagogical Counselling Centre in Brzozów), where the boy was assessed.

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

During the speech and language assessment, Aleksander was initially slightly withdrawn, but after a short while he established rapport with the assessor. He initiated the conversation and said whatever he felt like at the time. While his mother was speaking with the speech and language therapist, Aleksander began to play independently.

The Speech and Language Assessment

The speech and language assessment, which the boy completed readily, showed that his breathing pattern is normal. The upper respiratory tract infections he has had are typical for his age and should not affect praxis or kinaesthesia. Articulatory motor function is reduced, and the tongue is not elevated. A multiple speech sound disorder is also present.

Assessment using the Speech Examination Questionnaire by Grażyna Billewicz and Bożena Zioło showed interdental production of alveolar sibilants. The postalveolar and alveolo-palatal sibilants were substituted with alveolar sibilants, with additional /j/→/l/ speech sound substitution. This results in substantial difficulties in understanding Aleksander's speech. The articulation errors require speech and language therapy, ideally delivered on the premises of the kindergarten he attends.

An in-depth interview with the mother revealed that the older son (now nine years old) had also been an anxious and withdrawn child, although not to the extent observed in Aleksander. It is also noteworthy that both parents were described as shy in their own childhood.

The interview with his mother indicates that after leaving the kindergarten, Aleksander responds with anger and boisterous behaviour as a reaction to prolonged silence and tension. At home, he enjoys painting and playing with toy dinosaurs. He is exposed to screens (TV) for around three hours a day; his parents monitor the programmes he watches.

Psychological Examination

The interview with the mother did not indicate any motor or cognitive dysfunctions or developmental delays.

Aleksander cooperated with the assessor and completed the assessment. The psychological assessment using the IDS-2 indicated that his intellectual function-

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

ing is within the normal range. His analogical reasoning is within the norm: he was able to solve tasks requiring logical operations involving categories and relationships. Aleksander performed well in recognising relationships between stimuli and the changes to which they are subject. His verbal reasoning, which requires knowledge of words and their meanings and the ability to form broader categories on this basis, is slightly below average. Aleksander communicated with the psychologist both verbally and non-verbally. He showed a sense of humour and was able to wait his turn during play. At the local clinic, the boy was provided with psychological support and speech and language therapy.

Cooperation with the kindergarten was established; however, as the setting is stressful for the boy, level of anxiety does not allow him to attempt verbal communication there. The mother was advised to consult a psychiatrist to confirm or rule out the suspected disorder; however, she decided not to proceed. A consultation with a psychologist and a psychotherapist was attempted at another diagnostic centre; however, the child did not engage with the professionals.

Study Summary and Therapeutic Guidelines

Based on the course and results of the assessment, Aleksander can be considered at risk of selective mutism (SM). He does not have a formal diagnosis because his parents decided against a psychiatric evaluation to determine whether the disorder is present. Nevertheless, the overall clinical picture suggests emerging selective mutism. Aleksander also has an anxiety disorder. Both parents were described as very shy in their own childhood. The boy's mother has a marked fear of spiders, which is expressed verbally and with observable anxiety in the child's presence. Aleksander's older brother also experienced communication difficulties in unfamiliar settings (albeit to a lesser extent) and continues to show food selectivity.

Signs of SM emerged in the kindergarten setting, which is clinically characteristic. It appears that being in kindergarten and separation from a trusted caregiver acted as triggers.

Aleksander does not eat meals on the premises. He does not communicate his needs or emotions in any form, including pain, sadness, or satisfaction. To date, he has not begun signalling his toileting needs in the kindergarten setting (on one occasion, when staff did not notice in time that he needed to use the toilet, the boy urinated involuntarily in the presence of his peers).

Aleksander falls silent upon entering the kindergarten; however, immediately after leaving the building he gives his mother a very detailed account of his day, including what happened, what needs to be brought for the next session, and

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

which songs or poems were learned. It is also notable that after an entire day of self-monitoring and heightened vigilance, he releases accumulated tension at home and may become loud, restless, and oppositional.

The child shows a need for contact with peers. He likes attending kindergarten and has a friend there. His speech development is delayed. A multiple speech sound disorder is present, including rhotacism, absent palatalisation, consonant cluster reduction, and substitutions. His speech is clearly impaired relative to his developmental age; however, his vocabulary (both receptive and expressive) is fairly rich.

Aleksander requires intensive speech and language therapy; however, delivering therapy in the kindergarten setting is very difficult due to his limited cooperation. By contrast, during clinic sessions he speaks readily and at length. He can sustain attention for extended periods and establishes and maintains eye contact.

Following the assessment, the preschool speech and language therapist was contacted and detailed guidance for working with anxious children was provided. Recommendations were also given to educators and other kindergarten staff, as consistency of approach is key in anxiety-related difficulties.

It was recommended that the child receive psychological and educational support within the kindergarten setting (this is currently feasible, as institutions are obliged to employ such specialists). Interventions aimed at developing communication and socio-emotional competences were considered the most important component of support. Their goal is to build skills related to appropriate interpersonal relationships, social communication, and coping with emotionally challenging situations.

When ensuring the child's comfort, he should not be forced into public performances. If he feels like it, he may, for example, 'sing' within the group, hold a prop, or take on a static role. Any non-verbal form of communication should be acknowledged and valued, as it does not deprive the child of communicative intent and supports a sense of agency. Allowing time to respond is another important form of support. Answering on the child's behalf reduces his willingness to attempt independent verbal expression, which might otherwise emerge if he were given the space.

It is important to involve the boy in various activities related to group life so that he feels part of it. This may include wiping down tables, handing drawing pins to the teacher when putting up children's work, distributing sheets of paper, crayons, and so on.

It is very important that Aleksander is not labelled by his peers as 'the one who does not speak'. To this end, a session on anxiety can be conducted with the children. It should take place in Aleksander's absence, and its aim should be to make the children aware that everyone is afraid of something. Fear and feelings of anxiety are normal and accompany everyone in life; they can even serve a protective function. There are also ways to overcome them. Some people are

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

afraid of spiders, others of the dark, and Aleksander is afraid of speaking, but he is working on it and will speak to the children one day. If Aleksander begins to speak, the situation should be handled calmly, without excessive excitement.

The parents were advised to establish close cooperation with the kindergarten teachers in order to standardise the methods and forms of support provided to Aleksander. They were also instructed to be patient, to observe the child's behaviour carefully, and to try to understand his needs. It is important not to rush Aleksander, not to pressure him to speak, not to demand promises that he will do so, and not to use enticement.

It is very important to initiate meetings with peers in settings where he feels safe and communicates verbally, in order to promote the generalisation of speech to other environments.

It is often overlooked that one should not discuss the child's difficulties in his presence; instead, the child should be gradually and gently familiarised with situations that evoke anxiety but cannot be eliminated from everyday life. The boy's parents were specifically prepared for this.

In anxious children, clear organisation of family life and the establishment of rules and expectations are also important. This will provide Aleksander with a sense of security and predictability and may help him to overcome his fears.

Summary

Selective mutism, also referred to as situational mutism, is an anxiety disorder that is being diagnosed increasingly often in children. The pervasive pace of life, a lack of time for everyday routines appropriate to the child's age, over-assisting children 'because it will be quicker', a lack of meaningful social interactions, peer violence, an excess of changes, and the constant stream of news about tragedies and misfortunes contribute to the development of anxiety disorders in some children. Not every child will be affected; however, some children, unable to cope with an overload of stimuli, respond maladaptively and stop communicating verbally.

A lack of an adequate response, limited access to specialists, and insufficient conditions for therapy mean that the number of such children continues to rise. Undiagnosed or late-diagnosed selective mutism increases the risk of social maladjustment later in life.

In a child burdened by anxiety, it is not possible to work on other problems (for example, articulation), which generates further difficulties. How a child functions in a group affects their future, social relationships, and career choices, and thus their overall wellbeing.

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

The longer diagnosis and support are postponed, the more anxiety escalates and the range of situations the child is unwilling to face expands. Yet many parents still appear to downplay the situation, reassuring themselves with the common belief that children 'grow out of' such difficulties. Therefore, it is crucial to raise awareness among parents, teachers, and professionals working with children about the need for prompt intervention. Technology and civilisation continue to develop, but nothing can replace a sensitive and responsive parent for a child.

References

Bala J., Cabała M., Giese-Szczap K., Kiepiela-Koperek A., Miękina-Pindur J., Młynarska I., Pilch A., Szczęśniak S., Szyszka K. (2022). *Terapie szyte na miarę. Mutyzm wybiórczy w praktyce terapeutycznej*. Oficyna Wydawnicza *Impuls*.

Bernstein B. (1980), Socjolingwistyka a społeczne problemy kształcenia. In: M. Gowiński (ed.), *Język i społeczeństwo*. Wydawnictwo Czytelnik.

Bystrzanowska M. (2017). Mutyzm wybiórczy. Poradnik dla rodziców, nauczycieli ispecjalistów. Oficyna Wydawnicza Impuls.

Cabała, M., Leśniak-Stępień A., Szyszka K. (2019). *Mutyzm wybiórczy. Trzy spojrzenia*. Oficyna Wydawnicza *Impuls*.

DSM-5 (2013). Diagnostic and Statistical Manual of Mental Disorders. Draft criteria. Task force on DSM-V. American psychiatric Association.

DSM-iV (1994). Diagnostic and statistical manual of mental disorders. 4. American psychiatric Association.

Herzyk A. (1992). *Afazja i mutyzm dziecięcy. Wybrane zagadnienia diagnozy i terapii*. PFZM.

Johnson M., Wintgens A. (2021). *Mutyzm wybiórczy. Kompendium wiedzy*. Grupa Wydawnicza Harmonia.

Kaczmarek L. (1975) Korelacyjna klasyfikacja zaburzeń słownego i pisemnego porozumiewania się. *Logopedia*, *12*, 5–13.

Kozłowska M., Famuła-Jurczak A., Hryniewicz G. (2018). Dziecięcy mutyzm wybiórczy – studium przypadku, *Zeszyty Naukowe Państwowej Wyższej Szkoły Zawodowej im. Witelona w Legnicy*, *27*(2), 203–214.

Panasiuk J. (2019). Mutyzm w autyzmie. Studium przypadku. *Logopedia*, *48*-1, 315–338.

Piekot T. (2008). *Język w grupie społecznej*. Wydawnictwo Państwowej Wyższej Szkoły Zawodowej im. Angelusa Silesiusa

Styczek I. (1983). Logopedia. PWN.

Monika Kij – Doctor of Humanities in linguistics, neurologopedist, assistant professor at the Institute of Polish Studies and Journalism at the University of Rzeszów. Her scientific interests include speech therapy and broadly understood onomastics.

mkij@ur.edu.pl

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02

Agnieszka Leśniak-Stępień – neurologopedist, psychologist, co-author of the book "Selective Mutism. Three Perspectives". She works therapeutically with children aged 3 to 14.

adalik@wp.pl

https://doi.org/10.31261/LOGOPEDIASILESIANA.2025.14.01.02