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THE SILENT MINORITY

# The Silent Minority: Supporting students with Selective Mutism using systemic perspectives

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**Selective Mutism (SM) is an under-researched area of child development. While the incidence rate is low, the impact of this difficulty can be pervasive and can present as a significant risk for student mental health and wellbeing. The following article presents a case study focusing on parent-student intervention for a preadolescent male, using an eclectic programme which blended psycho-education, aspects of a manualised Cognitive Behavioural Therapy (CBT) programme, and specific selective mutism strategies. This article does not seek to evaluate the effectiveness of the programme but instead highlights practice considerations derived from systemic theoretical perspectives and present considerations for school staff.**

***Key words*: intervention, selective mutism, secondary school.**

## Introduction

In classrooms across the United Kingdom, there are children who quietly focus on their work, and can appear to be 'under the radar' of their teachers, teaching assistants and even their parents' attention. They may be described as 'quiet' or 'shy' and 'peculiarities' only become visible when these same 'quiet' and 'shy'


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children are placed in situations that focus on spoken communication. In such situations, the 'quiet' child may display a set of behaviours that are extremely alert, oppositional, have an extreme inability to communicate verbal sentences, words or sounds and/or present with a catatonic state. No longer is this likely to be considered as being quiet or shy, or a reluctant speaker, but patterns emerge of the child communicating in certain settings and/or with certain people. In the absence of a social communication difficulty, this presentation is that of Selective Mutism (SM).

The origins of selective mutism date back to the 19th century. Literature (e.g. Kussmail, 1897 cited in Krysanski, 2003) outlines that this was referred to as *aphasia voluntaria* and in the 1930s described as *elective mutism.*

The characterisation of SM being 'elective' suggests that children make a choice in their communication with others. As professionals' understanding of the behavioural presentations of children with SM was explored, understanding was reframed to consider the significant reduction of communication, and fear of communication was observed in individuals in selected environments and around selected people.

As an Educational Psychologist (EP) my experience of this group of students in my practice was isolated to one case during a period of six years in a Local Authority (LA) Educational Psychology Service (EPS). Employment in another LA has highlighted an alarming statistic where at least one primary aged student in at least all of the schools to which I am attached presents as a reluctant speaker or selectively mute. This is the equivalent of less than 1% of the children on the allocated schools' special educational needs and disability (SEND) register. All students appeared to be unnoticed until explicit questions about SM in the school population were asked, and these students were brought to conscious attention.

The SM incidence rate reported in research studies varies between 0.2-2% (Kearney and Vecchio, 2007), 0.47-0.76% (Reuther, Davis, Moree and Matson, 2011), 0.75% (Cohan, Chavira and Stein, 2006), and under 1% (Muris and Ollendick, 2015) of the child population.

SM tends to be noticed when a child enters an educational setting (including Nursery) for the first time which would suggest the 'age of onset' is between the ages of 2 and 6 years old (Krysanski, 2003; Kearney and Vecchio, 2007) and is consistent across cultures.

Nevertheless, SM could be present before this proposed age of onset. SM is not gender specific; however, the rate of incidence is increased for girls and as with many other childhood difficulties, there is a relationship between SM persistence and the duration of the remediation needed. Studies suggest that this can range from seven days to two years (Cohan et al., 2006) and in extreme cases SM can last through to adulthood. Consequently early intervention and systemic (family and school) awareness is instrumental in helping children to overcome their fear around communication. Oerbeck, Stein, Pripp and Kristensen (2015) found that school based treatments are more efficacious between the age of 3 and 9 years old.

The case study presented in this article outlines a SM approach to supporting a 12-year-old student which, based on the research evidence, has implications for 'effective' treatment.

## Aetiology and prevalence of SM

The Office for National Statistics state that 10% of school age students have a mental health diagnosis (Atkinson, Corban and Templeton, 2011). It is helpful to consider the clinical markers for SM according to the Diagnostic and Statistical Manual Fifth Edition (DSM V, 2013). This outlines SM as being based on the following criteria:

- Consistent failure to speak in specific social situations in which there is an expectation of speaking (e.g., at school) despite speaking in other situations.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better explained by a communication disorder (e.g., childhood onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Why does SM occur? The last criterion of the DSM V is important for practitioners in education and allied professions who are working with students with

possible SM. There is an abundance of literature that links SM to a social phobia (Oerbeck, et al, 2015); anxiety disorders (Black and Uhde, 1995); neurodevelopment difficulties including Aspergers, language difficulties (Manassis et al., 2003); English as an additional language (which should be excluded before an SM diagnosis) (Krysanski, 2003) and psychiatric disorders (Yeganeh, Beidel and Turner, 2006). Hultquist (2002) further explored SM, describing subtypes. Therefore, the origins of SM are varied.

The DSM-V criteria is succinct and does not imply a 'diagnosis' of SM be made by a specialist practitioner such as an EP or Speech and Language Therapist (SALT). It implies that anyone with a basic understanding and knowledge base can identify SM, begin to intervene, and explore this further through appropriate access to targeted training. Demarcation will be needed to establish whether the LA protocol defines SM as an emotional difficulty needing EP or child and adolescent mental health services (CAMHS) involvement, or is defined on the basis of it being a difficulty associated with language development and thus requiring SALT input.

## Clinical Formulation and Intervention

Theoretical perspectives on the aetiology of SM have considered psychodynamic (relational), genetic, behavioural or linguistic in nature. As a result, a multifactorial aetiology is considered the most appropriate framework for clinical formulation or intervention.

Pre-intervention formulation and assessment aims to provide an indicator of whether SM is the presenting difficulty; considerations for symptom resolution and the potential efficacy of the chosen intervention method.

Across the research literature, SM is explored through a number used in all reported studies of SM; use of questionnaires e.g. Connors 3; or cognitive assessments.

Meta-analysis of SM literature (Hung, Spencer and Dronamraju, 2012; Cohan et al., 2006; Muris and Oerbeck, 2015) and specific implications linked to EP practice (e.g. Cleave, 2009) outline that a multifactorial model (multiple perspectives or theories considered) and multimodal treatments (use of more than one method) are the most effective approach. However, regardless of intervention

approach, practitioners need to be able to work open ended, and not be bound by time or pressures from competing demands of the EP role.

## Case Study

This case study is presented with permission of Peter* (pseudonym) and his mother. Neither the school, its staff nor LA are identifiable in this work. The data from the intervention is held on the LA system through parental informed and written consent gained on commissioning the intervention and EP involvement. The aims of presenting the case study in this journal format were made transparent. The conditions of the Data Protection Act (1998) and the BPS Code of Human Research Ethics (2010) were not breached in reporting the data gathered.

Peter is a 12 year old, Year 7 student attending a secondary school judged by Ofsted as under the category 'Notice to Improve'. He is the eldest of three boys. Peter had a history of 'reluctance to speak' or silence throughout his primary school education; Speech Therapists were unable to assess his skills; and he was never referred to the EPS. Peter was raised for discussion through the secondary school planning meeting between myself and the school Special Educational Needs Coordinator (SENCo). Concerns were raised about his behaviour and his long periods of 'not following' adult instruction.

The SENCo and senior school staff described Peter as:

> 'manipulative, he wants things his own way and he just stares into space when you talk to him. . . .he's a disruption and we want something done about him. Sometimes when he gets into that mood, he will just sit there! He's even been here until 5pm and couldn't be moved. The teacher had to go home. He only responds to Mr Brown and the librarian. He would spend all his time in the library if he could. In some lessons he will talk but in others he's just difficult! He's as bad as the rest of the kids here..they all come into Year 7 with problems no-one has addressed at primary school. Its not our job, we have GCSEs to attain'

It became evident in the school consultation that Peter's file had not been read by any of the teachers concerned and he was considered as at risk of exclusion due to the impact of his behaviour on the class functioning.

At home, Peter's behaviour was also a source of frustration. He only spoke to his mother, and this was difficult to understand for his father, siblings and extended family.

Consultation with his mother highlighted the depth of his communication difficulties in primary school, and the DSM-V criteria for SM were considered further in exploring his patterns of behaviour. I suggested working with Peter and his mother to explore his anxiety around communication. The longer term aim was to develop a school-based (systemic) approach to supporting Peter in the wider school environment; and for Peter and his family to develop an understanding of SM. This would also help to facilitate a positive understanding and restore the relationships in the family. The reader is guided to consider the multifactorial approaches that are needed to intervene with a student presenting with SM.

## Intervention material

The intervention was designed to be run on a weekly basis for six weeks. Reflective notes and observations of Peter's engagement in the session were used to inform next steps in the intervention. Two resources were used eclectically and so the research does not seek to draw conclusions for professional practice with respect to the choice of materials to use and intervention efficacy. Psycho-education guidance was derived from the Clinician's Guide to Think Good – Feel Good (Stallard, 2005); explicit CBT approaches from a manualised programme 'Cool Kids' (Rapee, Lynham, Schniering, Wuthrich, Abbott, Hudson and Wignall (2006) and ideas from the Selective Mutism Resource Manual (Johnson and Wintgens, 2016). Student voice approaches were also used. Appropriate 'homework' activities were given for continued parent-student work, which is often a feature of cognitive behavioural therapy approaches. At the end of each session, Peter received a summary note of the session foci. A therapeutic letter was sent to Peter at the end of the intervention alongside a pack of his work from the sessions.

Peter's school was resistant to further work with him beyond the six sessions and rejected psychoeducation for his peers and staff. Instead, Peter created a presentation for his subject teachers, outlining his understanding of his difficulties and wanting to be seen in a positive light.

## Qualitative and Quantitative Data

Intervention data to explore the impact of the intervention were gathered using the following measures:

- The Beck Youth Inventories Second Edition (BYI-II) (Beck and Beck, 2005) was administered pre and post intervention. This is a collection of inventories focus on depression, anxiety, anger, self-concept and disruptive behaviour. The collated inventory was administered as a guide for Peter's perceptions in the above domains. It was also an indicator for the extent of the anxieties that are often associated with SM.
- Parent and student non-standardised evaluation of the intervention; and Peter's experience of each of the tasks in the intervention using rating scales.

## The Intervention: Joint Child-Parent work

Peter and his mother met me for 1.5 hours per session from January to March 2017 for six sessions. The sessions were planned initially for a weekly intervention but this was adjusted to accommodate student timetabling. Follow-up reflective notes from the session were noted and used to inform the next therapeutic session.

The session foci and abbreviated session notes are in Table 1.

The multimodal approach to the 6 week intervention highlighted the following:

- The importance of preparing the student in advance of the intervention. Before the intervention, I met Peter, his mother and school staff once. In the week preceding the first session, Peter was sent a therapeutic letter to prepare him for what to expect – a start to the psycho-education process.
- Both family and school need to be invested in the intervention. It was challenging to involve school staff in 'noticing' small positive changes in Peter, which was suggestive of a lack of commitment to change.
- The longer the prevalence of SM, the longer the duration of intervention needed. It is more challenging to intervene with adolescent students due to the barriers that exist in secondary schools, in particular, missing lessons to attend an intervention.

**Table 1.** Abbreviated Intervention Notes

| | |
|---|---|
| **Session 1** | |
| Outline of the sessions for 6 weeks/purpose of the work | Frozen response to attend the session – non communicative even with prompting from Mother. This continued for the entire session. |
| Exploring Peter's social network | Anxiety observed with continuous fiddling of an object in his hand. |
| Psychoeducation: intervention foci | Ecomap highlighted relationship with his immediate family. Two other significant adults in school. No peer relationships noted. This is socially isolating. Is this linked to the communication barrier or lack of social interest? |
| CBT foci: What is anxiety | |
| CB1 foci: Anxiety and the body's responses | Anxiety prevalent throughout the session. He stared into space and was non responsive to his Mother. |
| | Anxiety and the body – given as homework. |
| **Session 2** | He non-work completed. |
| Renew homework | He non-verbally acknowledged his anxious behaviour based on feedback from EP. |
| CBT foci: Anxiety as fight-fight-freeze | |
| CBT foci: Body changes in social situations | He identified bodily changes when he's anxious – unable to move his foot: (this would relate to him not being able to leave the classroom after period of heightened anxiety) |
| Is this selective mutism? | Social situations that involve excessive numbers of people, the possibility of being embarrassed, performing, asking questions, speaking aloud and generally being in the school environment are anxiety-provoking situations. |
| | Appears to understand the symptomatology of selective mutism specific phobia of speaking to certain people in certain places etc. |
| | Peter more engaged in the session. Non-verbally. |
| | Homework – to read 'when the words won't come out' selective mutism leaflet: (Selective Mutism Resource Manual). |
| **Session 3 (26.1.2017)** | Selective mutism explained as a phobia. Which Peter appeared to understand. Mother read the leaflet with him. |
| Psychoeducation: Reflect on the leaflet given to read 'when the words won't come out' | Discussed the link between thoughts-feeling-behaviour as the negative triad in anxiety. Peter's presentation and the responses of subject teachers. |
| Use the ocomap to reflect on school relationships | He could identity positive traits in adults in comparison to the negative relationships he experiences with teachers e.g. listen, care, have time for him, and friendly. Other teachers are perceived as direct contrasts. |
| SM foci: Complete a taking map | School talking map highlighted that there are few places he communicates comfortably – Head of Year's classroom: two teachers to seek out and the Library. Anxiety is experienced in all other areas of the school he has lessons in and external areas including the corridors. |
| **Session 4 (21.2.20 17)** | This was the first session after nearly a month break. |
| CBT foci: 'Worrying thoughts' feedback | Peter was very anxious, and there was a decline to presenting with significantly reduced non-verbal communication: he wouldn't engage even with prompts from his mother. |
| SM foci: Secondary communication rating scale | |

**Table 1.** *Continued*

| | |
|---|---|
| SM foci: Review taking map – who can communication be instated with importance of communication | He was reluctant to engage in ranking staff members in terms of case of communication – less to most scary. This list is available from the EP – kept off file for Peter's privacy. |
| CBT foci: Formulating specific goals | Looking at the importance of communication with different people in settings was explored. Peter rated that it's important to: 1. Make people understand about selective mutism 2. Cope better when he's spoken to in class; 3. Be able to talk to least 2 teachers/adults. It was 'quite important' to rely less on his mother as a communication 'bridge'. He saw it as less important to be able to communicate with peers on the phone or communicate in other social contexts. |
| | Peter is unable to engage with low level communication. Future communication goals cannot be planned for at this time. |
| **Session 5 (1.3.2017)** | Peter wants to make positive changes in spite of debilitating anxiety. He was reluctant to think about how to communicate his experience of selective mutism in the session. Instead completed this as homework. |
| Review importance of communication (previous session) | |
| SM foci: The case of communicating with teachers. | |
| SM foci: Creating a message to explain his experience of selective mutism | |
| **Session 6 (2.3.2017)** | Peter completed amendments to the PowerPoint for his message to school staff about his difficulties. |
| End of intervention Evalu ation | Peter and his Mother completed their respective evaluation sheets. |

- The long break between the sessions led to a reversal in the progress Peter made in the first three sessions.
- Silence has been reinforced due to Peter's family and schools not understanding SM. This increased the social isolation experienced by Peter within the family, and the absence of peer relationships inside and outside school.
- The experience of transference which gave meaning to Peter's anxiety experienced in the sessions. This led to a negative identification with his subject teachers' frustration. Teacher misunderstanding of Peter's behaviour reinforced the SM, and led to labelling him as being an oppositional or manipulative student. If adults experience powerful feelings in SM cases, it is important to reflect on the student's experience.
- Six sessions were an introductory intervention for Peter and his family to psycho-educate them to understand and respond sensitively to his behaviour; and to consider the length of additional intervention needed.
- Peter has an ideal view of how he would like to be 'understood' and related to by school staff.

**Table 2.** BY-II Pre and Post Intervention

| *Domain* | *T-Score October 2016* | *T-Score March 2017* |
|---|---|---|
| **Self-Concept**<br>*Explores self-perceptions such as competence, potency and positive self-worth* | 52<br>Average | 48<br>Average |
| **Anxiety**<br>*Reflects fears, worrying and physiological symptoms associated with anxiety.* | 52<br>Average | 63<br>Moderately Elevated |
| **Depression**<br>*Identifies symptoms of depression in children and reflects negative thoughts about the self, their life and future, feelings of sadness, and physiological indications of depression.* | 40<br>Average | 46<br>Average |
| **Anger**<br>*Perceptions of mistreatment, negative thoughts about others, feelings of anger and physiological arousal.* | 41<br>Average | 41<br>Average |
| **Disruptive Behaviour**<br>*Behaviours and attitudes associated with Conduct Disorder and oppositional-defiant behaviour are included in this inventory.* | 38<br>Average | 38<br>Average |

* Self-Concept Average T-Score are 45–55; where 'Above Average' is a T-Score of 55+ and 'Much Lower than Average' is a T-Score under 40
*Average T-Scores for the other domains are T-Scores of 55 and under; and 'Extremely Elevated' is a T-Score of 70 and above.

- The importance of psycho-education, namely the use of specific SM resources e.g. a leaflet outlining SM and also access to a film helped the family unit to understand Peter's difficulties (Channel 4 Television, 2006)

## Quantitative Results: Assessment of intervention efficacy

Peter completed the BYI-II at the initial consultation with his mother, and after the six week intervention. This collection of inventories focuses on depression, anxiety, anger, self-concept and disruptive behaviour. The collated inventory was administered as a guide for Peter's perceptions in the above domains. It was also an indicator for the anxieties that are often associated with social communication and/or selective mutism. See Table 2.

The T-scores derived from the pre and post intervention suggest that there was one significant change in Peter's self ratings in the area of anxiety. The assertion could be made that as Peter became aware of why he has been experiencing

difficulties, this raised his anxiety levels. A hypothesis for this may be a fear of how these difficulties would be understood by family members, peers and school staff, when at present this has been challenging.

This finding appears contrary to Fung, Manassis, Kenny and Fiskenbaum (2002) who found after the use of a CBT programme for younger children, the rates of anxiety had decreased in their case study of a 7-year-old male. However, as the clinical diagnosis of SM is often given at the school entry age, the process of the intervention may have shown greater success as the SM profile had not persisted into adolescence as in Peter's case. Reuther et al. (2011) reflected on the challenge of ascertaining conclusive results in a single case study with an older student. As the current intervention also featured an older student, this appears to corroborate this intervention finding.

With regard to Peter's ratings of self confidence, his increased self knowledge about SM may have had a converse effect on how he sees himself. Having a 'label' for the difficulties may be helpful for adults in terms of implementing an intervention, but for a student this may lead to lowered self esteem. Therefore, a negative cycle can inadvertently be created.

While it is difficult to report possible reasons for Peter's increased depressive type feelings, research studies have suggested that SM can coexist with this mood disorder (Kearney and Vecchio, 2007). Hayden (1980) reported that depressive symptoms were found in a subtype of SM: 'reactive type', which is associated with traumatic events, surgery or being told not to speak. A tenuous association could be the negative impact of SM on an adolescent's ability to interact with his peers, the social isolation this causes and the impact on self esteem and general mood. There are few reported studies explicitly linking depression and SM.

The tabulated data suggests there were no changes in the other assessed domains. While school staff may have characterised Peter's behaviour as disruptive, he does not appear to perceive his difficulties in the same way.

## Qualitative Results: Parent and Pater's evaluations

Qualitative (non-numerical feedback) were gathered after the six sessions and aimed to explore the intervention experience of Peter and his Mother which would inform future intervention planning. The qualitative information was gathered through two sources: (1) Peter and his Mother answered questions that

explored their experience of the intervention (2) Peter was presented with a description of the completed activity and asked to rate each his experience based on a scale (1 = easy - 5 = difficult). Please see Figures 1, 2 and 3 for examples of the evaluations; and the responses are also presented.

Mother's key responses to the questions that focused on the duration, learning and desired school feedback were as follows:

Question: Were there enough sessions planned? If not, how many would you have liked?

> 'I would have liked a few more (sessions), I was hoping that Peter would have relaxed a bit more and also due to us missing some time due to the school.'

Question: what do you think you have learned from the sessions? What has your child learned from the sessions?

> 'I have learned a lot about what my child is going through. I think my child has learned that he is not the only person to be going through this and in turn seems to have changed slightly for the better.'

Question: What do you think needs to be communicated to school about the intervention and next steps for your child?

> 'The next steps would be for the teachers to understand Peter's situation, also the pupils and for him to have further help in overcoming his selective mutism.'

Peter's responses to the questions that focused on what he had learned from the sessions; and his hopes for the future were as follows:

Question: What do you think you have learned from the sessions?

> **'**How I behave isn't how I want to behave and I can get help.'

Question: How did you feel about having 1 to 1 sessions? Were you comfortable? How did you feel about your mum being present?

> **'**I was scared because I did not know what will happen (it was helpful having Mum present)'

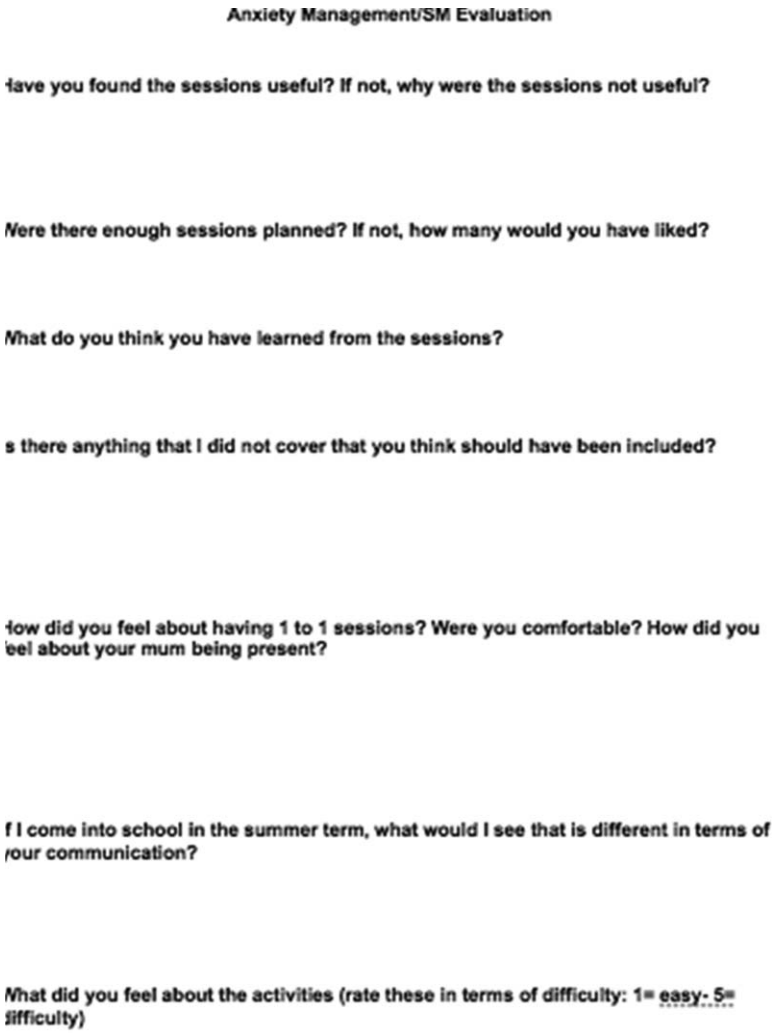

**Figure 1.** Parent (Mother) evaluation of SM intervention.

Question: If I come into school in the summer term, what would I see that is different in terms of your communication?

'Hope to answer questions'

Peter's rating scale responses were noted in Figure 3 as follows:


Anxiety Management/SM Evaluation

Have you found the sessions useful? If not, why were the sessions not useful?

Were there enough sessions planned? If not, how many would you have liked?

What do you think you have learned from the sessions?

Is there anything that I did not cover that you think should have been included?

How did you feel about having 1 to 1 sessions? Were you comfortable? How did you feel about your mum being present?

If I come into school in the summer term, what would I see that is different in terms of your communication?

What did you feel about the activities (rate these in terms of difficulty: 1= easy- 5= difficulty)

**Figure 2.** Peter's qualitative evaluation of the intervention.

As can be seen from Peter's ratings, he reported finding the intervention activities challenging, and he rated these as either '3' or '4'. This suggests that in the absence of being able to openly communicate in the sessions, it is imperative to rate activities as these progress. Additionally, with the knowledge that

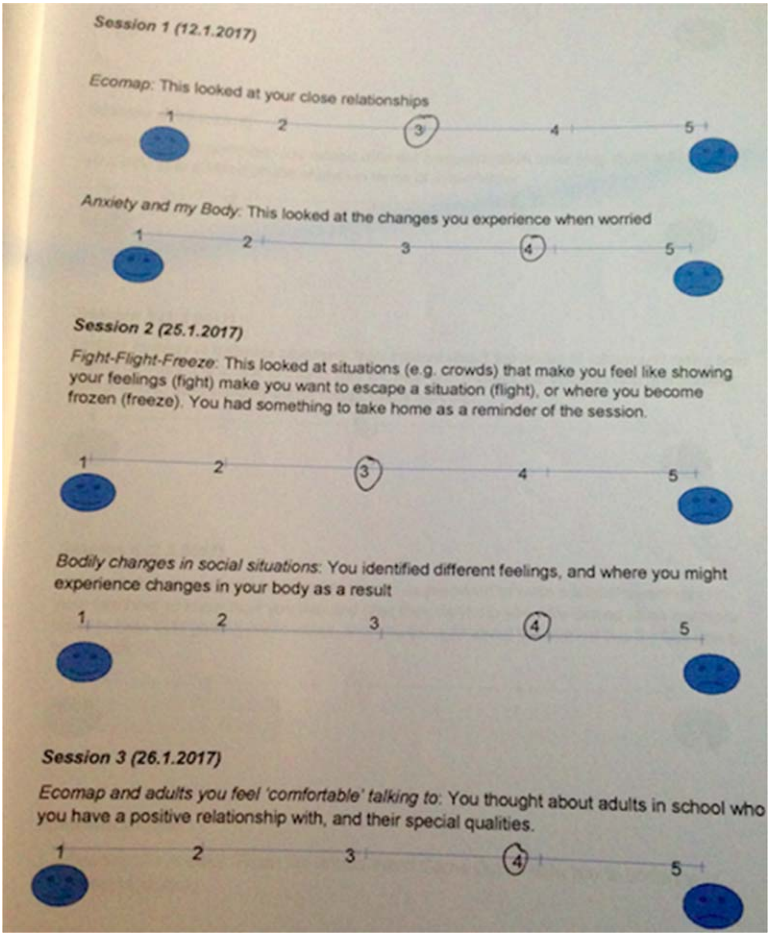



**Figure 3.** Peter's ratings of the intervention tasks [Colour figure can be viewed at wileyonlinelibrary.com]

the Cool Kids programme being used was for 12 years and under, a significant amount of adaption may be needed for students with an SM profile.

## Discussion

Concepts from Family Therapy were drawn upon throughout this intervention and are helpful in considering facilitators and barriers to engagement with

families and schools. The key interlinking terms considered are: *belief systems; context; circularity and punctuation; alliances and coalitions;* and *reframing*.

*Belief Systems* are based on knowledge and understanding. Burnham (1986) cites Reiss' (1981) view that families work within a pattern of behaving and knowing that maintains behaviour. In the context of the intervention, contrary belief systems exist: his mother's knowledge of Peter's difficulties and the understanding that he can be helped. This is in opposition to the school view of Peter being a problem like the 'other kids' and risking expulsion. For an EP, challenging the rigidity of the school belief that Peter's 'problem' could be remedied would destabilise the school (system) position of having children attending who cannot be helped. This reinforces *homeostasis* – maintaining the functioning of a system, in spite of it being counterproductive.

*Context* is the environment in which individuals exist. Systemically, context is non singular, but multiple in levels. However, for simplicity, the intervention sought to join the two systems Peter is part of: his family and school. From an ecological perspective, Bronfenbrenner (1994) conceptualised an ecological systems model which highlights the layers of systems around an individual. Dowling and Osborne (1994, 2003) used a 'joint systems' approach to link home and school to support the focus child. The model looks at the contextual factors that may influence how behaviour is understood. In the wider view of the 'context', Peter's SM and attendance at a school is positioned within multiple contextual layers that have wider implications for all students with special educational needs (SEN) or social emotional and mental health (SEMH) needs e.g. high staff turnover.

The opportunity to join Peter and his mother in the intervention bore witness to a close *alliance*: the joining of two people for a common purpose. It was clear that in Peter's views gathered via an ecomap (a concentric circle mapping system of key relationships in order of closeness to the individual), that his closest relationship is with his mother who was able to dedicate her time to supporting him in the sessions and with follow up activities at home. This contributed to the relative success of the intervention. Opposing this is the concept of a *coalition,* where there is a joining of forces against another, often covert. The school have blocked further involvement such as psychoeducation for Peter's peers or training in SM for support staff. The intervention closed with Peter 'communicating' his challenges via a powerpoint for his teachers as a way of by-passing the coalition. Needless to say, the apparent coalition of school staff 'against' Peter presents as a long-term barrier to his SM diminishing.

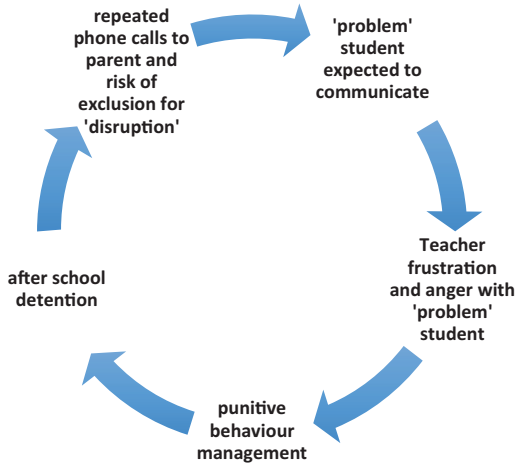



**Figure 4.** Cycle of causality for Peter [Colour figure can be viewed at wileyonlinelibrary.com]

Cases of SM can be *reframed* or viewed in an alternative way, thus changing the personal significance of the situation in question. Instead of using Peter as a rotating scapegoat amongst all the other 'bad kids', a problem or a student to be expelled, the research evidence and intervention described suggests that a true understanding of SM and intervention is needed to punctuate (interrupt) the cycle of casualty that can exist in SM case presentations. See Figure 4: Cycle of causality

A final theoretical point coming from a psychodynamic perspective is the experience of *transference* (Freud, 1920) which is the unconscious experience of powerful feelings that is often experienced in the therapeutic encounter. This involves the 'therapist' experiencing or absorbing the feelings of their 'client'. In the work with Peter, the experience of teachers was reflected upon. There was a danger of viewing Peter as oppositional and needing to manage the feelings of frustration that occasionally clouded my ability to think about him, and not collude with the schools' view. It is not uncommon for school staff to describe children with SM as being manipulative and I encourage the reader to think about how the powerful feelings generated in oneself are equally overwhelming for the student.

At a practitioner level, the use of therapeutic interventions broadens the skill set of EPs. Pugh (2010) highlights that CBT is effective with children experiencing

anxiety difficulties. It remains unclear whether there is a clear demarcation between SM, anxiety disorders, and a social phobia, or if there is co-morbidity. The use of this highly structured and flexible therapeutic method is evidence based and can generate clear intervention outcomes. EPs have been positioned as gatekeepers to statutory services or 'IQ testers' and many welcome opportunities to use their skills broadly. Wade's (2016) research into therapeutic practice within educational psychology found themes of 'safety as a practitioner' and there being 'something stopping us from doing it' as common experiences that many EPs can identify with.

Atkinson et al. (2011) highlight in their exploration of EPs use of therapeutic interventions that the EP role has evolved, and there are a number of factors identified using a Strengths-Weakness-Opportunities-Threat (SWOT) analysis to be borne in mind in integrating this into professional practice. Factors such as restricted views of the EP role, negotiation with stakeholders, accessing specialist supervision, opportunities for multiagency working and perceptions of the EP role are not to be ignored. An EPS leadership ethos of widespread and innovative practice is beneficial for all service users in a climate of public sector cuts and restricted CAMH services.

From a wider professional perspective, due reference needs to be paid to understanding the mental health risks of undiagnosed social, emotional and mental health difficulties. The SEND Code of Practice (2001) classifies behaviour, emotional and social development/difficulties (BESD) into an updated description that takes a broader account of the variety of needs of children and young people using the category 'social and emotional mental health' (SEMH):

> 'Children and young people may experience a wide range of social and emotional difficulties which manifest themselves in many ways. These may include becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour. These behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder' (SEND Code of Practice, 2015: 99)

The re-classification and subtle changes now capture a broader range of needs, to which SM should be more clearly identified. Advisory teachers, EPs and

mental health professionals are well placed to support schools with SEN identification processes. Due reference to the SEN Code of Practice by school SENCos and SM being viewed as an emotional or language barrier should ensure that these 'silent' children are no longer invisible. School context is dependent on swift identification.

## Considerations for school staff

The research literature suggests that a mutli-factorial and multi-modal approach is needed in SM case presentations. SM is an area with a small evidence base and cases described are often single case study designs.

Intervention work in cases of SM is rewarding and challenging. Systemic and psychological frameworks are not always going to be quickly referenced in the day-to-day 'real world' of primary or secondary education.

In considering the key implications for supporting a student identified as having SM, the EP approach of thinking at different levels of context is useful. The following encapsulates working at a systemic, group and individual level, and the list is not exhaustive.

- *Whole school level (organisational)*: It is imperative that both teaching and support staff receive appropriate training in SM. The English idiom states 'knowledge is power', and this is apt in cases of SM. Many LA schools are organised in locality groups to enable sharing of practice between SENCOs in neighbouring schools. These groups are a forum to discuss the challenges of the SENCo role but also offer opportunities to establish local SM training. Primary and secondary SEN forums run by the LA, or in-service training (INSET) provided by an EP or SALT is a cost-effective method ensuring skills are developed at an early intervention level. Opportunities to maintain skills will be imperative alongside ongoing consultation with LA agencies. With the latter, establishing the LA position on whether SM is an emotional problem is a key starting point.
- *Early intervention*: When children start preschool, nursery or the Reception class, school staff should be aware of the key indicators for SM. As stated earlier in this article, a diagnosis can be made after one month, and should not be confused with a reluctant speaker (speaks but has elements

of SM) or a shy child. A detailed parent interview should be implemented by Early Years staff to capture the range of communication patterns the child displayed, prior to entry into an educational setting. This may lend itself to liaison with the link SALT attached to the school, or project-based work with the EPS to set up support mechanisms. The Foundation Stage Profile lends itself to ongoing observation and assessment, and with this and trying should identify possible SM.

- *Challenging myths*: SM can present with additional behaviours that include a 'frozen' response when directly spoken to or being placed in certain situations that expect communication. This is mistaken for oppositional behaviour and manipulation, when consideration of the fight-flight-fright response would be more appropriate. SM is evident in different contexts and with different interpersonal relationships. Managing one's own responses towards the student and reframing the behaviour into a 'fright' response will help to manage personal anger and demonisation of the student. The Special Educational Needs and Disability (SEND) Code of Practice (2015) stipulates that behaviour should be seen as a form of communication and the term, 'social and emotional mental health' is the descriptor used, and is helpful in considering the mental health risks of not intervening in SM cases.
- *Time for implementation*: Interventions take time to plan, implement and evaluate. The SM Resource Manual (Johnson and Wintgens, 2016) is an invaluable resource and can compliment the use of psycho-educative and CBT materials. It is advisable that the selected worker is given ample time to support a student and their family. Meta-analyses highlight variations in the duration of interventions and practice should be supervised by an experienced specialist. It is recognised that within the caring professions, supervision is increasingly important (Dunsmuir, Lang and Leadbetter, 2015).
- *Comorbidity*: In the initial 'fact finding' exploration concerning the possibility of co-morbid difficulties, liaison with the Child and Adolescent Mental Health Service (CAMHS), EPS or Speech and Language Therapy Service is necessary. This supports a multiagency approach to supporting students (Farrell et al., 2006) and effective targeted support to establish the primary need.

SM is a difficulty occurring mainly in early childhood, or as the result of a wide range of factors. The intervention outlined has highlighted the need to position oneself as being curious and neutral in professional stance, and offers the chance

for a practitioner to give the time and space needed to support a student with overcoming the debilitating 'fright' response associated with the expectation to communicate. The 'silent' minority need not remain silent forever.

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