Selective Mutism: An Exploration of School-Based Interventions and the Role of the Educational Psychologist

Niamh Molamphy

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Research Supervisor: Dr. Joyce Senior

Head of School: Associate Professor William Kinsella

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Dedication

To mam and dad... 'the measure of my dreams'

Abstract

The focus of this thesis is to explore Selective Mutism (SM), which can be a barrier to a pupil's engagement in the school context, the role of the educational psychologist (EP) and appropriate school-based interventions. This thesis consists of an introduction to the topic, a systematic literature review, an empirical research paper and a discussion of the potential implications of the findings for EPs. The systematic literature review synthesised the literature across fourteen studies describing a school-based intervention to support a pupil presenting with SM. Results identified the potential appropriateness of the school as a setting to support pupils presenting with SM. The systematic literature review further identified positive effects of behaviourally based intervention strategies in the school context, particularly when implemented by those within the pupil's system where a rapport had been established.

The empirical research paper, conducted through a two-phase approach, explored the role of EP in an Irish school-based psychological service to support a school to meaningfully include a pupil with SM, through the lens of ecological systems and consultation theory. A total of 41 EPs completed an online survey and five EPs participated in a semi-structured interview. Results from an online questionnaire and interviews found that, although 98% of EPs stated that they have a role in supporting schools with SM, nearly half of them reported feeling uncertain about the appropriate interventions to implement. Thematic analysis yielded the salient themes of empowerment, building relationships, consultation, flexibility and pupil-centred practice. The results indicate that EPs have a pivotal position in facilitating systemic

change for a pupil presenting with SM. Implications of the findings from the systematic literature review and the empirical research paper for EP practice are also discussed.

*Keywords: s*elective mutism, educational psychology, school psychology, school-based interventions

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Protecting and enhancing the well-being of a child is fundamentally one of the most important considerations of society. Well-being is central to a child's development as it enables them to fully engage and participate in society (Department of Education and Skills [DES], 2019). The American Psychological Association [APA] defines well-being as a *"state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life"* (APA, 2015, p. 1154). Well-being comprises many interrelated aspects, including resilience and connectedness (National Centre for Guidance in Education [NCGE], 2017).

Mental health difficulties in childhood can have a negative impact on a person's development (Gore et al., 2011). Globally, the World Health Organisation (WHO) reported that anxiety represents one of the leading causes of disability (WHO, 2017). The condition has been reported to affect approximately 30% of children and adolescents (Child Mind Institute, 2018). In the Irish context, there has been a growth in the number of referrals to services such as the Child and Adolescent Mental Health Services (CAMHS), which has seen a 27% increase in referrals between 2012 and 2017 (Health Service Executive [HSE], 2018). Mental health conditions are typically considered to be either internalising or externalising (Merrell, 2008). Externalising mental health conditions often result in overt, disruptive behaviour. Conversely, internalising mental health conditions, such as anxiety, are often characterised by the over-regulation of an emotional state (Achenbach, 1982, p. 35). Externalising mental health conditions are often identified earlier as they are potentially more disruptive in the school setting. Anxiety, and other internalising conditions, can

therefore go unnoticed or unsupported which may compromise a child's well-being, potentially resulting in disengagement from school.

The school environment therefore has the active responsibility to promote and protect a pupil's well-being. Those within the school system are required to ensure that each pupil in the school is meaningfully included and is achieving their personal potential. Educators are recognising the importance of supporting a pupil's well-being in the school context, which is evidenced in the 'Well-being Policy Statement and Framework for Practice' (DES, 2019). This framework details the promotion of well-being of pupils, acknowledging the vital role the school has to play in doing so. In order to ensure that all pupils are encouraged to reach their potential, schools must adopt a whole-school approach to improve on the areas of the school life and curriculum that impact on wellbeing (DES, 2019). Research on whole-school approaches to support well-being has grown in the last number of years, with the school setting being identified as an appropriate context for the support for a pupil's mental health (Paulus et al., 2016). Within such an approach, the role of the teacher is crucial (Organisation for Economic Co-operation and Development [OECD], 2017). The protective relationship between a pupil and their teacher has a significant influence on a pupil's well-being (DES, 2019). Research has identified that building the capacity of teachers to foster protectiveness can have a positive impact on the school system in general (Hargreaves et al., 2018).

Selective Mutism (SM), which is the focus of the current research, is a complex and multi-faceted condition, characterised by a consistent lack of speech in specific situations (e.g. school), despite speaking freely in other settings (e.g. home) (APA, 2013). The condition can substantially impact a pupil's social life and their academic functioning, making it challenging for them to participate in education (Akaltun & Ayaydin, 2020). SM

is an internalising mental health condition which can often go unnoticed in the school context. As this can impact on the pupil's mental health and overall sense of well-being, it is pertinent to consider the contextual factors which may contribute to the manifestation of symptoms in order to consider how the school context can support pupils with SM. Considering SM from a systemic perspective suggests that there are a variety of possible risk factors across genetic, environmental and neurodevelopmental factors, such as bilingualism (Koskela et al., 2020). Further factors may include a life transition such as starting a new school or moving to a new house (Koskela et al., 2020). Family temperament (e.g. shyness or anxiety) has been found to be positively correlated with children who have SM (Kristensen & Torgersen, 2001). For example, Chavira et al. (2007) found that parents of children with SM were three to four times more likely to have social phobia compared to parents of children in a control group.

The construct of language around SM is sensitive and needs to be fully understood in order to ensure appropriate support. SM was traditionally termed 'elective mutism', suggesting that a child was being wilful, defiant and making an explicit choice not to speak (Muris & Ollendick, 2015). Reconceptualising SM as an anxiety disorder in the Diagnostic and Statistical Manual, fifth edition (APA, 2013) brought better recognition and understanding of the condition. Although progress has been made in this regard, it has still been challenging to fully ascribe the aetiology of SM to anxiety, as children with SM are a heterogeneous group and often have a varying level of co-occurring developmental or behavioural difficulties. It is important that SM is considered beyond the deficit-based model, by considering a broader conceptualisation of the challenges and the risk factors that can lead to the expression of the condition.

According to experts in the field, SM is established at a subconscious level, where a child develops an internalised rule system that enables them to recognise their pattern of anxiety triggers, and to predict situations where they will not be able to speak (Johnson & Wintgens, 2016). It appears that the longer the child experiences symptoms of SM, the greater the risk of these symptoms becoming entrenched, which can threaten a child's self-image (Johnson & Wintgens, 2016). If untreated, the child's anxiety is intensified and generalised, taking longer to resolve their condition which can lead to additional complications such as low self-esteem, escalating social anxiety and school avoidance (Johnson & Wintgens, 2016).

This thesis is seeking to explore SM in the context of well-being and mental health through the lens of ecological systems theory and consultation. It is important that conditions such as SM, which can have negative consequences on well-being and mental health, are considered from a biopsychosocial perspective. Using Bronfenbrenner's (1979) ecological systems theory, the importance of considering an individual with SM in the context of their environment and their relationships in the social context is highlighted. By applying this theoretical framework, a child with SM can be perceived as being at the centre of many different layers of society, which interact together to create the context from which the child develops their own model of understanding regarding their world. This model can, in turn, inform our awareness of the role that other people have in affecting the expression of SM, indicating the importance of recognising this when considering the school environment (Johnson & Wintgens, 2016). Previous literature on SM has primarily explored it through the lens of the first system, the microsystem, and looks at the impact of SM in isolation of context. Current research suggests that the second system, the mesosystem, may be influential in the exploration of SM (Kail & Cavanagh, 2010). Therefore, by exploring

SM through the lens of ecological systems theory, the current study facilitates a greater understanding of the perspectives and roles of people who are surrounding a child with SM.

Schools are a complex system involving multiple social interactions with peers and adults, thus presenting a challenge for pupils presenting with SM, placing them at risk of isolation (Paulus et al., 2016). While awareness of SM is beginning to increase, there remains a lot of misconception, with many educators having limited knowledge of the presentation (Kehle et al., 2012). This means that many pupils may not be identified at a timely stage and can spend many years in the school system suffering from this condition (Sharp et al., 2006).

Johnson & Wintgens (2016) contend that presentations of SM could largely be reduced if identified early and managed appropriately. Onset of SM typically occurs between the ages of three and six and is usually noticed when a pupil enters formal education, thus highlighting the importance of early identification and intervention in the school setting (Wong, 2010; Vecchio & Kearney, 2005). Whole-school approaches to well-being are generally non-invasive, relatively affordable and easy to implement (Johnson & Wintgens, 2016). The modification of parenting and teaching interaction styles may be all that is required for early intervention, so that communicative effort is reinforced (Johnson & Wintgens, 2016). The alternatives for older pupils with entrenched SM include more expensive interventions, medication and significant involvement with mental health services (Johnson & Wintgens, 2016). This highlights the importance of investment in early whole-school approaches to well-being and SM in the early years.

There has been an increasing focus on consultation as an effective model of service delivery within the educational psychology literature (Nugent et al., 2014). Consultation can be defined as “a voluntary, collaborative, non-supervisor approach, established to aid the

functioning of a system and as interrelated systems" (Wagner, 2000, p. 11). It can involve the Educational Psychologist (EP) working at a systemic level in collaboration with school staff to address difficulties (Larney, 2003). Further, Sheridan et al. (2017) state that consultation involves problem solving where psychologists (consultants) and teachers (consultees) can work together to provide solutions for a client (pupil). Larney (2003) detailed the key characteristics of consultation, which include a collaborative and active consultant-consultee relationship. It is also important that rapport is created and that the EP has an awareness of the school climate (Larney, 2003).

Gutkin and Conoley (1990) contend that consultation appears to have the capacity to address psychological difficulties experienced by pupils (such as SM) by the EP working with the key adults around the pupil. It has been argued in the literature base that consultation is an appropriate means to offer this support (Gutkin & Curtis, 2008). While there are a range of models of consultation reported in the literature, Miller and Frederickson (2006) state that there are common features to all such models, which include participation in problem identification and encouraging a change and belief that consultees have skills that can be applied to the client. Consultation can build a bridge between families and schools (Hoskins et al., 2006), which is essential for pupils with SM. The extent of the use of consultation to support pupils with SM appears unclear in the current literature base. It is therefore of interest in the current study to explore whether consultation is an effective model to effectively support pupils presenting with SM.

EPs are applied scientist-practitioners, with a holistic understanding of child development and the school system intertwined with the wider community (Lane & Corrie, 2006). EPs have a crucial role in the application of psychology in the educational context, which can contribute to the promotion of pupil and staff wellbeing within the school system

(Engelbrecht, 2004). This role is particularly pertinent when the school system is required to shift its methodology for supporting and including pupils presenting with SM.

Research Focus

Understanding how pupils presenting with SM can be appropriately supported in the school context has the potential to inform professional practice, both to support the meaningful inclusion of pupils with SM in the school context and also to contribute to the development of their overall sense of wellbeing. This research will focus on SM in the school context through both an exploration of school-based interventions to support pupils with SM and an exploration of the role of the EP in collaborating with schools to support such pupils. Research to date has identified that the school context is an appropriate setting in which to provide support and intervention for a pupil with SM (Sanetti & Luiselli, 2009). However, Omdal (2007) reported that teachers may be unaware of how best to support a pupil with SM in the school environment and that they hold a crucial role in enlisting professional support for guidance (Harwood & Bork, 2011). There is, however, a dearth of information regarding how EPs, from a systemic perspective, work collaboratively with a school to ensure that the pupil is supported in the most appropriate way. Research indicates that early intervention is effective (Kovac & Furr, 2019). With growing awareness, it has been found that pupils with SM typically find the symptoms of the condition to be most debilitating in the school setting, where there is a significant demand on communicating and socialising (Zakszeski & DuPaul, 2017). This highlights the urgency of early intervention in the school context. EPs are well placed to support a school when a pupil presents with a debilitating condition that is affecting their mental health. This highlights the importance of an increased understanding of the available school-based interventions and the role of the EP in working with the school system to implement them.

Significance of the Research

The findings of the systematic review and empirical journal article have relevance for practitioners within educational psychology as well as the school community. This study has the potential to contribute to the growing research on the importance of early intervention for pupils presenting with SM within the school system. The findings may help in promoting intervention in the school setting as opposed to the clinical setting, reflecting an eco-systemic approach. It is hoped the research will be significant in informing the professional practice of psychologists, providing them with a roadmap which synthesises available interventions. It has the potential to empower teachers to apply their skills to support this vulnerable group of pupils in their classroom settings, through the provision of practical interventions and liaison with other relevant professionals, as appropriate. Furthermore, the study may have the potential to assist parents in comprehending and supporting their child's condition.

As with any psychological work involving a child or young person, their needs are of primary importance. This holds true in the current study, whereby it is hoped that the findings can help improve the pupil's school experience through the implementation of timely interventions and also that the school can ensure the environment is safe, welcoming and sensitive to the needs of a pupil with SM. This is significant to pupils presenting with SM, which is, to date, an under-researched condition in the Irish context.

Background to the Systematic Literature Review

The aim of the systematic literature review was to examine the current evidence base for school-based interventions to support pupils presenting with SM in the formal education system (pre-school, primary school and post-primary school). The paper reviewed published studies which have detailed the implementation of an intervention for a pupil with

a diagnosis of SM in the school setting. Findings of the studies were synthesised to evaluate the evidence of available school-based intervention strategies and their relative effectiveness. The review also explored who was involved in the implementation of the school-based interventions, with a particular emphasis on the role of the EP. Of particular interest was the evaluation of the school context as an appropriate setting to implement interventions for pupils presenting with SM.

Rationale

Arising from my awareness of school-based interventions as an effective means to support pupils with mental health conditions, I was curious to explore if it would be possible to specifically evaluate school-based interventions targeting SM. While emerging, the literature base for SM is relatively small. However, much of the existing research on the topic consists of case studies. The majority of the Randomised Controlled Trials (RCTs) available on the topic examine medical interventions. I wished to explore the practices currently utilised in the school setting in order to highlight the most commonly used strategies to support SM in the least intrusive way at school. It was decided that case study research provides rich information for this purpose.

This topic is relevant for psychologists who work closely with schools in terms of synthesising the available research conducted since 2005. It is hoped that this research will also be of relevance to teachers of pupils presenting with SM, as the identification of school-based strategies may promote confidence, so that they can be more involved in the support of a pupil by implementing identified strategies. The pupil, as always, is central to this process and the goal of the research was to identify the least intrusive strategies to support them. In conclusion, this topic was chosen as there is a gap in the evidence base in terms of a systematic review of school-based interventions for SM. Where such reviews do exist,

they are predominantly medical interventions. This review sought to address interventions in the school-based setting as opposed to the clinical setting, which is of relevance to contributing to academic research on the topic of SM.

Research Journey

Prior to beginning the systematic review, a systematic review protocol, outlining the plan for the systematic review, was compiled in May 2019, before commencing the systematic search for research articles. Writing the protocol helped to shape the topic and to clearly outline exactly which type of papers I wanted to examine for my research. This helped to shift my mindset to a systematic way of thinking and become scientific in my approach. The initial research aims which I set out in my protocol remained unchanged in my systematic review. As I began to apply inclusionary and exclusionary criteria, initially I was surprised by the low level of rigorous data available, but, subsequently, as I began to look at the literature identified, I was struck by the value in these papers which capture the common goal of supporting a pupil with SM in the school setting.

Background to the Empirical Journal Article

The focus of the empirical journal article was to examine the perceived role of the EP within a psychological school-based service in Ireland in collaborating with schools in supporting pupils presenting with SM. The empirical journal article comprises a two-phase study which includes an online questionnaire and semi-structured interviews. The study sought to explore the intervention practices of EPs, including implementation duration and personnel involvement. It also examined the awareness of SM within the school system, underpinned by consultation and systems theories. Implications for EP practice are discussed in relation to the findings.

Rationale

I have been interested in SM for many years, from when I first learned of the condition at a younger age from my mother, a primary school teacher, who was involved in supporting a pupil with SM. This sparked my interest in the condition so when it came to considering the focus of my research, I realised immediately that SM would be the area I would like to further explore. As a trainee EP, I wanted to explore SM through the lens of EPs working in schools. I have always felt a sense of unease when I read about SM as a 'rare' disorder when, in fact, it really is not. One in every 140 children under the age of eight has been found to present with SM (Johnson & Wintgens, 2016). This prevalence rate means that SM is present in many school settings, highlighting the need for all school personnel to be aware of the condition.

Given the prevalence of SM, I believe it is of significant relevance to all practising EPs to be fully informed of the current research and best practice. I conducted this research because I wanted to investigate what is currently known about SM amongst EPs and how common it is for those working within the school system daily to encounter it. I was curious about whether EPs receive initial and continuing professional development (CPD) training or if there is any particular referral pathway within a psychological service for SM. I wanted to highlight positive practices for pupils with SM and believed this research to be a good platform for so doing. As stated, the prevalence rate is no longer considered rare, this means that the majority of EPs in the school system will typically be involved with a pupil with SM during the course of their careers. I believe this research will help to synthesise the work that is being conducted in a school-based psychological service for pupils with SM and develop a coherent message regarding approaches to intervention. Furthermore, it is hoped the research will assist the collaborative process between the EP and the classroom teacher.

This, it is hoped, will enable the teacher as practitioner to implement effective strategies to support pupils in their classroom presenting with SM. This study is also of relevance to academic research in that it is filling a gap where no such research currently exists. From a national perspective, SM in Ireland is under-researched and there is no research available from the perspective of the EP.

Philosophical Perspective

Willig (2013) postulated that a researcher's epistemological position regarding the study of knowledge influences the framework within which research is situated. In order to conduct research with a full sense of understanding, it is imperative to make explicit the philosophical perspective of the research, as this has implications for every decision made throughout the research process (Mertens, 2005). This study framed the role of the EP in supporting schools with SM through a constructivist paradigm. Such a paradigm believes that knowledge is socially constructed and there exists multiple, constructed realities (Ponterotto, 2005). This positional stance views reality as subjective, one that is influenced by an individual's experience and by the interaction between the participant and the researcher (Ponterotto, 2005).

Such a paradigm is based on the ontological assumption that knowledge is socially constructed by those active in the research process, with the researcher attempting to understand and reflect on the lived experiences from the perspective of the research participants (Schwandt, 2000). Throughout the present study, the author acknowledges that, while the experiences and perceptions of the participants are constructed and flexible, they were real to the participants experiencing them (Willig, 2013). The empirical article explored the perceptions of EPs in relation to their role, which aligned with a constructivist epistemology. Such an epistemological perspective encourages the researcher to rely on the participants'

views as much as possible, removing the researcher from the core of the research, shifting towards the focal point of the participants' views (Creswell, 2009).

The research tool utilised to explore the perspectives of EPs in relation to their role in the school system was a semi-structured interview, which required active participation from the researcher, and aligns with a constructivist paradigm, acknowledging that knowledge is socially constructed and is the outcome of the interaction between participants and the researcher (Mertens, 2005). Through this interaction, it was acknowledged that the researcher's values and personal experiences cannot be separated from the process, which underpins the reason for describing the researcher's own personal reflections and research journey within this chapter.

Research Journey

This research involved careful consideration of how best to synthesise the role of the EP and their approaches to intervention. Initially, it was thought that the perspectives of EPs working in different settings, such as clinical settings, could be included in the research. It was subsequently decided to narrow the focus to school-based EPs, allowing for a deeper insight into a specific psychological school-based service. As this research was conducted with EPs, with no direct contact with, or information from, pupils under the age of 18, it was appropriate to apply to the UCD Human Research Ethics Committee for an exemption from a full ethical review (Appendix A). It was also necessary to apply for research approval from the Research Advisory Committee of the Irish school-based psychological service (Appendix B). This involved completing a detailed application form and justifying how the research was in line with the key research directions of the organisation. It was important to be mindful during the research journey that the data collected was that of the participants and not reflective of the specific psychological service.

The Stage Transfer Assessment Panel proved helpful in guiding the research and ensuring that I was being mindful of the theoretical framework to align with my methodology. Engaging in the research and professional development planning also proved helpful for ensuring I was cognisant at all times of the relevance to educational psychology practice and I was mindful to return to my focus throughout i.e. purpose of the research. This study was also conducted whilst engaging in professional placement practice in the educational psychological service. Being in situ in the service at the same time of conducting the research enabled me to get a better understanding of the model of service and to observe the practices of the EPs in the service in general.

Reflections

Engaging in this research as part of my training in educational psychology has proven to be a challenging yet rewarding experience. I feel privileged to have had this opportunity to immerse myself in the research on SM and explore a topic in which I am truly invested. The time spent engaging with the data has facilitated the development of my own understanding of SM and I believe that this will be of relevance to me as I commence my journey as an EP.

This study was limited in its scope, focusing on the role of the EP. In future research, I envisage value in gaining a fuller understanding of the teachers' perspectives of SM. Furthermore, future research could explore the parental experience of how SM has impacted on their family system. I would also like to gain insights from a pupil experiencing SM; for example, how do they feel they could be better supported? What helps them to feel less anxious? What do they value in terms of an intervention? With that in mind, it is hoped that this study will act as a form of advocacy for the child with SM.

Summary

This chapter has provided a rationale for an exploration of how SM can be appropriately supported in the school context. The school system has been identified as an important context for the support of SM, so that the debilitating symptoms do not become entrenched and lead to negative consequences for the pupil. The role of the EP has been identified as essential in assisting pupils presenting with symptoms of SM. Chapter Two will detail a systematic literature review which focused on exploring school-based interventions and the implementation process. An exploration of the role of the EP in supporting schools with pupils presenting with SM is outlined in Chapter Three in the empirical journal article. In conclusion, Chapter Four will contain an overarching view of the findings and the implications these have in terms of the relevance for EP practice.

Definition of Key Terms

Selective Mutism: SM is classified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) as an anxiety disorder (APA, 2013, p. 195) The diagnostic criteria for SM are:

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g. at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E. 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.

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Chapter 2: Systematic Literature Review

A Systematic Review and Synthesis of Evidence of School-Based Interventions for Selective Mutism

Abstract

Selective Mutism (SM) is an anxiety disorder that can have a negative impact on a pupil's engagement in the school context. The school environment is the most common setting for the manifestation of symptoms of SM. Therefore, it is important that educational psychologists (EPs) and school staff are aware of current school-based intervention practices to support pupils presenting with SM. This current systematic literature review synthesised studies of school-based interventions to support pupils presenting with SM. Fourteen studies which were located across pre-school, primary and post-primary school settings and published between 2005 and 2019 were included. The review examined each study in terms of approach to intervention and implementation practices. The interventions varied in relation to study design, length of the intervention, personnel involved and the methods of assessing baseline, outcome and follow-up performance. Overall, positive findings were demonstrated for the use of behaviourally-based intervention strategies for SM in the school setting. Positive results were identified for a multi-modal approach to intervention (including a therapeutic approach). Rapport building and adopting a pupil-centred approach was found to be important in order to establish the foundation for the intervention. The results of the systematic literature review indicate that the school context can be considered an appropriate, non-invasive setting for SM intervention. Potential implications for the EP are further discussed.

Keywords: selective mutism, school-based interventions, educational psychology

A Systematic Review and Synthesis of Evidence of School-Based Interventions for Selective Mutism

Selective Mutism (SM) is an anxiety disorder that can have a significant impairing impact on the educational achievement and social functioning of pupils attending formal education (Grover et al., 2006). As spontaneous improvement of the symptoms of SM is rare (Bergman et al., 2002), early intervention is therefore essential for pupils presenting with risk factors for SM, so that the symptoms are not maintained or further entrenched (Cohan et al., 2006). It is within the school environment that SM is most prevalent (Kehle & Bray, 2009) and where the impairments of the condition can be the most debilitating (Steinhausen et al., 2006). It is therefore imperative that school-based practitioners are appropriately equipped to support pupils presenting with SM in the school environment (Zakszeski & DuPaul, 2017).

There is a dearth of systematic reviews focusing specifically on interventions for SM in the school setting. Many of the available systematic reviews tend to be primarily concerned with medical treatment in a clinical setting. Therefore, this review served to synthesise the interventions available to support pupils presenting with SM in the school environment and to explore the implementation of those interventions.

Definition of Selective Mutism

SM is included under the category of anxiety disorders in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013). The condition is characterised by a consistent lack of speech in specific social settings where there is an expectation for speaking (e.g. school) despite speaking freely in other situations (e.g. home) (Oerbeck et al., 2020). With the classification of SM as an anxiety disorder, came the recognition that those with the condition experience overwhelming anxiety which

can result in being physically unable to speak in particular settings where oral language is expected (Sluckin, 2011). A shift from the term 'elective' mutism to 'selective' mutism in 1994 broadened the diagnosis phenomenology to an understanding that SM is not an act of defiance, but a lack of ability to speak in select situations due to anxiety (Oerbeck et al., 2020). Thus, the absence of speech typically interferes with educational achievement, making SM a debilitating condition (Dreissen et al., 2020)

Prevalence of Selective Mutism

A recent figure published by the National Health Service in the United Kingdom, reported that one in 140 (0.71%) young children present with SM (National Health Service [NHS], 2017). Previous prevalence studies have reported various figures that typically range from between 0.18% (Kopp et al., 1997) to 1.9% (Kumpulainen et al., 1998). Studies that explored the prevalence of SM specifically within the primary school setting reported figures ranging from 0.033% to 2% (Bergman et al., 2002; Karakaya et al., 2008; Kopp et al., 1997; Kumpulainen et al., 1998). Prevalence rates specific to the post-primary school context have yet to be identified in the literature. The use of different diagnostic criteria, settings, recruitment strategies and ages of participants sampled can all result in variance of the prevalence rates cited (Starke, 2018). Studies examining narrow age ranges (between four and six years) yield a higher prevalence rate in comparison to studies which explore wider age ranges (Sharkey & McNicholas, 2012). SM may often go unnoticed until the pupil enters formal education (Viana et al., 2009). According to Sharkey and McNicholas (2012), school and community-based studies tend to yield consistently higher prevalence rates compared to clinical samples.

Co-occurring presentations

SM is a condition that often presents with other conditions. In a recent meta-analysis, Dreissen et al. (2020) found that 80% of pupils with SM (n = 837) were also diagnosed with an additional anxiety disorder, most commonly social phobia (69%). Research conducted by Steffenburg et al. (2018) found that Autism Spectrum Disorder (ASD) also commonly co-occurs with SM. Steffenburg et al. (2018) found that, in a clinical sample of 97 participants with SM between the ages of four and eighteen, 63% (n = 61) also presented with ASD. It must be cautioned that this study is based on retrospective chart reviews, which indicates some uncertainty as to the quality of the data obtained (Steffenburg et al., 2018).

Sharkey and McNicholas (2012) explored SM and co-occurring presentations in a study of pupils (n = 10,927) aged between four and twelve attending primary schools situated in an urban region in the Republic of Ireland. Twenty children were identified as having symptoms suggestive of SM (Sharkey & McNicholas, 2012). Of these twenty children, fourteen consented to a full clinical assessment to confirm the diagnosis, all of whom met the diagnostic criteria (0.12%). The diagnosis of SM was made based on DSM-IV criteria. Of these fourteen children, nine (64%) also had a history of speech and language delay and three (21%) further met the diagnostic criteria for a co-occurring diagnosis of dyspraxia (Sharkey & McNicholas, 2012). Three children (21%) met the criteria for an anxiety disorder based on a self-report measure (Sharkey & McNicholas, 2012).

Aetiology of Selective Mutism

There is little consensus regarding the aetiology of SM in the literature (Krysanski, 2003). A multi-factorial aetiology is suggested, integrating multiple theoretical perspectives, such as biological and environmental factors, which would classify SM as a multi-dimensional condition associated with biological, psychological, and social factors

(Steinhausen et al., 2006). Symptoms of SM were once considered a result of trauma, family dysfunction or defiance (Smith-Schrandt & Ellington, 2018). Current research, however, acknowledges that most pupils presenting with SM have not experienced any form of trauma (Schwartz et al., 2006). Instead, it is likely that SM occurs due to complex individual and environment interactions occurring at multiple levels over time (Cohan et al., 2006).

Selective Mutism in Schools

As stated, school is the most common context for the presentation of SM symptomology (Kehle & Bray, 2009). The condition is encountered daily in the school environment and teachers are often the first to recognise the presentation (Crudwell, 2006). Teachers thus have a pivotal role in the inclusion of pupils with SM (Cunningham et al., 2004). SM can be a barrier to curricular engagement, and it can affect the acquisition of academic and social skills (Mitchell & Kratochwill, 2013). As a result, many pupils with SM perform academically lower than their peers and are more at risk of social isolation (Theodore et al., 2003). Teachers can often have difficulty assessing a pupil's academic skills, such as oral reading (American Psychiatric Association, 2013). As a result, teachers have expressed concern in terms of appropriately supporting a pupil with SM in the classroom (Omdal, 2007).

Zakszeski and DuPaul (2017) describe how school-based practitioners are in an ideal position to support the implementation of school-based interventions for SM. Ford et al. (1998) describe how parents identified school-based practitioners as the most helpful of all treatment providers. However, the literature states that school professionals have reported limited knowledge regarding the condition and minimal experience in terms of implementing interventions for SM (Kehle et al., 2012). It is therefore important for school

practitioners to be aware of the evidence-based interventions available to support pupils presenting with SM (Zakszeski & DuPaul, 2017).

Dunsmuir et al. (2006) contend that educational psychologists (EPs), along with speech and language therapists (SLTs), are the key professional groups to support pupils with SM. Davidson (2012) states that both EPs and SLTs are well-placed to support a pupil with SM, given their background in academic, language and emotional support. EPs can have a significant role in terms of supporting schools with SM and can use their professional skills to engage in intervention at a systems level (Busse & Downey, 2011). According to Kratochwill and Stoiber (2000), there is a growing need for the establishment of the empirical basis for treatment programmes for pupils with SM in the school environment. If left unsupported, the impairing features of SM, such as social isolation and academic functioning, can increase and the development of depressive symptoms from the burden of anxiety may emerge (Smith-Schrandt & Ellington, 2018). To minimise the negative effects that SM can pose to a pupil's academic and social development, it is necessary for school-based practitioners to be informed of SM intervention in order to effectively provide support (Zakszeki & DuPaul, 2017). Given that the school environment is a challenging context for a pupil with SM, it is logical that the school is the most appropriate setting in which to provide support compared to a clinical setting (Sanetti & Luiselli, 2009).

Rationale and Aim of the Current Review

The aim of the review was to gain an understanding of school-based interventions that can be utilised to support pupils presenting with SM. This systematic review focused on interventions for SM through a systemic lens, by exploring the school as an appropriate context to implement such interventions. The research base on SM predominantly stems from clinical settings, resulting in little focus on the school system and the interventions

implemented by school-based professionals (Omdal, 2007). It is appropriate to examine interventions that can be used in the setting where the condition is typically the most debilitating.

It has previously been reported that SM can be a challenging condition to treat (Østergaard, 2018). SM cannot typically be treated in the same way as general anxiety disorders. Cognitive Behavioural Therapy (CBT), for example, is often a treatment of choice for anxiety. However, for those presenting with SM, speaking with a therapist as required can present significant challenges (Østergaard, 2018). It is also important to consider that pupils with SM tend to be younger than other people presenting with anxiety disorders, meaning pharmacological treatment is not always appropriate (Bergman et al., 2013).

The research, up to recently, had a limited number of empirical studies on the methods for treating SM (Østergaard, 2018). Cohan et al. (2006) carried out a review of the psycho-social interventions for pupils with SM by analysing the literature from 1990 to 2005. The review identified support for the use of behavioural (shaping, stimulus fading and social skills training) and cognitive-behavioural (systematic desensitisation) interventions for pupils with SM. Cohan et al. (2006) found that shaping and stimulus fading techniques work well within the school context, whereas systematic desensitisation may be best placed in individual therapy sessions. This research concludes with the important finding that a potentially effective treatment approach for supporting a pupil with SM is individual therapy which focuses on communication skills and managing anxiety, whilst simultaneously engaging in a behavioural programme in the school environment to shape appropriate verbal communication (Cohan et al., 2006). Within the school context,

behaviour interventions should be slow and systematic, with the use of positive reinforcement (Cohan et al., 2006).

Zakszeski and DuPaul (2017) built on the review by Cohan et al. (2006) and explored a review of treatment for SM between 2005 and 2015. The researchers analysed 21 studies and found that treatment commonly consisted of behavioural and systems approaches including behavioural strategies such as contingency management, shaping, hierarchical exposure and stimulus fading and systems strategies included adult skills training, psychoeducation and consultation (Zakszeski & DuPaul, 2017). The authors found that most of the treatments were effectively delivered in the school setting (Zakszeski & DuPaul, 2017).

Østergaard (2018) carried out a systematic review examining the evidence of treatment for SM using CBT, psychopharmacology or a combination of both across the home, clinical and school settings. The review included 15 studies; six based on CBT, seven on medication and two were based on a combination of both. Results were strongest for CBT as treatment for SM with evidence supported by Randomised Controlled Trials (RCTs) and the use of consistent outcome measures. The results were weaker for medication (Østergaard, 2018). Combination therapy is only sparsely investigated in the literature with just two studies.

SM is a debilitating condition which can negatively impact on the whole-school experience of the pupil experiencing the condition, which strengthens the rationale for identifying school-based interventions to support pupils within the school context. If a pupil is not appropriately supported, the symptoms of SM may continue to cause significant challenges, reinforcing the need for intervention (Crundwell, 2006). As established, the school environment is a very common setting for SM, meaning it is imperative for school-

based practitioners to be both aware of the condition and to implement subsequent interventions (Zakszeski & DuPaul, 2017). Interventions for SM are particularly important at the school-based level (Pionek Stone et al., 2002), as it is important to support the pupil in this challenging setting so they can be safely supported. According to Cleave (2009), it is important that the SM intervention is implemented by a person who is well known to the pupil. It is unclear in the current literature who is commonly involved in terms of implementing interventions in the school setting.

There is currently no identified systematic review on this specific topic. Whilst Zakszeski and DuPaul (2017) conducted a similar systematic review of SM, the study also analysed medical intervention. Much of the available research on the treatment of SM stems from a medical approach, where the disorder is pathologised and considered to be a within-pupil issue, with treatment taking place in a clinical setting. Systematic reviews for SM in general are limited. In conclusion, this systematic review aims to identify school-based interventions to support pupils presenting with SM in the school context. Specifically, the aim of the review is to synthesise the literature in order to address the following aims:

(1) To identify the school-based interventions utilised to support pupils presenting with SM in the school context.

(2) To explore the personnel involved in the school-based interventions in supporting the pupil with SM.

By synthesising the literature on school-based interventions for SM, the overarching aim was to address a gap in the literature in relation to a specific focus on the intervention strategies where the condition is most commonly identified. It is envisaged that it will contribute to the knowledge base in relation to SM and school-based interventions whilst also informing educational psychology practice.

Method

Selection of Empirical Studies

The methodology for this systematic literature review was designed in relation to the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Moher et al., 2009). The PRISMA statement is endorsed by over 170 peer-reviewed journals in the health sciences (Tao et al., 2011). The systematic review further adheres to the Cochrane Handbook for Systematic Reviews guidelines (Higgins & Thomas, 2019).

Inclusionary and Exclusionary Criteria

The criteria for including studies in the systematic review was outlined by the SPIDER Tool (Table 2.1).

Table 2.1
SPIDER Inclusionary Criteria

Sample	Pupils of any age or gender presenting with Selective Mutism attending either Pre-school, Primary or Post-Primary schools. The pupil can present with Selective Mutism co-occurring with another diagnosis. The review will consider papers from all geographical areas. The review will only include papers published between 2005 and 2019.
Phenomenon of Interest	School-based intervention types.
Design	All types of studies will be included. Randomised Controlled Trials, Quasi-Experimental Design, Case Study Design, Single-group pre-post-test design or single subject design will all be considered. Having a control group is not an inclusion criterion.
Evaluation	The study must assess intervention effects on Selective Mutism.
Research Type	Qualitative or quantitative.

Literature Search and Synthesis

A comprehensive database search was carried out in June, July and August 2019. Studies of school-based interventions for SM between 2005 and 2019 were identified across the following sources:

Table 2.2
Results from Searching the Literature to Identify Relevant Results

Databases	**Additional Records**
PsychINFO	National Association of School Psychologists (NASP)
ERIC	Journal of School Psychology
EBSCO (British Education Index, Academic Search Complete)	Pupils & Schools
ProQuest	Contemporary School Psychology
ProQuest Dissertations and Theses	Psychology in the Schools
	Education and Treatment of Pupils
	Journal of Pupil Psychology/Psychiatry
	Journal of Educational and Psychological Consultation
	Journal of Emotional and Behavioural Disorders

A number of relevant databases for education and psychology were searched (Table 2.2). Appropriate journals were also hand-searched. Reference lists of the published studies were also searched in an attempt to identify any additional relevant studies that were not returned in the electronic database search. Each database was searched using the following search string (Table 2.3):

Table 2.3
Search Terms and Keywords

‘Selective Mutism’ OR ‘Elective Mutism’
AND
‘Pre School’ OR ‘Primary School’ OR ‘Post-Primary School’ OR ‘elementary school’ OR ‘middle school’ OR ‘secondary school’ OR ‘kindergarten’
AND
‘intervention’ OR ‘treatment’ OR ‘therap*’ OR ‘evaluation’ OR ‘programme’ OR ‘trial*’ OR ‘experimental’ OR ‘evidence-based

Exclusionary Criteria

Studies where the participant did not have a diagnosis of SM were excluded. Studies in which the intervention was not delivered in a school-based setting were also excluded. Studies not written in the English language were excluded. Studies that were published prior to 2005 were excluded.

Data Extraction and Management

Data was managed using a Microsoft Excel spreadsheet. EndNote was used to manage references and to save the studies. For each study, information was extracted relating to the authors, year of publication, study design, sample, setting, details of the intervention (e.g. length) and who implemented the intervention (Appendix C).

Study Quality Appraisal

The included studies were evaluated using the Weight of Evidence (WoE) framework by Gough (2007). This framework allowed the reviewer to assess each identified article across three different areas (WoE A: quality of the methodology; WoE B: relevance of the methodology for the research question; WoE C: topic relevance). These WoE scores are combined and averaged to give an overall WoE score, WoE D.

Results

Overview of the Selected Studies

The literature search flow is outlined in Figure 2.1. Sixty-five papers were returned from the initial search (database search and additional records e.g. hand-searching relevant journals and reference lists) (Appendix D). Duplicate papers were removed (n = 15). The author screened all the titles and abstracts from the search returns to determine their relevance for the present study. Inclusionary and exclusionary criteria were applied to all studies. Fifty records were screened (title and abstract). Studies that could be excluded based on the title and abstract screening were omitted (n = 23). Twenty-seven papers were assessed in full. A further thirteen papers were removed (see Appendix E for justification), leaving fourteen full text, peer-reviewed papers to be included in the current systematic review (Table 2.4). The research focus of the studies was to explore school-based interventions for supporting pupils with SM. Of these fourteen, five studies were published within the last five years reflecting the emerging nature of the field. The research studies were located across pre-school, primary and post-primary school settings. Nine of the studies were conducted in the USA, three in Norway, with one study each in Ireland and the United Kingdom.

Figure 2.1
Systematic Review Process

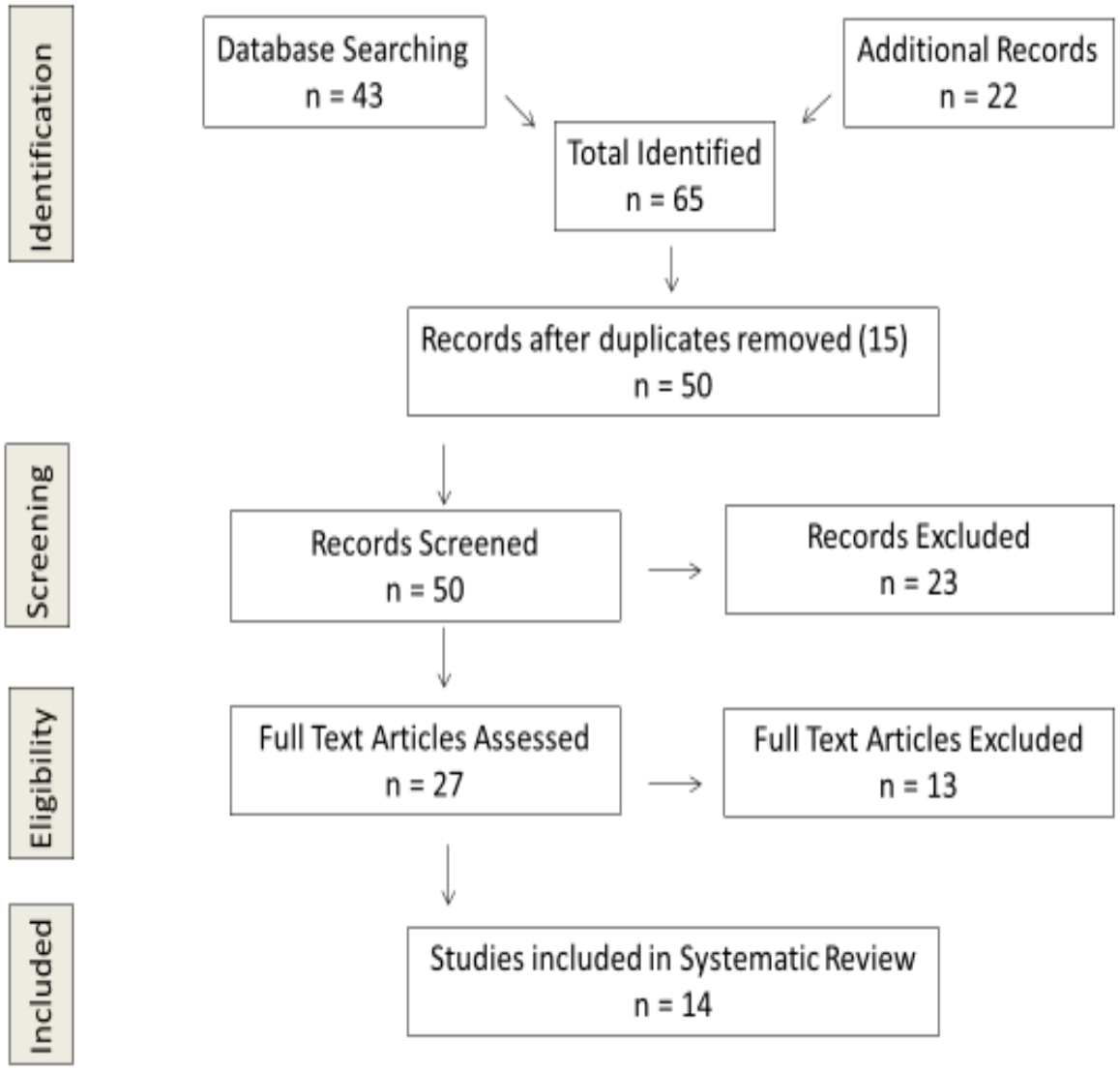


Table 2.4

Studies Included in the Review

	Paper	Author(s)	Year
1	Assessment and Treatment of Selective Mutism with English Language Learners	Mayworm et al.	2015
2	Functional Assessment-Based Intervention for Selective Mutism.	Kern et al.	2007
3	Evidence-Based Practices for Selective Mutism: Implementation by a School Team.	Sanetti & Luiselli.	2009
4	Examination of a Social Problem-Solving Intervention to Treat Selective Mutism	O'Reilly et al.	2008
5	A randomized controlled trial of a home and school-based intervention for Selective Mutism – defocused communication and behavioural techniques.	Oerbeck et al.	2014
6	Selective Mutism: A home and kindergarten-based intervention for pupils 3-5 years: a pilot study	Oerbeck et al.	2011
7	Treatment of Selective Mutism: Applications in the Clinic and School Through Conjoint Consultation	Mitchell & Kratochwill.	2013
8	Increasing Verbal Behaviour of a Student who is Selectively Mute	Beare et al.	2008
9	Evaluation of a Packaged Intervention for Treating Selective Mutism: Application in a School Setting. (Thesis).	Cotton-Thomas.	2015
10	The silent minority: Supporting students with selective mutism using systemic perspectives.	Lawrence.	2017
11	Selective mutism: Practice and intervention strategies for pupils.	Hung et al.	2012
12	Selective Mutism in pupilhood: Assessment and treatment of an African American pre-school boy.	Conn & Coyne.	2014
13	Accountability steps for highly reluctant speech: Tiered-services consultation in a Head Start classroom.	Howe & Barnett.	2013
14	Including children with selective mutism in mainstream schools and kindergartens: problems and possibilities	Omdal.	2008

Critical Appraisal of Included Studies

The current systematic review included papers of various design types. Therefore, it was necessary to assess each paper using the most appropriate appraisal tool and standardise the scores in order to calculate a WoE A score. The single-subject experimental designs were evaluated using the Horner et al. (2005) guidelines (Appendix F), case studies were evaluated using the checklist for case reports from the Joanna Briggs Institute (JBI) (Appendix G), and the RCT was evaluated using the Critical Appraisal Skills Programme

(CASP) checklist for RCTs (Appendix H). As each of the three checklists had different numbers of questions, scoring criteria was adopted from Yasin et al. (2020) for calculating a WoE A score for papers of various study designs. To achieve a standardised score between 0 and 3, the number of positively answered questions relative to each checklist's total questions (as a percentage) was multiplied by three. For example, a positive response to 17 of the 21 questions for a given checklist would result in a score of $\frac{17}{21} * 3 = 2.42$, which according to Gough (2007) equates to a high rating. The scoring process for each of the checklists can be found in appendices F to H.

WoE B (Appendix I) examined the methodological relevance (Gough, 2007). Study designs were allocated different weightings depending on the design type (Appendix I). The RCT is in the 'high' category (high degree of experimental control), single-subject experimental designs are in the 'medium' category while case studies are in the 'low' category (lacking experimental control).

WoE C examined topic relevance (Gough, 2007) by evaluating the studies based on the detail of the intervention provided and the ability to generalise the study to another pupil with SM (Appendix J). Lastly, an overall WoE D score was identified by combining scores from WoE A, B and C (Gough, 2007) (Table 2.5). One study (Oerbeck et al., 2014) was identified to be of high quality, six studies were found to be of medium quality and seven studies were found to be of low quality. The WoE provided useful information in terms of study quality. Given that SM is an under-researched condition, the data in each of the fourteen studies provided valuable information. Therefore, all fourteen papers were included in the review despite seven papers being identified as being in the 'low quality' range, as determined by Gough's WoE.

Table 2.5

Results from the Weight of Evidence Study Quality Appraisal

	WoE A	**WoE B**	**WoE C**	**Overall**
Mayworm et al. (2015)	2.3 (medium)	1.0 (low)	2.0 (medium)	1.7 (low)
Kern et al. (2007)	2.0 (medium)	2.0 (medium)	2.0 (medium)	2.0 (medium)
Sanetti & Luiselli (2009)	2.3 (medium)	1.0 (low)	2.0 (medium)	1.7 (low)
O'Reilly et al. (2008)	2.1 (medium)	2.0 (medium)	2.0 (medium)	2.0 (medium)
Oerbeck et al. (2014)	2.2 (medium)	3.0 (high)	3.0 (high)	2.7 (high)
Oerbeck et al. (2011)	2.3 (medium)	1.0 (low)	2.0 (medium)	1.7 (low)
Mitchell & Kratochwill (2013)	2.3 (medium)	2.0 (medium)	2.0 (medium)	2.1 (medium)
Beare et al. (2008)	2.7 (high)	2.0 (medium)	2.0 (medium)	2.2 (medium)
Cotton-Thomas (2015)	2.7 (high)	2.0 (medium)	2.0 (medium)	2.2 (medium)
Lawrence (2017)	1.5 (low)	1.0 (low)	2.0 (medium)	1.5 (low)
Hung et al. (2012)	1.5 (low)	1.0 (low)	2.0 (medium)	1.5 (low)
Conn & Coyne (2014)	2.6 (high)	1.0 (low)	1.0 (low)	1.5 (low)
Howe & Barnett (2013)	2.3 (medium)	2.0 (medium)	2.0 (medium)	2.1 (medium)
Omdal (2008)	1.5 (low)	1.0 (low)	1.0 (low)	1.2 (low)

Low: at/less than 1.8, medium: 1.8 – 2.4, high: at/greater than 2.4

Participant Demographics

Table 2.6

Participant Characteristics

Paper	N	Gender	Age	Setting	Specific Setting	Country	Diagnosis
1	1	Female	6	Elementary school	Mainstream (phased from one-to-one in a room to the typical classroom setting)	USA	SM / English Additional Language
2	2	Female Male	13 11	Elementary school	1: special education class 2: Mainstream	USA	SM / English Additional Language / EBD SM
3	1	Female	8	Elementary school	Mainstream and one-to-one in a separate class for stimulus fading	USA	SM
4	2	Females (sisters)	5 and 7	Primary school	Resource room, mainstream classroom	Ireland	SM
5	2 4	16 females, 8 males	3 – 9 years	Pre-school and Primary School	Home, pre-school and school (separate classroom)	Norway	SM (6 participants EAL)
6	7	5 females, 2 males	3 – 5 years	Kindergarten	Home, Pre-school (separate classroom)	Norway	SM (4 participants EAL)
7	4	2 males, 2 females	5 – 10 years (Average = 7)	Elementary school	Clinic phased to mainstream school classroom (after school hours and phased to school day)	USA	SM (3 confirmed and 1 suspected)
8	1	Male	12 years	Middle school	Resource room, study room, mainstream classroom	USA	SM & EBD (emotional and behavioural disorder).
9	3	2 male, 1 female	5 – 10 years old Average age: 8	Elementary school	Mainstream school in an empty classroom	USA	SM (I participant had co-morbid ADHD)
10	1	Male	12 years	Primary school	Post-primary, mainstream, empty classroom	UK	SM
11	1	Female	4 years	Pre-school	Mainstream classroom and separate resource room	USA	SM
12	1	Male	3 years	Head Start Pre-school	Mainstream: social skills group and classroom	USA	SM
13	1	Female	4 Years	Head Start Pre-school	Mainstream classroom and separate room	USA	SM
14	5	2 Males, 3 Females	4-13 years	Kindergarten, Primary & Secondary School	Home and Mainstream	Norway	SM

Table 2.6 summarises the participant demographics in the included studies. Participant sample sizes varied from one participant (Mayworm et al., 2015; Sanetti & Luiselli, 2009; Beare et al., 2008; Hung et al., 2012; Conn & Coyne, 2014; Howe & Barnett, 2013) to 24 participants (Oerbeck et al., 2014), with participants ranging in age from three to thirteen years. In total, an aggregate of fifty-four participants was involved in the studies. There were thirty-four female participants and twenty male participants in the studies. Fifty-three participants had a diagnosis of SM and one participant had a suspected case of SM. English was an Additional Language for twelve participants.

Study Designs

This systematic review was not limited by the type of study design. The fourteen studies included a variety of study designs: one randomised controlled trial (RCT), six single-subject experimental designs and seven case studies. As the literature base on school-based interventions for SM is quite small, it was deemed appropriate to include a mixture of papers with study designs. The RCT featured was the first RCT published examining psychosocial treatment for SM (Oerbeck et al., 2014). In the study, twelve participants were given the intervention while twelve participants were placed in the wait list control group.

Six studies employed a single-subject experimental design, which is a valid way to evaluate the effectiveness of an intervention (Kratochwill et al., 2010). Beare et al. (2008) state that a single-subject research design is the most appropriate design for the purpose of analysing the effects of a tailored treatment plan that uses behavioural intervention strategies to support a pupil presenting with SM. The seven case studies provided rich contextual information.

Intervention Type

This study explored the type of school-based interventions utilised to support pupils with SM in the school context (Table 2.7).

Table 2.7
Intervention Type Utilised

Paper	**Author**	**Intervention Type Utilised**
Paper 1	Mayworm et al. (2015)	Rapport building, response initiation, contingency management, shaping, stimulus fading, behaviour chart, role-play, sliding-in.
Paper 2	Kern et al. (2007)	Functional assessment-based intervention, reinforcement schedule, token economy.
Paper 3	Sanetti & Luiselli (2009)	Token economy, stimulus fading, peer intervention, goal setting, shaping, contingent reinforcement.
Paper 4	O'Reilly et al. (2008)	Social problem-solving, psychoeducation, role-play, modelling.
Paper 5	Oerbeck et al. (2014)	Reward schedule, defocused communication, gradual exposure, psychoeducation, sliding-in technique.
Paper 6	Oerbeck et al. (2011)	Same strategies as in Paper 5 applied to younger age group.
Paper 7	Mitchell & Kratochwill (2013)	Conjoint behavioural consultation, stimulus fading, shaping, contingency management, rapport building.
Paper 8	Beare et al. (2008)	Reinforcement, stimulus fading, generalisation.
Paper 9	Cotton-Thomas (2015)	Conjoint behaviour consultation & integrated behaviour therapy programme (Bergman et al., 2013). Contingency management, stimulus fading, fear hierarchy, shaping exposure.
Paper 10	Lawrence (2017)	Psychoeducation, therapeutic approach, home-work activities, therapeutic letter.
Paper 11	Hung et al. (2012)	Play therapy, exposure, shaping and desensitization.
Paper 12	Conn & Coyne (2014)	Contingency management, hierarchical exposure, shaping, social skills training, stimulus fading.
Paper 13	Howe & Barnett (2013)	Contingency management, prompting, shaping, consultation.
Paper 14	Omdal (2008)	Video-observations of the child's interactions in natural situations in the home and school setting.

The included studies reported the use of a tailored, individualised approach to intervention, which predominantly included behavioural intervention types. The behavioural intervention strategies most commonly reported included: shaping (n = 7), stimulus fading (n = 7), desensitisation (n = 1), exposure (n = 5), reinforcement (n = 3), contingency management (n = 5), token economy system (n = 3).

Kern et al. (2007) advocated for the use of a functional-based assessment to inform the intervention. Similarly, Mitchell and Kratochwill (2007) discussed the use of a comprehensive behavioural assessment to link the assessment results to the data. O'Reilly et al. (2008) discussed the use of a social problem-solving intervention protocol, which is a form of behavioural intervention. The social problem-solving intervention involves teaching the pupil a generic set of social rules that can be adapted to different social interactions (O'Reilly et al., 2006).

Mitchell and Kratochwill (2007) and Cotton-Thomas (2015) reported the use of supporting SM in the school using conjoint consultation. This intervention method is an indirect service delivery model where parents, teachers and school personnel collaborate to address the academic, social and/or behavioural needs of a pupil (Sheridan & Kratochwill, 2008) through a problem-solving approach (Mitchell & Kratochwill, 2007). The studies adapted this conjoint consultation model to explore if the psychosocial approach would improve SM behaviour, impact on anxiety and if the parents and teachers would rate the treatment as acceptable and effective in treating SM.

Omdal (2008) explored the use of video observation to analyse the social interactions of five children with SM across the home and school setting. Parental and staff semi-structured interviews were also completed. The focus of the study was to explore the inclusion of children with SM in the school setting and to understand the contribution of

teachers in this regard. The study found that the schools who actively held the expectation that the child would speak, and those who worked in partnership with parents, were more successful in helping the child to communicate verbally.

Psychoeducation was identified as an important feature in a number of the studies. Oerbeck et al. (2014) and Oerbeck et al. (2011) utilised the same intervention protocol across two different school settings (pre-school and primary school), with psychoeducation included as a fundamental aspect of the intervention. Psychoeducation involved informing staff and parents about the nature of SM (prevalence, aetiology, co-occurring presentations), their understanding of their pupil's condition, how to cope with SM in social interactions and feelings of helplessness and anger and how to cope with such feelings (Oerbeck et al., 2014; Oerbeck et al., 2011).

Three of the fourteen studies referenced the use of therapeutic interventions that formed part of the overall intervention programme. It was reported that therapeutic activities can be paired together with behavioural interventions, such as shaping techniques (Lawrence, 2017; Hung et al., 2012). Cotton-Thomas (2015) applied a multi-modal approach through behavioural strategies and a therapeutic approach, based on an integrated therapy for SM programme created by Bergman et al. (2013). The intervention involved placing emphasis on the four main components of CBT for pupils with anxiety: development of a fear hierarchy, psychoeducation, exposure therapy and maintenance of learned behaviour. The psychologist in training worked closely with the SM participants by creating a talking ladder and working towards exposure at a safe, gradual pace (Cotton-Thomas, 2015).

Lawrence (2017) also involved both a behavioural and therapeutic approach. The psychologist used anxiety materials to inform the tailored intervention, including "Think

Good Feel Good" (Stallard, 2002), "Cool Kids" (Rapee et al., 2006) and information from the Selective Mutism Resource Manual (Johnson & Wintgens, 2016). The psychologist used the approach of writing a therapeutic letter to the participant following the completion of the intervention.

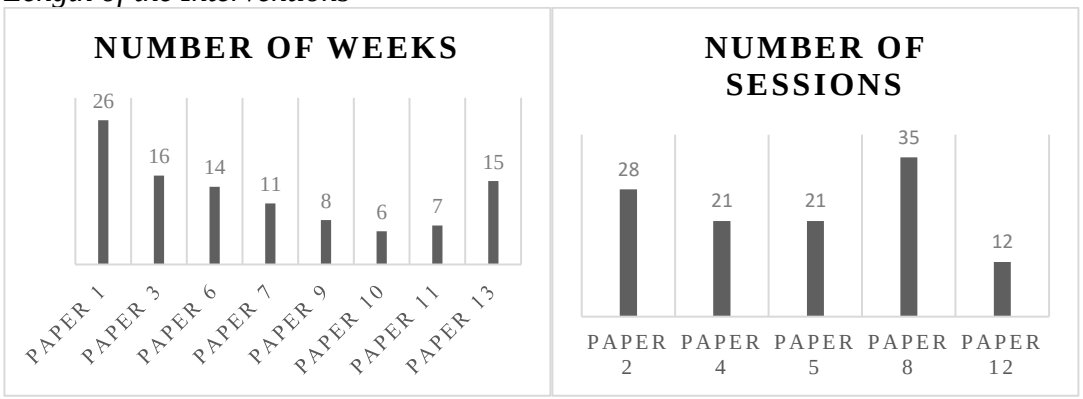
Hung et al. (2012) employed play therapy in their approach to intervention with a pre-school pupil with SM. The therapist in the study informed the pupil that they would engage in safe activities preferred by the pupil. Drawings and conversation through puppets were employed as age-appropriate therapeutic activities. These activities were combined with behavioural strategies such as desensitisation and shaping techniques (Hung et al., 2012).

Howe and Barnett (2013) explored the use of a consultation-based problem-solving approach to support a pupil with SM in a pre-school setting. The use of a consultation-based approach served as a method towards providing support for the teacher to take ownership of the SM intervention strategies.

Intervention Duration

The included studies varied in the duration and frequency of the intervention (Figure 2.2).

Figure 2.2
Length of the Interventions

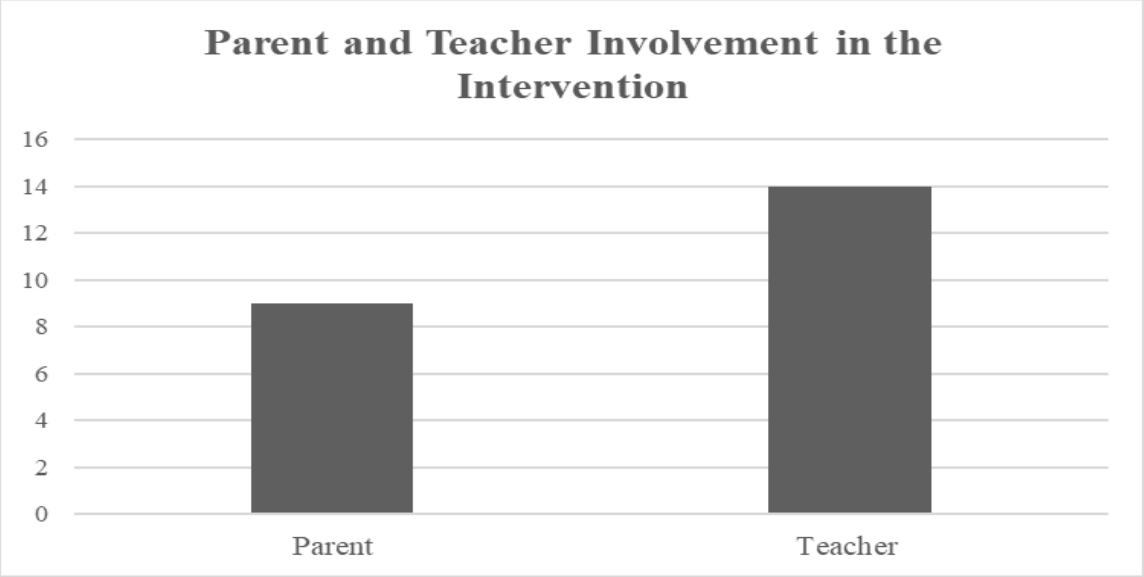


The studies varied in the way in which they reported the length of the intervention. Some studies reported the length of the intervention in weeks while other studies reported the length of the intervention by total number of sessions. The average length of the intervention was thirteen weeks and the average number of sessions reported was twenty-three. The study by Omdal (2008) did not provide details in relation to intervention length, instead the author included details of the video-observations and semi-structured interviews.

Intervention Implementation

The fourteen studies were analysed to explore who was involved in implementing the school-based interventions. Administration of the interventions varied across the studies.

Figure 2.3
Parent and Teacher Involvement



School personnel were involved in all the included studies (Figure 2.3). Teacher involvement varied across the studies, including completing weekly speaking assignments with the pupil, providing positive reinforcement and involvement in stimulus fading. One

study (Lawrence, 2017) reported the resistance of school personnel to continue intervention beyond six sessions. Parents were involved in 64% (n = 9) of the studies, which involved either coming into the school context to facilitate the intervention, engage with a therapist in the home setting or to attend a psychoeducation session about SM.

In terms of overall co-ordination and implementation of the interventions, school/educational psychologists (including graduates and trainees) were involved in 64% (n = 9) of the studies. Ten therapists working in CAMHS were involved in one study (Oerbeck et al., 2014), three psychologists and two therapists with no detail specified in relation to their respective disciplines were involved across 38% (n = 5) of the studies. One study was implemented by teachers and parents solely, following training by the author of the paper (researcher in psychology) (Mitchell & Krachtowill, 2013) and one study was implemented by three teachers (Beare et al., 2008).

In relation to the setting, all studies (as per inclusionary criteria) were located in the school setting. All of the pupils included in the systematic review studies were attending education in the mainstream school setting. Some of the pupils were also attending special educational classes for support with EAL or behaviour. The studies by Oerbeck et al. (2014) and Oerbeck et al. (2011) started the implementation of the intervention in the home setting with the parents until the pupils progressed to a degree that the intervention could progress to the school setting. Omdal (2008) began video observations in the home setting prior to video observations in the school setting. Similarly, the study by Mitchell and Kratochwill (2013) progressed from the clinic setting to the school setting.

Baseline Measures, Results/Outcomes and Follow-Up

The included papers were analysed to explore the baseline measures, results/outcomes of the studies and any included follow-up information. The paper by Omdal (2008) differed in that no baseline, results and follow-up data was provided. Instead, information of a qualitative nature was provided and therefore not included in this analysis. The results from the other thirteen papers differed in terms of study design, length and intervention type, while the method for reporting baseline measures, outcomes and follow-up all varied (Table 2.8). The effect sizes were rarely reported in the included studies, despite most of them indicating positive findings. Whilst there are a number of limitations reported, these aspects are understandable given the complexity of SM as a condition. Omdal (2008) reported that two of the five children included in the study demonstrated significant improvement and started to speak in school/kindergarten one year following the research. The sliding-in technique (Johnson & Wintgens, 2001) was particularly helpful with one child.

In 86% of the studies (n = 12), an improvement in SM symptoms across participants was reported, with 50% (n = 7) of these studies demonstrating that follow-up improvements were maintained or had increased for some participants. While Mayworm et al. (2015) discussed that progression had been made, seven months post-intervention the participant was still not speaking at a normal volume on a regular basis in the classroom setting. The participant made progress from baseline to the results, for example, exhibiting zero verbal responses to opportunities at baseline to exhibiting sixty-five verbal responses to opportunities at the end of the intervention. The RCT trial (Oerbeck et al., 2014) demonstrated positive results in terms of a home and school psychosocial intervention, finding that the intervention group was more effective than the waitlist control. The results

from the RCT found that there was a more significant increase in the younger participants in the intervention group (Oerbeck et al., 2014).

Table 2.8

Baseline Measures, Outcomes and Follow-up Information

	Paper	Baseline	Outcome	Follow Up
1	Mayworm et al. (2015)	Non-verbal Initiations = 17 Verbal Initiations = 0 Opportunities to respond = 77 Verbal Responses to opportunities = 0	Non-verbal initiations = 57 Verbal initiations = 22 Opportunities to respond = 149 Verbal responses to opportunities = 65	Maintained
2	Kern et al. (2007)	0 questions asked of student and 0 vocal responses	Each child increased the number of responses to questions asked (changing criterion design)	Maintained
3	Sanetti & Luiselli (2009)	0 words spoken	11 words spoken at a conversational volume	Maintained
4	O'Reilly et al. (2008)	0 response to 5 questions asked	P1 improved to 100% in 69% of sessions P2 improved to 100% responses in 71% of sessions	Maintained
5	Oerbeck et al. (2014)	SSQ = 0.68	SSQ = 1.22 (significant increase)	Maintained. Greater improvement in younger participants
6	Oerbeck et al. (2011)	SSQ = 0.59 CGI = 4.43 PRF (Anxious/Depressed) = 56 TRF (Anxious/Depressed) = 58 EAS = 3.9	SSQ = 2.68 CGI = 1.14 PRF = 57 TRF = 56 EAS = not included	SSQ = 2.26 (one year later)
7	Mitchell & Kratochwill (2013)	TRF (Anxious/Depressed): P1: 51, P2: 56, P3: 51, P4: 70	TRF (Anxious/Depressed): P1: 43, P2: 51, P3: 51, P4: 68	Maintained

8	Beare et al. (2008)	Verbal responses: Resource room = 0 Study room = 0 Classroom = 0	Verbal responses: Resource room = 25 Study room = 23 Classroom = 25	No follow up included
9	Cotton-Thomas (2015)	SMQ = 0.87 Mean (SD = 0.74) SSQ = 0.83 Mean (SD = 0.71) BASC-2 Teacher = 49.3 (Mean) BASC-2 Parent = 47 (Mean)	SMQ = 0.98 SSQ = 1 BASC-2 Teacher = 53 BASC-2 Parent = 44.3 (Mean)	Improvement of verbal responses
10	Lawrence (2017)	BYI: Self-concept = 52 Anxiety = 52 Depression = 40 Anger = 41 Disruptive Behaviour = 38	BYI: Self-concept = 48 Anxiety = 63 Depression = 46 Anger = 41 Disruptive Behaviour = 38	No follow up included
11	Hung et al. (2012)	0 vocalisations in school context	Vocalisations with some classmates/talked to teacher in the reading room with no pupils' present	Normal speech frequency
12	Conn & Coyne (2014)	PRF (Total Problems) 16th Percentile TRF (Total Problems) = 34th Percentile	PRF (Total Problems) 44th Percentile TRF (Total Problems) = 28th Percentile	CBCL Total Problems: 14th Percentile, 21st Percentile
13	Howe & Barnett (2013)	No verbal initiations	Response rate of 28% to verbal initiations	No follow-up detailed
14	Omdal (2008)	No specific details in relation to speech frequency at baseline	No specific details in relation to speech frequency at outcome	Schools that were encouraging and provided support were more likely to support vocalisations

Note: SSQ = School Speech Questionnaire, SMQ = Selective Mutism Questionnaire, CGI = Clinical Global Impression Scale, CBCL = Child Behaviour Checklist, TRF = Teacher Rating Form, PRF = Parent Rating Form, BYI = Beck Youth Inventories-II, Second Edition, BASC-2 = Behaviour Assessment System for Children, Second Edition, EAS = Emotionality, Activity, Sociability Questionnaire.

A number of key measures were included across the studies: SSQ, SMQ, CGI, CBCL (TRF and PRF), BYI and the BASC-2. Eight of the fourteen studies did not include details in relation to the use of a psychometric tool to assess baseline and outcome results. The SSQ was used in three papers (Oerbeck et al., 2014; Oerbeck et al., 2011; Cotton-Thomas, 2015), the SMQ was used in one study (Cotton-Thomas, 2015), the CGI was used in one study (Oerbeck et al., 2011), the CBCL (TRF and PRF) was used three times (Oerbeck et al., 2011; Mitchell & Kratochwill, 2013; Conn & Coyne, 2014),), the BYI was used in one study (Lawrence, 2017) and the BASC-2 was used in one study (Cotton-Thomas, 2015).

Selective Mutism Questionnaire (SMQ). The SMQ is a parent questionnaire (Berman et al., 2008) that is designed to provide a quantitative measure of severity, scope and impairment related to SM across three contexts (home, school, in public). Seventeen of the thirty-two questions are used to compute a total factor score. The severity scores range from 0 (never speaking) to 3 (always speaking). It assesses treatment effects and is not a diagnostic tool. A lower score on the SMQ denotes greater severity in terms of SM behaviour across the home, school and public settings. Bergman et al. (2001) reported support for the psychometric properties of the SMQ.

School Speech Questionnaire (SSQ). The SSQ is a modified version of the Selective Mutism Questionnaire (SMQ) (Bergman, 2012). It is used to collect information based on speech frequency in the school context as rated by a child's teacher. There is no cut off score on the SSQ. Six of the ten questions are used to derive a total factor score and there is an acceptable internal consistency (Bergman et al., 2002). A lower score on the SSQ denotes greater severity in terms of SM behaviour in the school setting.

Clinical Global Impression Scale (CGI). The CGI is a clinical-rated tool to establish the severity of a condition at the point of assessment and following intervention. It is a 7-point scale with a score of one denoting normal and seven denoting very severe. A higher score on the CGI denotes greater severity of SM symptomatology. The CGI-S form is used for baseline ratings whilst the CGI-I is used to compare follow-up presentations.

Child Behaviour Checklists (CBCL: PRF and TRF). The CBCL PRF and TRF are part of the Achenbach System of Empirically Based Assessment, which have acceptable validity and reliability (Achenbach & Rescorla, 2001). An anxiety/depression syndrome on the scale was used when considering SM. A higher score on the CBCL forms denotes greater severity.

The Emotionality, Activity, Sociability Questionnaire (EAS). The EAS questionnaire assesses four dimensions of temperament: emotionality, activity, shyness and sociability (Oerbeck et al., 2011). Each dimension includes five items with values of 1–5, with 1 = not characteristic/typical for the child, through to 5 = very characteristic/typical. In the study by Oerbeck et al. (2011), the researchers used the 'shyness' scale from the EAS, where a high score indicates greater severity. A study by Mathiesen and Tambs (1999) has found the internal consistency of the Emotionality, Activity, Shyness, and Sociability scales to be moderately high.

Behavioural Assessment System for Children, 2nd Edition (BASC-2). The BASC-2 is a tool that measures a wide range of behaviours across the home, school and community (Reynolds & Kamphaus, 2004) and includes a teacher and parent rating scale designed in accordance to the DSM symptoms of disorders (Cotton-Thomas, 2015). The BASC-2 has good reliability; internal consistency, test-retest reliability, and inter-rater reliability are good (Cotton-Thomas, 2015). The scores that fell within the range of 41-59

were considered average. Scores that fell within the 60-69 ranges on the clinical scales were considered at-risk and scores that fell at or above 70 were considered clinically significant (Cotton-Thomas, 2015).

Beck Youth Inventories, 2nd Edition (BYI-II). The BYI-II is a collection of inventories that focus on depression, anxiety, anger, self-concept and disruptive behaviour. The BYI-II has good to excellent internal consistency with no information available in relation to reliability (Measure Profile, 2012). A score of 55 or less on the BYI-II denotes an average score.

Mayworm (2015) did not report the use of a psychometric tool to measure results of the intervention and follow-up. Data was collected through use of a behavioural verbalisation chart, where the child's verbal and non-verbal initiations and opportunities to respond were recorded. The results found that the child demonstrated improvements across all three measured areas.

Two of the studies did not report positive effects following the intervention. In the intervention implemented by Cotton-Thomas (2015), the purpose was to explore the transportability and acceptability of a packaged behavioural intervention in a school setting for pupils with SM. The study investigated if the intervention would result in an increase in vocalisations in the school environment. The results varied in the support for this hypothesis. Visual analysis of the school-based observation for SM indicated minimal gains from baseline to intervention phases across participants in vocal responses (Cotton-Thomas, 2015). However, small to modest gains were made in terms of non-vocal responses. The SSQ and SMQ show that parents observed a decrease in SM symptomatology, but school professionals did not observe the same decrease. In terms of the transportability of the intervention to a school setting, the intervention was rated as acceptable by school

professionals. Overall, Cotton-Thomas (2015) reported that the results of the study indicate that a more intensive treatment may be required to reduce SM symptomology and to increase vocal and non-vocal behaviours in a school setting or to intervene when the pupil is younger and to provide more parent and teacher training.

Lawrence (2017) found varied results in a case-study intervention in a post-primary setting. The results of the Beck-Youth Inventory found that the participant's level of anxiety and depression were elevated post-intervention (which the author predicts is due to a heightened awareness of SM). The participant improved in his self-knowledge of SM. No follow-up was included in the results of the study, so it is not known if the participant's symptoms improved as a result of the intervention.

Discussion

This systematic review set out to synthesise studies of school-based interventions to support pupils presenting with SM. The following section summarises the results from the current review, implications for practice and limitations of the review before final conclusions.

Fourteen studies published between 2005 and 2019 were included in the review. All studies detailed the results of an intervention implemented in the school setting, as well as some studies documenting an intervention in the home setting also. The review aimed to examine intervention and implementation practices. The studies analysed 54 participants presenting with SM across pre-school, primary and post-primary school settings. The interventions varied greatly in terms of study design, length of the intervention, personnel involved in the implementation and methods of assessing baseline, outcomes, and follow-up. The review identified that all studies utilised behaviourally-based intervention strategies. A multi-modal, therapeutic approach to intervention was also utilised.

The results of the review demonstrate positive findings for the use of behaviourally-based intervention strategies in the school setting. The results also found that the available literature consisted primarily of case study research and single-subject designs, with only a very small number of RCTs published. This summary will detail the main findings from the systematic review, including details of the intervention strategies, personnel involved in implementing the intervention, effective approaches to intervention and potential implications of the results for the practice of an EP.

School setting

The fourteen papers included pupils with SM across a variety of settings. The most common setting was the primary school setting (n = 9 papers) followed by the pre-school

setting (n = 4 papers) Only one study sampled a pupil in a post-primary school setting. This finding is in keeping with the prevalence of SM being higher in younger children (Muris & Ollendick, 2015) and also that children with SM tend to be first identified when they enter the formal education system (Ford et al., 1998). The majority of the interventions took place in the mainstream school setting. Most studies involved a graded exposure from speaking in a separate classroom to working towards speaking in the mainstream class setting.

Co-occurring conditions

SM is a condition that typically co-occurs alongside other presentations. Children that may be vulnerable, or pre-disposed, to SM need to be identified early to ensure that the environmental stressors are appropriately adapted to encourage a supportive school climate. The sample of children included in the studies in the current review primarily had a diagnosis of SM. Only three of the pupils reportedly had a co-occurring condition (ADHD or an emotional behavioural disorder). It is thought that due to the nature of the school-based intervention, other presentations may have been undiagnosed or had not yet received clinical attention.

English as an additional language

Twelve of the included participants in the systematic review spoke English as an additional language (EAL). In a study by Toppelberg et al. (2005), the researchers reported that the prevalence of SM is at least three times higher amongst immigrant language minority children. The sample of children included in this review reports that 22.2% (n = 12) were EAL students. While this is a lower prevalence than reported by Toppelberg et al. (2005), it must be interpreted with caution given the strict inclusionary criteria applied.

Gender

There were thirteen more females (n = 34) included in the review compared to males (n=20). This finding reflects previous research stating that SM is more prevalent in females (Cunningham et al., 2004; Kumpulainen et al., 1998).

School-based Intervention Strategies for Selective Mutism

The results highlight that there is no standardised school-based intervention available to support pupils presenting with SM. All the included studies utilised an individualised, tailored approach to intervention.

Behaviourally-based Approach to Intervention

As stated, all included studies described the use of behavioural strategies, supporting the finding by Cohan et al. (2006) that behavioural interventions are the most common approach to supporting pupils with SM. This approach to intervention is based on the conceptualisation that SM is a learned behaviour (Johnson & Wintgens, 2016). Behavioural interventions tend to, through direct or indirect means, target the behaviour (mutism) and the function for that behaviour (escape the feeling of anxiety). The behavioural intervention strategies most reported in the current review included shaping and stimulus fading. Interestingly, some studies in this review utilised behavioural assessments to inform the protocol for the intervention. Kern et al. (2007) highlighted the potential use of a functional assessment-based intervention for SM. The authors linked the results from a functional assessment to develop hypotheses leading to the least intrusive approach to intervention (Kern et al., 2007). The study described a flexible approach, with results indicating that an assessment-based intervention was effective in reducing SM symptomology in the school context (Kern et al., 2007).

The use of behavioural interventions appears to be more appropriate to the school context, in comparison to clinical settings. For example, a number of other systematic reviews in the area of SM have focused on medical interventions for pupils. Manassis et al. (2016) reviewed the literature for evidence of the efficacy of selective serotonin reuptake inhibitors and monoamine oxidase to treat SM. The researchers found that, although there was some evidence for a symptomatic improvement in SM symptoms with medication, the literature was limited. In contrast, the studies included in the current review did not include any pharmacological intervention. Favourable results were found which highlight the importance of utilising a less intrusive approach when supporting a pupil with SM. Given that SM is an anxiety-based condition, the results further highlight the need to take a systemic, pupil-centred approach, one that does not appear to be offered through medical intervention.

Multimodal Approach to Intervention

Three studies highlighted the use of therapeutic interventions. This form of intervention seeks to address the relationship between speech behaviour and environmental conditions and to explore how the mutism is being maintained in the environment. The use of an integrated therapy programme for SM devised by Bergman et al. (2013) was used in the study by Cotton-Thomas (2015), which placed emphasis on the main components of CBT for pupils with anxiety, for example, psychoeducation and exposure therapy. This approach advocated the importance of working towards exposure at a safe and gradual pace, which is essential when working with a sensitive and complex condition such as SM. Lawrence (2017) and Hung et al. (2012) also utilised both a behavioural and therapeutic approach.

Consultation. The use of consultation was included in three papers: those by Mitchell and Kratochwill (2013), Cotton-Thomas (2015) and Howe and Barnett (2013). The type of consultation used by both Mitchell and Kratochwill (2013) and Cotton-Thomas (2015) was defined as conjoint consultation. This is a method of service delivery where all relevant personnel in the pupil's life collaborate to address the needs of a pupil through a problem-solving consultation-based approach (Mitchell & Kratochwill, 2013). Encouraging results were found in the study by Mitchell and Kractochwill (2013), where follow-up data completed four months post-intervention found that parents of the four pupils with SM indicated that the improvements in their children's speech had been maintained or increased. Conversely, Cotton-Thomas (2015) reported minimal gains from baseline to intervention in relation to vocal responses. Cotton-Thomas (2015) reported that small to moderate increases in non-vocal behaviours were observed. However, three-month follow-up data demonstrated evidence of improvement in verbal responses in the classroom.

The use of consultation, in the form of a consultation-based problem-solving approach, was used by Howe and Barnett (2013). The authors used this approach in relation to supporting a pupil with SM in a pre-school setting. Howe and Barnett (2013) recommended consultation as a method of working in close partnership with school personnel to enable the teachers to take ownership of the intervention. Although only three of fourteen included papers used consultation as a method of school-based intervention for SM, the results from the three included papers indicate positive findings for the use of consultation.

Psychoeducation. SM is a complex condition that often poses challenges in school settings where teachers may not be aware of the presentation. Analysis of the included studies found that a number of studies highlight the need and importance of the inclusion of

psychoeducation as part of an intervention programme. Zakszeski and DuPaul (2017) describe psychoeducation as informing those connected to the pupil about the needs and challenges of SM. The studies by Oerbeck et al. (2014) and Oerbeck et al. (2015) discussed the fundamental element of psychoeducation across both the home and school settings, advocating for psychoeducation as a method of spreading awareness of the condition both to school personnel and parents. Learning about the condition in an informed manner can also help to create a space in which people close to the pupil can explore any feelings they are having as a result of supporting the pupil with SM (Oerbeck et al., 2014; Oerbeck et al., 2011). Psychoeducation also formed an important aspect in the intervention detailed by Cotton-Thomas (2015), consisting of a fact sheet about SM and the characteristics of the condition

Implementation of the Intervention

This systematic review was also interested in exploring who was involved in the implementation of school-based intervention programmes for pupils with SM. The results varied across the included studies in terms of who was involved with the administration of the intervention. However, it was identified that school/educational psychologists in collaboration with teachers were the most common personnel involved in implementing the intervention. Only one study (Mitchell & Kratochwill, 2013) identified that teachers and parents together were involved in the implementation of the intervention following training from the researchers. This finding identified that external professionals appeared to be the most common personnel in terms of intervention implementation in the school setting. This warrants the exploration of the role of the EP in terms of facilitating training, such as behavioural intervention strategies, in order to reduce the need for professions outside the school setting to directly implement an intervention. This does not suggest that other

professionals do not have a role in the support of SM in the school setting, it is instead intended as a reflection on the consideration of alternative ways in which they could provide support. Although all the included studies were selected based on meeting the criteria for being based in the school setting, it did not mean that those working within that setting were the ones overseeing the intervention. This highlights the need for more ownership, training and awareness for school staff in terms of implementing behaviourally-based interventions in the school setting, with possibly the external professional taking more of a consultative role.

Mayworm et al. (2015) reported that one of the most important findings in the study was that a team approach is necessary for successful SM intervention and that contribution from all team members is critical. Hung et al. (2012) highlighted that the role of the external professional was gradually phased out as the school personnel became more confident in implementing the intervention strategies and that gradually the role of the therapist was transferred to the teacher. O'Reilly et al. (2008) acknowledged that the social problem-solving model utilised in their intervention could be adapted by teachers for use in the classroom context. The authors stated that such an adaptation of an intervention programme would serve to reduce the level of input from school/educational psychologists.

The included studies did not highlight any multi-disciplinary work in terms of collaborating with other disciplines i.e. SLTs, psychiatrists. EPs/school psychologists implemented the intervention in 62% of studies, with a team of CAMHS therapists involved in implementing the RCT. Other studies were implemented by psychologists or therapists, with no detail described in relation to their discipline. Parents were involved in over half of the studies also (62%), which involved entering the school setting to facilitate the intervention process.

Effective Approaches to Intervention

Aspects of interest which emerged from the synthesis of the fourteen included studies included rapport building and taking a person-centred approach.

Rapport Building. Elizalde-Utnick (2007) described that, when a pupil with SM is expected to speak, they can experience a barrier and it is therefore critical that rapport is built to serve as the foundation for a trusting relationship. Several studies described the importance of establishing a rapport with the pupil as part of the intervention process. Mayworm et al. (2015) reported that the first stage of the intervention involved play and friendly statements of encouragement to establish rapport with the pupil. The study by O'Reilly et al. (2008) also detailed the importance of establishing a rapport with the pupil. The psychologist implementing the intervention met with both participants in the study for eight 30-minute sessions for five weeks. The rapport building sessions consisted of joint play, which served as a method for ensuring the participants felt comfortable with the person implementing the intervention. Cotton-Thomas (2015) also emphasised the necessity to build rapport with the pupil as part of the foundational work of the intervention. In their intervention study, Conn and Coyne (2014) acknowledged the importance of building rapport and for the person implementing the intervention to approach and work with the pupil in a non-threatening manner. The authors referenced research by Ducharme and Harris (2005) who stated that laying the groundwork in the form of rapport building makes it easier to place a more challenging demand on a pupil because the trust will already be established. Conn and Coyne (2014) further mentioned the importance of an external psychologist building a rapport in the school where they are working, in the form of a therapeutic alliance with a view to promoting consistency in relation to intervention implementation.

Person-Centred Approach. It is important that the child with SM at the centre of an intervention is provided with an opportunity to express their opinions. A few of the included studies emphasised the importance of taking a person-centred approach. In the study by Kern et al. (2007), for example, the authors developed interview schedules for the participants that explored their feelings in relation to their SM. The interviews also served to identify potential intervention strategies that the pupils would consider the least intrusive. A person-centred approach was also evident in the intervention by Sanetti and Luiselli (2009), where the pupil was provided with a written survey where she could detail who she wanted to talk with and how difficult she felt it would be to talk with them. This written survey allowed the pupil to communicate in a safe, non-threatening way and ensured the pupil was central to the intervention process.

The studies by Oerbeck et al. (2014; 2011) emphasised the method of defocused communication, which details ways to make an environment safe and less threatening, such as sitting beside the pupil as opposed to opposite them or using an activity the pupil enjoys rather than just focusing in on the pupil. This method suggests the person implementing the interventions are putting the pupil's needs first. Another way in which the intervention process was seen as person-centred was in the study in the post-primary school setting by Lawrence (2017), where the psychologist met with the pupil prior to the intervention in order to explain the process and to give him a letter explaining the intervention. The psychologist encouraged the pupil to create a presentation for his teachers to explain his challenges and to explain SM. On completion of the intervention, the psychologist included the pupil in the evaluation of the intervention, ensuring his feedback was received through a rating scale and a survey.

Relevance and Implications for Educational Psychology Practice

The results of the systematic review highlight a number of findings that may have relevance for practising EPs throughout their work with pupils presenting with SM. The school context was found to be an effective setting in which to implement an intervention, with 85% of the studies demonstrating positive outcomes in this setting. This may have implications for EPs to consider that the naturalistic setting of the school, as opposed to a clinical environment, can be effective for the support of a pupil with SM. Conn and Coyne (2014) reported that the school context is the setting that results in heightened anxiety for the pupil, thus this is the setting where support should be provided, allowing for generalisation into the classroom routine.

Within the school setting, it was evident that psychoeducation and the development of awareness of SM was needed in order to implement an intervention. Psychoeducation was identified across a number of studies as being a useful method for working collaboratively with the school system and to involve a number of key people in the pupil's life in order to understand the condition. The involvement of parents in the psychoeducation, and intervention in general, was identified as helpful to generalise the skills learned to the home context.

The findings of this systematic review, in terms of approach to intervention, may be helpful for EPs who are supporting a pupil with SM in the school context. The findings highlight the effectiveness of a non-intrusive, behavioural approach to intervention, with stimulus fading and shaping identified as common approaches. EPs may have an important role in working collaboratively with school personnel to explore how combinations of the strategies identified in the current review can be adapted and tailored to the needs of the individual pupil, by continually exploring contextual factors. These findings place emphasis

on the need for more training, both for EPs and for school personnel. The findings of the review would be suggestive that EPs receive training on behavioural interventions, such as implementation of functional behavioural assessments to inform an intervention plan, throughout their post-graduate studies. Furthermore, it emphasises the need for EPs to provide training to schools on the implementation of behavioural strategies, which will empower school personnel to take ownership of the intervention. The EP's awareness of such intervention strategies is an invaluable resource to the school communities (Carlson et al., 2008).

The review highlights the importance of early intervention for SM, before the symptoms of the condition become maintained or entrenched, similar to the findings of Auster et al. (2006), who reported the effectiveness of early intervention for pupils with SM. The findings from the study conducted by Oerbeck et al. (2011) with pupils aged between three and five years, highlighted the importance of early intervention in a pre-school setting. The RCT trial conducted by Oerbeck et al. (2014) also found that the younger participants in the trial showed greater improvements of SM symptomology, again highlighting the need for early intervention. The EP may have a significant role in terms of acting as an advocate for SM pupils at a whole-school organisational level. EPs are appropriately placed to provide this advocacy through training and creating awareness in the school communities, which is crucial for pupils presenting with risk factors for SM. As Lawrence (2017) found in the study with the pupil in the post-primary school setting, the longer the person lives with SM, the longer the duration of the intervention appears to be. Early intervention may be implemented in a timely manner through the EP working closely with schools to develop awareness of SM.

It was evident also from the results of the systematic review that the clinicians implementing the interventions in the school setting were required to be flexible and adaptive in their approach to the intervention. All the included studies utilised a tailored approach to suit the needs of the pupil. It must be noted, therefore, that practising EPs may be required to be flexible and available to work collaboratively with school personnel to spread awareness of SM, so that these school personnel will be in a position to continue and follow through with the intervention (Conn & Coyne, 2014).

Limitations

Limitations of the current systematic review include the small sample size across the included papers. In total, the fourteen included papers had a total of 54 participants. Many of the papers (n = 6) had just one participant. Only one paper had a relatively higher number of participants (Oerbeck et al., 2014) which included 24 participants. This is a clear limitation given that larger sample sizes can provide greater statistical power and can be considered to be more representative. This deems it challenging to draw consistent conclusions from the fourteen papers. However, it is argued that the included studies were drawn upon to document the use of school-based interventions and the number of participants were not considered a critical aspect of the current review.

The papers included in the review were variable in terms of methodology. One RCT was included whilst the remainder of studies were case study designs or single-subject experimental designs. It was therefore challenging to analyse pooled outcomes (Zaszkeski & DuPaul, 2017) as not all of the studies detailed evidence of follow-up information. While several studies reported maintenance or improvement in symptoms, other studies did not provide such details leading to difficulty in comparing studies.

As the SM literature base continues to grow, more information is becoming available on school-based interventions. There is a need for a clear, detailed approach to intervention as the studies in the review differed greatly in terms of the procedures of implementation, making it difficult to replicate. The procedures for intervention were included in significant detail in some papers while other studies did not provide much detail on this. There was also a lot of inconsistency with respect to reporting of the results. Although most of the studies reported positive results, effect sizes were rarely reported. Whilst there are a number of limitations reported, these aspects are understandable given the complexity of SM as a condition.

Conclusion

This systematic review synthesised fourteen studies examining school-based interventions to support pupils with SM. The results are generally positive, indicating that the school environment can be an appropriate setting for behavioural-based interventions. Single-subject experimental designs, case studies and one RCT were included. There are limited RCTs for SM, particularly from a systemic perspective. Given that the literature specially focusing on school-based interventions is relatively limited, it was appropriate to include a mixture of study designs in the current review.

The review described the range of intervention strategies most typically utilised and found that shaping and stimulus fading proved to be a useful strategy to support a pupil with SM. EPs were found to work most frequently with school personnel to implement SM intervention. The results indicated that rapport building and taking a person-centred approach was key in terms of establishing a foundation for the intervention, as well as ensuring staff and parent psychoeducation. The studies were inconsistent in terms of

approach to monitoring the outcomes of the intervention, duration and follow-up procedures.

Despite the lack of methodological rigor in some studies, there are positive findings and implications for educational psychology practice regarding the efficacy of a behavioural, multi-modal approach to systematically support schools with pupils presenting with SM. Overall, behavioural interventions are effectively utilised in the school setting and there is a recognition that these interventions should be implemented as early as the symptoms of SM become apparent. In summary, this review highlights that school-based interventions may be the most appropriate setting for support, as clinical interventions remove the pupil from the setting where they may find the symptoms most challenging, leading to difficulty in generalising skills learned in a clinic to the school environment. This review has contributed to an understanding of school-based interventions which can be implemented to support pupils presenting with SM.

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Chapter 3: Empirical Research Paper

The Role of the Educational Psychologist in Supporting Schools with Pupils Presenting with Selective Mutism

Abstract

Selective Mutism (SM) is a complex, multi-faceted condition which can have a debilitating effect on a pupil in the school context. While Imich (1998) conducted research on SM and provided practical implications for educational psychologists (EPs) regarding implementation of behavioural interventions in the school context, relatively little is known about how schools and EPs collaborate to support pupils presenting with SM. The aim of this two-phase study was to examine the role of the EP, and approaches utilised, in providing support for SM. An online survey of 41 EPs and semi-structured interviews with five EPs within an Irish psychological service was conducted. Results found that 98% (n = 40) of participants said that it is the role of the EP to support a school with SM, with 71% (n = 29) reporting experience of supporting a school with SM. Nearly half (42%; n = 17) reported feeling uncertain about appropriate interventions while 71% (n = 29) of EPs reported a lack of training in SM throughout their professional careers. Thematic Analysis yielded the most salient themes as empowerment, building relationships, consultation, flexibility and pupil-centred practice. This research found that the EP is in a pivotal position to facilitate systemic changes towards positive outcomes for a pupil presenting with SM.

Keywords: selective mutism, educational psychologists, school psychology, childhood anxiety

The results are considered the personal opinions of each participant and not representative of the psychological service.

The Role of the Educational Psychologist in Supporting Schools with Pupils Presenting with Selective Mutism

Supporting the participation and inclusion of pupils with Selective Mutism (SM) in the school context is pivotal, as SM can impede a pupil's academic and social functioning if left without appropriate support (Kehle et al., 2012). A fundamental aspect of SM within the school context is how the condition is understood and supported within that environment. Dunsmuir et al. (2006) contend that school-based psychologists, or educational psychologists (EPs), have an important role in working with a school to support a pupil presenting with SM. The school context has been identified as an important setting to facilitate an intervention for pupils presenting with SM (Harwood & Bork, 2011, Kovac & Furr, 2019; Lawrence, 2017).

To date, few empirical studies have explored the role of the EP in systemically supporting the needs of a pupil presenting with SM in the school context. Lawrence (2017) highlighted the importance of supporting pupils with SM through parent, teacher and professional collaboration, while Cleave (2009) recommended that EPs work closely with those who know the pupil best. Within an Irish context, the role of the EP in supporting schools with SM has not been researched, deeming it challenging to ascertain the approaches and interventions utilised.

In the present study, the aim was to focus on the role of the EP in working systemically with schools to support pupils with SM. Consultation has been identified as an effective model of working within the wider school system in general (Beaver, 2011; Wagner, 2000). Therefore, the role of the EP in SM school support was explored through the lens of systems and consultation theory. This study will help to identify the pivotal role

of the EP in supporting the school, thereby assisting these pupils who are experiencing a very challenging and debilitating anxiety disorder. With that in mind, it is hoped that this study will act as a form of advocacy for the child with SM, that it can give them a voice, in what is at times for them, a silent world.

Theoretical and Empirical Framework

The theoretical framework underpinning this study is systems theory interconnected with consultation theory. Systems theory views individual behaviour within the context it occurs (Dowling & Osborne, 2003). This perspective acknowledges that, in order to appropriately support a pupil with SM, the support must come from the most influential people in the pupil's life. The 'Paradox of School Psychology' research which has spanned thirty years reflects this perspective, arguing that in order to support a pupil effectively, the psychologist must work with the key adults within the pupil's system (Gutkin & Conoley, 1990).

School-based consultation is grounded in systems theory, which focuses on the strengths of the connections between home, school and the wider community. Consultation is a significant aspect of an EP's role as it can create space for the expertise of all involved to be shared and acknowledged (Pettersson & Ström, 2019), whilst encouraging general systemic impact (Beaver, 2011). In the Irish context, consultation underpins much of the EP work (Nugent et al., 2014). In an exploration of consultation as a model for supporting SM in schools, Auster et al. (2006) advocate that consultation allows for a broader impact of services, with all members gaining valuable skills which can be generalised to pupils with SM.

Overview of Selective Mutism

SM is classified as an anxiety disorder where a child consistently fails to speak in specific situations where there is an expectation to speak, such as at school, but can speak in situations where they feel comfortable, such as at home (American Psychiatric Association [APA], 2013). Symptoms must be present beyond the first month of school, failure to speak is not due to lack of knowledge or comfort with the language expected in the situation and the symptoms are not better explained by a communication or psychiatric disorder (APA, 2013).

The prevalence of SM may be greater than is currently reported, as symptoms often go unrecognised (Kumpulainen et al., 1998). Currently, prevalence rates are estimated to be one in every 140 children under the age of eight (0.71%) (Johnson & Wintgens, 2016). School and community-based studies tend to yield consistently higher prevalence rates compared to clinical samples, which indicates that many children are not referred for clinical support (Sharkey & McNicholas, 2012). There is little consensus regarding the aetiology of SM (Krysanski, 2003). It is likely that SM occurs as a result of complex individual-environmental interactions occurring at multiple levels over time (Cohan et al., 2006). Various factors are involved in the aetiology of SM, such as genetics and temperament (Muris & Ollendick, 2015).

SM is a condition which has been linked with a number of additional conditions (Sharp et al., 2006). The APA (2013) reported that SM commonly presents with social anxiety disorder. Oerbeck et al. (2014) found that, in a sample of 24 children with SM aged between three and nine years, all of them also presented with social phobia. Recent research by Steffenburg et al. (2018) examined the co-occurrence of SM and ASD. The authors found that, of a clinical sample of 97 participants with SM between four and eighteen years, 63%

(n = 61) also presented with ASD (Steffenburg et al., 2018). Sharkey and McNicholas (2012) explored SM and co-occurring presentations in a study of pupils (n = 10,927) aged between four and twelve years attending primary schools in an urban region in the Republic of Ireland. The study found that twenty pupils were identified from the total number of pupils as having symptoms indicative of SM, of which fourteen received a full assessment confirming SM (prevalence rate of 0.12%) (Sharkey & McNicholas, 2012). Of those diagnosed with SM, Sharkey and McNicholas found that 64% (n = 9) presented with a history of speech and language delay, 21% (n = 3) with dyspraxia and 21% (n = 3) scored in the clinical range for an anxiety disorder (social phobia or separation anxiety disorder). The authors concluded that SM often presents with other conditions and that efforts to identify and treat SM in the early school years need to be increased so that early intervention treatment programmes can be delivered in the school context (Sharkey & McNicholas, 2012).

Selective Mutism and the School Context

Manifestation of SM symptomology is most prevalent in the school context and this can be a debilitating barrier to educational participation (Zakszeski & DuPaul, 2017). SM can have a significant impact on the development of academic and social skills during a critical developmental period (Mitchell & Kratochwill, 2013). Although the mean age of onset of SM varies between two and five years, these symptoms may not manifest until the pupil enters formal education (Muris & Ollendick, 2015). Often, SM symptoms can go unnoticed due to its internalised presentation (Viana et al., 2009). Schwartz et al. (2006) contend that, if teachers are unaware of the symptoms of SM, there is a risk of these symptoms becoming entrenched or maintained. Therefore, earlier identification in the school setting could prevent, or limit, functional impairment.

Teachers have expressed uncertainty in relation to providing an inclusive schooling experience for a pupil with SM (Omdal, 2007). It has also been found that teachers can have difficulty ascertaining a pupil's academic functioning (American Psychiatric Association, 2013). Given that the school environment is a challenging context for a pupil with SM, it is logical that such an environment is the most appropriate setting in which to provide support (Sanetti & Luiselli, 2009). This was reported from a study by Keen et al. (2008) who reported that management of SM at the site of presentation is based on evidence suggesting that intervention in the school context is feasible.

Role of the Educational Psychologist in Supporting Schools with Selective Mutism

There is a lack of consensus in terms of professional support for SM (Keen et al., 2008). In the UK, speech and language therapists are proposed to be the main professional support for educational staff (Keen et al., 2008). In a study of the views of educational and clinical psychologists regarding the professional role of SM support, Keen et al. (2008) found that all participants (n = 13) viewed their role as a psychologist as being suited to supporting SM, but acknowledged that their training to do so was inadequate.

Davidson (2012) stated that EPs are well placed to provide guidance to a school on SM, given their training in academic and emotional support. EPs are part of the ecology within which pupils, families and schools function (Sheridan & Gutkin, 2000). As SM was considered a within-child condition, support was traditionally given directly to the pupil. Currently, SM is best viewed as a response to a perceived challenging environment. Therefore, rather than working with the pupil directly, the role of the EP may be to support people within the challenging environment to identify the presentation of SM, facilitate problem-solving and suggest approaches to intervention (Auster et al., 2006; Elizalde-Utnick, 2007). This suggestion is based on the findings of Johnson and Wintgens (2016)

who state that SM is a condition best supported by those with whom the pupil has a secure relationship, which suggests that parental involvement with the school is important, as they too have a crucial role in understanding SM and in not reinforcing the pupil's anxious behaviour.

Schools may not view themselves as having an influential role in supporting pupils with SM, instead viewing the EP as the 'expert' who will provide the answers (Christie et al., 2000). To empower schools to support pupils with SM, change must occur within the system (Duffy & Davidson, 2009). School-based psychology services operate most successfully when they can collaborate with the key people in the pupil's life through consultation (Gutkin, 2009).

The Current Study

The current study, drawing on systems and consultation theories, aimed to examine the role of the EP in supporting schools with pupils presenting with SM. There is a paucity of research focusing particularly on the role of the EP and the specific approaches and intervention practices utilised. Furthermore, there is a dearth of knowledge about the use of consultation to support pupils presenting with SM. Specifically, in relation to supporting pupils with SM, the research aims were:

1. To identify the role of the EP in collaborating with schools in relation to SM.
2. To explore the approach to intervention utilised by the EP in relation to SM.

Methods

Design

The study implemented a two-phase study combining a questionnaire (Appendix K) and interviews (Appendix L) in order to ascertain a fuller understanding of the research aims.

Sample and Procedures

Participants were psychologists working in an Irish school-based psychological service who were recruited using purposive sampling. The research was carried out in two phases. Phase One consisted of an online questionnaire, distributed by e-mail through the service gatekeeper. Participants were asked to complete the survey questionnaire, which took approximately twenty minutes to complete. The interviews took place over the telephone, which was most convenient for the participants. The interviews lasted approximately 30 to 45 minutes and were audio-recorded with written informed consent to facilitate transcription. Interviews were transcribed verbatim and all identifiers were removed.

The quantitative questionnaire data was analysed using SPSS (frequencies and multiple response analysis). The open-ended questionnaire data and the semi-structured interviews were analysed using the Braun and Clarke (2006) approach to Thematic Analysis.

Ethical Considerations

Exemption from a full ethical review was obtained from the UCD Human Research Ethics Committee and research approval was granted from the Research Advisory Committee of the psychological service. An information sheet detailing the nature of the research was outlined at the beginning of the online survey. Informed consent was built into

the questionnaire as participants had to give consent in order to proceed. To volunteer for Phase Two, participants were informed they could contact the researcher directly or provide their contact details at the end of their questionnaire. Only the participants who had experience of supporting a pupil with SM were invited to participate in Phase Two, which consisted of a semi-structured interview.

All participants were informed that their anonymity would be respected, and there would be no identifiers in the write-up. Participants were informed that they could withdraw from the questionnaire any time prior to clicking submit and that they could withdraw from the interview up to two weeks post-interview. The semi-structured interviews were audio-recorded and stored on a secure, encrypted laptop. No participant names were used in the transcription. All audio-recordings were permanently deleted two weeks following transcription of the interviews.

Measures

The two-phase study consisted of a researcher-designed online questionnaire and a semi-structured interview schedule. Both measures were piloted to check for readability, estimation of completion time and the item relevancy amongst professionals in the field of SM (primarily EPs and Speech and Language Therapists in Ireland and the UK), accessed through the Selective Mutism and Research Association (SMIRA) online forum and professionals known to the researcher. Piloting resulted in the inclusion of additional questions and re-phrasing of some items in the interview schedule.

Questionnaire. An online questionnaire was created using the EU Survey platform in line with GDPR guidelines. The survey consisted of closed, open-ended and Likert Scale question responses with questions categorised into five sections: 1) demographics 2) case involvement 3) awareness of SM 4) role of the EP and 5) interventions. Examples of

questions included: *"Do you think that schools are aware of which professionals are available to support them in relation to queries of SM?"*, *"To what extent do you consider it your role to engage in interventions to meet the needs of pupils presenting with risk factors for SM?"* and *"What do you think are the main reasons a school would seek the support of an EP to support them with cases where a pupil is presenting with risk factors for SM?"*.

Semi-Structured Interview Schedule. The semi-structured interview schedule was designed based on the emergent data from the online questionnaire. It focused on participants' experiences of supporting a school with SM casework, approach to intervention, and training. For example, participants were asked: *"How would you describe your particular role in supporting cases of SM from your past experience?"*, *"Do you notice any challenges for EPs working with cases of SM?"* and *"Have you attended additional training on SM?".* The interview schedule was designed to guide conversation and not constrain it (Howitt, 2016). Relevant areas were probed when appropriate which ensured a flow in the interview process (Galetta & Cross, 2013).

Analysis

The data collected from the online questionnaire was analysed using SPSS to explore frequencies. The qualitative questionnaire data and the semi-structured interviews were analysed using the six-phase manual thematic approach, as outlined by Braun and Clarke (2006), which is a method for identifying, analysing and reporting patterns with a dataset (Table 3.1). The research took an inductive approach, whereby codes and themes were developed from the data. The codes were clustered together into themes so to give an indication of their prevalence. Inter-rater reliability took place with the principal supervisor of the research study so to ensure the reliability of the reported themes. Thematic analysis

was selected as an appropriate method for the purpose of this research, as it is a flexible approach which provides a rich and detailed account of the data (Braun & Clarke, 2006).

Table 3.1

Six-phase Approach to Thematic Analysis (Braun & Clarke, 2006)

Data familiarisation	Repeated listening to the audio recordings and reading the interview transcripts several times. Interviews transcribed verbatim.
Generating initial codes	Codes were produced from the data. Codes were analysed semantically to provide a summary of the explicit content of the data. Codes of particular interest were highlighted.
Searching for themes	Similar codes were grouped together to generate themes which captured a rich picture of participants' views. A brief heading was used to capture the essence of the group of codes as a pre-cursor to theme identification.
Reviewing themes	The early themes and sub-themes identified in Phase Three were reviewed. This involved deciding which themes were reflective of the research question and which themes were no longer of relevance.
Defining and naming themes	Themes were refined and further analysed. A final name for each theme was decided upon (Table 3.2).
Producing the report	Article was written and themes reported in the results section.

Results

Forty-one participants (response rate of 20%) responded to the online questionnaire. Over half of the survey participants (n = 21) were working as psychologists for less than ten years, with 44% (n = 18) of respondents reporting they had worked in the surveyed school-based psychological service for less than five years. Five of the forty-one participants, who reported experience of supporting a school with SM, completed a semi-structured interview in Phase Two of the research. Of these five interview participants, all had been qualified as a psychologist for at least six years. Two of the interview participants had supported over ten pupils with SM. Four of the five interview respondents supported more than one pupil with SM. Two of the interview participants supported pupils with SM in a post-primary school setting.

Thematic analysis of the interviews identified five main themes and two sub-themes which will be discussed under the related research aims. Figure 3.1 outlines a thematic map while Table 3.2 identifies the themes, subthemes, a sample code and a sample quote from the interview transcript to describe how the themes were identified.

Figure 3.1

Thematic Map

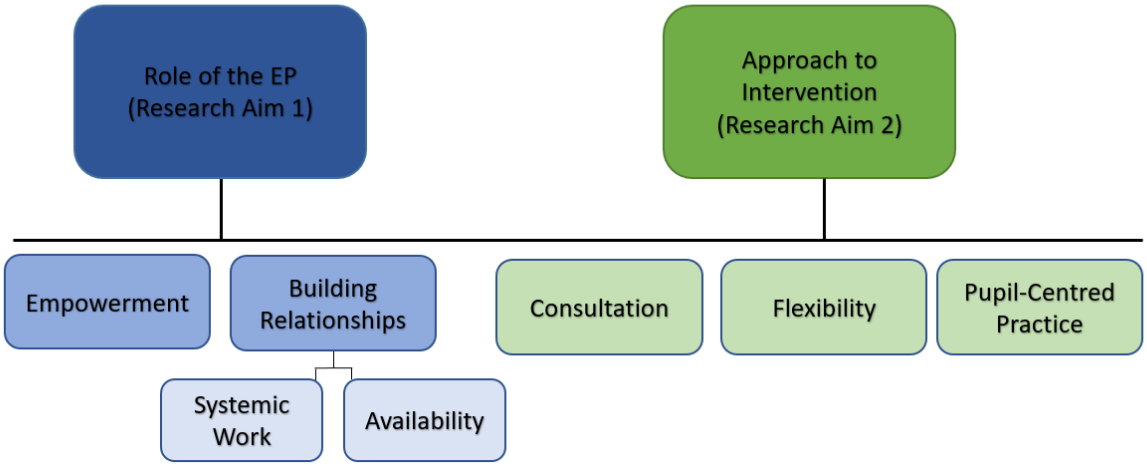


Table 3.2
Themes and Subthemes

Theme	Subtheme	Example Code	Example Quote
Building Relationships	Systemic work	Relationship with school is needed for collaborative work	*"it is the investment of time and the investment of people who are well-informed and know what they are doing"* (P1) *"having a relationship with school is key. You need everyone to be on board"* (P2)
	Availability	Supportive and available for intervention	*"you need the teacher and the parents to be supportive and available to the school for the intervention"* (P1)
Empowerment		Important that teachers are empowered	*"I found it so important that the teacher was empower"* (P5) *"the big part of my role was to support the teacher"* (P3)
Consultation		Consultation model Consultation group to support teachers to feel less isolated	*"our consultation group is evidence-based, and they (teachers) have the confidence in knowing the approach that they are using is coming from a sound, reliable base"* (P4)
Flexibility		Encouraging flexibility in their approach	*"So it is about, you know, being flexible in the approach to take. We see a lot of variability in the role of principal saying, supporting the intervention" (P4)*
Pupil-Centred Practice		Not pressuring pupil Ensure safe environment	*"the person who is doing the intervention needs to have a really good rapport with the student and I suppose we talk to principals about that in advance in terms of making sure it is somebody that the student will get on well with"* (P2)

Role of the EP in Collaborating with Schools to Support Pupils Presenting with SM

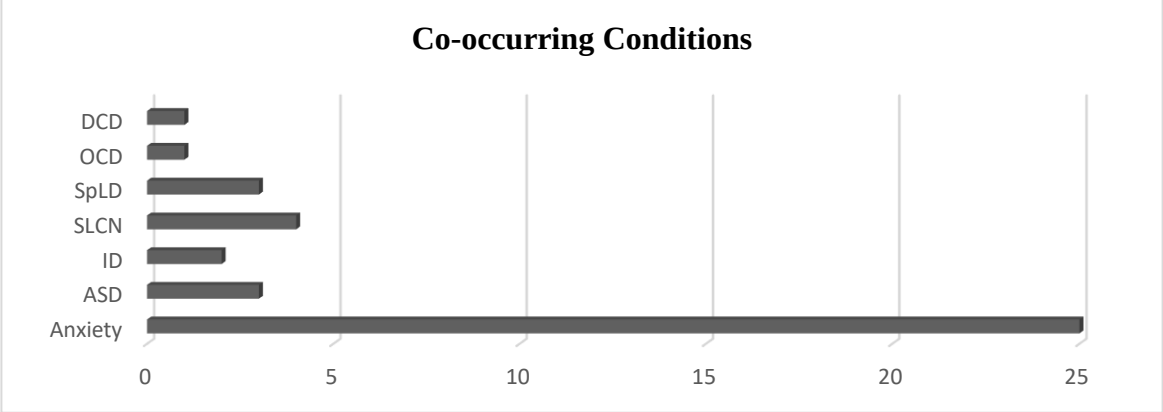
Two main themes and two sub-themes were identified from the thematic analysis of the item responses in relation to the role of the EP. The first main theme was empowerment, and the second main theme was building relationships with two sub-themes of systemic work and availability.

Case Demographics

Most of the participants (97.6%; n = 40) considered EPs to have a role in collaborating with schools to support pupils presenting with SM. Many (70.7%; n = 29) of the EPs reported having direct experience of supporting a pupil with SM. The average number of cases an EP had supported was four, with 13.7% (n = 4) reporting experience of more than ten cases. Referrals from primary schools accounted for nearly 90% of referrals (89.6%; n = 26). The pupil was typically aged between six to seven years (48.2%; n = 14) and 79.3% (n = 23) were female. Participants also reported the co-occurring conditions with which pupils presented (Figure 3.1).

Figure 3.2

Co-occurring conditions



Twenty-five (89%; n = 25) out of the twenty-nine EPs with direct case involvement reported that the pupil they supported most recently presented with anxiety (either social anxiety or separation anxiety). Speech, Language, Communication Needs were identified

in 13.7% (n = 4) of pupils, with three presenting also with ASD or a Specific Learning Difficulty. Two pupils had an Intellectual Disability, one pupil presented with Obsessive Compulsive Disorder and one pupil presented with Developmental Co-ordination Disorder.

Collaborative Work

Of the twenty-nine EPs who had direct case involvement, parents were involved in 82.7% of cases (n = 24), teachers (86.2%; n = 25), speech and language therapists (72.4%; n = 21) and clinical psychologists (41.3%: n = 12). Other personnel involved included: GPs (24.1%; n = 7), occupational therapists (6.89%; n = 2) and 3.44% (n = 1) respectively across social work and psychiatry. In 27.5% (n = 8) of cases, EPs reported that they were the first professional contacted by the school for support.

Empowerment

In terms of collaborative work, the theme of empowerment was identified in the interviews. A total of 80% of the participants (n = 4) discussed how their role involved facilitating intervention through instilling confidence in the school to: *"take ownership of the strategies"* (P2). Participants discussed how it was important for the school to feel they can manage an intervention. One participant spoke about how schools are eager to take ownership of the intervention: *"they are eager to do so, once they have the knowledge to work from"* (P4). Ensuring the teachers felt in control of the situation was crucial: *"I found it so important that the teacher was empowered"* (P5). Further, 'supporting the supporter' was identified as being important: *"the big part of my role was to support the teacher* (P3).

Reasons for Seeking Support

Participants were asked to state the reason a school may seek the support of an EP for SM cases (Table 3.3)

Table 3.3
Reasons Schools seek EP Support for SM

Response	Number (n = 41)	%
Social impact	39	95.1
Emotional impact	35	85.4
Impact of SM on academia	33	80.5
Teacher frustration	30	73.2
Lack of SM knowledge	30	73.2
Impact on independent skills	18	43.9
Query ASD	12	29.3
Pressure from parents	11	26.8
Other	2	4.0

The majority reported that a school seeks support from an EP in relation to the impact that SM has on a pupil's social skills (95.1%, n = 39). The emotional impact of SM (85.4%, n = 35) and the impact of SM on academic attainment (80.5%, n = 33) were also listed as reasons to seek EP support. EPs reported that teachers may experience frustration in terms of supporting a pupil with SM and seek external support (73.2%, n = 30) as well as having a lack of knowledge or experience of supporting a pupil with SM (73.2%, n = 30). Teachers who were concerned in relation to a pupil presenting with co-morbid ASD, or to investigate the differentiation between SM and ASD, may also seek support from an EP (29.3%, n = 12). Other reasons for referral included support for the underlying anxiety or to seek guidance on supporting a pupil's expressive language development.

Building Relationships

In the interview data, building relationships was also identified as a key theme. This encapsulates the view of the EP that they have a collaborative role with the key people in the pupil's life (parents and teachers). All EPs (n = 5) stated that it is imperative to build a relationship with a school prior to engaging in an intervention for SM: *"Having a*

relationship with schools is key. You need everyone to be on board" (P2). The relationship between the pupil and school was identified as being more important than the relationship between the pupil and the psychologist. Two participants also referred to the importance of forming a relationship with the pupil's parents. Within the theme of building relationships, the role of the EP was viewed as a consultant by all five participants, with one participant also viewing the role as a co-ordinator.

Systemic work was identified as a sub-theme of building relationships. All EPs (n = 5) reported that they operated through some form of inter-agency work, in partnership with the school, parents, colleagues or other services. The use of systemic work enabled the EP to provide a platform for joint problem-solving, instead of adopting an 'expert position'. Participants reflected that speaking to colleagues is key, particularly as supporting a school with an under-researched condition, such as SM, can be an isolating experience. A teacher consultation group was identified as an appropriate method for collaborating and sharing experiences. It was also stated that input, such as therapeutic support, from other services, such as CAMHS or Primary Care Psychology is important for SM support. Timely access to services was identified as an area of concern, particularly for pupils with a co-morbid presentation.

The sub-theme of availability was identified under the main theme of building relationships. The availability of the psychologist, the school and parents were viewed as essential to SM support: "*You need the teacher and the parent to be supportive and available to the school for the intervention"* (P1). To have a successful intervention, all key members need to be available: "i*t is very much contingent on the availability of staff and resources"* (P1). One psychologist reported that remote, indirect work with pupils is a more efficient method of supporting the pupil as: *"the child would always have noticed me*

straight away so it was best to work more remotely with the school and offer telephone consultations and be available for them" (P5).

EP Training and Awareness

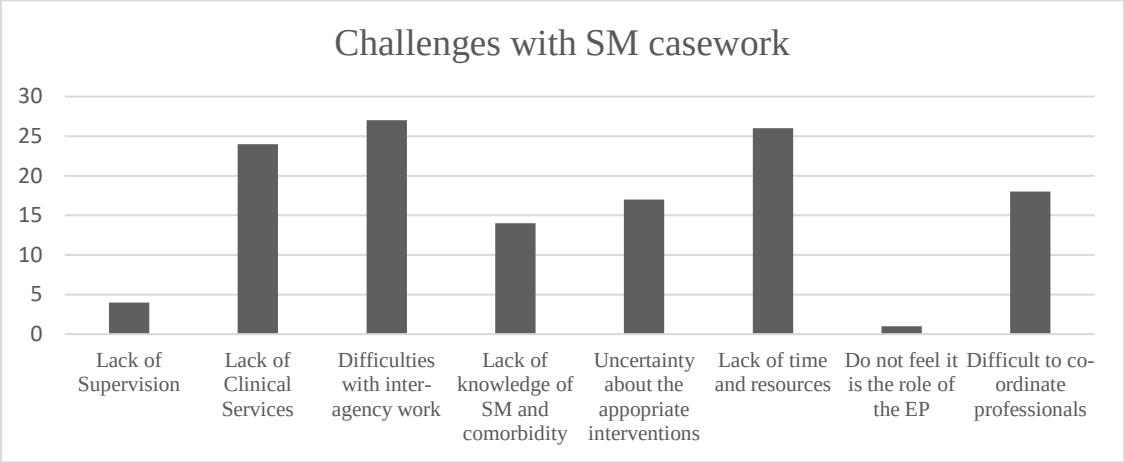
When asked to rate their understanding of SM in order to support a pupil, more than half of the participants (57.5%, n = 23) reported that they have an "adequate" understanding of SM. On a Likert scale, 55% (n = 22) reported feeling "confident" in meeting the needs of a pupil with SM. Most EPs (70.7%, n = 29) received no training on SM and 41.5% (n = 17) reported that their professional training did not equip them to support SM casework.

Strengths and Challenges of the EP Role

Most respondents to the survey (97.5%, n = 40) indicated that they are well positioned to support schools with pupils presenting with SM, with 27.5% (n = 11) stating that knowledge of both the school system and psychological theory was a strength of their role. An understanding of the presentation of anxiety as well as having the skills to implement an intervention was viewed as a strength by only a quarter (n = 10) of participants. Other strengths reported by EPs included formulation skills (15%, n = 6), ability to build relationships (17.5%, n = 7) and ability to work systemically (17.5%, n = 7). Survey participants were asked to report challenges in terms of supporting a school with SM (Figure 3.3).

Figure 3.3

Challenges Identified with SM Casework



Most EPs (67.5%; n = 27) reported difficulties with inter-agency work and a lack of time and resources (65%; n = 26) as the most significant barriers to practice. EPs also reported that a lack of clinical services for SM support was a challenge (60%; n = 24) as well as feeling uncertain about appropriate interventions (42.5%; n = 17).

Approach to Intervention Utilised by the EP to Support a Pupil Presenting with SM

Three themes were identified from the thematic analysis of the item responses in relation to the approach to intervention utilised by the EP. The three themes included consultation, flexibility, and pupil-centred practice.

Intervention Practices

Most participants (92.5%; n = 37) reported that it is within the role of the EP to support the implementation of an intervention for SM in the school setting. Survey participants who had experience of SM casework were asked to detail their approach to intervention and the practices utilised (Figure 3.4).

Figure 3.4

Implementation of Intervention Practices

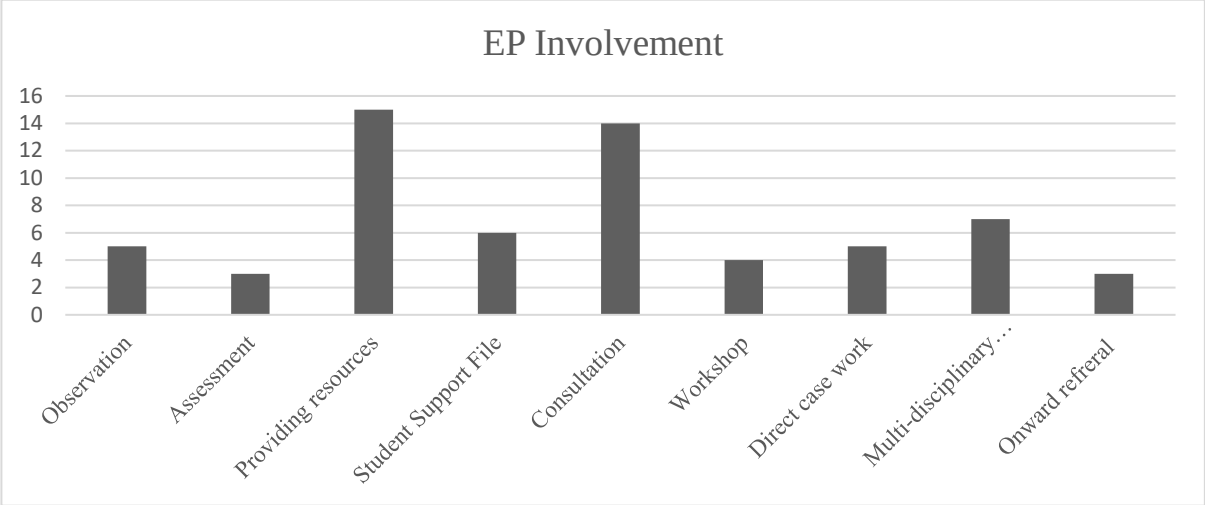


Figure 3.4 indicates that providing resources (handouts, recommended readings) was listed as an approach to intervention (51.7%; n = 15). Consultation was identified as another approach to intervention (48.2%; n = 14) by less than half of the participants who had experience of supporting schools with SM in the online questionnaire. All (n= 5) EPs in the interviews identified consultation as a method of intervention, which they identified to be an efficient method of service delivery. Three participants were involved in implementing a consultation group for teachers. The Selective Mutism Resource Manual (Johnson & Wintgens, 2016) was identified as the main intervention tool within the teacher consultation groups. One participant spoke of how the foundation for the teacher consultation group was based on best-practice evidence: "*they (teachers) have the confidence in knowing the approach that they are using is coming from a sound, reliable base"* (P4).

The twenty-nine participants who had experience supporting a school with SM were asked to describe particular interventions that they implemented in the school setting. In 31% (n = 9) of cases, participants used the Selective Mutism Resource Manual (Johnson &

Wintgens, 2016) to guide their approach to intervention, while 13.7% (n = 4) of participants used the 'sliding-in' technique. Other intervention practices included behavioural techniques (6.89%; n = 2), psychoeducation (10.3%; n = 3) and Cognitive Behavioural Therapy (6.89%; n = 2).

Informed Practice

Survey participants were asked to state the sources that would inform their approach to intervention. Of the total number of survey participants (n = 41), thirty-three (80.4%) reported that speaking with colleagues informed their practice. Books (73.1%; n = 30) and journal articles (58.5%; n = 24) were also identified as methods to inform intervention practices. Continuing Professional Development (34.1%; n = 14) and conferences (31.7%; n = 13) were reported as other sources that informed intervention practice.

Flexible Practice in relation to SM

The theme of flexibility was identified among the interview participants when they spoke about the need to take a creative, flexible approach to intervention: *"it is about us being creative in how we provide the time to support schools"* and *"it is about, you know, being flexible in the approach to take"* (P4). One interview participant described the need to be flexible with challenges and barriers: *"we take a novel approach to overcome barriers"* (P4). Approach to intervention was identified by interview participants as being: *"little and often"* (P2). The interview participants noted that schools are also required to be flexible; given that implementing an SM intervention can be a lengthy process, schools need to be in a position to be flexible to adapt to the process. Interview participants spoke of the need to take a problem-solving approach to tailoring an intervention. One interview participant reported that in order to effectively implement an intervention: *"you have to try and work with resistance"* (P4). Taking initiative was identified through the variety of

intervention practices identified, such as the consultation group for teachers. Another interview participant stated that, in order to ensure that all children at risk for SM were identified, awareness raising at the beginning of the academic year should be facilitated by offering workshops: "*we have a support and development booklet that we provide to schools where we offer different groups and workshops"* (P2).

Intervention Implementation

All forty-one survey participants were asked to rate the importance of factors involved in implementing an intervention. Motivation from the school to engage in an intervention was reported to be essential by 65.8% (n = 27), with the use of an evidence-based source deemed as being essential by 60.9% (n = 25) of participants. Capacity of those implementing the intervention to follow through consistently was also reported as being "absolutely essential" by 51.2% (n = 21). Time to engage in the intervention was reported as being "very important" by 56% (n = 23) of participants, along with simplicity of intervention implementation being deemed "very important" by 53.6% (n = 22).

Pupil-Centred Practice

The theme of pupil-centred practice permeated the interviews, as the interview participants stated that the intervention is most appropriately implemented by the person who knows the pupil best. The approach to ensuring the pupil's needs were met safely included psychoeducation and encouraging an understanding of SM from the pupil's perspective. This practice was identified as being within a biopsychosocial framework, in contrast to the medical model view of SM as a within-child condition. One participant identified the use of Personal Construct Psychology and solution-focused type work as an intervention practice. Two participants discussed how their practices drew from a practical approach, e.g. facilitating discussion around issues such as when to timetable the

intervention. The Selective Mutism Resource Manual was referred to by four participants as being a commonly used tool to draw and guide a pupil-centred intervention.

Collaborative Intervention

Survey participants were asked to indicate who they collaborated with in relation to an intervention (Table 3.4).

Table 3.4

Collaborative Intervention Implementation

	Always		**Often**		**Sometimes**
Teachers	48.7% (n = 20)	**SLT**	17% (n = 7)	**SNA**	21.9% (n = 9)
SET	43.9% (n = 18)	**CAMHS**	4.87% (n = 2)	**Clinical Psychologist**	17% (n = 7)
				OT	7.31% (n = 3)

In relation to collaboration and implementation of an intervention for SM, Table 3.3 indicates that EPs mainly collaborated with class teachers (48.7%; n = 20) and the special education teacher (43.9%; n = 18). Nine EPs (21.9%) reported that they 'sometimes' collaborated with a special needs assistant when implementing an intervention. In terms of professionals external to the school system, 17% (n = 7) of EPs reported that they 'often' collaborated with a speech and language therapist to implement an intervention and 17% (n = 7) reporting they 'sometimes' collaborated with a clinical psychologist.

Discussion

SM can be a barrier to a pupil's academic and social functioning in the school context (Kehle et al., 2012). Therefore, it is important to identify how a pupil with SM can be appropriately supported in the school environment. The role of the EP in supporting schools with SM has not been researched within an Irish context. Therefore, this two-phase study, combining questionnaires and interviews, aimed to explore the role of the EP and the approach to intervention practices for supporting schools with pupils presenting with SM within one Irish school-based psychological service. Results identified that nearly all the participants (98%) considered EPs to have a role in supporting a school with SM. Regarding their opinion on whether it is the role of the EP to engage in an intervention to meet the needs of a pupil presenting with SM, 41% viewed it as "definitely" being their role while 49% viewed it as "somewhat their role".

Although most of the participants (71%), who completed the online questionnaire had experience of supporting a school with SM, there still remains the 29% of respondents working as EPs within a school-based psychological service who reported no experience of supporting a school with SM. This figure may suggest that whilst most of the respondents had experience of supporting a school with SM, there still remains a large number of EPs who have not had the opportunity to support a school with SM or who had never received a referral for SM. There was a clear lack of SM training identified by 71% of EPs, with 43% feeling uncertain about appropriate SM interventions. The majority of EPs noted that building a relationship was essential in terms of school support and pupil support. Consultation was identified as an effective intervention practice by all five EPs in the semi-structured interviews. Intervention practices such as being flexible, taking initiative and always maintaining child-centred practice were emphasised. It was clear that EP

intervention practices stemmed from a very practical approach and also encouraged a school to take ownership of the intervention. Approach to intervention generally consisted of a creative, tailored programme.

The role of the EP was viewed by all participants as that of a consultant; to guide the key adults in the school context to support the pupil instead of the EP having direct involvement.

Contextual, Systemic Implications

Previous research has identified that SM support is most appropriate within the context where the symptoms can be the most debilitating, which typically is the school environment (Zakszeski & DuPaul, 2017). Schools can often find it challenging to seek support for SM, as the condition is not distinctly within the remit of any one specific professional group (Johnson & Wintgens, 2016). In an Irish context, the role of the EP in SM has not been clearly defined and there is inconsistency with regard to referral pathway, with no identified research in an Irish context on the topic. In the UK, Keen et al. (2008) highlighted that SM is a vulnerable condition as it does not explicitly fall into the remit of any one professional group. Research by Kelly (2008, p. 21) reported that the social system (i.e. school) is thought to be the most appropriate setting to implement psychological intervention as opposed to clinical settings which focus on the individual pupil. Newell and Coffee (2015) assert that EPs are well-placed to facilitate intervention at a systems level. In the context of SM, Keen et al. (2008) report that it is feasible to support the condition in the school context. This is in keeping with the results from the current study, where participants reported that the school is an appropriate context for a pupil with SM, as it facilitates collaborative work with teachers and parents.

Systemic work was highlighted as an effective framework for supporting schools with SM. Whitehead (2019) states that EPs have a role as change agents and that systemic work can have a ripple effect in terms of the pupil's home and school experiences; the nestled layers within which they function. The participants in the current study viewed themselves as a member of the school system who work in partnership with other members of the system. Many of the EPs who reported experience of supporting a school with SM had engaged in multi-disciplinary work with other professionals, such as speech and language therapists and clinical psychologists. The consensus was that EPs are well-placed to support SM in the school context, while acknowledging the need for clinical services for complex presentations.

The aim of the School Inclusion Model (SIM), which commenced piloting in September 2019, is to support schools at a systemic level to improve their capacity to provide a holistic, inclusive schooling experience for all pupils (National Council for Special Education [NCSE], 2019). This model includes speech and language therapists delivering support for pupils within the school context, which is in line with an eco-systemic approach of supporting a pupil in the school system as opposed to an external clinical environment. This project may have potential implications for increased interagency collaboration between EPs and speech and language therapists, which could be beneficial for pupils presenting with SM in the school context.

Foundations for Practice

Building relationships was identified as a key aspect to supporting a pupil with SM. All interview participants reported that SM support in the school must be underpinned by a solid relationship, which matters more to a pupil than anything else (Roffey, 2015). Positive adult relationships are the most important aspect in promoting positive pupil adjustment in

school (Sabol & Pianta, 2012). Findings from the My World Survey (Dooley & Fitzgerald, 2012) stated that the presence of 'One Good Adult' is important for a pupil's well-being, which, given the findings of the present study, also has particular relevance for pupils with SM. EPs have a role in highlighting the value of promoting quality relationships (Roffey, 2015) and to demonstrate the importance of the relational aspect as a protective factor for a pupil with SM (Longobardi et al., 2018). While an EP can build a relationship with a pupil, that relationship cannot be sustained to the same degree as the pupil's relationship with key school staff.

The My World Survey (Dooley et al., 2019) also explored the availability of the One Good Adult, finding that the availability of support is crucial in terms of pupil well-being. This is reflective of the finding from the current study whereby availability was identified as an essential requirement for SM support. This referred to the EP's availability to support the school, as school staff also need to be supported in the way a pupil requires an adult to care for them (Roffey, 2015). Further, it was found that the availability of the pupil's parents and teachers to implement an intervention was fundamental.

Empowerment was another key theme. As previously acknowledged, the school and key adults in the pupil's life are considered to be appropriately placed to support the pupil and it is important these adults feel empowered and confident to do so. This can have implications for wider service delivery with the role of the EP, which, reflecting on Miller's idea of 'giving psychology away' (Pinker, 2013), ensures that all the skills and knowledge are shared so that the pupil at the centre can benefit.

It was also identified that early intervention is important to support pupils presenting with SM, so that the symptoms do not become entrenched or maintained (Schwartz et al., 2006). It has been reported in the literature that EPs have a key role in terms of highlighting

the need for early intervention when symptoms of SM are first noticed when the pupil commences formal education. This finding reflects work that some of the participants in the research were doing at a systemic level in terms of implementing teacher consultation groups for SM. This form of early intervention can contribute towards reducing the debilitating effects of SM and help to ensure a whole-school approach is taken to creating an anxiety-free environment.

Consultation Model

All interview participants identified that they used consultation as an effective model of intervention or service delivery when supporting a school with SM. This finding is in contrast to the results from the online questionnaire where less than half of participants who reported having experience of supporting a pupil with SM utilised consultation as an approach to intervention. It can be argued that the interview participants had greater experience of supporting schools with SM and typically supported schools in clusters, thereby recognising consultation as an efficient means to do so. The high prevalence of consultation amongst the interview participants reflects previous research identifying consultation as a widely used practice of EP work (Boyle & Lauchlan, 2009). Consultation was reported as an effective model of service delivery, which is consistent with literature on school-based consultation, as a systemic, far-reaching model to address the needs of more than one child (Nugent et al., 2014; Beaver, 2011). This finding is in keeping with research conducted by Auster et al. (2006) who explored consultation as a model of service delivery for SM and found that it allows for a broader impact of services, with all members gaining valuable skills that can be generalised. Given that the prevalence rate appears to be greater than currently reported, it would be important for all schools to have an awareness of how to support a pupil with SM.

The interviews highlighted how SM can be an isolating and challenging condition for teachers to support. Roffey (2015) reflected that EPs play a role in validating and supporting teachers. The findings of this study indicated that the use of group consultation for teachers to come together to discuss support strategies for SM is a very useful and supportive intervention strategy. The finding, as reported by the interview participants, that consultation is widely used is in keeping with the findings by Nugent et al. (2014) that consultation underpins much of the EP work in Ireland. Consultation appears to be a fundamental aspect of intervention practices and also a key aspect of the role of the EP in terms of interpersonal service delivery.

Systems and Consultation Theory

The research reported in the empirical journal article was conducted through the lens of systems and consultation theory, which explored the role of the EP's work with the home and school systems to support a pupil with SM. The finding that many EPs organise teacher consultation groups to support the school system with SM is closely aligned to consultation theory, which focuses on creating a space for all people who are involved with a pupil presenting with SM, thus allowing a support network to be formed to draw upon the strengths of the respective individuals within the consultation group. As reported in the literature, SM is a condition that is affected by interactions with other people within the pupil's system. The EP's identification of a positive approach to intervention through the key people in the pupil's life, as opposed to external professionals, reflects the need to adopt a systemic, consultation driven approach to supporting SM in the school system.

Limitations of the Current Study

This study involved participants from one educational psychological service. As the literature has reported, the practices of EPs vary greatly from one EP to the next and from one service to the next (Boyle & Lauchlan, 2009). It is therefore important to be aware of the subjective experiences of EPs. The numbers of participants who completed the research was relatively small, meaning the results are considered a limited representation of the perspectives of EPs working with SM casework. However, the focus throughout this study was the quality of the participants' responses as opposed to obtaining a large sample size.

A second limitation of the research is that data collected may be considered biased, as it could be postulated that EPs who had experience with SM were more likely to respond to the survey than those who had little experience of SM. However, these findings were considered relevant as the aim of the study was to explore, in depth, the experiences of EPs in collaborating with schools to support pupils with SM. By gathering information from those EPs with significant experience, it was possible to provide greater information in terms of the role of the EP for SM in schools.

Implications for Future Research & Relevance to EP Practice

Several strengths of the current study are evident particularly regarding their relevance to EP practice. The results suggest that SM is a condition that can be appropriately supported by an EP within the school context. This study has highlighted the role of EPs at a systems level and how, through consultation and relationship building, they can cohesively work within the school system to provide support for SM. While this study has shed light on the valued role of the EP in supporting schools with SM, it has also highlighted the key roles of the school staff and child's family in SM intervention. The study supports

consultation as a model for collaboration and problem solving, so that all those involved can work together to appropriately support the child.

The study has highlighted the need for more training on the presentation of, and support for, SM to be made available for professionals to engage with, as 71% of EPs reported that they had received no training on SM throughout their professional careers. Training is available for EPs and other professionals in the UK, consisting of a four-module training programme, which would have value in an Irish context.

This research has shown the broader scope of the EP role. While many EPs may not be confident in terms of their own knowledge of SM, this study has highlighted that the core skills involved in an EP role (consultation and relationship-building) are the foundation to any support provided within a school. This finding might help an EP to be aware that, with these skills, they are well placed to facilitate support. The findings of the study encourage SM to be viewed within the wider context, moving away from direct work with the pupil to focusing instead on supporting those who can more appropriately support the pupil.

This study has implications for future research which could include exploring the role of psychologists not specifically within an educational psychological service, but EPs working in multi-disciplinary teams, such as within the Health Service Executive (HSE) to gather a wider perspective of SM support. A comparison between school-based support and clinical-based support would also be a valuable perspective to explore. It is also important to gather the perspectives of school staff who receive the support from EPs to explore their understanding of the role of the EP and how they believe the school system benefits from collaboration with an EP.

Conclusion

The current study sought to explore the role of the EP in the school context in order to contribute to the research on support for SM in an appropriate setting, as this has not yet been extensively researched, particularly in the Irish context. Through an online survey and semi-structured interviews, the perceived role of the EP and commonly utilised intervention practices were identified. The results found that EPs perceive themselves to have a role in supporting schools with SM, with relationship building and consultation identified as core aspects of the role. This study has highlighted the broad, systemic contribution that school-based professionals can make in terms of collaborating with, and identifying, key adults in the pupil's life to support them with a challenging condition. It has highlighted key practices which an EP may choose to implement when working with schools with SM presentations in the future. The results from the study support the contention that school-based EPs are well-placed to support a school and are in a leading position to make systemic, positive changes for the benefit of the pupil with SM and also for the teachers and parents working with the pupil. The current study will ultimately prove most beneficial for that vulnerable group of pupils with SM who require specific and timely interventions to give them a voice in what can be a silent world.

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Chapter 4: Implications for Practice

The current study set out to examine SM in the context of the school system, with a particular focus on the role of the EP in support and intervention. The research included review of the literature base on SM, awareness of which is continuing to grow in terms of knowledge of its nature and presentation as well as school-based interventions. At the core of the research are the implications of the systematic review and empirical research findings for the role of the EP in practice and how these findings can benefit, or have any impact on, a pupil presenting with SM in the school system. The research has yielded important information and implications that may contribute to the practice of EPs and school-practitioners (i.e. teachers) in considering appropriate approaches to intervention. These implication for practice will be discussed in this chapter.

SM is a complex, multi-faceted condition. The current study explored SM through the framework of Bronfenbrenner's eco-systemic theory (1979). As there is no identified referral pathway to support pupils with SM (Johnson & Wintgens, 2016), the school system may not be clear regarding their role in supporting a pupil with the condition. Misconceptions regarding SM are common (Hung et al., 2009), such as who should support the pupil, where should the pupil be supported and how should the pupil be supported. This lack of a consistent support pathway can have negative consequences for the pupil, as the longer the pupil is experiencing the debilitating symptoms, there is a higher risk that the symptoms become entrenched (Johnson & Wintgens, 2016). This inconsistency can lead to a delay in seeking support. As such, the school may not understand their important role.

Development of the Educational Psychologist's Role

The role of the EP is continually evolving and broadening, to consist of more consultative work to support the challenges faced by children throughout their development. The EP, through an eco-systemic approach, can interconnect biological, psychological and social factors with the development and maintenance of an array of academic and social-emotional challenges (Cameron, 2006). The current study shed new light on this growing role of the EP in terms of SM. The topic is under-researched in the literature base and thus it was considered timely to examine the important role of the EP. It has been 22 years since research by Imich (1998) explored the implications of research in SM for EPs and the paper stated SM to be a rare occurrence, which is no longer thought to be the case. The author made a number of practical recommendations for the role of EPs, including the effectiveness of behavioural interventions in the school context. Cleave (2009) also explored implications of SM research for EPs, stating how EPs need to be aware of emotions involved in SM casework, such as teacher frustration or anger and how a collaborative plan of individualised intervention is warranted. The current study develops these research articles and yields further insights into the EP's role to include highlighting the need for early intervention, advocating whole school approaches, contributing to the development of awareness of the condition and its complex nature, rapport building and awareness of intervention protocols.

A further important implication from the results of the current study was the view of EPs as being agents of change. The results from the empirical study found that EPs played an important role in encouraging change in the school climate in terms of the way pupils presenting with SM were being supported. The EPs who participated in the online questionnaire discussed the importance of working with all valuable members in the pupil's life, including their parents, so that change occurring in the school system would have a

knock-on, ripple effect in the home system. Further to the view of EPs as 'change agents' is the need for more training on the condition, which was identified in the findings of the empirical article. The online questionnaire identified that 71% of EPs reported a clear lack of training on SM, which would yield an important finding that the upskilling of EPs in SM, through means of Continuing Professional Development (CPD) is essential.

Contextual Implications of SM

The appropriateness of the setting for supporting a pupil with SM is important. As Imich (1998) described, we know that it is appropriate to intervene with SM, the more pertinent question is how to do so appropriately. EPs are in a unique position to contribute to the holistic support of this population of pupils (Carlson et al., 2008). This study shed light on the role of the school setting in intervention for SM. The results from the systematic review, which analysed the school setting for intervention, showed that 85% of the included studies found that the intervention in the school setting was effective. This finding is reflective of the finding by Grover et al. (2006), who reported that there is a significant need for school involvement in almost all cases of SM. The empirical study and the systematic review advocates for the school setting as the most appropriate context for SM support, particularly as it helps the pupil to learn how to communicate with those they will be meeting with on a daily basis in school as opposed to those in a clinical setting. This also reflects research from Imich (1998) who advocated for the appropriateness of the school setting in order to facilitate the involvement of the relevant people with whom the pupil needs to learn to speak comfortably i.e. their teachers. This is fitting given that schools are the most common setting for the debilitating manifestation of SM symptomology. It is important to note that SM intervention cannot always be solely treated in the school context, particularly if there are concerns in relation to co-occurring presentations such as Autism

Spectrum Disorder. In these cases, EPs can be a valuable resource in terms of providing information to schools and families about appropriate referral pathways.

Drawing from an eco-systemic approach means that the pupil with SM is in a system that is constantly interacting with other members of the system (i.e. teachers and peers). The papers included in the systematic review, therefore, highlighted the importance of adopting an intervention approach that highlights the importance of all members in the child's ecosystem working together to provide support. For example, the included study by Cotton-Thomas (2015) identified the importance of school psychologists, parents and classroom teachers working together in active collaboration to support the pupil. The use of the consultation model described in the study particularly emphases a home-school partnership, therefore, in keeping with an eco-systemic framework.

Given that an eco-systemic framework explores the role of all members within a system, a child's peers are of utmost importance. The included paper in the systematic review, Howe and Barnett (2013), stressed the importance of encouraging communication with peers. The use of peers as a way to initiate and expand social interaction was described e.g. engaging in an activity of mutual interest. Peers also formed part of the intervention described in the systematic review by Oerbeck et al. (2014), whereby the generalisation of speech to peers included as a specific intervention target.

Early Intervention Implications

A further implication which may be drawn from the current study is the necessity to target SM intervention early. It is worth considering the role of EPs in their work with schools to establish early intervention. As Carlson et al. (2008), noted, EPs have a key role in terms of highlighting the need for early identification of SM. The results from the current systematic review highlighted the need for early intervention when the symptoms are first

noticed when the pupil commences in formal education. This is the time to engage systemically and ensure a whole-school approach is taken to create an anxiety-free environment. It is also a time for schools to be aware with regard to the presenting characteristics of SM and to be aware that this warrants consultation with the EP.

In the current empirical study, it was found that EPs noted that school principals or teachers often did not raise presentations of SM as a significant issue. For example, a participant in the semi-structured interview identified that they included SM on the agenda at their school planning meetings in order to increase awareness of the significance of the condition. The results from the systematic review also shed light on how SM can be more challenging to support in the post-primary setting, as the symptoms may have become further entrenched and also the pupil has to navigate multiple classrooms and teachers (Lawrence, 2017).

Whole-School Implications

When considering the context of the school as an appropriate setting for SM intervention, it is important to consider the potential role of the EP in terms of supporting a school to foster a welcoming, safe and inclusive setting for pupils with SM. By adopting a whole-school approach to wellbeing which centres on positive language, positive home-school collaboration and developing relationships with pupils, family and the wider community, the system can become stronger and more inclusive for pupils presenting with SM. By adopting whole-school approaches that centre on positive wellbeing, the school is equipped to ensure that all aspects of school life are promoting a positive space for a pupil (Department of Education and Skills [DES], 2019). Programmes such as Weaving Wellbeing (Forman, 2017), FRIENDS for Life programme (Barrett, 2006) and Mindfulness programmes may also be useful whole-school approaches that an EP can promote in the

school system, knowing that this will have a knock-on positive affect for a pupil presenting with (risk factors of) SM.

Whole-school approaches to supporting pupils presenting with additional needs is being targeted at a national level in Ireland. The School Inclusion Model (SIM) was brought into effect, through a piloting phase, in September 2019. The purpose of the SIM model is to systemically improve the capacity of the school context to support the inclusion of all school pupils (National Council of Special Education [NCSE], 2019). At present, the model is piloting the role of the speech and language therapist to become embedded in the school system to provide support and intervention in the school context. The results from the current empirical study identified that 72% of the EPs identified that a speech and language therapist had also been involved in the support of their most recent pupil with SM. This high rate of inter-agency involvement indicates that the SIM may enable greater collaboration between EPs and speech and language therapists in supporting pupils presenting with SM. The positive findings of the systematic review indicate that the school setting is appropriate for delivering appropriate care and support for pupils with SM, drawing on the approach of the SIM. The EP may have a role in advocating the model and encouraging this approach as an appropriate model of service for the inclusion of pupils presenting with SM.

Development of Awareness

The results from the current empirical article indicated that many EPs stated that teachers may not have a thorough understanding of SM, with EPs identifying that many teachers seek the support of an EP due to their lack of understanding of the condition and also due to their frustration in not knowing how best to support the pupil. This important finding is indicative of the training and awareness of SM that may be warranted in the school system, with the EP being in a key position to provide such training. This aspect of the EP

role is in keeping with the shift in the model of service an EP provides to a school, moving away from the one-to-one direct work towards an all-encompassing whole-school systemic approach. This training could perhaps go one step further and commence with the involvement of the EPs in teacher education programmes at university level, to ensure a comprehensive approach to increasing awareness of SM, the manifestation of the condition in the school context and the teachers' critical role in supporting the pupil. However, it must be recognised that implementation for SM at a school level requires that teachers and support staff receive appropriate training (Ringeisen et al., 2003).

It is also relevant to highlight how EPs can have an important role in shifting the school system's mindset of SM and improving the narrative of the language used when discussing SM. Historically, there was an assumption that the aetiology of SM stemmed from early trauma, which has since been disregarded with the understanding that SM is an anxiety disorder (American Psychiatric Association [APA], 2013). This growth in knowledge is important and needs to be shared with key stakeholders so that misconceptions in terms of the condition are eliminated, the stigma removed and thus ensuring that the condition may be appropriately supported.

Protective Relational Aspect

The essence of the findings from the current study implies that building and sustaining relationships underpin the work of the EP. This relational aspect implies that establishing a close working relationship with school personnel is the foundation for the provision of support. Given the capacity of EPs to build an alliance with a school, they may be one of the first professionals consulted with reference to the pupil's challenges (Carlson et al., 2008). For a pupil with SM, the school environment, where he or she may not have one reliable person, can be an anxiety provoking setting to navigate. The empirical article

highlighted that having one key person available for the pupil is pivotal. This also mirrors the My World Survey (Dooley & Fitzgerald, 2012) which found that the presence of one good adult is important for a pupil's well-being. Both the empirical study and the systematic review were clear with regards to the relational aspect of SM as being a protective factor.

This finding was apparent in the empirical study and the systematic review in terms of intervention implementation where Mayworm et al. (2015), Cotton-Thomas (2015) and Conn and Coyne (2014) all documented the importance of establishing rapport with the pupil prior to the implementation of an intervention. It was also evident in the empirical article where interview participants reported that relational work underpinned SM intervention. This finding may be relevant for EPs in terms of their practice and also in terms of communication with schools. This may also be helpful in terms of working with schools to promote relationship building between pupils and teachers. The identification of trust and rapport as being significantly important in SM support, may provide a school with a foundation for supporting and developing the relational aspect of SM initially, prior to implementing an intervention.

Consideration of Multi-Faceted Cases

Bilingual pupils are at a higher risk for SM than native-born pupils (Toppelberg et al., 2005). Therein lies a challenge in recognising SM amongst bilingual pupils, given that SM can often be confused with the nonverbal period that is common in learning a second language (Toppelberg et al., 2005). The current systematic review identified that many participants sampled across the fourteen studies spoke English as an additional language. It is therefore important for school-based practitioners and clinicians to be aware of the vulnerabilities of pupils that present with risk factors for SM (anxious disposition, family immigration status). These vulnerabilities need to be made explicit so that the school

environment is a safe place and not one which could potentially trigger such vulnerabilities. Toppelberg et al. (2005) recommended that the school consultant (such as the EP) work with the school system to identify and target such vulnerabilities and the environmental stressors by means of appropriate intervention.

Co-occurring presentations are also an important aspect for consideration by EPs when supporting a school with SM. Participants in the current empirical article reported that a school often seeks the support of an EP where there are suspected ASD presentations with SM. This is in keeping with a recent study by Steffenburg et al. (2018) who explored the co-occurring presentation between SM and ASD and found that 63% of the participants also meet the criteria for ASD. Until recently, a diagnosis of both ASD and SM had not been strongly supported in the diagnostic manuals. However, Steffenberg et al. (2018) argued for awareness to be raised in terms of the need to explore symptoms of ASD in cases of SM. These findings, in terms of bilingualism and co-morbidity, have strong implications for EPs working with schools, to inform them of best-practice in terms of raising concerns of symptoms early and to ensure that pupils whose English is an additional language are appropriately supported in the school setting.

Recommendations and Implications for the EP

This current study has shed light on a number of interventions which an EP may use to support pupils with SM. The results from the current empirical article highlighted the role of EPs in terms of group consultation with teachers. The current systematic review also emphasised the use of a conjoint consultation-based service to collaborate and engage in joint problem-solving. The current study has thus indicated that there is not only one way for the provision of support and that practising EPs already have a wealth of familiar tools and skills. The systematic review and the empirical journal article have both shed light on

the available intervention strategies for SM. EPs' awareness of such intervention protocols is an invaluable resource to the schools and families with whom they work (Carlson et al., 2008).

Based on the current findings, it is recommended that EPs engage in psychoeducation with school staff so that classroom teachers, special education teachers and principals are aware of the presentation of SM. Given the information provided in the current research in relation to SM being an internalising condition, it can often go unnoticed in the school setting. EPs have a role in psychoeducation and in recommending appropriate school-based interventions. This use of psychoeducation was identified across a number of papers in the systematic review (Zakszeski & DuPaul, 2017; Oerbeck et al., 2014; Oerbeck et al., 2015; Cotton-Thomas, 2015).

The use of consultation is recommended based on the results of the current study. As the current research found, it is most appropriate for EPs to work indirectly with pupils with SM. Therefore, the role of the EP in facilitating consultation with school personnel (principals, teachers, special education teachers and SNAs) can be an effective means of identifying SM and creating a space for the sharing of knowledge. As referenced in Mitchell and Kratochwill (2013) from the systematic review, consultation can be an effective way of enabling teachers and special education teachers to take ownership of an intervention for SM. An interesting finding from the empirical study was the use of a teacher consultation group for supporting pupils with SM in one region. This collective approach was notable in terms of an efficient mechanism for supporting a group of school-practitioners and using the space to allow for collaboration and joint problem-solving. This model of support for teachers has the potential to be developed and utilised nationally, where service capacity allows. Such space is important so that an understanding of SM can be shared in a large-

scale format, thus benefiting more schools and pupils as a result. Further, the use of consultation, in the form of a consultation-based problem-solving approach, was used by Howe and Barnett (2013) to support a pupil with SM in a pre-school setting. They recommended consultation as a method of working in close partnership with school personnel to enable the teachers to take ownership of the intervention.

This study has highlighted the importance of early, whole-school support for pupils with SM. The findings identified that EPs have an important role in terms of raising awareness of SM with the schools in which they work. For example, at their initial meetings with schools at the beginning of each academic year, EPs could raise awareness of SM by discussing a typical presentation of SM in the classroom and thus the potential of using consultation as an effective means to discuss support for a pupil with SM. It is pivotal that EPs receive training on SM in their initial and continuing professional development given that the findings of the current study found that 71% of EPs reported no training on SM. Further, 42% of EPs reported that their professional training did not equip them to support SM casework. This reflects research by Kehle et al. (2012), who reported that most school professionals reported limited knowledge of the condition or experience in implementing interventions for SM. In addition to this, EPs require increased training for supporting the mental health needs of pupils in the school system, given the move from individual case work to whole-school systemic approaches.

The systematic review identified the school as an appropriate setting to support pupils with SM. The findings of the empirical research also supports the role that EPs have in working closely with school personnel and parents to implement a tailored intervention plan as opposed to immediately referring a child to an external clinical setting for support. This is with a caveat that children with SM may have a co-occurring presentation, such as

ASD, which warrants an onward referral. For cases where it appears that SM is the main presentation, it is recommended that EPs utilise their skill set to work with the school and family to offer appropriate support. The systematic review also found that twelve of the participants across the fourteen included studies spoke English as an Additional Language (EAL). It is recommended that EPs work closely with Special Education Teachers to discuss the risk factors of SM among children from an immigrant background.

Due to completing this research, the researcher felt that her own knowledge and professional practice as an EP has evolved. The researcher has developed greater insight into the potential role that an EP can have in supporting a school with SM. Further, the researcher feels a greater sense of awareness in relation to the creativity and flexible approaches that an EP can take when supporting a school systemically. This research has ignited passion in the researcher and a drive to carry out further research in the future into SM and subsequently share this knowledge with any schools or families with whom she will work in the future.

Conclusion

This research study focused on SM in the school context, through both an exploration of school-based interventions to support pupils and an exploration of the role of the EP in collaborating with schools to support such pupils. SM has been identified as a challenging condition that can negatively impact on a pupil's school experience. The study suggests that SM, as a multi-faceted condition, can be appropriately supported by an EP within the naturalistic setting of the school environment. The research has highlighted that, through a lens of consultation and relationship building, the school system can implement positive change to achieve desirable outcomes for the pupil presenting with SM. It is hoped that the current research has also contributed towards developing insight into the role of the

EP in relation to supporting pupils presenting with SM. EPs have the appropriate skillset to ensure that these vulnerable pupils are protected and receive timely intervention. It is envisaged that EPs can work towards bridging the gap between educational and clinical services, so that SM can be holistically supported when required, ensuring a seamless transition from diagnosis to intervention. In conclusion, this study has the potential to contribute towards the improvement of the experiences of pupils presenting with SM in the school setting.

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Appendices

Appendix A: Exemption from Full Ethical Review UCD

Human Subjects Low Risk Projects Form

(an exemption from a full committee review)

Includes: Insurance Process, Requests to Access UCD Students & University-Wide Surveys

Taught Masters Submissions: Please check if your school has a local level Taught Masters REC (TMREC).

This is not an exemption from ethical best practice and all researchers are obliged to ensure that their research is conducted according to REC Policies and HREC Guidelines. Depending on the nature of the study described below your study may require a preliminary review by the HREC Chairs and may be subject to further clarification. ***Please note that all questions requiring either a 'yes' or 'no' answer must be answered –if you fail to do so, or leave them blank, your form will be returned.***

Please do not alter the format of this form and submit it as either an unsigned word doc or a signed pdf

Section A: General Information

I apply for Exemption from Full Ethical Review of the research protocol summarised below, on the basis that *(select Yes or No)**:***	***Yes***	***No***
a) All aspects of the protocol have received ethical approval from an approved body (e.g. Hospitals, hospices, prisons, health authorities)		No
b) The research protocol meets one or more of the criteria for exemption from review as detailed in Section 3 of *Further Exploration of the Process of Seeking Ethical Approval for Research (HREC Doc 7)*	Yes	
I am also requesting permission to access UCD Students for one of the following *(select Yes or No)**:***		
c) I am accessing students from one school only and will seek permission from the Head of that school		No
d) I am seeking permission to access UCD Students from more than one school *(accessing students in more than one school will require HREC approval)*		No
e) I am seeking permission to conduct a university-wide survey of UCD students *(if the research is a campus-wide student survey[1] and involves students from two or more schools, then permission to schedule the survey will be sought from the University Student Survey Board (USSB) on your behalf after this form has been reviewed by a HREC Chair and/or HREC Committee).*		No
I have also read the following Guidelines *(select Yes or No)**:***	***Yes***	***No***
(i) HREC Guidelines and Policies specifically Relating to Research Involving Human Subjects http://www.ucd.ie/researchethics/policies_guidelines/	Yes	
(ii) The UCD Data Protection Policy http://www.ucd.ie/dataprotection/policy.htm	Yes	
(iii) The Data Protection Guidelines on Research in the health sector, (if applicable) https://www.dataprotection.ie/documents/guidance/Health_research.pdf	Yes	

[1] Where the target population comprises students drawn from two or more schools and the survey encompasses university-wide activities or services

1. PROJECT DETAILS

a)	**Project Title:**	The role of the educational psychologist in supporting schools with students presenting with Selective Mutism.		
b)	**Study Start Date:** **(dd/mm/yy)**	18/05/18	**Study Completion Date:** **(dd/mm/yy)**	21/08/20
c)	**Start Date of Data Collection:** **(dd/mm/yy)**	14/01/19	**Completion Date of Data Collection:** **(dd/mm/yy)**	26/06/19

NOTE: In no case will approval be given if recruitment and/or data collection has already begun

2. APPLICANT DETAILS

a)	**Name of Applicant** *(please include title if applicable):*	Niamh Molamphy			**UCD Student Number:** *(if applicable)* 17201159
b)	**Applicant's position in UCD** *(please put 'yes' in relevant space): If the position of the applicant is not clear the form will be returned to you*	**Staff**	**Postgraduate**		**Undergraduate**
			Taught Masters?	***PhD?***	
				Yes	
c)	**Academic/Professional Qualifications**	BA Applied Psychology, MA Applied Psychology, currently undertaking Professional Doctorate in Educational Psychology.			
d)	**Applicant's UCD Contact Details**	**UCD Telephone** *(if applicable)*	**UCD Email *(not a student number or an external email address – UCD addresses only)***		
			niamh.molamphy@ucdconnect.ie		

e)	**Applicant's UCD School Address** *If it is not clear what school the applicant is from the form will be returned*	School of Education, University College Dublin, Belfield, Dublin 4.	
f)	**Name of Supervisor** *(please include title if applicable):*	Dr. Joyce Senior	
g)	**Supervisor's UCD Contact Details**	**UCD Telephone**	**UCD Email:**
		01 716 7980	joyce.senior@ucd.ie
h)	**UCD Investigator(s) and affiliations**	*(name all investigators & co-investigators on project)*	
		N/A	
i)	**Funding** *if applicable*	**Source**	**Amount**
		N/A	**€**

j. EXTERNAL APPLICANTS ONLY *(if study is not associated with any UCD staff member or school)*			
a) External Investigator(s) *if applicable*	**Yes / No**	**If YES, please provide name(s)**	
b) Name of Organization			**Relationship with External Organization**
c) Address of Organization			
d) External Investigator(s) *if applicable*			
e) Project Title:			

f) Start Date of Data Collection:	(dd/mm/yy)	**Completion Date of Data Collection:**	(dd/mm/yy)

k. INSURANCE *Please note that UCD's existing insurance policy providing cover in relation to research work and placements, being undertaken by UCD staff and students, is currently limited to* ***Public Liability*** *only. Provisions of other types of insurance cover, as listed in the table below, are the sole responsibility of the researcher.*
Please select ***Yes*** *or* ***No*** *and provide details, where required. Please do not assume that you do not require insurance.*
NOTE: ***This section is mandatory*** *– your application will not be processed unless this section is completed.*

	YES	**NO**
i. Does this study require medical malpractice or clinical indemnity insurance? Yes or no?		No
Is relevant insurance cover already in place? (Yes/No) Insurance Holder's Name:		
ii. Is this study covered by Clinical Indemnity Scheme (CIS)[2]? Yes or no?		No
Healthcare Provider's Name:		
iii. Is there any blood sampling involved in this study? Yes or no?		No
Who will be taking samples? Insurance details:		
iv. Are there other medical procedures involved in this study? Yes or no?		No
Details of Procedures:		
v. Does this study involve travelling outside of Ireland? *If* ***Yes****, please name the country/countries where the researcher will travel in the field below*		No
Name country/countries outside of Ireland:		

[2] The **Clinical Indemnity Scheme** (CIS) is the main scheme under which the State Claims Agency (SCA) manages all clinical negligence claims taken against healthcare enterprises, hospitals and clinical, nursing and allied healthcare practitioners covered by the scheme. Under the CIS, the State assumes full responsibility for the indemnification and management of all clinical negligence claims.

The Office of Research Ethics will liaise with the Insurers and will advise you of any specific requirements, if necessary.

Section B: Research Design & Methodology

3. RESEARCH PROPOSAL

a) Methods of data collection		***Yes***	***No***	*(please select the appropriate box and provide brief details)*
i	standard educational practices			
ii	standard educational tests			
iii	standard personality tests			
iv	standard psychological tests			
v	interviews or focus groups	Yes		The research study will involve semi-structured interviews. The participants for the interviews will be identified following the administration of the online surveys. Participants will be asked to volunteer to participate in the interview. It is intended that interviews will be carried out with approximately five

				participants. The content of the interviews will be guided, and informed by, the data gathered from the online surveys. The interviews will explore in-depth the role of the educational psychologists in supporting students with Selective Mutism.
vi	public observations			
vii	persons in public office			
viii	using existing data only			
ix	surveys/questionnaires	Yes		The research study will consist of distributing an online survey (through a 'gate-keeper' in NEPS) to all educational psychologists who are currently employed with NEPS (approximately 180). The survey will explore information about the role of

				the educational psychologist in working with students with Selective Mutism.
x	audio/video recordings	Yes		Interviews will be audio-recorded using a recording device for the purpose of transcription.
xi	Other*(please specify)*			
b) Who are the participants or informants? *(including size and composition*)		The target sample is all psychologists (approximately 180) employed with the National Educational Psychological Service, Ireland. Pending research approval from NEPS, it is intended that all of the psychologists will be invited to participate in the online survey, which will be distributed by NEPS.		
c) Where are you recruiting the participants from?		It is intended to recruit participants from the National Educational Psychological Service in Ireland.		
i	**Are participants external to UCD?**	Yes		

ii	**Do you have permission to access these participants?** *(provide details of organization/group and attached a copy of the permission if applicable)* *If you are recruiting UCD students please ensure that you complete* ***Section E*** *below.*	Pending ethical approval (exemption) from University College Dublin HREC, the researcher will be required to seek research approval from NEPS. All research proposals for research with NEPS are required to have ethical approval from the relevant supervising body, University or College before an application will be considered by the NEPS Research Advisory Committee.
d)	**Aims and Objectives of the study** *(in brief lay language – no more than 300 words)*	This research study aims to explore the role of the educational psychologist in working with students with Selective Mutism. Selective Mutism is a complex anxiety disorder that typically becomes evident when a child enters into formal education. Classroom teachers tend to be the first people to suspect that the child is having difficulty with expressive communication. Teachers typically will seek the advice of and support from an educational psychologist. The objectives of the study: ● To ascertain the knowledge and current understanding of Selective

	Mutism amongst educational psychologists working with the National Educational Psychological Service throughout primary and post-primary schools in Ireland. ● To identify the role of the educational psychologist in working with cases of Selective Mutism and to explore the challenges that the educational psychologist may face given the limitations of their role. ● To explore the approach to intervention used by the educational psychologist and the collaborative process between the educational psychologist and the school community. ● To contribute to the growing body of knowledge of Selective Mutism with regard to psychological support.
e) Research Design *(in brief lay language – no more than 300 words)*	The study will employ a mixed-methods sequential exploratory design, where the results of the quantitative design will inform the qualitative data collection. The researcher intends to collect and analyse the quantitative data first and use the findings of the quantitative data to guide the selection of content of the interview schedule. The mixed methods study will consist of two elements: 1. A survey of all educational psychologists who are currently employed by the National

	Educational Psychological Service in Ireland. 2. Semi-structured individual interviews with approximately five NEPS psychologists.

Section C: Basis for Exemption

4. RESEARCH PARTICIPANTS: RISK, HARM, SELECTION AND CONSENT

a) Is this research likely to involve any foreseeable risk to participants, above the level experienced in everyday life? *(select Yes or No)*		**Yes**	**No**
			No
Does this research involve the following: *you are advised to read the HREC Guidelines documents – see HREC Policies & Guidelines (select Yes or No): http://www.ucd.ie/researchethics/information_for_researchers/policies_guidelines/]*			
i	Any vulnerable groups? *(this includes UCD Students)*		No
ii	Sensitive topics that may make participants feel uncomfortable? *(i.e. sexual behavior, illegal activities, racial biases, etc.,)*		No
iii	Use of drugs?		No
iv	Invasive procedures? *(e.g. blood sampling)*		No
v	Physical stress/distress, discomfort?		No
vi	Psychological/mental stress/distress?		No
vii	Deception of/or withholding information from subjects?		No
viii	Access to data by individuals or organizations other than the investigators?		No
ix	Conflict of interest issues?		No
x	Any other ethical dilemma? *(if the answer is **YES** please provide details below)*		No

5. ETHICAL APPROVAL FROM ANOTHER BODY

a) Has this study received Ethical Approval elsewhere? *(e.g. hospital REC or other external body or for data collected by another organization for a specific purpose – select Yes or No)*		**Yes**	**No**
			No
*If your answer is **No** please proceed to Section 6*			
b) Ethical Approval from body other than UCD for this study or parts of this *study (select Yes or No)*			
i	Name of Organization that has approved the study?		
ii	Approval Number/Ref		
iii	Approval Date		
Please provide a copy of the approval with this form as a supporting document			
c) Provide a brief account of aspects of the study not covered by external approval			
d) Can you confirm that you will seek full ethical approval from UCD HREC for all non-approved aspects of the study? *(select Yes or No)*			
Please note that a grant of exemption from full ethical review will only be granted by UCD HREC for those aspects of the study that have been approved and are under the jurisdiction of the approving body			
Approval from an approved body *(select Yes or No)*			
i	Have <u>all</u> aspects of the study received ethical approval from an approved body?		
ii	Does the approving body have jurisdiction over aspects of the study?		

6. USE OF EXISTING DATA

a) If you are using existing data, please explain why this study is exempt from a full ethical review? *(e.g. data collected by another organization for a specific purpose)*

Section D: Confidentiality and Data Protection

7. DATA COLLECTION DETAILS

a)	**What arrangements are in place to ensure that the identity of each participant remains confidential?**			
	● The research will be underpinned by the Psychological Society Code of Ethics and the principles of ensuring confidentiality in research as well as UCD HREC Guidelines and Policies specifically Relating to Research Involving Human Subjects and UCD Data Protection Policy. ● The surveys will be anonymous and completed online and the participant will not be asked to give any identifying details about their service, region or schools. ● Log in details to the website where the surveys will be stored will only be managed by the researcher. ● The audio recordings will be stored on the researcher's password-protected, encrypted laptop. ● The audio recorder will be stored in a locked cabinet in the supervisor's office in the interim between interviews and transcription. ● The audio recordings will be deleted from the audio recorder immediately following transcription (maximum two weeks). ● All interviews will be assigned a pseudonym. The researcher will de-identify any reference to identifiers that may be mentioned over the course of the interviews. ● The interview transcripts will also be stored on the researcher's encrypted laptop. ● Interview consent forms will be stored separately to the transcripts in a locked filing cabinet.			
b)	**Please indicate the form in which the data will be collected** (*select Yes or No and provide short details, if applicable)* *For explanation of the terms below please refer to* ***Personal Data Definitions & Examples*** *short guide*			
i	Anonymous	**Yes** **Yes**	**No**	The on-line surveys will be anonymous.
ii	De-identified (or anonymised)	Yes		The interview transcripts will be given pseudonyms and any identifiers will be removed.
iii	Identifiable		No	
iv	Potentially identifiable		No	
c)	**Indicate the form in which the data will be stored and/or accessed** (*select Yes or No and provide short details, if applicable)*			
i	Anonymous		No	

ii	de-identified (or anonymised)	**Yes**		As soon as it is practical (within two weeks of the interview), the data from the audio recordings will be transferred from a digital voice recorder to a password-protected laptop. The files on the data recorder will then be deleted. All participants will be given a pseudonym. The files on the computer will be given a pseudonym, or code name, and they will be encrypted.
iii	Identifiable		No	
iv	Potentially identifiable		No	

d)	**Describe the measures that will be taken to protect the confidentiality of the data to be collected**	
i	Who will have control of the data generated by the research?	The primary researcher
ii	Where will the data will be stored/ or archived, does this comply with the HREC guidelines?	Surveys will be stored online on the website used to gather surveys. The primary researcher will be the only person to have these details. All audio recordings will be transferred within two weeks of the interview from the audio recorder to an encrypted folder on the researcher's laptop following transcription. The transcribed interviews will be saved in word format and encrypted also.
iii	In what format will the data be stored?	The audio files will be stored in an encrypted folder on the researcher's laptop. The transcribed interviews will be encrypted also. The surveys will be stored online, and access will only be known by the researcher
iv	For how long will the data be stored?	The data will be stored for five years following completion of the research project to facilitate publication of articles.

e)	**Responsibility for data collected in the study** *(select Yes or No)*	**Yes**	**No**
i	Will the data generated by the research be destroyed?	Yes	
ii	Will the data be destroyed at or before the end of the study?		No
iii	Who will be responsible for destroying the data at the end of the period indicated in 7 d) iv?	The primary researcher	
iv	Will the data be archived?		No
v	Will the archived data be intended for personal use only?		N/A
vi	Will the archived data be made available to other researchers?		N/A
If yes, please provide details of where the archive will be held and what restrictions for use will be put in place			

vii	Who will be responsible of the archive and future use of data? *(please provide a name)*			
viii	Do you intend publishing all or part of your data?		Yes	
If yes, *please note that some journal editors require assurances (in addition to ethical approval) that data were collected ethically and that all consents, assents and other permissions were granted prior to the start of data collection.*				

Section F: Signed Declaration

8. SIGNATURES ARE REQUIRED ONLY POST-REVIEW AND FOLLOWING SATISFACTORY RESPONSES TO ANY CLARIFICATIONS. Exemption Forms should be signed by the applicant and supervisor/head of school and the signed forms should be retained by the school.

I, the undersigned researcher, have read the *UCD Guidelines and Policy for Ethical Approval of Research Involving Human Subjects* and *Further Exploration of the Process of Seeking Ethical Approval for Research* and agree to abide by them in conducting this research. I confirm that, based on my understanding of these guidelines and policy documents, I consider that this research protocol meets the requirements for exemption from a full ethical review. I confirm that the information provided on this form is correct and accurate.

We the undersigned researchers acknowledge or agree with the University:

(a) It is our sole responsibility and obligation to comply with all domestic Irish and European legislation and to obtain such statutory consents as may be necessary;

(b) Not to commence any research until any such consents have been obtained;

(c) To furnish to the proper officer of UCD a true copy of any consent obtained;

(d) That neither the University, the Committee, nor individual members of the Committee
accept any legal obligation (to us or to any third party) in relation to the processing of this application or to any advice offered in respect of it nor for the subsequent supervision of the research;

(e) That the research will be conducted in accordance with any approval for an exemption from full review granted by the Committee and in conformity with the documentation submitted with this application and with licence granted under any legislation;

(f) That the undersigned researcher(s) have read the most recent UCD Research Ethics Committee Guidelines and Policy for Ethical Approval of Research involving Humans – which are available on the UCD website (www.ucd.ie/researchethics) and agree to abide by them in conducting this research;

(g) Confirm that the information provided on this form is correct and accurate;

(h) In conducting research a researcher has both ethical duties and legal obligations. Compliance with one set of responsibilities does not guarantee compliance with the other - what is legally permissible may not be ethical and vice versa. It is for the researcher to inform himself and herself as to what ethical duties and legal obligations apply to his or her research and to comply with these duties and obligations;

(i) It is not acceptable for an applicant to treat the grant of ethical approval as absolving them from the responsibility of informing themselves of their legal responsibilities in relation to data protection and of complying with these;

(j) It must be understood that any ethical approval granted is premised on the assumption that the research will be carried out within the limits of the law; (k) *Ethical approval does not constitute any sort of advice or representation to the applicant that compliance with the requirements, as laid down by the UCD Human Research Ethics Committee, will be sufficient to comply with the applicable law in the area.*
Signature of Applicant: **Date: 10/12/2018**

Endorsement of Supervisor *(if applicable***:** students who are being supervised are required to have their supervisor's knowledge and endorsement of the study. Supervisors confirm that they have read the above application, and are satisfied that the study appears to meet all requirements for a grant of ethical approval with Exemption from full review from UCD HREC.

Signature of Supervisor*(or designate):* **Date: 10/12/2018**

Approval of Head of School: Acknowledging exemption for this study and, if applicable, permission if the research concerns students from **one** UCD School or Unit, permission can be given by the relevant Head of School/Unit.

Signature of Head of **School or Organization** *(or designate):* **Date:**

Appendix B: NEPS Research Approach form (Non NEPS personnel)

Title of project:

The role of the educational psychologist in supporting schools with students presenting with Selective Mutism (SM).

Name of researcher(s):

Niamh Molamphy (BA Applied Psychology, MA Applied Psychology)

Date: December 2018

Name of Supervisor (for student research):

Dr. Joyce Senior, Course Director of the Doctorate in Educational Psychology, University College Dublin.

Purpose and rationale of project and relevance to NEPS:

Selective Mutism (SM) is a complex anxiety disorder that manifests during childhood (Muris & Ollendick, 2015). It is conceptualized as an emotionally determined, consistent, failure to speak in select social situations, where there is an expectation for speaking, for example, at school (Sharkey & McNicholas, 2012). A child with SM will consistently fail to speak in these situations, despite speaking competently in more familiar situations, such as, at home (Sharkey & McNicholas, 2012).

SM is an under-researched disorder and is particularly pertinent within the field of educational psychology (Lawerence, 2017).The disorder is most commonly expressed within the school context and therefore, educational psychologists are well placed to provide a consultative service for schools with students presenting with SM (Carlson, Mitchell & Segool, 2008). SM can present as a challenge in the classroom, and recent research states that SM is commonly presenting as comorbid with a range of other conditions. For example, in their recent study exploring ASD and SM, Steffenburg, Steffenburg, Gillberg and Billstedt (2018) found that in their sample of children with SM (n=97), 63% had a comorbid ASD, which highlights the risk of overlap between ASD and SM.

This research is being carried out within a systemic framework, which is in keeping with NEPS model of service, which adopts a consultative and systems-based approach. NEPS strive to support schools by considering the environment and wider community in which it exists. Traditionally, SM was explored through a medical model whereby the disorder was pathologized and considered within-child. We are now aware that SM is multi-faceted. With this knowledge, we are better placed to adopt a systems approach to explore how

schools and professionals can best respond so to ensure continuity of support across contexts.

One of the key objectives of NEPS is to ensure the well-being and the participation of all students throughout primary and post-primary schools in Ireland, as outlined in the well-being guidelines for mental health promotion (National Educational Psychological Service, 2015). Schools play a vital role in promoting positive mental health amongst their students. The support that NEPS provide to schools is essential to the development of well-being amongst all children and staff, including those who are challenged by an anxiety disorder, such as SM.

This research, furthermore, is in line with the Action Plan for Education as proposed by the Department of Education (Department of Education and Skills, 2017). This plan spanning 2016-2019 has set goals that this research project reflects and is in keeping with. For example, the first goal of the Action Plan is to improve the learning experience and success of others. This research intends to explore how schools can be supported by NEPS psychologists to ensure the school environment provides a positive learning experience for children with SM. Another goal of the Action Plan is to improve the progress of learners with special educational needs, which is reflective and in keeping with ensuring that children with SM are supported, included and can progress throughout the education system in line with their peers.

The literature states that psychologists are typically the most helpful profession for supporting individuals with SM and that psychologists provide services more often for SM than any other professional (Stone, Kratochwill, Sladezcek & Serlin, 2002). There is no existing research in an Irish context that explores the role that EPs have in working with schools where there is a student with SM present. It is essential, and timely, that this role is explored and considered. NEPS psychologists would lend a powerful voice to this process.

The objectives of the study:

- To ascertain the knowledge and current understanding of Selective Mutism amongst educational psychologists working with the National Educational Psychological Service throughout primary and post-primary schools in Ireland.
- To identify the role of the educational psychologist in working with cases of Selective Mutism and to explore the challenges that the educational psychologist may face given the limitations of their role.
- To explore the approach to intervention used by the educational psychologist and the collaborative process between the educational psychologist and the school community.

- To explore the reported level of comorbidity of SM and other conditions e.g. Autism Spectrum Disorder.
- To contribute to the growing body of knowledge of Selective Mutism with regard to psychological and educational support.

Brief description of methods and measurements:

The study will use a mixed-methods, sequential exploratory design, where the results of the quantitative design will inform the structure of the qualitative data collection.

There will be two phases of data collection.

1. The first phase of data collection will consist of asking NEPS psychologists to complete an online survey. The online survey will be created using EUSurvey tool, which is in line with GDPR regulations. The online survey will take approximately 20 minutes to complete. It will not ask for any identifying information. It is intended that this survey will be distributed by e-mail by NEPS to all psychologists currently employed by NEPS in Ireland. The e-mail will contain a link to the online survey (which will direct participants to the EUSurvey platform) and an information sheet which will explain the nature and purpose of the study, involvement, confidentiality and how the data would be used. Participants will be required to provide online consent. If they do not agree to consent to the study, the online survey will be closed and they will not participate any further. If they agree to consent, they will be invited to answer questions tailored to exploring their role as an educational psychologist within NEPS in working to support schools with students presenting with SM.

   Examples of the questions include: “How many referrals for Selective Mutism have you had during your time with NEPS?” and “What are the challenges you face working with schools with cases of Selective Mutism?”. The last section of the online survey will contain information about the second phase of data collection and participants will be invited to express interest in volunteering to participate in the second phase of data collection.

2. The second phase of data collection will consist of individual semi-structured interviews at a mutually convenient location. It is envisaged that there will be approximately five NEPS psychologists interviewed about their role as an educational psychologist in supporting schools and students with Selective Mutism. The researcher will collate the responses of the online surveys and construct a semi-structured interview informed by the content of the responses. The participants will be required to read an information sheet and provide written consent prior to the interview commencing. The participants will also be required to consent to allow

the researcher to audio record the interviews in order to facilitate transcription. The semi-structured interviews will take approximately one hour in duration. The interviews aim to explore in-depth the particular educational psychologists' experience of SM, their awareness of the disorder and their case involvement. No identifying information about cases or services will be asked. The information gathered will all be anonymous. All participants will be given a pseudonym.

Participants: recruitment methods, number, age, gender, inclusion/exclusion criteria

The target sample is all psychologists employed with the National Educational Psychological Service, Ireland.

Pending approval from NEPS, it is intended that all of psychologists will be invited to participate in the online survey (EUSurvey platform).

Consent and participant information arrangements, debriefing

Information Sheet
All participants will be sent an information sheet, explaining the nature of the study, the confidentially agreements, any potential risks/benefits and the opportunity to contact the researcher to clarify any questions that they may have.

Consent
Participants must tick a box to provide online consent prior to proceeding with the online survey (on the EUSurvey platform). The survey will not be available to any participants who do not consent.

Written consent will be obtained for participants who take part in the second phase of the study, the individual semi-structured interview.

Confidentiality

- The research will be underpinned by the Psychological Society Code of Ethics and the principles of ensuring confidentiality in research as well as UCD HREC Guidelines and Policies specifically Relating to Research Involving Human Subjects and UCD Data Protection Policy.
- The surveys will be anonymous and completed online and the participant will not be asked to give any identifying details about their service, region or schools.
- Log in details to the website where the surveys will be stored will only be managed by the researcher.

- The audio recordings will be stored on the researcher's password-protected, encrypted laptop.
- The audio recorder will be stored in a locked cabinet in the supervisor's office in the interim between interviews and transcription.
- The audio recordings will be deleted from the audio recorder immediately following transcription (maximum two weeks).
- All interviews will be assigned a pseudonym. The researcher will de-identify any reference to identifiers that may be mentioned over the course of the interviews.
- The interview transcripts will also be stored on the researcher's encrypted laptop.
- Interview consent forms will be stored separately to the transcripts in a locked filing cabinet.
- The online survey will be created using the platform: EUSurvey, which is GDPR regulated.

<u>Debriefing</u>

- All participants will be debriefed following participation in the study. Participants will be provided with information regarding directions to support groups for Selective Mutism and also recent relevant journal articles.

	Yes	**No**
Is your research in line with NEPS key Research Directions for 2011 – 2016	Yes	

	Yes	***No***	***Does not apply***
Has your research proposal received ethical approval by a University or college?	Yes		
Will you describe the main experimental procedure to participants in advance, so that they are informed about what to expect?	Yes		
Will you tell participants that their participation is voluntary?	Yes		
Will you obtain written consent for participation?	Yes (for the interview. Submission		

	of the online survey gives implicit consent).		
If the research is observational, will you ask participants for their consent to being observed?			*X*
Will you tell participants that they may withdraw from the research at any time and for any reason?	Yes - they can withdraw their data from the interview within a specified time. Once the online survey is submitted it cannot be withdrawn.		
If you're using a questionnaire, will you give participants the option of omitting questions they do not wish to answer?	Yes		
Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	Yes		
Will you debrief participants at the end of their participation?	Yes		

Do you agree to have your abstract, if your proposal is approved, openly available to NEPS colleagues?	Yes		
Do you agree to have a summary of your completed research , if your proposal is approved, openly available to NEPS colleagues?	Yes		
If you have ticked NO to any of the above questions, please give an explanation on a separate sheet			
Will your project involve deliberately misleading participants in any way?		No	
Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If yes please give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g. who they can contact for help).		No	
Do you consider that this research has any significant ethical implication not covered by the questions above?		No	
If you have ticked YES to any of the above questions, please give an explanation on a separate sheet			

Considerations	
In line with NEPS key Research Directions for 2011 – 2016	This research is in keeping with the vision that NEPS holds in relation to ensuring the well-being of students accessing primary and post-primary education in Ireland. The purpose of the research is to provide information on Selective Mutism in Ireland and how NEPS' psychologists can support schools to ensure all students can access school and the curriculum. This research intends to explore how schools can be supported by NEPS to ensure that school is a positive learning experience for children with Selective Mutism and ensure that they are supported to progress through the education system.
Relevance/value to NEPS	This research study is in line with NEPS vision of promoting well-being in schools. This research will explore the role that the NEPS educational psychologist has in supporting schools to ensure all children are participating and are being included meaningfully.

NEPS Staff Time involved	The online survey will take approximately 20 minutes to complete. For the small number of NEPS educational psychologist (n=5) who will be interviewed, this will take approximately one hour.
Costs (financial)	No financial costs to NEPS.
Duration (including proposed starting date)	The researcher hopes to disseminate the survey in February 2019. The interviews will take place in March.
Ethical standards applied	Application for ethical approval from the University College Dublin HR Ethics Committee.
Intention to publish/present at conference	It will be intended that the results of this research will be published and presented at conferences. A summary of the research findings will also be provided to NEPS Research Advisor Committee before its publication.
Supervision (University etc.)	Supervision will be provided by Dr. Joyce Senior, Course Director of the Doctorate in Educational Psychology at University College Dublin.

References

Carlson, J.S., Mitchell, A.D., Segool, N. (2008). The current state of empirical support for the pharmacological treatment of selective mutism. *School Psychology Quarterly, 23*(3), 354-372.

Department of Education and Skills. (2017). Action Plan for Education. Dublin: Author. Retrieved from https://www.education.ie/en/Publications/Corporate-Reports/Strategy-Statement/ Action-Plan-for-Education-2017.pdf

Lawrence, Z. (2018). The Silent Minority: Supporting students with Selective

Mutism using systemic perspectives. *Support for Learning, (32)*4, 352-374.

National Educational Psychological Service. (2007). Special educational needs: A continuum of support—Guidelines for teachers. Dublin, Ireland.

National Educational Psychological Service (2015). *Well-being in Primary Schools.* Dublin, Ireland.

Muris, P., & Ollendick, T. H. (2015). Children who are anxious in silence: a review on selective mutism, the new anxiety disorder in DSM-5. *Clinical Child and Family Psychology Review, 18*(2), 151-169.

Sharkey, L., & McNicholas, F. (2012). Selective Mutism: A prevalence study of primary school children in the Republic of Ireland. *Irish Journal of Psychological Medicine, 29*(1), 36-40.

Steffenburg, H., Steffenburg, S., Gillberg, C., Billstedt, E. (2018). Children with autism spectrum disorders and selective mutism. *Neuropsychiatric Disease and Treatment, 14,* 1163-1169.

Stone, B. P., Kratochwill, T. R., Sladezcek, I., & Serlin, R. C. (2002). Treatment of selective mutism: A best-evidence synthesis. *School Psychology Quarterly, 17*(2), 168-190. doi:10.1521/scpq.17.2.168.20857

I declare the above to be true. I am familiar with the PSI Code of Professional Ethics and I agree to abide by it.

Signed: Niamh Molamphy
Print name: Niamh Molamphy
Date: December 2018
Please complete Research Disclaimer overleaf.
NEPS RESEARCH DISCLAIMER

I Niamh Molamphy intend to undertake research entitled: “The role of the educational psychologist in supporting schools with students with Selective Mutism” during the period February 2019 to August 2020. I am being supervised by Dr. Joyce Senior in University College Dublin. During this time I will conduct my research involving NEPS personally using an online survey and a voluntary individual interview in person.

I acknowledge that the responses I may obtain will consist of the views of individual psychologists in relation to the research questions being asked. I acknowledge that the responses I may obtain are not representative of the view of NEPS as an organisation.

I agree that a statement to verify this fact must be included in my research report and any other documentation connected with my research and also at any reporting of the research at conferences, seminars, symposia etc. I also agree that my supervisor will guarantee that a summary of the research once completed will be forwarded to the NEPS Research Advisory Committee. In addition I guarantee that a copy of any report of this research to be published will be forwarded to the NEPS Research Advisory Committee before its publication.

Signed: Niamh Molamphy **(Name of researcher). Date: December 2018**

Signed: Joyce Senior **(Name of Supervisor). Date: December 2018**

SUPERVISORS DISCLAIMER

I acknowledge that the responses from NEPS personnel that Niamh Molamphy under my supervision as part of a Professional Doctorate in Educational Psychology during the period 2018 to 2020, may be obtained during her research will consist of the views of individual psychologists in relation to the research questions being asked. I acknowledge that the responses to be obtained are not representative of the view of NEPS as an organisation.

I agree that a statement to verify this fact must be included in Niamh Molamphy's research report and any other documentation connected with her/his research and also at any reporting of the research at conferences, seminars, symposia etc.
I also guarantee that a summary of the research, once completed, will be forwarded to the NEPS Research Advisory Committee.
I also guarantee that a copy of any report of this research to be published will be forwarded to the NEPS Research Advisory Committee before its publication.

Joyce Senior

Signed:
Joyce Senior

Date: December 2018

Please send a hard copy of this application form and disclaimer document to:
Dr. Feargal O' Neill
Johnstown Business Park,
Waterford
Please send an electronic version to feargal _oneill @education.gov.ie

Appendix C: Data Extraction

Table A1
Data Extraction

	Article/ Author, year	Type	Setting, group size	Intervention type & Details	Sessions	Administration
1	Assessment and Treatment of Selective Mutism with English Language Learners (Mayworm, et al., 2015).	Case Study	School 1 Participant	Response initiation, contingency management, shaping, stimulus fading, behavioural chart. Behavioural observation in multiple settings in school. Frequency count observation techniques for vocalisations. Established: where, when, who and what does she communicate. Baseline data collected (4 W's).	One-to-one sessions with trainee psychologist and then generalised to classroom with teacher. 26 weeks of intervention	Trainee school psychologist. Classroom teacher
2	Functional Assessment-Based Intervention for Selective Mutism (Kern et al., 2007).	Changing criterion/ Multiple baseline Design	School 2 Participants	Changing criterion: questions answered. Dependent variable = vocal response to teacher (independent and prompted response). Intervention linked to assessment information and hypotheses and to develop least intrusive intervention measures.	Direct observations, Functional assessment (direct and indirect). Baseline measures obtained. 33 sessions	School psychologists graduate students
3	Evidence-based practices for Selective Mutism: Implementation by a School Team (Sanetti & Luiselli, 2009).	Case Study	School 1 Participant	Stimulus fading, goalsetting, shaping, contingent reinforcement. Monitored: how many points she earned for meeting her daily talking goals in the classroom and weekly talking goals.	Weekly activity based intervention sessions and daily classroom based goal attainment. 16 weeks	Behaviour Consultant, School psychologist
4	Examination of a Social Problem-Solving Intervention to Treat Selective Mutism (O'Reilly, et al., 2008).	Multiple baseline experimental design	School 2 participants	Social Problem-Solving: teacher trained to ask each child 5 questions.	2 times a week for 30 minutes for 5 weeks with trainee. 21 classroom observation sessions	Trainee educational psychologist, Teacher trained in the intervention
5	A randomized controlled trial of a home and school-based intervention for Selective Mutism – defocused communication and behavioural techniques. (Oerbeck et al., 2014)	RCT	Randomized to treatment or control for 3 mths (12 intervention, 12 control).	Psychoeducation, defocused communication, gradual exposure. Six modules/speaking levels.	Intervention: 21 sessions over 3 mths First three x 1 hr sessions in the home. 18 sessions in the school (1 x hr twice a week).	CAMHS therapists (10 therapists)
6	Selective Mutism: A home and kindergarten-based intervention for children 3-5 years: a pilot study (Oerbeck et al., 2011)	Pilot study Experimental	Home and kindergarten based intervention. No control group.	Assessment baseline, psychoeducation defocused communication and behavioural intervention (stimulus fading / sliding in).	Average length of treatment was 14 weeks. Treatment discontinued when reached level 6 of treatment protocol or after 6 mths.	Three clinicians (psychology)

7	Treatment of Selective Mutism: Applications in the Clinic and School Through Conjoint Consultation (Mitchell & Kratochwill, 2013).	Single case experimental design, multiple baseline design	Clinic and school setting. 4 participants.	Psychosocial intervention. Conjoint behaviour consultation framework. Treatment manual designed by the researchers. Stimulus fading, shaping, contingency management.	Weekly sessions after school hours. 6 sessions total on average. Intervention lasted 11 weeks in total but was interrupted due to school holidays (intervention spanned start of April to end of June) each participant due to receive 10 weeks of treatment.	Parents and Teachers
8	Increasing Verbal Behaviour of a Student who is Selectively Mute (Beare et al., 2008).	Single case experimental design, multiple baseline design	School, 1 participant	Reinforce verbalization while fading the intensity of prompts in establishing oral responses in settings that increasingly approximate the regular classroom IV and DV explicit Simple reinforcement procedure, stimulus fading across 3 sessions (set room, study room, classroom). Reinforcer – verbally respond to questions 20 times with 12 reminders. Number of reminders faded. Last phases were 3 or fewer prompts for 20 vocalisations.	Baseline lasted for 5 sessions in SET room, 14 sessions in study room and 27 days in mainstream classroom. Intervention = 35 sessions	Teachers (x3)
9	Evaluation of a Packaged Intervention for Treating Selective Mutism: Application in a School Setting. (Cotton-Thomas, 2015).	Multiple baseline across participants experimental design	School-Based intervention, 3 participants	Conjoint behaviour consultation framework (Mitchell & Kratochwill, 2013). Intervention materials used was the integrated behaviour therapy for SM programme by Bergman (2013). CBT and behaviour approach – contingency management, stimulus fading, fear hierarchy, shaping exposure. 4 stages: 1) Problem identification 2) Problem analysis 3) Intervention implementation 4) Intervention evaluation	8 sessions	Trainee school psychologist, parents, teachers
10	The silent minority: Supporting students with selective mutism using systemic perspectives. (Lawrence, 2018).	Case Study	School, based intervention, 1 participant, Post-Primary	Psychoeducation (think good feel good, cool kids, SM resource manual, homework activities and therapeutic letter).	1.5 hours a week for 6 weeks	Educational Psychologist
11	Selective mutism: Practice and intervention strategies for children. (Hung et al., 2012).	Case study	School, 1 participant	Multi-modal (behavioural, play therapy, school and family involvement) 1:1 session with therapist, exposure, shaping, desensitization	Weekly for 7 weeks	Therapist, two supervisors, parents and teachers

12	Selective Mutism in pupilhood: Assessment and treatment of an African American pre-school boy. (Conn & Coyne, 2014).	Case study	School, 1 participant	Three-step behavioral approach to addressing SM in collaboration with educators over a 3-month period. Rapport building, exposure, shaping, generalization	12 sessions (once a week)	Therapist, teacher
13	Accountability steps for highly reluctant speech: Tiered-services consultation in a Head Start classroom. (Howe & Barnett, 2013).	Single-subject experimental design	School, 1 participant	Problem-solving approach. The intervention was based on building practice opportunities and positive attention to establish typical patterns of classroom language.	15 weeks (once a week)	two preschool teachers teaming with a parent and school psychology consultant-in-training.
14	Omdal (2008)	Case study	School & home	Video observations to explore if teachers include pupils with SM appropriately	2 weeks of video observations	Parents, Teacher, Therapist

Appendix D: Systematic Literature Review Search

Table A2
Database Searching

Database searching	
PsychINFO	21
ERIC (international ProQuest)	6
EBSCO: British education index, Academic search complete	13
ProQuest Dissertations and Theses	3
Handsearching	
NASP	1
Pupils & Schools	1
Contemporary School Psychology	5
Psychology in the Schools	7
Education and Treatment of Pupils	1
Journal of Pupil Psychology/Psychiatry	1
Journal of Educational and Psychological Consultation	1
Citation handpicked	4
Journal of Emotional and Behavioural Disorders	1

Appendix E: Excluded Studies from the Systematic Literature Review

Table A3

Studies not Included in the Systematic Review and Justification

Title	Author and Year	Ineligibility reason
Assessment and Behavioral Treatment of Selective Mutism.	Fisak, B.J., Oliveros, A., & Ehreneich, J.T. (2006)	Intervention primarily based outside school setting.
Assessment and treatment of social anxiety disorder and selective mutism in pupils and adolescents.	Beidel, D.C., & Bunnell, B.E. (2014).	Clinical case descriptions.
Augmented self-modeling as an intervention for selective mutism.	Kehle, T.J., Bray, M.A., Byer-alcorace, G.F., Theodore, L.A., & Kovac, L.M. (2011).	Review of the literature.
Behavior observations for linking assessment to treatment for selective mutism	Shriver, M.D., Segool, N., & Gortmaker, V. (2011).	Clinic-based intervention.
Could selective mutism be re-conceptualised as a specific phobia of expressive speech? An exploratory post-hoc study	Omdal, H., & Galloway, D. (2007)	Adults population / post-hoc study.
Group therapy for selective mutism - A parents' and pupils's treatment group.	Sharkey, L., McNicholas, F., Barry, B., Begley, M., & Ahern, S. (2008).	Clinic-based intervention.
Integrated Behavior Therapy for Selective Mutism: A randomized controlled pilot study.	Bergman, L.R., Gonzalez, A., Piacentini, J., & Keller, M.L. (2013).	Primarily clinic-based intervention.
Intensive group behavioral treatment (IGBT) for pupils with selective mutism: A preliminary randomized clinical trial.	Cornacchio, D., Furr, J.M., Sanchez, A.L., Hong, N., & Feinberg, L.K. (2019).	Intervention based in simulated school environment.
Practitioner Review: Psychosocial interventions for pupils with selective mutism: a critical evaluation of the literature.	Cohan, S.L., Chavira, D.A., & Murray, S.B. (2006).	Literature review.
Selective mutism: A school-based cross-sectional study from Turkey.	Karakaya, I., Şişmanlar,, Ş. G., Öç, Ö.Y., Memik, N.Ç., Coşkun, A., Ağaoğlu, B., & Yavuz, C.I. (2008).	Prevalence study.
Selective Mutism: A Team Approach to Assessment and Treatment in the School Setting.	Ponzurick, J.M. (2012)	Did not detail an intervention.
Selective mutism: Follow-up study 1 year after end of treatment.	Oerbeck, B., Oerbeck, B.,Stein, M.B., Pripp, A.H., Kristensen, H. (2015).	Follow up study, did not warrant full inclusion. Original study included.
Too Anxious to Speak? The Implications of Current Research into Selective Mutism for Educational Psychology Practice.	Cleave, H. (2009)	Review of the literature.

Appendix F: Appraisal of Single-Subject Experimental Design

Functional Assessment-Based Intervention for Selective Mutism. Kern, L., Starosta, K.M., Cook, C.R., Bambara, L.M., & Gresham, F.R. (2007).
Design: Single Subject Experimental Design
Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision		✓
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	
Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		
Independent variable is described with replicable precision		✓
Independent variable is systematically manipulated and under the control of the experimenter		✓
Overt measurement of the fidelity of implementation for the independent variable is highly desirable.		✓
Baseline		

The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	
Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.	✓	
The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	
The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective		✓
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts		✓

Appraisal of Single-Subject Experimental Design

O'Reilly, M.O., McNally, D., Sigafoods, J., Lancioni, G.E., Green, V., Edrisinha, C., Machalicek, W., Sorrells, A., Lang, R., & Didden, R. (2008). Examination of a Social Problem-Solving Intervention to Treat Selective Mutism (2008).

Design: Single Subject Experimental Design (Multiple Baseline)
Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision		✓
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	
Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		
Independent variable is described with replicable precision		✓
Independent variable is systematically manipulated and under the control of the experimenter		✓
Overt measurement of the fidelity of implementation for the independent variable is highly desirable		✓
Baseline		
The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	
Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.	✓	

The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	
The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective	✓	
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts		✓

Appraisal of Single-Subject Experimental Design

Mitchell, A.D., & Kratochwill, T.R. (2013). Treatment of Selective Mutism: Applications in the
Clinic and School Through Conjoint Consultation
Design: Single Subject Experimental Design
Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision	✓	
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	

Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		
Independent variable is described with replicable precision		✓
Independent variable is systematically manipulated and under the control of the experimenter		✓
Overt measurement of the fidelity of implementation for the independent variable is highly desirable		✓
Baseline		
The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	
Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.	✓	
The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	

The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective	✓	
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts		✓

Appraisal of Single-Subject Experimental Design

Beare, P., Torgerson, C., 7 Creviston, C. (2008). Increasing Verbal Behaviour of a Student who is Selectively Mute
Design: Single Subject Experimental Design
Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision		✓
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	
Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		

Independent variable is described with replicable precision	✓	
Independent variable is systematically manipulated and under the control of the experimenter	✓	
Overt measurement of the fidelity of implementation for the independent variable is highly desirable	✓	
Baseline		
The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	
Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.	✓	
The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	
The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective	✓	
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts	✓	

Appraisal of Single-Subject Experimental Design

Cotton-Thomas, M. (2015). Evaluation of a Packaged Intervention for Treating Selective Mutism: Application in a School Setting. (Thesis).

Design: Single Subject Experimental Design

Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision	✓	
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	
Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		
Independent variable is described with replicable precision	✓	
Independent variable is systematically manipulated and under the control of the experimenter	✓	
Overt measurement of the fidelity of implementation for the independent variable is highly desirable	✓	
Baseline		

The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	
Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.		✓
The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	
The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective	✓	
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts	✓	

Appraisal of Single-Subject Experimental Design

Heather Howe & David Barnett (2013) Accountability Steps for Highly Reluctant Speech: Tiered-Services Consultation in a Head Start Classroom, Journal of Educational and
Psychological Consultation, 23:3, 165-184,

Design: Single Subject Experimental Design

Appraisal Tool: Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., and Wolery, M. (2005). The use of single-subject research to identify evidence-based practice in special education. *Exceptional Children*, 71(2), 165–179.

Description of Participants and Setting	**Yes**	**No**
Participants are described with sufficient detail to allow others to select individuals with similar characteristics (e.g. age, gender, diagnosis)	✓	
The process for selecting participants is described with replicable precision		✓
Critical features of the physical setting are described with sufficient precision to allow replication	✓	
Dependent Variable		
Dependent variables are described with operational precision	✓	
Each dependent variable is measured with a procedure that generates a quantifiable index	✓	
Measurement of the dependent variable is valid and described with replicable precision	✓	
Dependent variables are measured repeated over time	✓	
Data are collected on the reliability or inter-observer agreement associated with each dependent variable	✓	
Independent Variable		
Independent variable is described with replicable precision		✓
Independent variable is systematically manipulated and under the control of the experimenter		✓
Overt measurement of the fidelity of implementation for the independent variable is highly desirable		✓
Baseline		
The majority of single-subject research studies will include a baseline phase that provides repealed measurement of a dependent variable and establishes a pattern of responding that can be used to predict the pattern of future performance, if introduction or manipulation of the independent variable did not occur	✓	

Baseline conditions are described with replicable precision	✓	
Experimental Control/internal Validity		
The design provides at least three demonstrations of experimental effect at three different points in time.	✓	
The design controls for common threats to internal validity (e.g., permits elimination of rival hypotheses).		✓
The results document a pattern that demonstrates experimental control.	✓	
External Validity		
Experimental effects are replicated across participants, settings, or materials to establish external validity.	✓	
Social Validity		
The dependent variable is socially important	✓	
The magnitude of change in the dependent variable resulting from the intervention is socially important	✓	
Implementation of the independent variable is practical and cost effective	✓	
Social validity is enhanced by implementation of the independent variable over extended time periods, by typical intervention agents, in typical physical and social contexts	✓	

Appendix G: JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Assessment and Treatment of Selective Mutism with English Language Learners (Mayworm, A.M., Dowdy, E., Knights, K, & Rebelez, J. 2015).

	Yes	No	Unclear	Not applicable
Were patient's demographic characteristics clearly described?	✓			
Was the patient's history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?	✓			
Were diagnostic tests or assessment methods and the results clearly described?	✓			
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?			✓	
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Evidence-Based Practices for Selective Mutism: Implementation by a School Team. Sanetti, L.M.H., Luiselli, J.K. (2009).

	Yes	No	Unclear	Not applicable
Were patient's demographic characteristics clearly described?	✓			
Was the patient's history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?	✓			
Were diagnostic tests or assessment methods and the results clearly described?	✓			
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?		✓		
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Oerbeck, B., Johansen, J., Lundahl, K., & Kristensen, H. (2011). Selective Mutism: A home and kindergarten-based intervention for children 3-5 years: a pilot study

	Yes	No	Unclear	Not applicable
Were the patients' demographic characteristics clearly described?	✓			
Was patient history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?			✓	
Were diagnostic tests or assessment methods and the results clearly described?	✓			
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?	✓			
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Lawrence, Z. (2018). The silent minority: Supporting students with selective mutism using systemic perspectives.

	Yes	No	Unclear	Not applicable
Were the patients' demographic characteristics clearly described?	✓			
Was patient history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?			✓	
Were diagnostic tests or assessment methods and the results clearly described?				✓
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?		✓		
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Hung, S., Spencer, M.S., & Dronamraju, R. (2012). Selective mutism: Practice and intervention strategies for children.

	Yes	No	Unclear	Not applicable
Were the patients' demographic characteristics clearly described?	✓			
Was patient history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?			✓	
Were diagnostic tests or assessment methods and the results clearly described?				✓
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?		✓		
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Conn, B.M., & Coyne, L.W. (2014). Selective Mutism in Early Childhood: Assessment and Treatment of an African American Preschool Boy.

	Yes	No	Unclear	Not applicable
Were the patients' demographic characteristics clearly described?	✓			
Was patient history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?	✓			
Were diagnostic tests or assessment methods and the results clearly described?	✓			
Was the intervention(s) or treatment procedure(s) clearly described?	✓			
Was the post-intervention clinical condition clearly described?	✓			
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

	Include	Exclude	Seek further info
Overall Appraisal	✓		

JBI Critical Appraisal Checklist for Case Reports

Reviewer: Niamh Molamphy
Author: Omdal (2008). Including Children with Selective Mutism in Mainstream Schools and Kindergartens: Problems and Possibilities.

	Yes	No	Unclear	Not applicable
Were the patients' demographic characteristics clearly described?	✓			
Was patient history clearly described and presented as a timeline?	✓			
Was the current clinical condition of the patient on presentation clearly described?	✓			
Were diagnostic tests or assessment methods and the results clearly described?		✓		
Was the intervention(s) or treatment procedure(s) clearly described?			✓	
Was the post-intervention clinical condition clearly described?			✓	
Were adverse events (harms) or unanticipated events identified and described?		✓		
Does the case report provide takeaway lessons?	✓			

Overall Appraisal	Include	Exclude	Seek further info
	✓		

Appendix H: Critical Appraisal Skills Programme Checklist for RCT

CASP checklist for RCT.
Paper for appraisal and reference: Oerbeck et al. (2014).

Did the trial address a clearly focused issue?
Yes

Was the assignment of patients to treatments randomised?
Yes

Were all of the patients who entered the trial properly accounted for at its conclusion?
Yes

Were patients, health workers and study personnel 'blind' to treatment?
No

Were the groups similar at the start of the trial?
Yes

Aside from the experimental intervention, were the groups treated equally?
Yes

How large was the treatment effect?
Outcome measures: SSQ, SMQ.SSQ: significant difference favouring the intervention group. Significant increase in speech (pre-score = 0.68, post-score = 1.22 No significant change in control group. More pronounced increase in the younger children in the intervention group. SMQ: significant difference in time changes between groups within an improvement in the intervention groups. All participants spoke to the therapist within the school setting. 3 participants spoke to therapist only, 3 children spoke freely in some but not all groups and to some/not all adults.

How precise was the estimate of the treatment effect?
SSQ: Speech - Confidence Interval 95% 0.19 - 0.89 SSQ: Time - Confidence Interval 95% 95% 0.23 - 0.87

Can the results be applied to the local population or in your context?
Yes

Were all clinically important outcomes considered?
Yes

Are the benefits worth the harms and costs?
Yes

Appendix I: Weight of Evidence B

Table A4

Weight of Evidence B

High Rating (3)	Medium Rating (2)	Low Rating (1)
Oerbeck, B., Stein, M.B., Wentzel-Larsen, T., Langsrud, O., & Kristensen, H. (2014)	Kern, L., Starosta, K.M., Cook, C.R., Bambara, L.M., & Gresham, F.R. (2007) O'Reilly, M.O., McNally, D., Sigafoods, J., Lancioni, G.E., Green, V., Edrisinha, C., Machalicek, W., Sorrells, A., Lang, R., & Didden, R. (2008) Mitchell, A.D., & Kratochwill, T.R. (2013) Beare, P., Torgerson, C., 7 Creviston, C. (2008) Cotton-Thomas, M. (2015) Howe, H., & Barnett, D. (2013)	Mayworm, Dowdy, Knights & Rebelez (2015) Sanetti, L.M.H., Luiselli, J.K. (2009) Oerbeck, B., Johansen, J., Lundahl, K., & Kristensen, H. (2011) Lawrence, Z. (2018) Hung, S., Spencer, M., & Dronamraju, R. (2012) Conn., B.M., & Coyne, L.W. 2014 Omdal (2008)

Appendix J: Weight of Evidence C

Criteria: Do the studies detail, with reputable precision, a school-based intervention for a pupil with SM?

Table A5
Weight of Evidence C

High (3)	Medium (2)	Low (1)
Study is based in the school-setting and clearly identifies the steps in implementing an intervention for a pupil with SM.	Study is based in the school-setting and describes the intervention with less precision.	Study is located in one of many contexts (including the school) with no of the intervention implementation.

Appendix K: Online Questionnaire

Online survey for psychologists with the National Educational Psychological Service.

Fields marked with * are mandatory.

Thank you for taking the time to open this survey. Your voice, as a NEPS psychologist, is crucial in terms of learning more about Selective Mutism and in gaining a better understanding of the role that psychologists have in supporting schools where there are pupils presenting with risk factors for Selective Mutism. Regardless of your experience with Selective Mutism, I would encourage you to please take the time to fill out this survey.

Survey Participant Information Sheet

Introduction
My name is Niamh Molamphy and I am a doctoral student on the Professional Doctorate in Educational Psychology programme at the School of Education, University College Dublin. This research project is being completed under the supervision of Dr. Joyce Senior.

Project Title
The role of the educational psychologist in supporting schools with pupils presenting with risk factors for Selective Mutism.

What will happen if I take part?
I am inviting psychologists employed by the National Educational Psychological Service in Ireland to participate in this research. Should you agree to participate in this study, you will be asked to complete an online survey. At the end of the survey, you will be asked if you would like to volunteer to participate in an individual interview at a later stage. The aim of this research is to gain a deeper understanding of Selective Mutism and the role that the educational psychologist has in providing support to schools.

Phase One
This phase is an online survey, where you are invited to share your knowledge of Selective Mutism, your experiences with schools to support pupils presenting with risk factors for Selective Mutism and any challenges that you may have faced in your role as a psychologist to this school. The last section of the survey will ask if you would like to participate in Phase Two of the research.

Phase Two
This phase will involve an individual interview with the researcher to further discuss Selective Mutism and the role of the educational psychologist. The interview can take place either in a mutually convenient venue or over the phone. The interview will be audio-recorded.

What time commitment is involved?

The survey typically takes 15 minutes to complete. Should you choose to volunteer to complete the individual interview, this will last approximately 45 minutes.

Will my privacy be protected?
The data collected will not include any personal information about you. For participants who volunteer for the interview, it will be recorded on an audio-device, for the purpose of facilitating transcription. The audio recordings will be stored on an encrypted, password-protected laptop. The recordings will be deleted immediately following transcription (held for a maximum of two weeks). The transcription will be anonymised and there will be no identifiers.

How will the data be used?
The results will be written up as a thesis and submitted to UCD for examination for the degree of Doctorate in Educational Psychology. I also intend to write a research article which will be submitted for publication in professional journals. When the research is complete, a summary of the findings will be provided to the NEPS Research Advisory Committee.

If I agree to take part, can I change my mind?
Participation in either Phase One or Phase Two is completely voluntary. You can decide to withdraw from the survey at any time prior to clicking submit. If you indicate that you want to take part in the interview and subsequently change your mind, that will not be an issue. You can withdraw from the interview phase up to two weeks after the interview has taken place, as after that, data analysis will have commenced.

What are the benefits and/or risks of taking part?
Taking part in this research may not benefit you directly in any way. However, your experiences of Selective Mutism are pivotal regarding the development of your understanding of Selective Mutism in terms of the presentation of difficulties, intervention and support. There are no known risks for you in taking part.

For further information
Should you require any further information you can contact me by e-mail at niamh.molamphy@ucdconnect.ie. Alternatively, you can contact my supervisor, Dr. Joyce Senior, at joyce.senior@ucd.ie.

Consent

Please take a moment to read through the following points:

- I agree to participate in an online survey which aims to explore the role of the educational psychologist in working collaboratively with schools to support pupils presenting with risk factors for Selective Mutism.

- I confirm that I have read the information sheet (above) and I have been afforded the opportunity to clarify anything that I did not understand.

- I understand that participation in this survey is completely voluntary.

- I understand that I can withdraw from the survey any time until I press the submit button.

- I understand that the information I submit will be completely anonymous. Any identifiers will be removed by the researcher.

- I understand that the information I provide will be used as part of a doctoral research thesis on the Educational Psychology programme at University College Dublin and may feature in any subsequent conferences or publications.

* I consent to the above and agree to proceed to the survey:
  - ◎ Yes
  - ◎ No

Section 1. Demographics

For how many years have you been working as a qualified psychologist:
- ◎ Less than 1 year
- ◎ 2 - 5 years
- ◎ 6 - 10 years
- ◎ 11 - 15 years
- ◎ 16 - 19 years
- ◎ 20 years +

For how many years have you been working as a psychologist with NEPS:
- ◎ Less than 1 year
- ◎ 2 - 5 years
- ◎ 6 - 10 years
- ◎ 11 - 15 years
- ◎ 16 - 19 years
- ◎ 20 years +

Where did you work as a pychologist prior to commencing employment with NEPS (if applicable):
Please tick all of those which apply
- ☐ HSE
- ☐ Charity Services
- ☐ Private Practice
- ☐ Abroad
- ☐ Other

If other, please describe:

Four sections remaining

Section 2. Case Involvement

Have you had involvement in supporting a school with a query for Selective Mutism during your time with NEPS:

- Yes
- No

How many cases of Selective Mutism have you been involved in during your employment with NEPS to date:

- 1
- 2
- 3
- 4
- 5
- 6 - 9
- 10 +

In your most recent case involvement, please outline the following information:

School Setting:

- Primary
- Post-Primary
- Special School

Age of the pupil with Selective Mutism:

- 4 - 5 years
- 6 - 7 years
- 8 - 9 years
- 10 - 11 years
- 12 - 13 years
- 14 years +

Gender:

- Male
- Female
- Transgender Male
- Transgender Female
- Non-binary

Presenting difficulties:

Please tick all of those which may apply.

- ☐ Anxiety Disorder (e.g. Social Anxiety, Separation Anxiety)
- ☐ Depressive Disorder
- ☐ Autism Spectrum Disorder
- ☐ Communication Disorder (e.g. Developmental Language Disorder)
- ☐ Intellectual Disability
- ☐ Specific Learning Difficulty
- ☐ ADHD
- ☐ OCD
- ☐ ODD
- ☐ Other

If other, please describe:

Were you the first professional contacted by the school principal in relation to seeking support:

- ○ Yes
- ○ No
- ○ Unsure

Who else was involved with this case:

Please tick all of those which may apply

- ☐ Parent(s)
- ☐ Teacher(s)
- ☐ Clinical Psychologist
- ☐ Speech and Language Therapist
- ☐ Occupational Therapist
- ☐ Psychiatrist
- ☐ Social Work
- ☐ GP
- ☐ Other

If other, please describe:

Please detail your involvement with this case:

Three sections remaining

Section 3. Awareness of Selective Mutism

Do you think that teachers have an understanding of Selective Mutism as a condition that would explain the challenges a pupil has with speaking in school?

- Yes
- No
- Unsure

Do you think that schools are aware of which professionals are available to support them in relation to queries of Selective Mutism?

- Yes
- No
- Unsure

As a psychologist, do you think that you have the knowledge to meet the needs of pupils presenting with Selective Mutism in your schools?

- Yes
- No
- Unsure

Were you trained in Selective Mutism in your initial psychology studies?

- Yes
- No
- Unsure

Have you attended any additional training or information day on Selective Mutism:

- Yes
- No
- Unsure

If yes, and if you can recall, please explain where this was, the duration and who provided the training /information:

How would you rate your knowledge of Selective Mutism?

- ○ I have a lot of knowledge of Selective Mutism
- ○ I have adequate knowledge of Selective Mutism
- ○ I have limited knowledge of Selective Mutism

If applicable, where did you get your knowledge of Selective Mutism?

Please tick all of those which may apply

- ☐ Personal Research
- ☐ Supervision
- ☐ Professional Training
- ☐ CPD
- ☐ Conferences
- ☐ Personal Experience
- ☐ Discussion with Colleagues
- ☐ Other

If other, please describe:

On a scale of 1 - 5, please rate the following statement: My professional training in psychology has equipped me to support cases where there is a query of Selective Mutism:

- ○ 1 - Strongly Disagree
- ○ 2 - Disagree
- ○ 3 - Neutral
- ○ 4 - Agree
- ○ 5 - Strongly Agree

Two sections remaining

Section 4. Role of the Educational Psychologist

Do you consider yourself to have a role in supporting schools to meet the needs of pupils presenting with a query of Selective Mutism?

- ○ Yes
- ○ No
- ○ Unsure

To what extent do you consider it your role to engage in interventions to meet the needs of pupils presenting with risk factors for Selective Mutism?

- ○ Definitely my role
- ○ Somewhat my role
- ○ Not my role

In your opinion, has Selective Mutism increased as a referral issue in NEPS:

- ○ Yes
- ○ No
- ○ Unsure

What do you think are the main reasons a school would seek the support of an educational psychologist to support them with cases where a pupil is presenting with risk factors for Selective Mutism:

Please tick all of those which apply

- ☐ Lack of knowledge of Selective Mutism
- ☐ The disorder is impacting on the pupils academic skills
- ☐ The disorder is impacting on the pupils social skills
- ☐ The disorder is impacting on the pupils independent skills
- ☐ The disorder is impacting on the pupils emotional needs
- ☐ Teacher(s) feeling frustrated regarding their ability to support the pupil
- ☐ Pressure from Parents
- ☐ A query of Autism Spectrum Disorder
- ☐ Other

If other, please describe:

What do you think are the unique strengths that educational psychologists can contribute to cases of Selective Mutism?

How do you think educational psychologists could work systemically with other services to provide holistic support to the pupil presenting with risk factors for Selective Mutism?

One section remaining

Section 5. Selective Mutism Interventions

On a scale of 1 - 5, how confident do you feel in being able to meet the needs of a school requesting support for a pupil with Selective Mutism?

- 1 - Very confident
- 2 - Confident
- 3 - Neutral
- 4 - A little confident
- 5 - Not confident

How important do you rate the following when you are implementing an intervention:

	Not important at all	Of little importance	Of average importance	Very important	Absolutely essential
Evidence base for the effectiveness of the intervention					
Time					
Simplicity of implementation					
Capacity of those involved to follow through with the intervention					
Motivation and buy-in					
Skills generalisation					

Please describe any particular interventions which you have been involved with implementing in schools to support a pupil with Selective Mutism:

How often have you worked collaboratively with the following professionals in implementing an intervention for pupils with Selective Mutism?

	Never	Rarely	Sometimes	Often	Always
Classroom Teachers	○	○	○	○	○
SNAs	○	○	○	○	○
Special Education Teachers	○	○	○	○	○
Clinical Psychologists	○	○	○	○	○
Psychiatrists	○	○	○	○	○
Speech and Language Therapists	○	○	○	○	○
CAMHS	○	○	○	○	○
GPs	○	○	○	○	○
Occupational Therapists	○	○	○	○	○
Paediatricians	○	○	○	○	○

If you have worked with another professional not listed above, please specify here:

Which sources have informed your practice regarding support and intervention for pupils with Selective Mutism?

Please tick all of those which apply

- ☐ Journal Articles
- ☐ Colleagues
- ☐ CPD Training
- ☐ Google Search
- ☐ Information from conferences
- ☐ Professional Membership (PSI, NASP, BPS etc.)
- ☐ University Seminars
- ☐ Books

Are there any other sources you find helpful to support you in your intervention work with pupils with Selective Mutism?

In your opinion, how could educational psychologists be further assisted to provide support to schools with cases of Selective Mutism?

What are some of the challenges, or envisaged challenges, you face when working with cases of Selective Mutism:

Please tick all of those which apply

- ☐ Lack of supervision
- ☐ Lack of clinical services
- ☐ Difficulties with inter-agency work
- ☐ Lack of knowledge about the disorder and comorbid presentations
- ☐ Uncertainty about the appropriate interventions
- ☐ Lack of time and resources
- ☐ Do not feel it is the role of the educational psychologist
- ☐ Difficult to co-ordinate professionals working on the case

Are there any other challenges not listed above that you have encountered:

Are there any other thoughts that you would like to include on this topic? Please feel free to share these in the box below.

Stage Two of the Research

I am inviting participants to take part in a one-to-one interview (approx. 45 minutes).

This interview can take place either face-to-face (in a convenient location for you) or over the phone. The interview will be semi-structured and will ask further questions about your experience of supporting a school with Selective Mutism. Your participation would be highly valued.

If you are interested in participating, please insert your e-mail address here:

Or alternatively you can e-mail me directly to express your interest at niamh.molamphy@ucdconnect.ie. You can also telephone me on 086-1958851 or Dr. Joyce Senior on 01-7167980.

I truly appreciate your contribution to this research. I am passionate about Selective Mutism and your participation will greatly help in developing our knowledge base around this complex disorder in Ireland. Thank you.

End of Survey

Thank you for taking the time to open this survey. You have not provided consent to proceed to the survey and therefore it will not load. Even if you have no experience of Selective Mutism, your participation in this study is highly valued and you are encouraged to re-open the survey to complete it if you wish. Thank you for your time.

Appendix L: Semi-Structured Psychologist Interview Schedule

1. Informed consent – will be audio recording this interview (audio will be held for two weeks to allow for transcription) – can withdraw information during this time.
2. The purpose is to explore their role as a NEPS psychologist in guiding schools to support pupils with Selective Mutism. (really curious to speak with you… high record of cases…so for the purpose of this discussion I am really hoping to talking about your case involvement, schools awareness of SM and your role as the ed psych supporting schools).

Demographics

1. How long have you been working as a psychologist overall?
2. How long have you worked as a Psychologist with NEPS?

Case Involvement

1. How many cases of Selective Mutism have you worked with overall?
2. How many cases of Selective Mutism have you worked with in NEPS?
3. Can you pick one case (most recent) and explain your involvement:
    a. Length
    b. Direct work with the child? What did that involve?
    c. What did the intervention look like? How was the intervention evaluated?
    d. Was there a cognitive assessment?
    e. Was the child taking medication for anxiety?
    f. Did the parents come into school to participate in an intervention?
    g. Did you provide an official diagnosis or lay-diagnosis?
    h. Presentation (co-morbid?)
    i. What went well? (protective factors)
    j. What would you do differently if you were to do it again?

Awareness

1. What do you think could be done to improve awareness in Ireland and within the education system?

2. Thinking back to your NEPS induction were pathways for Selective Mutism referrals discussed?
1. Have you attended any additional training? (If yes, how has that been beneficial to your practice?) Do you feel your training as an EP prepared you for your work with cases of Selective Mutism? (Which aspect: academic, placement work, encountering a child with SM early on in career?)

Role of the Educational Psychologist

2. What role do you feel NEPS psychologists have in supporting schools with Selective Mutism?
3. How would you describe your particular role in supporting cases of SM from your past experience?
4. What do you think the main reasons a school would seek the support of an EP?
5. What strengths do EPs provide in cases of Selective Mutism?
6. Do you notice any challenges for EPs working with cases of Selective Mutism?
7. Do you think EPs have the adequate training and expertise to get involved in the implementation stage?
8. I am curious about multi-disciplinary work. Has your work involved collaboration with any other professionals? Did any of these professionals take on a more prominent role? Probe - Experience of liaising with primary care / CAMHS etc.

Any additional comments / questions.