“It Feels Like It Doesn’t Belong Anywhere in Its Own Right”: The Challenge of Identifying and Supporting Selective Mutism in Early Childhood.

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1. Thesis Introduction

1.1 Thesis Rationale

This thesis, submitted as part of the Doctoral Training in Educational Psychology, focuses on Selective Mutism (SM), a topic of both personal and professional significance to the researcher. SM is a complex anxiety disorder that typically manifests in early childhood. Although it is rare, most educational institutions likely have at least one child with this condition enrolled, often without formal recognition (Manassis, 2009). SM is classified as an anxiety disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), as well as in the International Classification of Diseases, Eleventh Revision (ICD-11). Officially recognised by the American Psychiatric Association in 2013, SM presents persistent challenges in identification and intervention, which can lead to adverse impacts on a child's social, emotional, and academic development.

An important context for this research is the increasing prevalence of speech, language, and communication needs (SLCN) within educational settings. According to Speech and Language UK (2023), an estimated 1.9 million school-aged children in the UK are currently affected by SLCN, an increase from 1.7 million the previous year. Since SM often results in communication difficulties, it can be considered part of a broader category of needs. This notable rise in prevalence has served as a professional motivator for the researcher, who, as a Trainee Educational Psychologist (TEP), has identified a pressing need to improve early understanding and identification of SM in early years contexts. It also underscores the necessity for professionals, particularly Educational Psychologists (EPs), to acquire the relevant skills and knowledge required to support this population effectively.

Building on this context, existing literature highlights significant gaps in current practices regarding the identification and support of SM. Studies by White et al.

(2022) and Edwards (2022) emphasise the importance of targeted training for teachers and EPs, particularly during the initial stages of identification.

In addition to professional motivations, the researcher brings a deeply personal perspective to this topic as a parent of a child with SM. This dual lens allows for a nuanced and empathetic exploration of how families and professionals interact with identification and support systems. The personal dimension of this research will be further reflected upon and discussed in Part Three of this thesis.

1.2 Researcher Positionality

Bourke (2014) emphasised researchers' critical role in shaping the direction of their studies, highlighting how their characteristics and backgrounds can influence their work. Understanding the identity of the researcher is essential for grasping the research process. In this study, the researcher identifies as an "insider researcher," specifically as a parent of a child experiencing SM. According to Chavez (2008, p. 475), insider positionality refers to the aspects of a researcher's identity that resonate with those of the participants. While the advantages and disadvantages of being an insider researcher will be explored in part three, it is important to acknowledge this positionality at this stage to recognise the potential for researcher bias and to develop strategies that enhance the trustworthiness of the literature review.

To address these concerns, the researcher has utilised Yardley’s (2000) criteria for qualitative research (see Table 10). The literature review will employ a narrative approach, supplemented by systematic elements for selecting studies. This dual methodological strategy helps to address researcher bias and promotes increased transparency throughout the review process. Narrative reviews are particularly valuable for providing historical perspectives on how a phenomenon evolves, a feature especially relevant to the field of SM (Siddaway et al., 2019). By adopting a narrative approach, the researcher can capture SM's dynamic and evolving nature as a topic and integrate academic and non-academic sources, offering a richer and more nuanced understanding. The methodological approaches will be discussed in more detail in part three.

1.3 Definitions of Selective Mutism and Early Childhood

In this thesis, SM is defined as a speech-related phobia in which the expectation to speak triggers a neuropsychological fear response, leaving the individual feeling frozen and unable to communicate (Johnson & Wintgens, 2016, p. 31). For this thesis, "early childhood" is the developmental period from birth to seven years of age. While the term can refer to the years from birth to five, as indicated by statutory frameworks such as the Early Years Foundation Stage in England (DfE, 2021, p. 6), it is important to note that many aspects of these frameworks extend beyond age five. For example, the Early Years Framework for Scotland states, "We are defining early years as pre-birth to 8 years old" (TSG, 2009). Similarly, the Foundation Phase in Wales is described as "the statutory curriculum for all three- to seven-year-olds" (Welsh Government, 2015, p. 2).

1.4 Summary of Thesis

This thesis is structured into three main sections: a comprehensive literature review, an empirical research paper, and a critical appraisal.

Part One: Major Literature Review
Part 1A: The first section of the major literature review thoroughly examines the literature related to the identification and diagnostic processes associated with SM. It begins by outlining the historical and legislative context of SM and then explores its aetiology and presentation. This sets a strong foundation for a detailed discussion of the SM identification process.

Part 1B: The second section explores the role of EPs in supporting children with SM while also examining the relevant theoretical framework. This part will present a framework alongside two key psychological theories applicable to the phenomenon of SM. The aim is to enhance our understanding of how SM is perceived in society and how this condition may impact children's mental health.

Part 1C: Finally, a critical literature review is presented, highlighting the methodologies used in the research. This section goes beyond the diagnostic processes of SM to explore the perceptions of various stakeholders involved in identifying and supporting children with SM in early childhood. The central question is: "What are the experiences and perceptions of parents, early childhood educators, and other stakeholders in identifying and supporting children with SM?" The section concludes with a summary of the research rationale and outlines specific research questions, emphasising areas that require further exploration and understanding in this field.

Part Two: An Empirical Research Paper

The second part of the paper consists of the empirical research. It begins with a brief overview of the relevant literature, establishing the study's rationale and research questions. Next, it describes the methodology and research design employed, including conducting seven semi-structured interviews with parents and early years staff to gather their insights on the support received during the identification process of SM. This section outlines the data analysis methods and presents the overarching themes and sub-themes developed from the research. Finally, it discusses the study's practical implications concerning the role of EPs, acknowledges the study's limitations, and suggests potential directions for future research.

Part Three: A Critical Appraisal

The final section presents a critical appraisal, providing a reflective and reflexive account of the literature review and the empirical research paper. This appraisal aims to synthesise the insights gained from the previous sections and offers a holistic view of the research conducted.

List of Abbreviations

ALN- Additional Learning Needs
ADHD- Attention Deficit Hyperactivity Disorder
ASC- Autistic Spectrum Condition
BPNT- Basic Psychological Needs Theory
BPS- British Psychological Society
COMOIRA- A Constructionist Model of informed and reasoned action.
DECP- Division of Educational and Child Psychology
DfE - The Department for Education
DSM-V- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EPNET- Educational Psychology Network
EP- Educational Psychologist
EVT- Expectancy Violations Theory
HCPC- The Health and Care Professions Council
ICD11- International Classification of Diseases, Eleventh Revision
IPA- Interpretative Phenomenological Analysis
IDP – Individual Development Plan
LA – Local Authority
RTA- Reflexive Thematic Analysis
PEP- Principal Educational Psychologist
SAD- Social Anxiety Disorder
SaLTs- Speech and Language Therapists
SEN – Special Educational Needs
SM- Selective Mutism
SMIRA- Selective Mutism Information Research Association
SoP- Standards of Proficiency
TEP- Trainee Educational Psychologist
NAPEP- National Association of Principal Educational Psychologists
NHS- National Health Service
NICE- National Institute for Health and Care Excellence
UK- United Kingdom
US- United States

WG -Welsh Government

WHO- World Health Organisation

Part 1A - Major Literature Review

"It Feels Like It Doesn't Belong Anywhere in Its Own Right": The Challenge of Identifying and Supporting Selective Mutism in Early Childhood

Wordcount: 12,519

Setting the Scene

This first section will examine Selective Mutism's (SM) historical and legislative context, focusing on its clinical diagnostic process, aetiology, and presentation. The objective addresses the central question: "What is the process for identifying and diagnosing SM in early childhood?" Key themes will be presented and critically evaluated.

Scope and Selection of Literature

This literature review draws on diverse sources to provide a comprehensive overview of current understandings of SM, particularly in early childhood contexts. It includes peer-reviewed journal articles, academic books, and grey literature such as legislation, national guidance, audits (Hipolito & Johnson, 2021), and materials produced by professional bodies and charities like the Selective Mutism Information and Research Association (SMIRA). News articles and case-based resources are also included when they offer unique insights into practice or highlight emerging issues in the field. Sources were identified using a systematic approach supported by the snowballing technique (Creswell & Creswell, 2017), which allowed for identifying foundational and emerging literature across various disciplines.

Grey literature is valuable in specialised areas like SM, especially where peer-reviewed research may be limited. As Kamei et al. (2021) point out, grey literature—which includes materials from charities, government audits, and professional guidance documents—offers practical insights drawn from real-world experiences, clinical practice, and expert consensus. Sources such as those from SMIRA contribute to research by capturing perspectives and contexts that may be overlooked in academic publications. However, it is important to acknowledge the limitations of grey literature, such as variability in methodological rigor and the absence of formal peer review.

1.5 The Historical Context of Selective Mutism (SM)

A helpful starting point is to consider the terminology used when discussing SM. SM is a complex condition characterised by a lack of verbal communication in specific social situations, even though the individual can speak in other contexts. The understanding of SM has evolved significantly, and various names have been used to refer to it. Its recognition in medical research literature dates back to the nineteenth century. Notably, the condition was first documented in 1877 by German physician Adolf Kussmaul, who referred to it as "Aphasia Voluntaria," which translates to "voluntary inability to speak" (Driessen et al., 2020, p. 331; Segal, 2003).

In 1934, researcher Tramer investigated similar behavioural characteristics and proposed "elective mutism," suggesting that affected children were "choosing" to remain silent. This perspective influenced the literature of that era, often framing oppositional behaviour as a central characteristic of SM (e.g., Browne et al., 1963). Halpern et al. (1971) further characterised selectively mute children as "characteristically immature" and "controlling."

The term "elective mutism" was officially included in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in 1980, classifying it under disorders of infancy, childhood, or adolescence (Driessen et al., 2020; Khan & Rank, 2018). However, families of individuals with SM raised concerns regarding the implications of the term "elective," which suggested a voluntary choice to speak (Segal, 2003).

In response to advocacy from families and researchers, the terminology was revised in 1994 to "Selective Mutism." This change emphasised that individuals with the condition exhibit mutism in specific contexts rather than across all situations (Sharkey & McNicholas, 2008). In 2013, further developments reclassified SM as an anxiety disorder due to its significant overlap and familial connections with social anxiety disorder (SAD) (Stein et al., 2011).

SM is now recognised as a speech-related phobia where the expectation to speak triggers a neuropsychological fear response, leaving the individual feeling frozen and unable to talk (Johnson & Wintgens, 2016, p. 31). Our understanding of SM has developed over time, reflecting the growing research on the condition. This thesis adopts the conceptualisation offered by Johnson and Wintgens (2016) as a lens for understanding the anxiety-based mechanisms associated with SM and the implications these have for identification and support practices.

1.6 The Current Context of SM

The understanding of SM has evolved over time, leading to changes in its definitions and terminology. SMIRA, a registered charity in the UK established in 1992, plays a crucial role in supporting families and guiding professionals in the health and education sectors. The organisation also provides context that reflects current perspectives on SM.

According to Selective Mutism Information and Research Association (n.d.) SM is an anxiety-related mental health condition that typically emerges in early childhood. Children with SM may communicate comfortably in familiar settings but often remain silent in other situations, appearing "frozen" or blank when expected to speak. This aligns with Johnson and Wintgens (2016), who describe the condition as one characterised by an inability to speak rather than a refusal to do so.

Selective Mutism Information & Research Association (2024) highlights an ongoing debate about using the term "Situational Mutism." Some families and professionals argue that this alternative label better reflects the context-dependent nature of the condition. However, Selective Mutism Information & Research Association (2024) cautions that Selective Mutism remains the only medically recognised diagnostic term and should be used in formal documentation and support services. Referring to the condition as Situational Mutism may hinder access to support groups, educational provisions, and disability benefits.

Selective Mutism Information & Research Association (2024) clarifies that "selective" refers to the situational nature of speaking—communicating in some settings but not in others—rather than implying a conscious choice. Misunderstanding this can reinforce harmful stereotypes that depict SM as a behavioural choice rather than an anxiety-based condition. Understanding the terminology is crucial for accurate identification, support, and advocacy.

While medical definitions help structure diagnosis and access to services, they can oversimplify the complexities of SM and individual experiences. The medical model often focuses on the individual’s deficits, which can unintentionally pathologise children and overlook the relational and contextual factors contributing to SM.

The social model of disability encourages us to view SM not simply as an individual impairment but as a communication difference shaped and sustained by environmental and social contexts (Connors & Stalker, 2003). From this perspective, challenges experienced by children with SM are often a product of their surroundings, including the expectations, norms, and interactions that define their educational and social environments. The Bioecological Model of Human Development (Bronfenbrenner & Morris, 2006, 2017) further deepens this understanding by framing development as a result of ongoing interactions—referred to as *proximal processes*—between the child and the multiple layers of their environment, ranging from immediate settings such as home and school (microsystem) to broader societal influences (macrosystem). These systems are interrelated and evolve (chronosystem), highlighting the importance of considering structure and change.

This thesis consistently uses the term "Selective Mutism," as it remains the official diagnostic label in educational and clinical contexts. Although "selective" may be misunderstood as implying choice, its continued use promotes clarity, access to services, and consistency in professional discourse. Nonetheless, EPs must remain critical and reflective, recognising how language shapes understanding and influences available support and interventions. As Burr (2015) reminds us, language is not neutral; it actively constructs social realities and guides social action.

1.7 Prevalence of SM

SM is primarily observed in young children, with its prevalence typically decreasing as they enter adolescence and adulthood. Research indicates that approximately 1 in 140 children under the age of eight are affected by SM (Bergman et al., 2002; Elizur & Perednik, 2003), and about 1 in 550 children up to the age of 15 exhibit symptoms (Kopp & Gillberg, 1997; Sharkey & McNicholas, 2012). The average age of onset ranges from 2.7 to 4.1 years (Viana et al., 2009; Steffenburg et al., 2018), although Diliberto and Kearney (2018) suggest a broader range of 2.7 to 6.5 years. Formal diagnoses usually occur during the primary school years, when social and academic expectations—especially regarding verbal communication—intensify (Diliberto & Kearney, 2018).

Despite early onset, many children with SM do not receive treatment until later. Standart and Le Couteur (2003) highlight delays in recognition, and Kumpulainen et al. (1998) report that children are typically referred for evaluation between the ages of 6 and 11, with an average age of 9. These delays are often attributed to a lack of awareness or misinterpretation of symptoms, particularly within school environments.

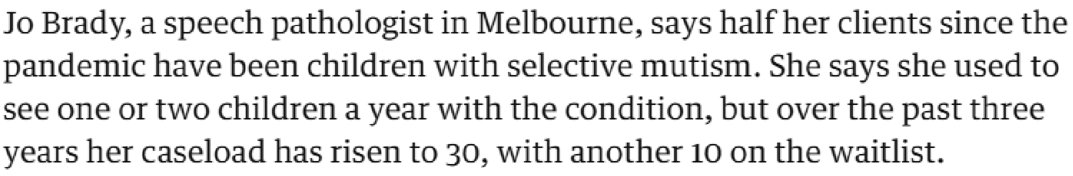
Estimating the current prevalence of SM is challenging due to the reliance on older studies (Bergman et al., 2002; Elizur & Perednik, 2003). Broader societal factors, such as the rise in anxiety and depression during the COVID-19 pandemic, may also affect the expression and detection of SM. The World Health Organisation (2022) reported a 25% increase in global anxiety and depression rates, which could influence the incidence and severity of SM in children.

Recent studies have identified certain groups that are at higher risk for SM. For instance, bilingual children are more likely to be affected, often mistakenly attributing their silence to the "silent period" of second language acquisition (Elizur & Perednik, 2003). This misunderstanding can delay accurate diagnosis and intervention. Additionally, SM often co-occurs with Autism Spectrum Conditions (ASC), although the two are distinct conditions (Steffenburg et al., 2018), complicating the process of differential diagnosis.

1.8 Published News Articles Concerning SM

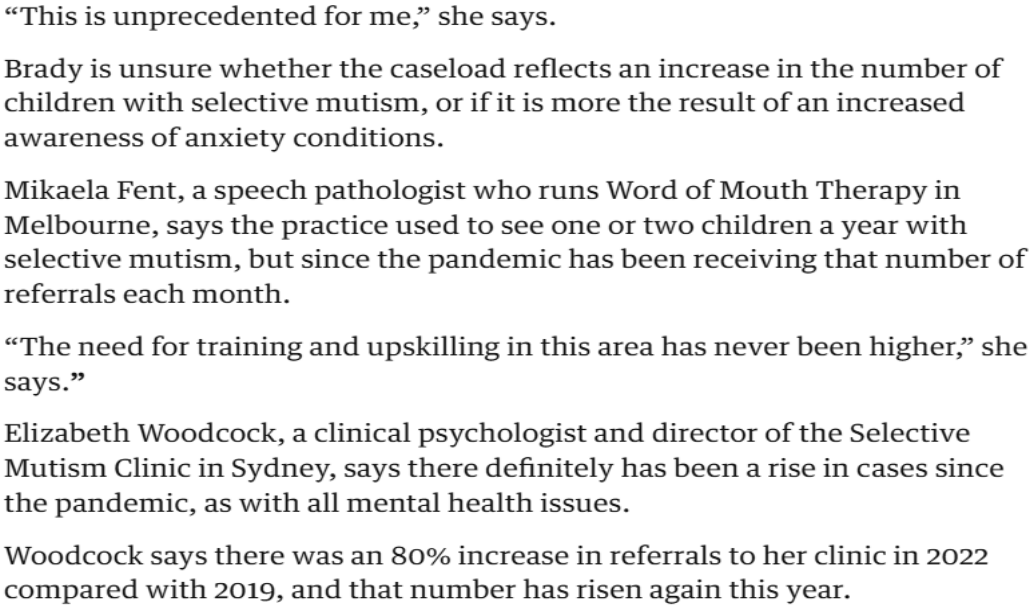
Australia has observed a significant increase in the number of children experiencing SM. Although updated prevalence rates are not widely available in academic literature, various media sources indicate that the incidence of SM is on the rise, particularly following the COVID-19 pandemic. For instance, Brady's (2023) article in The Guardian highlights this growing trend and emphasises the need for enhanced professional development. The article states that this unprecedented period has led to a greater demand for staff training and skill development to support the increasing number of children affected by SM effectively. Below, the researcher has included Figure 1 and Figure 2 from The Guardian's article that illustrate the rising caseloads for speech pathologists (Brady, 2023).

Figure 1 - Guardian Article (2023)



Jo Brady, a speech pathologist in Melbourne, says half her clients since the pandemic have been children with selective mutism. She says she used to see one or two children a year with the condition, but over the past three years her caseload has risen to 30, with another 10 on the waitlist.

Figure 2- Guardian Article (2023)



"This is unprecedented for me," she says.

Brady is unsure whether the caseload reflects an increase in the number of children with selective mutism, or if it is more the result of an increased awareness of anxiety conditions.

Mikaela Fent, a speech pathologist who runs Word of Mouth Therapy in Melbourne, says the practice used to see one or two children a year with selective mutism, but since the pandemic has been receiving that number of referrals each month.

"The need for training and upskilling in this area has never been higher," she says."

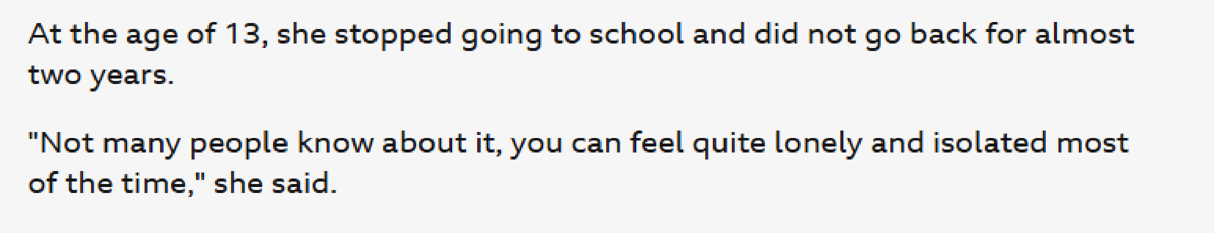
Elizabeth Woodcock, a clinical psychologist and director of the Selective Mutism Clinic in Sydney, says there definitely has been a rise in cases since the pandemic, as with all mental health issues.

Woodcock says there was an 80% increase in referrals to her clinic in 2022 compared with 2019, and that number has risen again this year.

While Brady’s (2023) article reflects the trends in the Australian population, it is vital to acknowledge global SM trends and consider how other countries, such as the UK, may experience a continued increase in prevalence rates of SM in the post-pandemic culture.

A recent article published in Wales highlights the significant impact that SM can have on children's well-being and development. According to BBC News (2024), there is an urgent need to enhance public and professional understanding of the condition. The article also emphasises the importance of early identification and timely intervention to ensure that children receive appropriate support before the condition becomes more entrenched and difficult to manage (BBC News, 2024). Direct quotes from the article are included in Figure 3 below.

Figure 3- BBC Wales Article (2024)



At the age of 13, she stopped going to school and did not go back for almost two years.

"Not many people know about it, you can feel quite lonely and isolated most of the time," she said.

This insightful article (BBC News, 2024) emphasises the ongoing invisibility of SM today, where many people remain unaware of it. However, it's a positive development that media such as BBC Wales is beginning to publish articles to raise public awareness of this condition.

1.9 Legislation and Guidance for SM in the UK

A comprehensive understanding of the identification process for SM necessitates an examination of the relevant legislation and guidance pertaining to education, early childhood, Special Educational Needs (SEN), Additional Learning Needs (ALN), and health services. The subsequent tables will outline the pertinent legislation and guidance, highlighting their significance in identifying SM. It is noteworthy that the scope of applicable legislation is relatively limited. However, a growing body of guidance, including assessment pathways, is emerging across the UK.

The researcher has created the table below to summarise the guidance, detailing its key points, recommended implementation methods, and implications for children's families and educational professionals. Following this, the researcher will discuss how this guidance might inform the role of EP.

Table 1- UK SM Guidelines

Title of Guidance	**Description of Guidance**	**Implications of guidance for families and professionals**
National Institute for Health and Care Excellence (NICE) guidelines (NICE guidance, 2013, p. 8).	Social Anxiety Disorder: Recognition, Assessment, and Treatment emphasises the importance of acknowledging that socially anxious children may hesitate to communicate with unfamiliar individuals. It further notes that children suspected of having SM might find it challenging to speak verbally during assessments or treatment sessions.	The guidance states, “While it is essential to incorporate insights from parents or caregivers, it is equally important to provide the child or young person with opportunities to respond autonomously—whether through writing, drawing, or with the support of a parent or caregiver when needed.” For good practice to occur, practitioners should provide opportunities for children with SM to share their views.

Selective Mutism Guide Derbyshire County Council (2020)	The guide has been produced by a multi-agency group involving representatives from Derbyshire and Derby City Speech and Language Therapy Service, Clinical Psychology, Child and Adolescent Mental Health Service (CAMHS) Paediatrics, and Derbyshire and Derby City Educational Psychology Services. Hopefully, this guide will help staff feel more confident in identifying and supporting children and young people who are anxious about speaking.	The guide provides an overview of the graduated response outlined by the Derby & Derbyshire Multi-agency Selective Mutism Information, Advice, and Pathway.
"Supporting the Development of Speech, Language, and Communication in the Early Years" (Welsh Government, 2023, p. 12).	The Welsh Government (WG) (2024) emphasises the importance of enhancing practitioners' skills to better support children and young people with speech, language, and communication needs. Their "Talk with Me"	WG has indicated that it is developing resources targeted at parents and educators to provide universal and specialised support for children with SM.

	delivery plan is designed to achieve this goal.	
Supporting Children and Young People with Selective Mutism Practice Guidelines (2024)	This document aims to support staff in their work with children and young people with SM. It has been produced by a multi-agency team involving Royal Aberdeen Children's Hospital (RACH) Clinical Psychology and Speech and Language Therapy Services, and Aberdeen City and Aberdeenshire Educational Psychology Services.	In Aberdeenshire, a staged approach is used for assessment and intervention. A resource booklet serves as a guide for practitioners, helping them understand the condition and offering strategies and information on pursuing further assessments for identification purposes.

The guidance in the tables above highlights the variety of resources available across the UK to support professionals and families dealing with SM. Documents such as the NICE guidelines and the Welsh Government's "Talk with Me" delivery plan emphasise the importance of alternative communication methods such as writing, drawing, or utilising a caregiver's support. However, they serve as flexible frameworks rather than strict regulations. EPs can advocate for low-pressure environments that allow children to communicate in ways that suit their needs, gradually helping build their confidence. They can also assist in creating resources for parents and educators to ensure adequate support for children with SM.

The researcher has created the table below to summarise the legislation regarding SM, outlining its description, implementation methods, and implications for educational professionals. The researcher will also discuss briefly how this legislation can inform the roles of EPs.

Table 2- UK SM Legislation

Legislation Title	**Description of Legislation**	**Implications of Legislation on Educational Professionals**
Equality Act (2010) (Section 6)	SM is classified as an anxiety disorder and is recognised as a disability under the Equality Act 2010. According to Section 6 of this act, a person is considered disabled if they have a physical or mental impairment that significantly and adversely affects their ability to carry out normal day-to-day activities over the long term.	SM is an anxiety disorder that can significantly impede children's ability to engage in typical daily activities over an extended period. Consequently, educational institutions must adhere to relevant legislation and appropriately support affected individuals to ensure they are not directly or indirectly discriminated against.
The Department for Education (DfE) Code of Practice for Special Educational Needs (SEN) and the Disability Rights Commission Code of Practice, (2015) (p.16)	Many children and young people who have SEN may have a disability under the Equality Act 2010 – that is '…a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'. This definition provides a	This legislation, including the Equality Act (2010), requires schools in the UK, specifically in England and Wales, to identify and monitor children with Special Educational Needs (SEN).

	relatively low threshold and includes more children than many realise: ‘long-term’ is defined as ‘a year or more’ and ‘substantial’ is defined as ‘more than minor or trivial’.	
The Additional Learning Needs Code for Wales (2021) (p. 21)	Additional Learning Needs (ALN) are identified when a child has a disability as defined by the Equality Act 2010. ALN applies if the disability impedes the child’s ability to access educational facilities offered to peers of the same age in mainstream maintained schools or institutions.	Schools in Wales must adhere to the ALN code, which includes evaluating whether SM impacts a child’s access to education. The ALN Act places the responsibility on schools and local authorities to develop Individual Development Plans (IDPs) that outline the necessary support to ensure the child receives inclusive educational opportunities.

The legislation outlined above is crucial in guiding educational institutions, such as schools and preschools, to adopt inclusive practices and effectively respond to the needs of children with SM. Recognising SM as an anxiety disorder enables professionals to provide appropriate support in line with the Equality Act (2010), which protects individuals with disabilities from discrimination and ensures equal access to education.

EPs must operate within legal frameworks, particularly when supporting children with Additional Learning Needs (ALN). In Wales, this involves complying with the

Additional Learning Needs and Education Tribunal (Wales) Act (WG, 2018) and the ALN Code for Wales. EPs work collaboratively with teachers, families, and other professionals to create Individual Development Plans (IDPs) that are tailored to meet each child's specific needs. The development of these IDPs ensures that children receive targeted interventions and accommodations, thereby promoting inclusion and legal compliance in educational settings, especially when considering a personalised plan for a child with SM.

EPs also play a key role in the ongoing monitoring and review of the support provided, ensuring that the child's educational and emotional needs are met effectively. Through these processes, EPs uphold statutory responsibilities while advocating for the rights, well-being, and meaningful inclusion of children with SM within the school community.

1.10 Diagnostic Criteria

SM is categorised as an anxiety disorder in both the DSM-V and the ICD-11. These classification systems detail the essential characteristics of SM. Additionally, NHS (n.d.) provides guidelines for this condition, which are summarised in Table 3.

The table below compares the diagnostic criteria from the DSM-V, ICD-11, and NHS guidelines.

Table 3- Diagnostic Criteria

Comparing Diagnostic Criteria for SM

Diagnostic Criteria	DSM-V	ICD-11	NHS Guidelines
Speech Context	Inability to speak in social situations like school, while speaking freely at home or in other familiar settings.	Inability to speak in specific social settings, such as school, while speaking normally in others, like at home.	Refusal to speak in situations like school or public settings but speaking comfortably at home or in private spaces.
Duration of non-speaking	Must persist for over one month, excluding the first month in a new environment.	Must last at least one month and not be limited to the first month of school.	Inability to speak for at least one month (or two in new environments like school).
Impact on Functioning	Interferes with educational, social, or work-related interactions.	Interferes with educational achievement or social communication.	Inability to speak interferes with the ability to function in specific settings.
Exclusion Criteria	Not due to a communication disorder,	Excludes conditions like schizophrenia,	Excludes other communication or mental

	psychosis, or separation anxiety.	transient mutism from separation anxiety, and autism spectrum disorder.	disorders, such as separation anxiety or autism.

In the UK, EPs should be familiar with the diagnostic criteria outlined in the DSM-V and NHS guidelines. Both frameworks require that SM persists for at least one month and significantly interferes with functioning in educational or social settings. They also stress the importance of ruling out alternative explanations, such as communication disorders or broader anxiety-related conditions.

Despite these similarities, there are notable differences in how each framework is applied. The DSM-V is commonly used in the UK. but referenced internationally, places emphasis on ruling out language comprehension deficits. In contrast, the NHS guidelines prioritise the observable impact of mutism in everyday contexts and recommend allowing a two-month adjustment period in new environments—longer than the DSM-V's one-month criterion.

Additionally, the ICD-11, while not UK-specific, permits a diagnosis of SM alongside comorbid ASC, whereas the DSM-V excludes ASC as a co-occurring diagnosis. This distinction is significant, as organisations such as the Selective Mutism Information and Research Association (n.d.) argue that the DSM-V's exclusionary criteria may limit the understanding of children with overlapping traits, potentially hindering accurate diagnosis and support.

These differences highlight the importance of EPs critically engaging with multiple diagnostic frameworks—both national and international—to ensure a comprehensive understanding of each child’s needs. Such an approach supports more accurate identification, effective intervention, and tailored support within educational and clinical contexts.

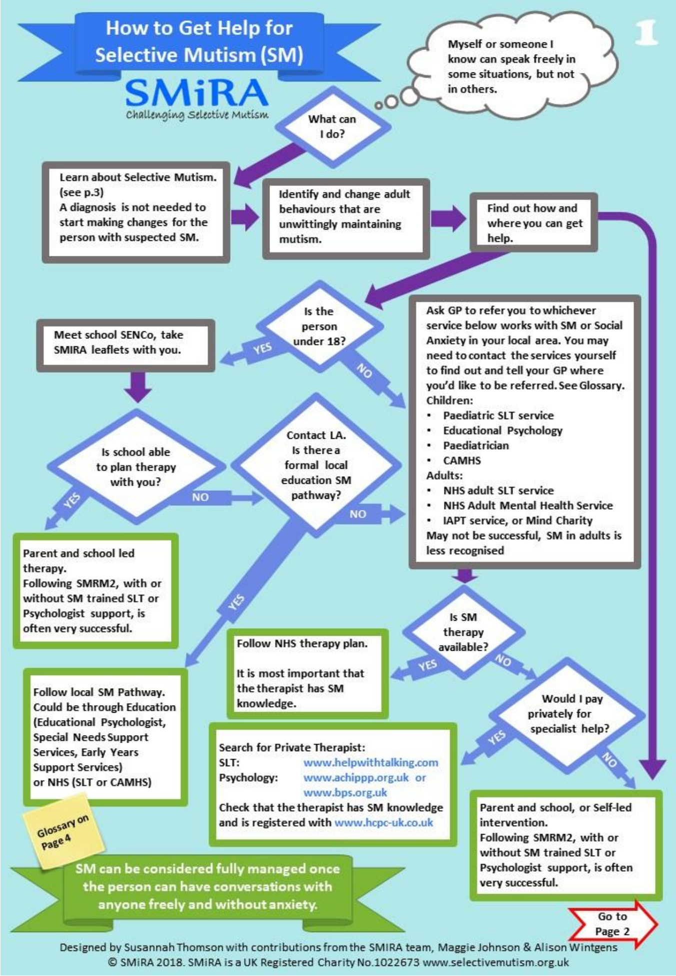
1.11 Key Resources and Support Mechanisms for Families Seeking Guidance on SM

SMIRA’s website is a vital resource for families in England and Wales seeking guidance on accessing support for children with SM. It features clear, user-friendly flowcharts that outline potential pathways to support and identify the professionals involved in the process. However, the site also addresses the significant inconsistencies in service provision—often referred to as a "postcode lottery"—which stem from regional variations in the availability and accessibility of services. Despite these challenges, the website offers practical advice on identifying and diagnosing SM, enabling parents and caregivers to navigate the often-complex landscape of referrals and support (see Figure 4 on the page below for more details).

While these resources are valuable in practice, it is worth noting that many parents frequently rely on voluntary sector organisations and research associations, such as SMIRA, for diagnostic guidance. This reliance highlights a broader issue within the field: the lack of empirically established best practices for identifying and diagnosing SM, particularly in early childhood contexts.

Much of the guidance available to families and professionals is not grounded in peer-reviewed empirical evidence but instead relies on clinical expertise, practitioner consensus, or anecdotal case material. For instance, resources such as The Selective Mutism Resource Manual (Johnson & Wintgens, 2017) offer accessible and practical strategies for assessment and intervention. However, while this manual has been influential, it is not rooted in peer-reviewed empirical research and typically draws from clinical expertise and case-based experiences. In the absence of robust, evidence-based models, such materials have become widely utilised frameworks guiding professional practice. This reliance underscores a significant gap in the literature. Although these resources provide valuable insights, they do not replace the need for systematically evaluated guidance. Consequently, there remains an urgent need for empirical research to establish effective, consistent, and contextually appropriate best practices for the early identification and support of children with SM.

Figure 4- How to get Help for SM



1.12 Aetiology

To enhance the understanding of SM and its clinical definitions and diagnostic criteria, it is beneficial to consider the potential origins of SM and the factors contributing to its development in children. The aetiology of SM has been extensively examined within medical and psychological literature over the decades (Henkin & Bar-Haim, 2015; Sharkey & McNicholas, 2008). Tramer (1934) was among the first to propose that multiple factors might play a role in understanding the aetiology of SM.

Early theories, as noted by Cohan et al. (2006), primarily emphasised psychodynamic issues, including family neurosis and unresolved intrapsychic conflicts. The initial literature posited that SM may arise as a response to early trauma. In more recent discourse, theorists have shifted their focus away from dynamic conceptualisations of the disorder, instead highlighting the parallels between SM and behaviourally inhibited temperament, as well as anxiety disorders like SAD. Recent studies have initiated examinations of the neural mechanisms associated with SM (Dreissen et al., 2020; Henkin & Bar-Haim, 2015).

From a developmental psychopathology perspective, it is important to integrate various viewpoints regarding the aetiology of SM in order to gain a comprehensive understanding of the challenges faced by affected children (Mayworm et al., 2015). Research indicates that a combination of familial factors—such as genetics and environmental influences—along with developmental aspects, neurobiological elements, psychodynamic factors, and behavioural components may contribute to the aetiology and manifestation of SM in individuals (Dreissen et al., 2020). Although this literature review does not aim to discuss all perspectives on aetiology, it will focus on familial factors, attachment theory, and environmental and cultural contexts.

Familial Factors

Evidence suggests that SM may have a familial component, indicating a potential genetic predisposition. In a pilot study involving 30 children who met the DSM-III-R criteria for SM, Black and Uhde (1995) found that 15% of parents and 19% of siblings also had a history of SM. Similarly, Segal (2003) reported that traits such as shyness, social anxiety, and fear of public speaking were often observed among family members, particularly among monozygotic twins. The occurrence of SM in identical female twins, along with maternal anxiety traits, bolsters the argument for hereditary influence.

However, these findings should be interpreted with caution. The sample sizes in both studies were relatively small, which limits generalisability and statistical power. Additionally, while genetic predispositions are suggested, the variation in symptom severity observed between twin pairs in Segal's study highlights the significant role of environmental factors. This interaction between genetic vulnerability and contextual elements—such as parenting styles, school experiences, or early attachment—requires further empirical investigation. Therefore, while familial patterns provide valuable insights into potential risk factors, they should not be considered in isolation when examining the causes of SM.

Attachment Theory

Attachment theory is widely discussed in the literature, positing that children rely on attachment figures to assess whether it is safe to explore their environments (Bowlby, 1988). Parents who exhibit anxiety may unintentionally signal to children that the world outside is unsafe, thereby affecting the children's willingness to explore (Bowlby, 1969; Bowlby, 1973; Khan & Renk, 2018). Within the context of SM, this may elucidate why children experience discomfort during communication situations outside their designated "safe spaces" or what attachment theory refers to as their "secure bases" (Bowlby, 1969; Khan & Renk, 2018).

Environmental and Cultural Contexts

It is essential to consider the impact of environmental factors and cultural contexts on children's communication styles. According to Bornstein (2006), parenting practices and children's behaviour are significantly influenced by the values and expectations present within each cultural context. In some cultures, silence and reserved behaviour are highly valued, leading children to be socialized in ways that encourage them to express themselves more subtly or in a controlled manner. This cultural emphasis on silence or reticence can affect children's communication patterns, regardless of attachment-related issues or conditions such as SM/

Therefore, understanding cultural nuances is crucial when assessing communication difficulties in children, as these factors can sometimes be misinterpreted as speech-related disorders. This indicates that communication patterns can vary significantly and may be shaped more by cultural norms than by parental influences. LeMonda et al. (2009, pp. 154-182) discuss how cultural practices impact language development and communication styles, highlighting the diversity that arises from cultural influences. While attachment theory offers valuable insights, it is essential to adopt a holistic approach that includes genetic, cultural, and individual factors when understanding and addressing SM.

1.13 Presentations of SM in Educational Settings

SM is a complex anxiety disorder that presents differently across individuals, particularly in educational settings like schools. According to the *Selective Mutism Guide* (Derbyshire County Council, 2020, p. 6), children with SM typically fall into two broad behavioural profiles: "High Profile" and "Low Profile." High Profile children are usually completely silent with specific individuals or in certain settings, while Low Profile children may speak minimally when required but rarely initiate speech, especially with adults. This latter group is at risk of being misunderstood or overlooked, as their behaviours may be mistaken for shyness, quietness, or compliance (Cline et al., 2015).

Understanding these subtleties is essential for educators and professionals. Low Profile children may appear to engage in classroom activities, offering short responses when prompted, yet their communication is often driven by high anxiety. Their quiet compliance can mask distress, leading to under-identification and missed opportunities for support.

The limited awareness among educators about the diverse manifestations of SM contributes to this issue. Research indicates that teachers often lack the training and knowledge to effectively identify and support children with SM. For instance, Harwood and Bork (2011) found that Canadian educators had limited understanding of SM, while Sloan (2007) reported a similar trend in the US. This gap is especially concerning for professionals without prior experience in supporting children with SM, who may struggle to recognise less overt symptoms.

Kearney (2010) offers further insight through case studies that illustrate the spectrum of SM presentations. In one example, a child named Jenny does not speak in the presence of unfamiliar individuals and communicates only with her parents, relying on gestures and non-verbal cues in public. This highlights the importance of recognising that effective support may sometimes require work beyond the school setting and collaboration with familiar adults. Another case study features Sunee, a child who completes nonverbal classroom tasks but avoids verbal participation, such as answering questions or reading aloud. Despite being capable and compliant, her silence results in social isolation and highlights the emotional cost of unaddressed SM.

Children with SM often blend into the classroom environment, which contributes to their needs being missed. They may appear diligent, well-behaved, and non-disruptive (Kotrba, 2015; Viana et al., 2009), reinforcing misconceptions that their silence is simply a personality trait.

1.14 Presentations of SM at Home

Many children with SM can speak comfortably at home, especially with close family members. This selective pattern of communication is a key characteristic of SM and significantly affects how the disorder is understood and diagnosed. Instead of being a primary communication disorder, like a phonological or expressive language impairment, SM is more accurately described as an anxiety-related condition that leads to situational silence (Kearney, 2010). According to Kearney (2010), children with SM generally demonstrate age-appropriate language skills in familiar settings, suggesting that their ability to communicate verbally is intact but inhibited in specific social situations, especially those that seem unfamiliar, evaluative, or anxiety-inducing.

The contrast between a child's verbal fluency at home and their silence in public or educational settings can lead to misunderstandings. Parents often perceive this behaviour as extreme shyness or a developmental phase that the child will eventually outgrow. This misconception is common and may delay seeking appropriate intervention (Oerbeck et al., 2014). However, evidence indicates that SM rarely resolves on its own. Without timely and targeted support, the condition may persist into later childhood or adolescence, potentially leading to serious consequences. As Cohan et al. (2006) point out, prolonged SM can adversely affect a child's academic performance, social development, and emotional well-being.

Understanding how SM manifests at home is crucial for accurate diagnosis and the development of effective early intervention strategies. Recognising the differences in communication patterns between home and school enables professionals to distinguish SM from other speech or language disorders and emphasises the importance of involving parents in collaborative, comprehensive support approaches.

1.15 What is the Process for Identifying and Diagnosing SM in Early Childhood?

Navigating the Diagnostic Challenges of SM and ASC

The diagnostic process for SM presents significant challenges, especially when its symptoms overlap with those of ASC. According to the Selective Mutism Information and Research Association (n.d.), SM and ASC often co-occur, yet their distinct characteristics are not consistently recognised during assessments. In many cases, SM is diagnosed before the evaluation for ASC, but it can also be identified afterwards. A key concern raised by the Selective Mutism Information and Research Association (n.d.) is the risk of diagnostic overshadowing, where clinicians attribute all observed behaviours to an existing ASC diagnosis, thereby overlooking SM and missing opportunities for targeted intervention.

Spiro (2021) provides valuable insights into clinicians' challenges when differentiating between SM and ASC. Spiro (2021) emphasises that behavioural consistency across contexts is a crucial diagnostic indicator: Children with SM often speak comfortably in familiar or low-pressure environments, while children with ASC typically experience persistent social communication difficulties across all settings.

The presence of social anxiety in some children with ASC adds further complexity to the diagnosis. This can make it challenging to determine whether a child's silence stems from anxiety, as is typical in SM, or from the core social communication impairments characteristic of ASC (Muris & Ollendick, 2015). These overlapping features can cloud diagnostic clarity and delay effective intervention.

Inconsistencies in diagnostic classification systems also exacerbate the issue. The DSM-V currently does not permit a comorbid diagnosis of SM and ASC, a position criticized by the Selective Mutism Information and Research Association (n.d.), which argues that this exclusion hinders accurate identification and limits access to appropriate support. In contrast, the ICD-11 allows for the concurrent diagnosis of SM and ASC, recognising the possibility of SM as a distinct condition alongside other neurodevelopmental disorders.

In 2024, the Selective Mutism Information and Research Association submitted written evidence to the UK Parliament based on a national online survey of 264 parents. Of those surveyed, 201 were parents of children with confirmed SM diagnoses, while 63 were either awaiting assessment or suspected their child had SM (Selective Mutism Information and Research Association, 2024). The sample included families from England, Scotland, Wales, and Northern Ireland, providing a reasonably broad representation of this rare condition. Although the data were based exclusively on parent reports—limiting the inclusion of professional and child perspectives—they offer valuable insights into the lived experiences of navigating the diagnostic process.

Findings from the Selective Mutism Information and Research Association (2024) survey indicated that 45% of parents of children with SM found the diagnostic process challenging (Selective Mutism Information and Research Association, 2024). Many reported needing to pursue private assessments due to long NHS waiting lists or dismissive attitudes from professionals. These experiences reflect broader concerns about accessibility and equity, where families with financial resources can expedite diagnosis while others face prolonged delays and uncertainty. Such disparities may increase parental stress and significantly delay access to early intervention—an essential factor in supporting children with SM (Muris & Ollendick, 2015).

A particularly significant finding from the Selective Mutism Information and Research Association (2024) was that some children were initially diagnosed only with ASC, with their communication difficulties attributed entirely to that diagnosis. This further highlights the risk of diagnostic overshadowing and underscores the importance of recognising SM as a potentially co-occurring condition that requires distinct consideration.

Should We Consider SM as a Diagnosis or as a Spectrum?

SM can significantly disrupt a child's academic performance and hinder their social communication skills (APA, 2000). For example, children with SM may struggle with verbal tasks, such as participating in class discussions or simply asking to use the toilet. These difficulties highlight the complex and often misunderstood nature of SM. While ASC has been extensively studied and recognised as a condition with various presentations, SM is often viewed more narrowly as a distinct diagnosis. However, emerging perspectives in the literature challenge this viewpoint, suggesting that SM may be better understood as existing on a continuum of communicative inhibition.

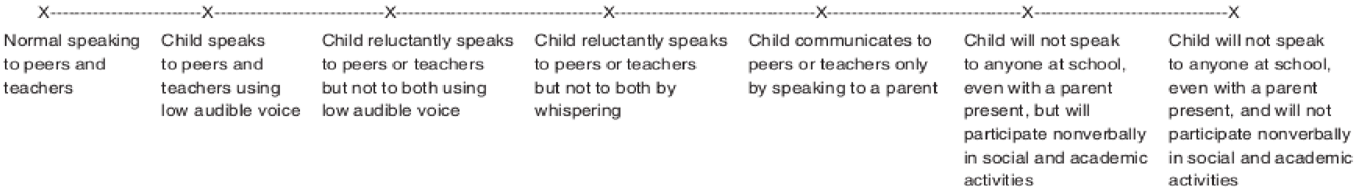


Figure 1.1. Sample spectrum of normal speaking, reluctance to speak, and selective mutism at school.

Figure 5- Kearney's (2010) Spectrum of SM

This figure, illustrated by Kearney (2010, p. 13), shows a range of communication, from normal speaking to reluctance to speak and finally to SM in a school setting.

Kearney (2010) proposes a model that positions communicative difficulties on a spectrum, from typical speech patterns and general reluctance to speak to the more severe and impairing features of formal SM. This broader view invites a more nuanced understanding of SM beyond the binary diagnosis framework versus non-diagnosis. It allows space for recognising children who do not meet the full diagnostic criteria but still face substantial communication barriers that impact their social and educational experiences.

Kearney (2010) proposes that children along this continuum may demonstrate varying degrees of verbal and nonverbal communication. Some may be capable of speech but are seen as excessively shy, while others may limit their interactions to a trusted peer or adult, remaining silent in structured environments. For example, one child may whisper to a parent, who then relays the message to school staff—another may use a sibling as a communication bridge. These behaviours, while not always reaching the threshold of a formal diagnosis, are indicative of the exact underlying anxiety mechanisms associated with SM.

Kearney's (2010) continuum model also highlights progression: from children who initially exhibit very low vocalisation, to those whose communication becomes increasingly limited and eventually absent, both verbally and nonverbally. At the far end of the spectrum, children may disengage entirely from the school environment, refusing to attend due to extreme anxiety around communication.

Recognising the varied ways SM may manifest can help educators, psychologists, and families adopt more flexible, early, and compassionate approaches—particularly for those children whose experiences might not align with conventional diagnostic frameworks. By broadening our understanding, there is potential to challenge common misconceptions that conflate SM with generalised shyness and more appropriately support these children's diverse needs across educational and social settings.

The impact of Environmental Influences on SM

While it is well-documented that SM significantly affects academic performance and social interactions (APA, 2000), it is equally important to consider the role of environmental influences in exacerbating or alleviating these challenges. A supportive and understanding atmosphere can be protective, reducing anxiety and creating opportunities for gradual verbal engagement. Conversely, rigid, high-pressure environments that lack awareness of SM can function as risk factors, reinforcing silence and social withdrawal.

Rather than focusing solely on the limitations imposed by SM, educators, and parents can play a proactive role in fostering emotionally safe and responsive environments that promote trust, inclusion, and verbal expression—when the child feels ready. Research by Saburi (2018) supports this idea, highlighting the importance of cultivating inclusive classroom environments where children with SM feel acknowledged, respected, and supported. However, traditional educational practices often fail to meet the complex needs of children with SM, especially when interventions are not adapted to the school context.

Most existing studies concentrate on clinical interventions (e.g., Bergman et al., 2013; Cohan et al., 2006), symptom profiles (Kristensen et al., 2019; Muris & Ollendick, 2021), or individual management strategies (Elizur & Perednik, 2003; McDaniel, 2021). However, few provide a structured, systems-level framework for integrating these approaches into real-world settings.

To better understand the interaction between children with SM and their environments, Bronfenbrenner’s Ecological Systems Theory (1979) offers a valuable perspective. This model conceptualises child development as occurring within nested systems, ranging from the microsystem (e.g., family, peers, school) to the macrosystem (e.g., cultural norms, educational policy). Within this framework, SM can be understood as influencing and being influenced by various layers of the child’s ecological context. For example, a child’s silence in the classroom (microsystem) may affect peer relationships and teacher perceptions, shaping the child’s experience and behaviour. Simultaneously, systemic responses (exosystem and macrosystem), such as teacher training or school policy, can either support or hinder progress, depending on how well they align with the child’s needs.

Thus, recognising the bidirectional relationship between the individual and their environment is essential. Children with SM are not merely passive recipients of support but active agents whose behaviour can shape the responses of those around them. Embedding this systems-thinking perspective within educational and therapeutic practices may enable more holistic and effective responses to SM, where interventions are child-centred and environmentally attuned.

Creating a supportive learning environment for children with SM requires thoughtfully adapting instructional methods to address their unique needs. These adaptations may include modifying content, selecting alternative materials, or adjusting teaching strategies to reduce communicative pressure and foster participation. As Kos (2023) argues, educators must tailor their approaches based on the individual abilities and requirements of students with SM to promote meaningful engagement in classroom activities.

While Kos (2023) provides a valuable foundation, the study lacks specific guidance on implementing adaptations across diverse educational contexts. It offers limited discussion on the practical challenges teachers face, such as balancing the needs of children with SM against the demands of large, mixed-ability classrooms and curriculum constraints. Furthermore, the focus on teacher-led adaptations may unintentionally overlook the importance of student agency; children with SM might benefit more from co-constructed strategies that acknowledge their preferences and anxieties.

In summary, environmental influences are crucial for EPs to consider when assessing a child's needs. The literature suggests that adapted approaches are essential for children with SM, yet there seems to be a lack of guidance for professionals to help staff in early years settings consider both the environment and individual needs.

Timely Identification Procedures

Despite ongoing efforts to raise awareness, understanding of SM remains limited, particularly in educational settings. Johnson and Wintgens (2016) emphasise that timely identification and intervention can significantly reduce the severity and persistence of SM. However, challenges in distinguishing SM from other conditions—such as ASC or generalised shyness—continue to delay support for affected children.

A noteworthy contribution to addressing these challenges comes from Hipolito and Johnson's (2021) retrospective audit of children with SM on the Speech and Language Therapy (SaLT) caseload in the St George area of the NHS. While the study's geographical focus may limit its generalisability, it provides valuable insights into the real-world diagnostic and referral processes surrounding SM.

Hipolito & Johnson's (2021) audit reviewed 45 cases involving children aged 3.2 to 11.7 years between September 2014 and August 2015, analysing demographics, referral timelines, interventions, and outcomes. A particularly significant finding was that 62.2% of the children were bilingual or multilingual—an underexplored demographic that raises important questions about how linguistic diversity may influence the presentation and diagnosis of SM. Nearly half of the cases were in the Early Years Foundation Stage (EYFS), while far fewer were in Key Stage 2, and none were in Key Stage 3 or above. This pattern reinforces the idea that SM typically emerges and is most observable in early childhood, highlighting the need for early detection frameworks.

What sets Hipolito & Johnson's (2021) audit apart is its demonstration of meaningful progress in referral timing compared to earlier research. For instance, Kumpulainen et al. (1998) reported average referral ages between 6 and 11, with a mean age of 9—indicating significant delays in identification. In contrast, Hipolito and Johnson (2021) found referral ages ranged from 2 to 9, with a median age of just 4. This marked progress likely reflects heightened awareness of SM and improved screening practices, particularly in community-based settings such as children’s centres and nurseries.

Early referrals are especially critical because of the importance of neurodevelopmental timing. Nelson (2024) highlights that the effectiveness of early intervention depends on the brain's plasticity during key developmental periods, when neural systems related to emotional regulation, language, and social functioning are still forming. Intervening during these critical windows can support more adaptive developmental trajectories and reduce the long-term impact of anxiety-related disorders like SM.

Another significant strength of the Hipolito & Johnson (2021) audit was its emphasis on multi-agency collaboration. The active involvement of SaLTs within early years environments, alongside teachers, parents, and key workers, facilitated a more comprehensive and timely recognition of SM. This integrated model not only supported the diagnostic process by triangulating observations across different settings but also allowed for the creation of more contextualized and effective intervention strategies.

Hipolito and Johnson’s (2021) findings offer a compelling model of best practice, demonstrating how embedding specialist services within children's everyday environments can lead to earlier diagnosis and more responsive interventions. Their audit underscores the potential of local service innovations to deliver systemic improvements—particularly when those services are accessible, collaborative, and attuned to both clinical and familial insights.

In summary, while the Hipolito and Johnson (2021) audit is constrained by its localised scope, it effectively illustrates how thoughtful service design and professional integration can transform the diagnostic pathway for SM. Future research should extend these findings by incorporating culturally and linguistically diverse family perspectives, exploring how systemic barriers affect diagnosis, and investigating the scalability of such collaborative models in settings with varying resources.

Lack of Clarity in Professional Services Supporting Children with SM

Research conducted by Keen et al. (2008) provides valuable insights into the identification and management of SM. Their consensus study is especially noteworthy for its thorough exploration of best practices through an extensive analysis of care pathways. Collaborating with SMIRA, the researchers expanded their initial focus from Nottingham and Kent to a more comprehensive national investigation. This broadening significantly enriches the study by integrating diverse perspectives from educational and clinical professionals, enhancing the overall validity of the findings regarding SM management.

The study employs a consensus-building approach using the Delphi method, which is well-suited for gathering expert opinions on complex issues such as SM management. Involving professionals from various fields allows for a wide array of viewpoints, adding depth and comprehensiveness to the findings. However, a potential limitation of the Delphi method is its reliance on the subjective judgment of experts, which may introduce bias. Additionally, while the study reports an impressive 100% response rate, it would be beneficial to understand how this was achieved and whether it might skew results, given the inherent challenges in motivating participation in such studies.

Keen et al. (2008) identified noticeable disagreements among professionals on several key points. One contentious issue was whether Speech and Language Therapists should serve as the primary support for educational staff. This disagreement arises from speech and language practitioners' differing roles and responsibilities across regions; educational and clinical psychologists argued that their skills might be better suited for this function. A collective acknowledgement of insufficient training across all professional groups involved further complicates the debate. This discussion highlights the need for more explicit role definitions and collaborative frameworks in managing SM. Such insights are significant as they address the interdisciplinary nature of SM management and underscore the necessity for ongoing dialogue among professionals to ensure effective intervention. However, the lack of resolutions or recommendations regarding these differences leaves a gap in implications for practice.

The findings also revealed varied responses to using age criteria for categorising levels of concern, further illustrating the complexities involved with SM. Given the low-incidence nature of this condition, establishing clear referral pathways is crucial. While Keen et al. (2008) acknowledges these challenges, it could be improved by offering potential solutions or frameworks to address the identified inconsistencies, thereby enhancing practical application.

The findings advance the discourse on effective management strategies for SM, and the emphasis on collaboration among different professional groups is commendable. By highlighting the importance of tailored interventions and early support, the research significantly contributes to evidence-based practice in this area. Nonetheless, the study would be strengthened by incorporating qualitative data or case studies that demonstrate real-world applications of the consensus findings, providing richer context and insights into the experiences of individuals with SM and their families.

What Best Practices Approaches are Available for Supporting Children with SM?

Building on the important finding by Keen et al. (2008) that professionals often struggle to determine which role is best suited to identify and support children with SM, it is commendable that they developed a best practice care pathway for SM. This pathway was developed through a Delphi consensus process involving a multidisciplinary panel of experts, including speech and language therapists, clinical psychologists, educational psychologists, child and adolescent psychiatrists, and specialist teachers. This structured framework aims to guide early identification, intervention, and coordinated multi-agency support. However, there are currently few examples of best practices available, and empirical evidence specific to SM remains limited.

The best practice care pathway proposed by Keen et al. (2008) advocates for child-centred, individualised support primarily delivered within educational settings. This pathway emphasises early recognition, active collaboration between parents and professionals, and structured, ongoing monitoring of progress. Specialist clinical input is recommended when difficulties persist or become more complex. Psychological therapy is prioritised as the main treatment approach, while medication—specifically selective serotonin reuptake inhibitors (SSRIs)—is reserved for severe cases in which anxiety significantly impairs functioning.

Additionally, the pathway highlights the importance of professional training that focuses on diagnostic criteria, understanding causal factors, and evidence-based intervention strategies. It also highlights the importance of establishing clear referral pathways and conducting timely assessments of co-occurring needs. These principles have contributed to calls for national guidelines and quality standards in the UK, aimed at promoting consistency, equitable access, and effective multi-agency collaboration in supporting children with SM.

However, while this consensus-based pathway represents a significant advancement, its real-world implementation—especially in flexible and varied early childhood environments—remains underexplored. Systemic barriers, inconsistent delineation of professional responsibilities, and gaps in service provision can limit its practical application, making the pathway more aspirational than operational in certain contexts.

Furthermore, although the pathway was developed by professionals with expertise in SM, it was not derived from empirical evaluations of the lived experiences of children and families. Currently, there is limited evidence regarding how well the pathway translates into the everyday realities of those it aims to support. Consistent with the principles of evidence-based practice in educational psychology, Fox (2003) emphasises the integration of research evidence, professional judgment, and service user perspectives. Therefore, there is a clear need for practice-based research that explores how current practices align with this pathway and how families and professionals experience and engage with it. Such research will help ensure that support for SM is not only theoretically sound but also accessible, contextually relevant, and responsive to the needs of children and families.

Chapter Summary

This chapter examines the processes involved in identifying and diagnosing SM in early childhood, focusing on six key themes:

1. Navigating the Diagnostic Challenges of SM and ASC
2. Should We Consider SM as a Diagnosis or as a Spectrum?
3. The Impact of Environmental Influences on SM
4. Timely Identification Procedures
5. Lack of Clarity in Professional Services Supporting Children with SM
6. Best Practice Approaches for Supporting Children with SM

These themes highlight the complexities and considerations necessary for understanding and addressing SM in young children.

One significant challenge discussed is the diagnostic overlap between SM and ASC, which often complicates accurate identification (Spiro, 2021). This overlap can lead to misdiagnosis or delays in obtaining appropriate support. A report by the Selective Mutism Information and Research Association (SMiRA, 2024) revealed that 45% of parents faced substantial barriers during the diagnostic process, often turning to private services due to limited access and long waiting times within the public system.

Instead of being viewed as a fixed diagnosis, the literature suggests that SM should be considered a spectrum of anxiety-driven behaviours (Kearney, 2010). This perspective encourages more flexible and individualised assessment and intervention strategies tailored to each child's unique needs.

Environmental factors also play a crucial role in the presentation of SM. Many children may speak confidently at home but become mute in unfamiliar or high-pressure situations. Bronfenbrenner’s ecological model (1979) illustrates how interactions within various systems—such as home, school, and community—affect a child’s behaviour and experience.

Timely identification of SM is critical, as interventions implemented during early neurodevelopmental stages can significantly improve long-term outcomes (Johnson & Wintgens, 2016; Hipolito & Johnson, 2021). However, there are notable inconsistencies regarding the availability and quality of services, often leaving families without the support they need.

While SMiRA provides valuable guidance for families navigating the diagnostic process, it also highlights the "postcode lottery" that many face when attempting to access timely support. This reliance on non-peer-reviewed resources, including The Selective Mutism Resource Manual (Johnson & Wintgens, 2017), underscores the scarcity of empirically grounded best practice models within early childhood contexts.

To address these issues, Keen et al. (2008) proposed a care pathway based on professional consensus, advocating for standardised practices throughout the UK. These pathways emphasise early recognition, multi-agency collaboration, and child-centred planning. However, they often depend on expert opinion rather than robust empirical research. In the absence of robust evidence demonstrating their effectiveness, even well-intentioned best practice care pathways may ultimately prove to be aspirational.

Ultimately, this chapter underscores the importance of practice-based research to ensure that best practices are not only realistic and equitable but also rooted in the real-world experiences of children, families, and professionals. As Fox (2003) argues, evidence-based practice must go beyond relying solely on empirical research; it should integrate professional expertise, contextual understanding, and the lived experiences of service users to inform meaningful and ethical interventions.

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Part 1b

2. Part 1B - The Role of the EP and the Theoretical Landscape of SM

This section will begin by outlining the responsibilities of EPs and highlighting the significance of their role in supporting children with SM. The researcher will then introduce a theoretical framework to enhance the understanding of SM.

2.1 The Role of the EP

The Health and Care Professions Council (HCPC) sets the standards for EPs throughout the UK, focusing on safeguarding and supporting vulnerable populations. The HCPC's 2023 Standards of Proficiency for Practitioner Psychologists outline the essential skills and competencies that psychologists must possess, highlighting the importance of understanding the psychological needs of vulnerable individuals. EPs are expected to engage in continuous professional development to address diverse and complex needs, including emotional and behavioural disorders. While SM may not be explicitly mentioned in these guidelines, the HCPC framework stresses the necessity of understanding mental health conditions that significantly impact children's learning and social participation.

Keen et al. (2008) emphasise that children with SM are often seen as vulnerable due to their communication and social interaction challenges, which require a thoughtful approach from professionals. To effectively support these children, EPs must have a strong understanding of various emotional, developmental, and behavioural conditions, including anxiety disorders. This knowledge enables them to recognise how SM affects a child's educational experience.

EPs are well-equipped to assist children with SM due to their diverse roles within educational systems. Their expertise includes psychological assessment, child development, consultation, and the implementation of targeted interventions. Fallon et al. (2010) identified five core functions of EPs: assessment, consultation, intervention, training, and research. Each area has significant potential to enhance outcomes for children with SM. The researcher has created the table below to outline these functions based on Fallon et al. (2010).

Table 4- Functions of the EP

Functions of the EP	**Description of Functions**
Assessment	It involves collecting information through observation, consultation, and psychometric tools to understand better a child's strengths, needs, and the context of their difficulties.
Consultation	A collaborative process involving EPs, school staff, early years staff, parents, and professional services that focuses on problem-solving, building shared understanding, and planning intervention strategies.
Intervention	Developing, executing, and assessing focused support strategies at individual, group, or systems levels to enhance positive outcomes.
Training and Development	Enhancing the professional development of educators and stakeholders through training, coaching, and resource creation to strengthen capacity in schools and early years settings.
Research and Evaluation	Conducting and applying research to inform practices, evaluate interventions, and support evidence-based decision-making in schools and services.

Systemic/Organisational Work	Collaborating at a whole-school or local authority level to influence policies, procedures, and practices that enhance inclusion and support pupil wellbeing.
Multi-Agency Working	Collaborating with health, social care, and education professionals to provide coordinated and consistent support for children and families.

In summary, EPs could potentially have an important role in supporting the needs of children with SM. Their training, grounded in a biopsychosocial framework, offers a foundation for integrating psychological theory, intervention, and systemic collaboration. The core functions of EPs—assessment, consultation, intervention, training, and research—may be particularly relevant to the complexities associated with SM. Through these roles, EPs could contribute to a deeper understanding, help build capacity within educational settings, and promote evidence-based, inclusive practices that support communicative and responsive environments for children with SM.

Introduction to the Theoretical Framework

This next section adopts an inductive approach, using a theoretical framework to demonstrate how EPs can support and address the challenges of facilitating change. The literature reviewed thus far highlights several difficulties related to SM, including the impact of the environment on SM, the spectrum of communication associated with SM, the complexities involved in obtaining a diagnosis, the intersection of SM with other conditions such as ASC, and the lack of a primary professional group leading in support of this condition. These complexities necessitate a shift towards more nuanced and responsive early identification and support methods.

While it is beyond the scope of this paper to examine the entire range of psychological theories, the Constructionist Model of Informed Reasoned Action (COMOIRA) (Gameson & Rhydderch, 2017) has been selected as the primary framework for understanding and enabling change. To enhance COMOIRA's structure and enrich the analysis of change processes, two additional theories are integrated: Expectancy Violations Theory (EVT) (Burgoon, 2015) and Basic Psychological Needs Theory (BPNT), which is part of the broader Self-Determination Theory (SDT; Ryan & Deci, 2017).

2.2 The Constructionist Model of Informed Reasoned Action (COMOIRA)

The Constructionist Model of Informed Reasoned Action (COMOIRA) (Gameson & Rhydderch, 2017) offers a structured and reflective framework designed to assist EPs and Trainee Educational Psychologists (TEPs) in facilitating meaningful and sustainable change, particularly within complex social and educational systems.

At its core, COMOIRA (Gameson & Rhydderch, 2017) is based on social constructionism, which asserts that knowledge, identity, and meaning are created through social processes, primarily through language. "Language is not a neutral medium for conveying meaning. It is a form of social action; it constructs versions of reality" (Burr, 2015, p. 55). This notion is central to COMOIRA's philosophy, highlighting that language and interaction are key mechanisms through which change is understood and enacted.

This social constructionism perspective is particularly relevant when examining the evolving understandings of SM, which has experienced at least three significant reconceptualisations throughout its history. Each of these iterations reflects not only changing diagnostic criteria but also broader societal discourses surrounding communication, anxiety, and childhood behaviour. COMOIRA enables EPs to critically evaluate how these narratives influence SM's identification, intervention, and perception.

The COMOIRA (Gameson & Rhydderch, 2017) framework incorporates foundational psychological concepts and encourages a reflective, ethical approach to assessment and intervention. It emphasises essential problem-solving components—definition, clarification, and resolution—while reframing these processes as co-constructed and iterative rather than linear and fixed. This approach fosters ethical, context-sensitive decision-making.

COMOIRA consists of four core elements:

- Social Constructionism: Recognising that meanings are created rather than discovered.
- Systemic Thinking: Understanding problems within broader relational and institutional contexts.
- Enabling Dialogue: Fostering collaborative and participatory approaches.
- Informed and Reasoned Action: Ensuring that decisions are transparent, evidence-based, and grounded in theory.

Drawing on the core element of informed and reasoned action from the COMOIRA framework (Gameson & Rhydderch, 2017), the researcher has selected two key psychological theories—Expectancy-Value Theory (EVT) and Basic Psychological Needs Theory (BPNT)—to deepen the understanding of the interpersonal, emotional, and motivational factors associated with SM.

2.3 The Expectancy Violation Theory (EVT)

To explore how children's silence is socially perceived and responded to, the researcher selected Expectancy Violations Theory (EVT) as a framework for understanding the social dynamics surrounding SM.

Expectancy Violations Theory (EVT) (Burgoon, 2015) explains how communication expectations are formed and how deviations from these expectations—like silence in situations where speech is anticipated—are perceived. This theory is particularly relevant for understanding the social challenges faced by children with SM, a condition characterised by unexpected silence in certain social settings.

Developed by Burgoon (1993), EVT suggests that individuals form communication expectations based on cultural norms, personal experiences, and context. When these expectations are violated, the behaviour is evaluated both cognitively and emotionally, leading to either positive or negative reactions. EVT distinguishes between positive violations (unexpected but favourable behaviours) and negative violations (breaches of social norms), and observers' responses are shaped by their interpretation of the situation.

EVT highlights the issue of oversimplifying SM as merely "shyness," which overlooks its complexity and can lead to misinterpretations. In environments such as schools, where verbal communication is the norm, a child’s silence may be perceived as a violation of these expectations, resulting in confusion, frustration, or punitive reactions. EVT suggests that these responses are more a reflection of breaching social norms than an understanding of the underlying causes of the silence.

Kearney’s (2010) continuum model of communication further contextualises SM, proposing a spectrum of communication behaviours rather than a strict division between speaking and silence. EVT complements this model by explaining that a child’s silence in expected communication contexts is viewed as a violation, with observers’ reactions dependent on their understanding of SM and the broader social setting.

For instance, in a preschool setting, staff who are unfamiliar with SM might interpret a child’s silence as defiance, leading to frustration or punishment. Conversely, staff who understand SM may recognise it as a form of anxiety and provide appropriate support.

The COMOIRA framework, with its social constructionist perspective, further enriches EVT by emphasising that communication norms are socially constructed. This perspective illustrates how these norms influence what is deemed appropriate communication and highlights how deviations from these norms—such as a child with SM's silence—are interpreted. Thus, EVT offers valuable insight into how societal expectations shape the understanding of communication behaviours in children with SM.

2.4 Basic Psychological Needs Theory (BPNT)

To better understand the emotional and motivational needs of children with SM, the researcher selected Basic Psychological Needs Theory (BPNT) as a framework for exploring how the satisfaction or frustration of core psychological needs impacts their well-being and communication.

Basic Psychological Needs Theory (BPNT), a sub-theory of Self-Determination Theory (SDT) developed by Ryan and Deci (2017), is highly relevant for understanding the experiences of children with SM. BPNT explores how unmet fundamental needs—autonomy, competence, and relatedness—can significantly affect psychological well-being and motivation, particularly in the context of the anxiety commonly experienced by children with SM.

At its core, BPNT asserts that individuals, regardless of age, ability, or cultural background, require the fulfilment of three essential psychological needs to thrive:

- Autonomy: The desire to control one's actions and decisions.
- Competence: The sense of mastery and effectiveness in one's environment.
- Relatedness: The need to feel connected and valued by others.

When these needs are met, individuals are more likely to experience positive psychological outcomes, such as motivation and engagement. However, when these needs are neglected or frustrated, it can lead to negative outcomes like anxiety, alienation, and maladaptive coping strategies (Chen et al., 2015; Ryan & Deci, 2017).

For children with SM, these fundamental needs are often unmet due to the very environments that are supposed to support them. Traditional educational systems, which heavily emphasise verbal communication, can unintentionally exacerbate feelings of pressure, inadequacy, and exclusion for children with SM. Misunderstandings and social stigma further hinder their ability to experience autonomy, competence, and relatedness, often increasing anxiety and limiting their ability to cope effectively.

By applying BPNT to SM, professionals are encouraged to adopt a strengths-based approach that focuses on the child's needs and prioritises emotional safety, relational support, and alternative forms of communication. This approach aims to reduce anxiety and foster the child's engagement and well-being, creating an inclusive and supportive environment.

The researcher has created the following table, which outlines the underlying psychological needs of BNPT (2015) and their potential impact on children with SM:

Table 5- Psychological Needs and their impact on children with SM.

Psychological Need	**Description**	**Impact on Children with SM**
Competence	Sense of mastery and effectiveness in one's environment.	Children with SM often face challenges in social situations, which may lead to feelings of incompetence or inadequacy. When they struggle to speak or engage in social interactions due to anxiety or fear of judgment, they may feel incapable of meeting others' expectations. This perceived lack of competence can heighten their anxiety,

		creating a cycle of avoidance in social situations and reinforcing symptoms of SM.
Autonomy	Desire to control one’s actions and decisions.	Children with SM may feel their autonomy is compromised when they face pressure to speak in social settings before they feel ready or capable. The fear of negative consequences—such as being reprimanded, ridiculed, or misunderstood—can diminish their sense of autonomy, leaving them feeling helpless. This anxiety and fear of losing control during social interactions can further prevent them from speaking, exacerbating the cycle of SM.
Relatedness	The need for relatedness reflects the desire to feel connected and valued by others.	In the context of SM, children often struggle to form social connections or maintain relationships due to their inability to speak. This frustration

		regarding relatedness can lead to feelings of isolation and loneliness, further hindering their social and emotional development. A lack of meaningful interactions may enhance their sense of not belonging, contributing to distress and reinforcing the avoidance behaviours associated with SM.

This table highlights how unmet psychological needs in the BPNT (2015) theory may help explain how symptoms exacerbate SM and negatively affect emotional well-being.

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3. Part 1C - Critical literature review

Introduction to the critical literature review

A critical literature review will now examine the experiences and perceptions of parents, early childhood educators, and other stakeholders regarding identifying and supporting children with SM. The researcher has chosen a narrative approach with systematic elements to accomplish this. This approach allows the researcher to capture SM's dynamic and evolving nature and provides a richer, more nuanced understanding of the topic (Siddaway et al., 2019). Further details on how the researcher utilised a narrative approach will be discussed in part three.

The literature review will begin by outlining the process of selecting papers for review. As previously mentioned, this process will incorporate elements of a systematic literature review, following the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA) model (Moher et al., 2009). This approach aims to reduce researcher bias, enhance transparency, and strengthen the trustworthiness of the literature review process. For the full PRISMA table, please refer to Appendix 4.

3.1 Review Strategy

The researcher entered the final search terms (Table 6) into the databases shown in Table 7. The initial literature search was conducted in August 2024, with subsequent updates in February 2025. For more information on how these search terms were developed, please refer to Appendices 2 and 3.

Table 6- Search Terms

Search Terms	
"selective* mut*" OR "elective* mut*" OR "situational mut*"	teacher* OR parent* OR father* OR mother* OR guardian* OR "primary carer*" OR "foster carer*" OR professional* OR stakeholder* OR "language therapist" OR nurs* OR "health visitor*" OR gp OR doctor OR psychologist*

Table 7- Databases for Literature Search

Database
PsycInfo®
Medline
SCOPUS
ProQuest Dissertations & Theses Global

The researcher then selected papers based on the criteria outlined in Table 8.

Table 6- Inclusion and Exclusion Criteria for Literature Review

Criteria	Inclusion	Exclusion
Population	Families, parents, early years staff, teachers, and key stakeholders—such as educational psychologists and health professionals—are directly involved in the	Studies focusing on secondary school children, adolescents, and adults will be excluded, as the research is specifically concerned with the early

	early identification and support of children with SM.	identification of Selective Mutism during early childhood.
Context	Papers that focus on SM will be included, with particular emphasis on the processes of early identification and the support mechanisms implemented during this critical period.	Papers concentrating solely on medical models and treatment interventions for SM will be excluded, as Part 1 of this thesis has already addressed the medical model and diagnostic aspects. The current focus is on exploring lived experiences related to identification and support.
Study Design	The inclusion criteria focus on primary sources such as empirical research, peer-reviewed articles, thesis publications, dissertations, and firsthand accounts. These sources are selected for their ability to provide reliable, authentic, and in-depth insights into the topic of SM in early childhood. This ensures that the research is grounded in	Secondary sources, such as opinion pieces and non-peer-reviewed publications, will be excluded due to their limited reliability and potential bias. Opinion pieces, while offering perspectives, lack the rigor of empirical research and may present unverified or subjective interpretations of the topic. Non-peer-reviewed publications also present a risk of

	scientifically validated evidence and rich, contextual understanding while also maximising the incorporation of emerging research into SM.	diminished scientific credibility, as they have not undergone the scrutiny of a peer-review process, which is essential for ensuring the accuracy, validity, and quality of the findings. Using these sources may introduce uncertainty and compromise the robustness of the research by relying on less reliable or anecdotal information.
Method	Qualitative research that provides in-depth insights into the lived experiences, perceptions, and personal narratives of individuals regarding the identification and support of Selective Mutism (SM). These studies are valuable for understanding the nuanced, subjective aspects of SM, including the emotional, social, and practical challenges faced by children,	Quantitative research, including surveys or statistical analyses, which does not explore lived experiences in depth. While such studies may provide valuable data on prevalence, correlations, or general trends, they often lack the detailed, subjective insights necessary to fully understand the personal and contextual factors influencing the identification and support

	parents, and early years staff. Qualitative research captures rich, detailed perspectives that enhance the understanding of how SM is experienced and supported in real-world contexts.	of Selective Mutism (SM). These studies are excluded due to their focus on numerical data rather than the rich, in-depth exploration of individual experiences and perceptions related to SM.
Date of Publication	Literature published from 2013 onward will be included, as this marks the reclassification of SM as an anxiety disorder in the DSM-V. This ensures that the review reflects current diagnostic understanding and contemporary research developments.	Studies published before 2013 will be excluded, as they precede the reclassification of SM as an anxiety disorder in the DSM-V and may reflect outdated diagnostic frameworks and theoretical perspectives.
Country	To capture diverse perspectives, all globally available literature will be included. Given the rarity of Selective Mutism, incorporating international research is essential to developing a more comprehensive and informed understanding of the condition.	N/A

Introduction to the Critical Literature Review

This literature review explores the experiences and perceptions of parents, early childhood educators, and other key stakeholders concerning identifying and supporting children with SM. Seven peer-reviewed studies were selected for final inclusion based on their relevance and quality. The Critical Appraisal Skills Programme (CASP) checklists were used as an aide-mémoire to guide the review process, supporting a consistent and reflective evaluation of each study's methodological strengths and limitations (see Appendices 5–10 for appraisal summaries and CASP checklists).

3.2 Parental Perspectives of SM

Challenges in Identification and Support

The literature consistently highlights parents' significant challenges in recognising SM and accessing appropriate support. Kadoma (2023), drawing on a bioecological framework, conducted interviews with fourteen U.S.-based parents to explore contextual factors influencing family experiences. Kadoma (2023) reveals that SM disrupts speech and impedes social development and the attainment of critical developmental milestones. This highlights the multifaceted impact of SM on children's lives and stresses the need for early recognition and intervention.

A noteworthy contribution of Kadoma's (2023) study is its identification of disparities in access to support. Many parents reported difficulties navigating educational and healthcare systems due to limited professional awareness of SM. This lack of understanding was particularly evident in families without a background in child development or psychology, where parents struggled to advocate for their children's needs. This finding emphasises the role of socio-educational capital in determining access to effective interventions. However, the study's reliance on a U.S.-based sample and exclusively on parental narratives limits the broader applicability of the findings. Without input from educators or professionals, the systemic context of service delivery remains underexplored. Furthermore, the insights from a U.S. context may not be easily transferrable to regions with different healthcare or educational infrastructures. Thus, while Kadoma’s (2023) findings provide valuable insights, they also highlight the need for further research in diverse global contexts and with more varied stakeholder perspectives.

Emotional Burden and Systemic Gaps

Douglas's (2021) study offers a valuable examination of parents' emotional and systemic challenges in the UK. Using Interpretative Phenomenological Analysis (IPA), Douglas explored the lived experiences of parents, revealing persistent feelings of stress, helplessness, and frustration. These emotions were often exacerbated by delays in diagnosis and a lack of clarity around professional roles. Additionally, the study found that parents' anxieties increased their emotional burden and hindered their ability to engage with professionals effectively.

Douglas’s (2021) work brings to the forefront the profound emotional strain parents experience, especially when faced with an unclear or fragmented support system. However, the study's small sample size and the timing of data collection during the COVID-19 pandemic must be critically considered. The unique challenges posed by the pandemic, such as increased isolation and restricted access to services, may have intensified the emotional burden on parents, potentially confounding the results. This limitation suggests that further studies should explore the long-term impacts of these barriers, particularly in non-pandemic contexts.

SM and Co-occurring Conditions: An Intersectional Lens

Keville et al. (2024) provide a much-needed contribution to the literature by investigating the co-occurrence of SM and ASC, which are often treated as separate despite sharing overlapping features. Keville et al. (2024) shed light on how the combination of SM and ASC exacerbates communication difficulties, especially in social settings. Parents in Keville et al.’s (2025) study reported that the intersection of heightened sensory sensitivities, social anxiety, and difficulties with flexibility intensified the challenges their children faced in accessing education and engaging in social environments, leading to increased emotional distress and withdrawal.

Keville et al. (2024) provide an important perspective by showing that conventional interventions for SM often do not meet the unique needs of children with co-occurring conditions such as Autism ASC. Children with ASC have distinct sensory and cognitive profiles that necessitate tailored interventions using a more neurodiverse approach. This finding has significant implications for practice, emphasising the importance of interventions that are not only child-centred but also take into account the complexities of co-occurring diagnoses.

Furthermore, Keville et al. (2024) highlight the substantial advocacy burden placed on parents, who frequently must navigate multiple systems without coordinated professional support. This issue points to broader systemic gaps that, as noted by Kadoma (2023) and Douglas (2021), affect families' ability to access timely and appropriate interventions.

However, like Kadoma's (2023) and Douglas's (2021), Keville et al.’s (2024) study has limitations. The reliance on parent-reported diagnoses, rather than clinically confirmed assessments, introduces potential inaccuracies in the diagnostic information, limiting the study’s generalisability. This issue further underlines the need for a multi-informant approach in assessing and identifying SM, where professionals, such as EPs, can play a key role in ensuring a comprehensive understanding of the child’s needs.

Implications for the Role of the EP

The studies conducted by Kadoma (2023) and Douglas (2021) highlight significant challenges that parents face when advocating for children with SM. These challenges are influenced by socio-educational capital and various systemic barriers that affect access to support. Kadoma (2023) points out that families with a higher level of education or knowledge about child development are often better equipped to advocate for their children. In contrast, Douglas (2021) emphasises that parental anxiety and a fragmented support system can exacerbate these issues.

EPs can play a vital role in addressing social inequalities by providing customized guidance and support. They can simplify complex information for parents, particularly those with lower levels of education, helping them understand available resources. By actively empowering these parents, EPs enable them to navigate various support pathways and engage meaningfully in decision-making processes. This not only fosters inclusion but also promotes equitable access to educational opportunities for all families.

EPs can lead initiatives to address systemic inequities by advocating for improved access to services and adopting an intersectional approach to supporting children with co-occurring conditions like ASC. This approach ensures that interventions are inclusive and tailored to each child's needs, recognising the complex, overlapping factors that impact vulnerable groups (Crenshaw, 2013; DECP, 2024). Crenshaw (2013) argues for an intersectional framework that considers the interconnectedness of various social identities essential in understanding and addressing the needs of children with co-occurring conditions. Similarly, the DECP (2024) underscores the importance of applying an intersectional lens in educational psychology to ensure that interventions are equitable and responsive to children's diverse challenges.

3.3 Teachers' Perspectives of SM

Teachers play a crucial role in the early identification and support of children with Selective Mutism (SM). Their daily interactions with students and firsthand observations of classroom behaviours allow them to gather important insights. These insights offer valuable perspectives on the barriers and facilitators to effective support for these children. This discussion will reference both Williams et al. (2021) and Ramon (2018) to illustrate these viewpoints.

Informal Categorisation and Its Implications

Using a grounded theory approach, Williams et al. (2021) examined how primary school teachers respond to socially anxious behaviours, including those linked to SM. A notable finding was that educators often informally categorised these children as socially anxious—a strategy that shaped their responses and expectations. While this child-centred approach reflects professional intuition and flexibility, it also raises concerns about the risk of misidentification or overgeneralisation. Without formal training on SM, such categorisation may rely too heavily on personal judgement, potentially overlooking nuanced or atypical presentations.

Using opportunity sampling in Williams et al.'s (2021) work further limits the generalisability of the findings, as participants were drawn from specific contexts that may not reflect the diversity of practice across different educational environments. Settings with varied resource levels or institutional cultures may yield significantly different outcomes.

Ramon (2018) adopted Interpretative Phenomenological Analysis (IPA) to explore the experiences of five educators working with children with SM. This research illuminated educators' value in fostering inclusive classroom climates and taking personal responsibility for communicative progress. While these insights contribute meaningfully to understanding teacher motivation and adaptive strategies, the homogeneity and limited scale of the participant group constrain the study’s broader applicability. Furthermore, the exclusive focus on teacher perspectives limits the scope of understanding; the absence of input from parents or external professionals restricts the potential for a multi-dimensional view of SM support within schools.

The Need for Targeted Professional Development

Williams et al. (2021) and Ramon (2018) underscore a persistent gap in teacher training. Despite their willingness to support children with SM, educators reported feeling underprepared due to a lack of clear, evidence-based guidance. Ramon (2018) highlighted feelings of isolation and uncertainty among teachers, who often had to navigate complex behaviours without access to specialist input.

Williams et al. (2021) and Ramon (2018) suggest a misalignment between inclusive educational values and their practical implementation. Although educators are broadly committed to inclusion, they frequently lack the training necessary to meet the specific needs associated with SM. Well-meaning intentions may fail to translate into practical action without structured professional development or consistent institutional support.

However, a key limitation of Williams et al. (2021) and Ramon's (2018) work is their insufficient focus on the wider school systems within which educators operate. Factors such as leadership support, training access, and workload pressures are largely absent from discussion despite their apparent influence on teachers' ability to implement effective strategies. Without examining these contextual elements, it isn't easy to assess the sustainability or scalability of the support methods described.

Collaboration Among Stakeholders

Collaboration appears to be a strong theme in Williams et al. (2021) and Ramon (2018), who emphasise the importance of multi-agency and family partnerships in supporting children with SM. Williams et al. (2021) identify collaboration between parents, teachers, and professionals as a key factor in ensuring continuity of care and consistency across home and school environments. Parental insight is particularly valued, offering context that can guide classroom adaptations. External specialists, including speech and language therapists and EPs, are recognised for designing and supporting tailored interventions.

Similarly, Ramon (2018) highlights the importance of peer and professional support networks in helping educators manage the complexities of SM. These collaborations enrich the intervention process and alleviate the emotional burden on teachers, reducing feelings of professional isolation.

The existing literature, including contributions from Williams et al. (2021) and Ramon (2018), highlights the critical role of collaboration in educational settings. However, an important area that remains unexplored is the examination of institutional structures that either facilitate or inhibit such collaborative efforts. Crucial questions persist regarding the extent to which schools provide adequate time, space, and resources to foster meaningful partnerships with external agencies and families. These identified gaps present limitations in the field's comprehension of the operational dynamics of collaboration and indicate a need for systemic changes that could potentially enhance these collaborative practices. Addressing these concerns could lead to more effective engagement strategies and improvements in educational outcomes.

Implications for the Role of the EP

The findings from Williams et al. (2021) and Ramon (2018) reinforce the potential for EPs to play a central role in strengthening support for children with SM in educational contexts. EPs are uniquely positioned to bridge educational and health systems, promoting coordinated and context-sensitive approaches to intervention.

Central to the EP’s role is facilitating collaboration between schools, families, and health professionals such as speech-language therapists and mental health specialists. This aligns with Bronfenbrenner’s (1979) Ecological Systems Theory, which positions child development within nested systems of influence. By attending to the interactions between home, school, and community contexts, EPs can ensure that SM is understood as an individual difficulty and as one shaped by environmental and relational dynamics.

EPs can also support the development of whole-school frameworks that foster inclusive practices for children with SM. Their consultation and training roles can help embed an understanding of SM into school policies and practices, moving beyond isolated interventions to sustained systemic support. This includes building staff confidence through training, improving referral pathways, and modelling collaborative working.

Overall, the insights provided by Williams et al. (2021) and Ramon (2018) reinforce the need for greater institutional support for educators and highlight how EPs can act as catalysts for more informed, equitable, and systemic responses to SM within educational settings.

3.4 Stakeholders’ Perspectives of SM

The insights of those who work most closely with children—teachers, parents, and EPs—are crucial for understanding how SM is identified and supported in educational contexts.

Gaps in Teacher Knowledge and Confidence

White et al. (2022) examined the experiences of primary school teachers and EPs, revealing a significant lack of knowledge about SM among educators. Many teachers reported that they had not heard of the condition before their training, which they attributed to the absence of SM content in Initial Teacher Training (ITT) programs. This lack of exposure left many educators unprepared to recognise or respond to signs of SM in the classroom.

However, targeted training that the teachers received demonstrated a positive impact. The teachers indicated increased confidence and a better understanding of practical strategies for addressing SM. However, it is important to note that the White et al. (2022) study does not investigate whether this newfound confidence led to sustainable changes in practice. Future research could explore whether the benefits of such training persist after the initial momentum fades.

EPs on the Margins of SM Support

Edwards's (2022) study examined EPs' experiences in supporting the needs of children with SM. The findings indicated that SM cases often occupied a marginal position within the EPs' casework. While EPs recognised that SM aligns well with their consultative and systemic roles, many reported having limited opportunities to work directly with the affected children. Factors such as time pressures, overloaded caseloads, and a lack of formal referrals for SM contributed to this minimal involvement.

Interestingly, the EPs in Edwards's (2022) study possessed some theoretical knowledge about SM, but they lacked the time and systemic support needed to apply it effectively. Edwards's findings suggest that SM should be understood within a broader ecological framework, considering the child's relationships, environment, and school culture. However, Edwards (2022) notes that current service delivery models often fail to accommodate this nuanced approach.

Willing Professionals, Limited Systems

White et al. (2022) and Edwards (2022) emphasise a theme of professional willingness. Teachers and EPs are eager to provide better support to children with SM, but they face structural limitations. White et al. (2022) indicate that teachers benefit from SM-specific training, while Edwards (2022) shows that EPs value systemic approaches. However, both groups report that institutional constraints—such as limited time, access to training, and prioritisation—undermine their efforts. This tension between personal commitment and systemic limitations is hard to overlook. While the potential exists for improved support, it is not fully realised, leading to a frustrating gap between what could happen and what does.

Beyond SM: Broader Benefits of Training

White et al. (2022) research also highlights the broader benefits of strategies focused on SM. Teachers noted that the tools and techniques they learned were helpful for a range of students—not just those with SM. For instance, students with English as an Additional Language (EAL) or those experiencing anxiety benefited from communication supports initially designed for SM. This finding supports the argument for incorporating SM training into broader inclusive education frameworks. However, it is important to note that these findings are based on short-term self-reports and do not capture whether these inclusive strategies were consistently adopted or evaluated over time.

Home–School Communication: A Persistent Hurdle

White et al. (2022) and Edwards (2022) highlight the challenges professionals face when collaborating with families. Teachers often began working with children without sufficient context about their communication development at home, making it difficult to develop proactive strategies or adjust expectations. Meanwhile, EPs in Edwards' (2022) research noted that unclear communication between home and school often delayed support and created inconsistencies in intervention plans. White et al (2022) and Edwards (2022) point to a familiar yet frustrating issue: Everyone agrees that collaboration is essential, but few systems are effectively designed to support it.

Broadening the role of the EP

White (2022) and Edwards (2022) provide valuable recommendations for improving support for children with SM, emphasising the need for EPs to adopt broader, more systemic roles. White et al. (2022) advocate for expanding training related to SM beyond teachers to include teaching assistants (TAs) and Special Educational Needs Coordinators (SENDCos). These professionals often have daily contact with children but are rarely included in focused training. Involving this wider network could significantly enhance the consistency and quality of support within classrooms.

Edwards (2022) highlights the underdeveloped role of EPs in addressing SM and suggests creating a position paper to guide their work, along with structured consultation protocols and accessible resources, such as screening tools and checklists. These resources could improve early identification and ensure that SM is not overlooked in busy school systems. However, both researchers note that SM remains a low-priority area, leading to inconsistent engagement, limited training, and unclear intervention pathways.

White et al. (2022) also point out that while early intervention is often emphasised as crucial, the definition of “early” remains vague. This raises the question of whether support should begin before formal schooling. Such an oversight could restrict timely and effective identification, especially given that many signs of SM appear during early childhood, often before age five. This situation highlights the urgent need for inter-agency collaboration that extends into early years settings.

3.5 Preschool Perspectives of SM

Preschool staff and childcare providers care for children under 5, making them likely the first to notice early signs of selective mutism (SM). Research indicates that the average age of onset for SM is between 2.7 and 4.1 years (Viana et al., 2009; Steffenburg et al., 2018). These early childhood professionals observe children's developing communication patterns, social interactions, and emotional responses in everyday situations, particularly during their initial experiences away from home. Therefore, the insights and experiences of preschool staff are crucial as they observe and support children who may be experiencing selective mutism at this early stage.

Case Study Insights

Huey et al. (2024) make a significant contribution to the literature on the early identification of SM through a case study of a 4-year-old child, using a mixed-methods approach that combines psychological assessments with qualitative input from parents and teachers. The findings emphasise the importance of early intervention and highlight the complexities involved in supporting young children with SM. Notably, Huey et al. (2024) highlight the value of a comprehensive approach, demonstrating that a collaborative model involving parents, teachers, and peers is essential to addressing the child’s needs and fostering communicative confidence. However, the single-case design limits the generalisability of the results, as the experiences of one child may not fully capture the diverse presentations of SM across different contexts.

A notable limitation of the study is the exclusion of perspectives from preschool staff, who are ideally positioned to observe early communication challenges in naturalistic settings. This omission highlights a broader gap in the literature, where the voices of early years practitioners are often underrepresented despite their critical role in identifying early signs of SM.

Incorporating insights from preschool staff could enhance our understanding of how SM manifests in early childhood settings and contribute to more timely and effective interventions. Future research should aim to include larger, more diverse samples and adopt a multi-informant design that integrates perspectives from parents, teachers, and early years practitioners. Additionally, there is a clear need for studies focusing on the training and professional development of early years staff in recognising and supporting children with SM. Such research would help close knowledge gaps and improve early detection and response frameworks.

Implications for the Role of the EP

The lack of engagement with preschool staff represents a missed opportunity for early and effective intervention, highlighting the important role that EPs could play. The Department for Education (DfE, 2015) and the Welsh Government (2021) specify that EPs are expected to work with children and young people from birth to 25 years. Within this framework, EPs are well-positioned to support preschool staff in identifying and addressing SM issues through training, consultation, and collaborative problem-solving.

Summary of The Critical Literature Review

This critical literature review explored the experiences and perceptions of parents, early childhood educators, and other key stakeholders in the identification and support of children with SM. Drawing on peer-reviewed literature and employing a systematic approach, the review aimed to ensure trustworthiness and provide a comprehensive analysis of current research.

Findings indicate a significant gap in knowledge and awareness among parents, educators, and professionals, often resulting in delayed recognition and inadequate support for children with SM. Misinterpretations of the condition and a lack of effective tools and strategies frequently hinder early intervention. Notably, there is a scarcity of research focused on SM in early childhood, especially regarding the experiences and perspectives of preschool staff during this pivotal developmental period.

The review highlights the urgent need for targeted training, practical resources, and greater awareness to enhance the early identification and effective support of children with SM.

3.6 Rationale for the Present Study

While awareness of SM has increased, there are still significant gaps in understanding how the condition is identified and supported in early childhood settings. One underexplored area is the perspective of preschool staff and early years educators. These professionals are uniquely positioned to observe the early signs of SM as they witness children’s developing communication and social behaviours during a critical developmental stage. However, their insights are often overlooked in formal systems and academic research. A preliminary search by the researcher found no published studies that specifically explored the views and experiences of preschool staff in identifying and supporting children with SM. This notable gap highlights the need for research that examines their perspectives, which could lead to more developmentally appropriate and responsive practices in early childhood contexts.

Parents play a crucial role in recognising and addressing the early signs of SM. However, their perspectives on the identification process, accessing support, and overcoming barriers are often underrepresented in the existing literature. Exploring their views can offer valuable insights into the challenges families face and highlight opportunities for improving professional engagement and support.

The selective Mutism Information Research Association (2024) survey presented to the UK Parliament underscores the urgency of these issues, revealing that many children suspected of having SM remain undiagnosed. These findings suggest that many children experience ongoing communication difficulties without formal recognition or support despite these difficulties' impact in educational settings.

To address these gaps, this study will explore the perspectives of early years staff and parents of children who meet the diagnostic criteria for SM, including those without a formal diagnosis. This inclusive approach acknowledges the ambiguity of the diagnosis and the variability in identification pathways that many families and professionals' encounter.

The study aims to generate a nuanced understanding of how SM is recognised and supported from the viewpoints of those closest to the child. These insights are expected to inform more timely, sensitive, and collaborative practices across educational and health systems, enhancing the support provided to children with SM.

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3: Major Empirical Study

"It Feels Like It Doesn’t Belong Anywhere in Its Own Right”: The Challenge of Identifying and Supporting Selective Mutism in Early Childhood

Wordcount:12, 912

Abstract

Aim: SM is a complex anxiety disorder that typically presents in early childhood. Although rare, most educational institutions likely have at least one child with this condition enrolled, possibly without formal recognition (Manassis, 2009). This study seeks to explore the experiences and perceptions of key individuals in children's lives during early childhood, specifically focusing on parents and staff members in the early years. Understanding these experiences is anticipated to provide valuable insights into the barriers and facilitators encountered during the identification process of SM.

Method: The research involved four parents and three early years staff members from England and Wales. Open-ended semi-structured interviews were conducted virtually with the participants, and the collected data were analysed using Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2022).

Analysis: In the analysis for parents and early years staff, three primary themes and their corresponding sub-themes were identified and discussed. Two collective themes developed: “It feels like it doesn’t belong anywhere in its own right” and “We could have identified the issue sooner.” These themes emphasised the marginalisation of SM due to systemic gaps and a lack of professional clarity. Furthermore, they highlighted missed opportunities for early identification, which were affected by insufficient training and a lack of interprofessional collaboration.

Limitations: This study is limited by its small sample size and its narrow focus solely on the viewpoints of parents and early years staff, omitting the perspectives of external service providers. This omission presents a missed opportunity for a more holistic understanding. Furthermore, it is acknowledged that the analysis presented reflects just one of many possible interpretations of the data (Braun & Clarke, 2013).

Conclusions: This research sheds light on the perspectives of parents and early years staff regarding SM and the support they receive in identifying the condition in England and Wales. While the findings reveal potential barriers and facilitators to supporting and identifying children with SM in early childhood, there is a pressing need for clearer pathways, assessments, and collaborative efforts between healthcare professionals, childcare providers, and schools. Addressing these

systemic inequities is crucial for future practice and ensuring that all relevant professionals take responsibility in the identification and support process.

3.7 Introduction

In 2013, SM was classified as an anxiety disorder, primarily due to its significant overlap and familial connections with SAD. (Stein et al., 2011). SM is conceptualised as a speech-related phobia, where the expectation to communicate induces a neuropsychological fear response, rendering the individual unable to talk (Johnson & Wintgens, 2016, p. 31). This condition is predominantly observed in young children, with a prevalence that generally declines as they move into adolescence and adulthood. Research estimates that approximately 1 in 140 children under eight years old experience SM (Bergman et al., 2002; Elizur & Perednik, 2003), while the prevalence increases to about 1 in 550 in population samples of up to age 15 (Kopp & Gillberg, 1997; Sharkey & McNicholas, 2012). The average age of onset for SM is reported to be between 2.7 to 4.1 years (Viana et al., 2009; Steffenburg et al., 2018). Considering its primary occurrence in early childhood, the study will focus on the urgent need for timely identification during this critical developmental phase.

Although the average onset tends to occur before the age of five, the literature indicates that children are often referred for treatment at significantly older ages (Standart & Le Couteur, 2003). Kumpulainen et al. (1998) noted that affected children typically range from 6 to 11 years, with an average age of 9. The prevalence of SM appears to be notably higher among bilingual children than previously acknowledged, as it is frequently conflated with the ‘silent period’ associated with additional language acquisition (Elizur & Perednik, 2003). Diagnosing SM can be further complicated due to its distinction from ASD, despite the significant co-morbidity that exists between the two conditions (Steffenburg et al., 2018). Consequently, published prevalence rates for SM are likely underestimated, leading to the reasonable assumption that most educational institutions have at least one child with this condition, even if it has not been formally recognised (Manassas, 2009).

While the diagnostic criteria for SM are well established (APA, 2013), many children affected by this condition encounter considerable delays in identification and access to necessary support (Hahn, 2008; Davidson, 2012; Conn & Coyne, 2014). The manifestation of SM is complex, marked by significant variability in how children present, thereby complicating the identification process. Existing guidelines, legislative frameworks, and diagnostic procedures contribute to this challenge.

Valuable insights into the identification and management of SM have been provided by research conducted by Keen et al. (2008). Their consensus study is particularly noteworthy for its comprehensive exploration of best practices through an extensive analysis of care pathways. Keen et al. (2008) identified notable disagreements among professionals concerning several key issues. One significant point of contention was whether Speech and Language Therapists (SaLTs) should serve as the primary support for educational staff. This disagreement stems from the differing roles and responsibilities of speech and language practitioners across various regions; educational and clinical psychologists have argued that their skills may be more suitably applied in this context. The debate is further complicated by a collective acknowledgment of insufficient training across all professional groups involved. This situation underscores the need for clearer role definitions and collaborative frameworks in managing SM. Such findings are crucial as they highlight the interdisciplinary nature of SM management and stress the importance of ongoing dialogue among professionals to ensure effective intervention. However, the absence of resolutions or recommendations regarding these disagreements leaves a significant gap in practice implications.

The existing research landscape regarding SM in early childhood highlights the perspectives of key stakeholders, including families, educators, and support services. While there have been some notable contributions in recent studies, significant gaps persist in understanding the identification process and the lived experiences of families and early childhood professionals. These gaps impede the development of effective interventions.

The current literature is underdeveloped in terms of exploring support services for SM. White et al. (2022) underscore the critical need for ongoing professional development and training for educators, mainly through the involvement of EPs, to deepen their understanding of SM. Their findings suggest that a lack of knowledge about SM considerably restricts practitioners' capacity to implement appropriate interventions, thereby underscoring the urgency of integrating SM-related content into initial teacher training (ITT) programs.

A particularly noteworthy gap in the literature is the insufficient attention given to preschool staff and childcare providers concerning the early identification of SM. Huey et al.'s (2024) study demonstrated that while preschool staff play an essential role in the identification process, their insights and experiences remain largely overlooked. This oversight highlights the need for a more inclusive approach that considers the perspectives of all stakeholders involved in early childhood education and intervention strategies for SM.

This research aims to address the following questions:

What are the perceptions of parents and early years staff regarding the support they receive during the SM identification process in early childhood?

1. What were the barriers to effective support during the identification process of selective mutism?
2. What were the facilitators of effective support during the identification process of selective mutism?

3.8 Methodology

Theoretical Paradigms

Research paradigms represent the perspectives through which research phenomena are perceived and understood (Cohen et al., 2018). Clarifying the paradigm that underpins this research is essential due to its significant implications for the "epistemological foundation of social science and its impact on educational research" (Cohen et al., 2018, p. 10).

Ontology pertains to the nature of reality, and this research is anchored in a critical realism ontological framework. SM can be measured through clinical diagnoses using the DSM-V and ICD-11, which are pivotal in quantifying SM. The researcher adopts a critical realist approach that reflects personal beliefs and perceptions, asserting that SM is a 'real phenomenon.' This understanding acknowledges the potential of anxiety to genuinely inhibit children's communication abilities, informed by the researcher’s personal experiences in parenting a child with SM.

Furthermore, the characteristics of SM can vary significantly among children. For instance, some may remain silent at home while others do not speak in public settings; some might only whisper, while others may communicate with select individuals. This variability creates a complex landscape regarding the condition (Klein et al., 2013). Consequently, when examining the perspectives of parents and early years staff, it is expected that their diverse experiences in identifying the characteristics of SM will lead to differing interpretations and meanings of the phenomenon. The critical realist perspective recognises the distinction between empirical evidence, such as clinical diagnosis, and the actual lived experiences of parents and practitioners, aiming to uncover fundamental causal mechanisms that link these elements.

Epistemology explores the fundamental assumptions that underpin knowledge. In this research, the epistemological stance is rooted in social constructionism. As Burr (2015, p. 233) notes, social constructionism emphasises a critical and sceptical approach to our taken-for-granted beliefs about reality rather than the pursuit of objective truth or an understanding of the nature of the real world. SM is perceived as a socially constructed phenomenon, with its diagnostic labels and definitions evolving significantly since 1877. To align with this epistemological perspective, the researcher employed semi-structured individual interviews to investigate how participants derive meaning from their experiences. Within this framework, subjectivity is regarded not as a challenge but rather as an essential component of the research process, further enriched by the researcher's active reflexivity (Braun & Clarke, 2021).

Participants and Recruitment

This research employed a purposive sampling technique, grounded in the assumption that certain participants are uniquely positioned to provide rich and in-depth insights regarding the research focuses being examined (Etikan et al., 2016). Given the specific interest in the experiences and perspectives of parents and early years staff concerning the identification process of SM, this approach was considered the most suitable.

The following table highlights the inclusion and exclusion criteria of parents and early years staff.

Table 7- Participants' Inclusion and Exclusion Criteria.

Parent Criteria	
Inclusion criteria	**Exclusion criteria**
Must be a parent/guardian of a child who has a clinical diagnosis of SM **or**	Not a parent/ guardian
Must be a parent/guardian of a child who displays the characteristics of the diagnostic criteria for SM, which include the following: • A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other	The child does not display the characteristics of the diagnostic criteria for SM, which include the following: • A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other

situations (e.g., to parents at home). - This pattern has continued for over a month, not including the first month of a new environment such as school. - The lack of speech impacts the individual's education, work, or social interactions. - The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.	situations (e.g., to parents at home). - This pattern has continued for over a month, not including the first month of a new environment such as school. - The lack of speech impacts the individual's education, work, or social interactions. - The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.
Parents or guardians must have a child between 2 and 7 attending or has attended an early-year setting, such as preschool, childcare, or school.	If the child is aged 2 to 7 and has never attended an early-year setting, such as preschool, childcare, or school.
Early Years Staff Criteria	
Inclusion Criteria	**Exclusion Criteria**
Must be a member of staff working within an early year setting (such as preschool, childcare, or school) with children aged 2-7.	Staff not working in an early year setting (such as preschool, childcare, or school) with children aged 2-7.

Must be a staff member with at least one month’s experience working with children with a clinical diagnosis of SM or with children who display the same characteristics as the diagnostic criteria, which include the following: • A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home). • This pattern has continued for over a month, not including the first month of a new environment such as school. • The lack of speech impacts the individual's education, work, or social interactions. • The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation	Staff members with less than one month’s experience working with children with SM. Staff that support children who do not display the same characteristics as the diagnostic criteria, which include the following: • A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home). • This pattern has continued for over a month, not including the first month of a new environment such as school. • The lack of speech impacts the individual's education, work, or social interactions. • The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation

anxiety, schizophrenia, or a psychotic episode.	anxiety, schizophrenia, or a psychotic episode.

Approach to Data Generation

Due to the perceived rarity of SM, a targeted recruitment strategy was developed to engage participants across the UK, focusing on early years professionals within LAs to maximise participation.

The researcher collaborated with gatekeepers such as Principal Educational Psychologists (PEPs), Early Years Panel leads, and Childcare Team Managers. Recruitment materials (e.g., posters, participant information sheets, consent forms) were distributed to PEPs through the National Association of Principal Educational Psychologists (NAPEP), who then shared them with early years professionals across the UK. (See Appendix 15)

Additionally, the researcher partnered with SMIRA to recruit parents of children with SM. After receiving ethical approval from Cardiff University, SMIRA allowed the researcher to share recruit details on their Facebook page, inviting interested parents to contact the researcher directly. Outreach efforts were further expanded through the Educational Psychology Network (EPNET) to engage additional participants.

This study employed a qualitative methodology, utilising semi-structured interviews conducted via Microsoft Teams. The interviews were scheduled at the participants' convenience to promote a comfortable environment for discussing sensitive issues.

The research is grounded in the understanding that language plays a crucial role in shaping data collection, as discussed by Burr (2015). Individual interviews were preferred over focus groups to build rapport and trust, which is essential for discussing sensitive topics like SM.

Open-ended questions were used to facilitate in-depth responses, as Cohen et al. (2018) note that such questions promote flexibility in exploring areas of interest. Kvale and Brinkmann (2009) further emphasise that semi-structured interviews allow for follow-up inquiries, yielding richer and more nuanced data.

While focus groups could foster collaborative dialogue, Smithson (2000) highlights the risk of dominant voices overshadowing less assertive participants. Therefore, individual interviews were chosen to ensure that every participant's voice was valued equally, providing a comprehensive understanding of their experiences.

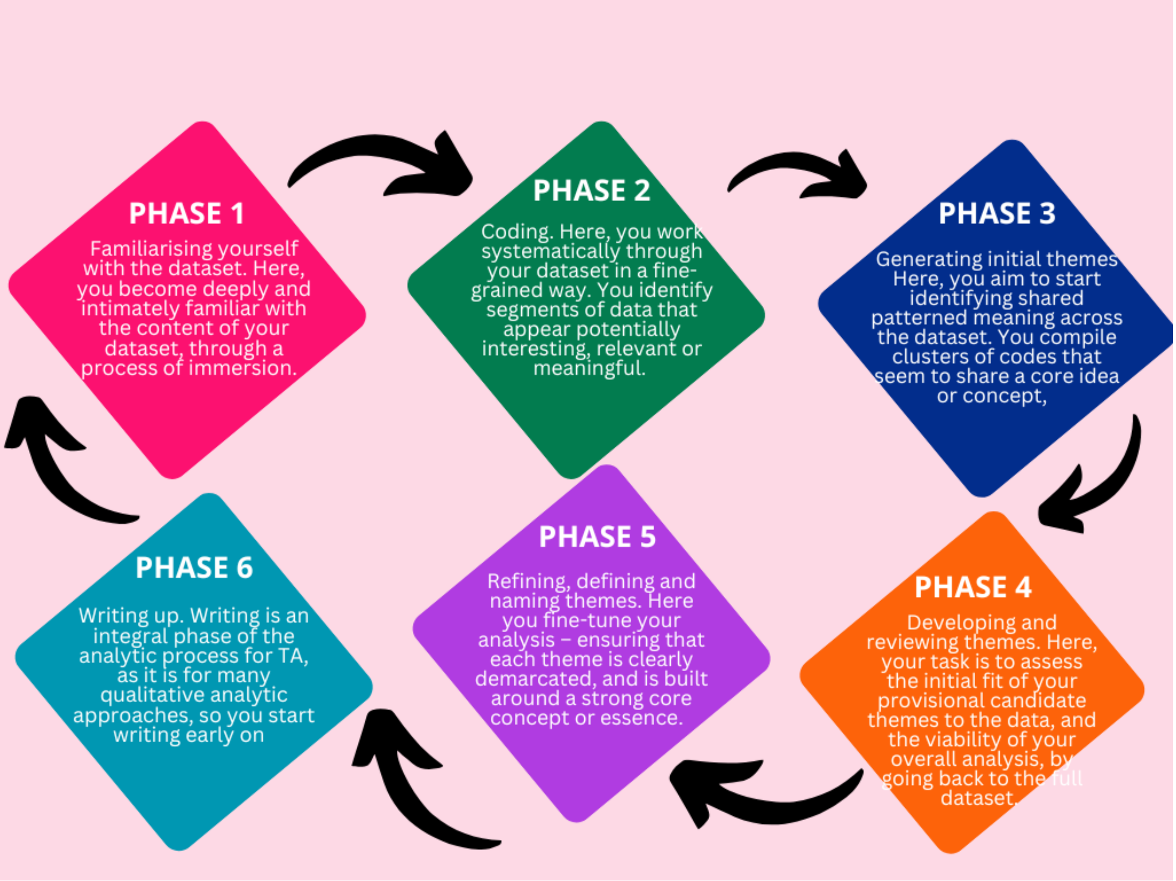
The interviews followed a structured schedule of open-ended questions, directly aligned with the research questions (Refer to Appendix 13). As Hermanowicz (2002) suggests, this approach encourages deeper exploration of participants' experiences and helps avoid superficial responses, ensuring the collection of rich, detailed data.

Approach to data analysis

Kidder and Fine (1987) highlight the diversity and complexity inherent in qualitative research, asserting that qualitative inquiry is not confined to a single methodological tradition but rather encompasses a range of approaches that capture the multifaceted nature of human experience. This aligns with the 'Big Q' stance, which recognises the variety of qualitative methods employed to explore complex social phenomena, making it particularly suitable for investigating issues like SM. Smith (2015) explains that "Big Q" qualitative research is grounded in a paradigm that prioritises open-ended exploration, contextual understanding, and the co-construction of meaning, whereas "small q" refers to the use of qualitative methods within a primarily positivist, quantitative research design (pp. 1–16). The Big Q approach reinforces the notion that a researcher's interpretations are fundamentally shaped by their theoretical foundations, thereby enriching the analysis.

Moreover, the researcher will consider the theoretical landscape of SM and apply the COMOIRA framework (Gameson & Rhydderch, 2017), drawing upon the core element of informed and reasoned action. This means that theoretical perspectives are applied to understand how a phenomenon is perceived, which informs, and guides change.

Reflexive Thematic Analysis (RTA) was utilised for data analysis, following the six-phased approach of Braun and Clarke (2022). The research created Figure 6 below to demonstrate each phase.



PHASE 1

Familiarising yourself with the dataset. Here, you become deeply and intimately familiar with the content of your dataset, through a process of immersion.

PHASE 2

Coding. Here, you work systematically through your dataset in a fine-grained way. You identify segments of data that appear potentially interesting, relevant or meaningful.

PHASE 3

Generating initial themes Here, you aim to start identifying shared patterned meaning across the dataset. You compile clusters of codes that seem to share a core idea or concept,

PHASE 4

Developing and reviewing themes. Here, your task is to assess the initial fit of your provisional candidate themes to the data, and the viability of your overall analysis, by going back to the full dataset.

PHASE 5

Refining, defining and naming themes. Here you fine-tune your analysis – ensuring that each theme is clearly demarcated, and is built around a strong core concept or essence.

PHASE 6

Writing up. Writing is an integral phase of the analytic process for TA, as it is for many qualitative analytic approaches, so you start writing early on

Figure 6- RTA Six-Phase Approach

RTA was chosen as a suitable method for data analysis due to its theoretical flexibility. This flexibility makes it well-suited for analysing semi-structured interviews from a social constructionist perspective. This adaptability enables RTA to effectively explore individuals' subjective experiences and perspectives regarding various issues, factors, and processes (Braun et al., 2016).

Braun and Clarke (2022) highlight that reflexive research acknowledges the contextual nature of knowledge, which is inherently shaped by the processes and practices involved in its production, including those of the researcher. Reflexivity requires a critical examination of the researcher's role and their research practices.

Another advantage of RTA is its emphasis on the researcher as an active and valuable "analytic resource" within the research process (Braun & Clarke, 2020, p. 3). This reflexivity is especially relevant and ethically significant for this research, particularly considering the researcher's positionality as a parent of a child with SM, which is discussed further in part three.

The researcher aimed to capture the voices of both parents and early years staff, analysing their perspectives separately and together. Consequently, the data were analysed in three stages: first, separately for parents, then separately for early years staff, and finally, as a collective. This approach resulted in three thematic maps. The researcher adhered to the six stages of RTA (as outlined in Figure 6) throughout the data analysis process.

Ethical Considerations

Before initiating this research, ethical approval was obtained from Cardiff University's Research Ethics Committee (EC.24.03.12.6989). The research adhered strictly to the British Psychological Society's (BPS, 2021a) four ethical principles: respect, competence, responsibility, and integrity. In addition, it complied with the moral guidelines outlined in the Code of Human Research Ethics (BPS, 2021b), which emphasises the necessity of conducting research that is per the core values of the psychology profession. These values ensure scientific integrity, promote social responsibility, maximise benefits, minimise harm, and respect the autonomy, privacy, and dignity of individuals, groups, and communities (BPS, 2021b).

Respect for the privacy, dignity, and autonomy of participants was paramount. The researcher avoided deception and ensured that informed consent was foundational to all data collection processes. Participants had to provide electronic consent after confirming they had read and understood the information provided in the Participant Information Sheet (See appendices 11-12). This document outlined the research aims, data analysis approach, and ethical considerations. Participants were informed of their right to withdraw from the study at any point without facing penalties or needing to justify. It was, however, clarified that withdrawal would not be possible after the interviews had been transcribed and anonymised.

In alignment with the principles of competence and responsibility, the researcher made significant efforts to conduct the research ethically. Issues related to confidentiality and data protection were carefully addressed, and participants were given opportunities to voice any concerns or ask questions regarding the study.

Following the interviews, participants were provided with a debrief sheet via email (Appendix 14). All research data and personal data collected were held separately and securely on the researcher's secure Cardiff University online Intranet portal, in compliance with Cardiff University's Research Record Retention Schedules. Furthermore, all data was processed in accordance with the General Data Protection Regulations (2016) and the Data Protection Act (2018).

Trustworthiness

To maintain the integrity and rigour of the research process, Yardley's (2000) criteria for qualitative research were employed as a framework for reflecting on data collection and analysis. The table below presents a concise overview of the vital considerations derived from these criteria.

Table 8- Yardley's (2000) Criteria for Qualitative Research

Yardley's (2000) Core Principles	**Key considerations**
Sensitivity to context	The narrative literature review aimed to clarify the context surrounding the clinical perspectives of the identification process for SM. It also examined the key experiences of individuals most involved in the lives of young children during this critical early stage, such as teachers, early years staff, and key stakeholders. This approach was designed to formulate informed questions sensitive to the limited literature addressing the identification process for SM. The interview questions were intentionally crafted as open-ended to facilitate participants' expressing their thoughts freely and discussing what they deemed significant rather than being influenced by the researcher's specific concerns (Wilkinson et al., 2004). This approach allows for a richer and more nuanced understanding of the participants' perspectives.
Commitment and Rigour	The researcher maintained a research diary and participated in regular supervision sessions to ensure ongoing reflection and reflexivity throughout the research process. This practice facilitated an awareness of any underlying assumptions or biases, allowing for necessary amendments to be made promptly and effectively. Throughout the research process, the researcher remained dedicated to thoroughly engaging with the literature on SM. This deep immersion was crucial for

	grasping the topic's nuances and complexities. For additional details, please refer to appendices 5-10.
Coherence and Transparency	The researcher utilised supervision to reflect on the study's epistemological and ontological positions and its design. The literature review provided the rationale for the study and highlighted its significance to the EP profession. In the methodology section, the researcher outlines all decisions made regarding the approach to data collection and analysis, with additional critical insights presented in part three. To improve transparency in the data analysis process, the analysis includes detailed excerpts that help readers understand the basis for the analytical interpretations. Furthermore, examples of the data coding processes can be found in Appendix 18.
Impact and Importance	The research highlighted a notable gap in the current literature regarding EPs' role in supporting children with SM. The findings underscore the potential influence EPs can have on individual cases and broader systems, including healthcare frameworks designed for children experiencing SM. Additionally, the study proposes several implications for the EP profession, advocating for enhanced collaboration and understanding within multidisciplinary teams. The discussion also opened avenues for future research, emphasising the need for further exploration

	into practical strategies and interventions that EPs can employ to assist children facing these challenges.

Overview of the Analysis Process

As outlined by Braun and Clarke (2022), RTA was used to analyse interviews with parents and early years staff. Each group's analysis was conducted separately to identify themes relevant to their experiences. After the initial analysis, a collective examination of the data from both groups was performed to uncover overarching themes that captured their support experiences during the SM's identification process.

This analysis followed Braun and Clarke’s (2022) six phases of reflexive thematic analysis, starting with a careful transcription of the interviews. During the transcription, it became clear that including verbal expressions was crucial to ensure the data accurately represented how participants conveyed their thoughts (Poland, 2002).

Subsequently, a comprehensive period of immersion and critical engagement with the datasets was carried out, involving repeated readings of the transcripts and listening to the interview recordings. This iterative process aimed to foster familiarity with the data and stimulate reflection on the emerging questions relevant to the analysis. Throughout this stage, reflexive journaling was utilised to document insights and reflections, providing additional context and depth to the analysis (see Appendix 17 for examples).

The interview transcripts were systematically examined in the second phase of the analysis to identify initial coding labels for each dataset. Both digital and manual methods were employed for coding during this phase. Qualitative data is inherently subjective and rich, often presented in textual formats. Analysing this data requires thoroughly reviewing transcripts to identify patterns leading to themes and categories. Traditionally, researchers have relied on manual methods for categorisation. However, as Wong (2008) suggests, advancements in technology have introduced software such as NVivo, developed by QSR International. NVivo enhances qualitative research by providing visual exploration and illustrating relationships through models. Its Modeler feature facilitates the creation of interconnected concepts and tracks theoretical development over time. By utilising NVivo, researchers can navigate the coding process while contemplating their assumptions, ultimately streamlining the analysis and deepening their engagement with the data. The digital coding process will be explored in greater detail in Part 3.

Semantic and latent codes were identified, highlighting intriguing and relevant aspects of the research questions. Semantic codes were based on the explicit meanings within the data, while latent codes were derived from the researcher's interpretation of underlying information present in the data (Byrne, 2022). In the third phase, initial themes were generated and subsequently developed, undergoing repeated reviews in phase four. Finally, the themes were refined, clearly defined, and named in phase five. It is crucial to emphasise that this analysis was not conducted linearly but encompassed a recursive process of navigating between all analysis phases

3.9 Demographics of Participants

Table 9- Demographics of Parents

Participant	Gender	Child's Age	Child's Gender	Child's Setting	Location
Parent 1	Female	3	Girl	Childminder/Nursery (applying to a private school)	England
Parent 2	Female	3	Girl	Pre-school	Wales
Parent 3	Female	6	Boy	School	England
Parent 4	Male	5	Girl	School	Wales

Table 10- Demographics of Early Years Staff

Role	Gender	Child's Age	Child's Gender	Educational Setting	Location
Staff in the Early Years of Year 1	Female	5	Girl	School	Wales
Staff in the Early Years Reception Class	Male	4	Girl	School	Wales
Staff in the Early Years for Year 2	Female	7	Girl	School	England

One of the parents and early years staff notably referenced the same child during their discussions about their experiences.

Introduction to Findings

This section presents the research findings on identifying and supporting SM from the perspectives of parents, early years staff, and a combined viewpoint drawn from both groups. Guided by Braun and Clarke's (2022) Reflexive Thematic Analysis (RTA), the analysis adopts a social constructionist epistemology, recognising that knowledge and meaning are co-constructed through language, interaction, and context. The findings are organised into three overarching categories—parents, early years staff, and shared perspectives—each supported by thematic maps visually representing the key themes developed through this interpretative process.

In alignment with the reflexive nature of the chosen analytical approach, preliminary researcher reflections are included alongside each group's findings. These reflections acknowledge the researcher's interpretative role in theme development and provide an initial orientation to the meanings constructed in the data. The subsequent discussion chapter will explore a more integrated and critical interpretation of these themes.

3.10 Findings: Superordinate Themes and Subthemes for Parents

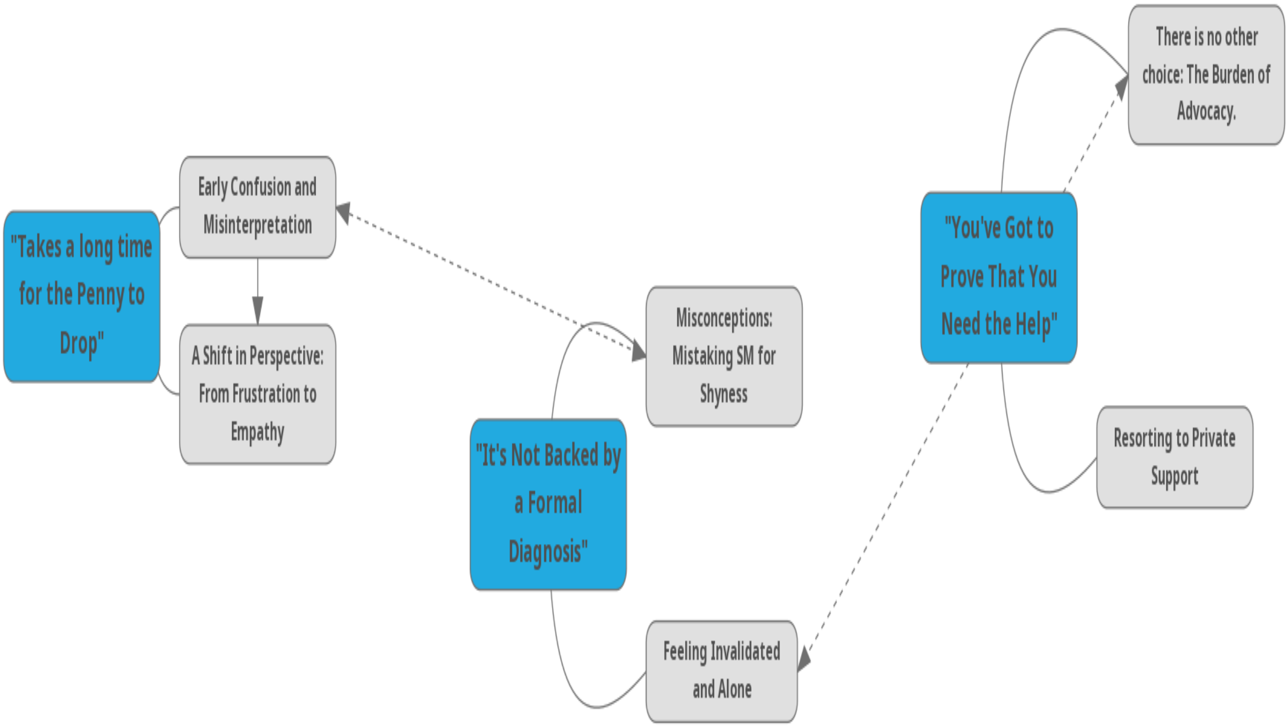


Figure 7- Thematic Map for Parents

Superordinate Theme One: “Takes a Long Time for the Penny to Drop

This theme captures the emotional and often prolonged journey parents experience as they come to understand SM as an anxiety-based condition. The metaphor of the “penny dropping,” articulated by Parent 4— ***“It took us quite a long time for the penny to drop that this is what he was experiencing”***—encapsulates a process of confusion, gradual reflection, and eventual realisation. Parent 1 said, ***“There is not enough awareness about it, so I didn’t realise for months.”*** These statements emphasise the lack of early recognition, often resulting from minimal public awareness, limited professional knowledge, and common misinterpretations of the child's behaviours.

Many parents initially attributed their child's silence to factors such as introversion, stubbornness, or defiance, rather than recognising it as a manifestation of anxiety. Parent 2 reflected, ***"I didn't know what was going on. I'd never heard of selective mutism,"*** while Parent 3 noted, ***"In hindsight, we can see that she completely shuts down… she never interacted with family or anyone else."*** Encounters with professionals unaware of SM often exacerbated this early confusion. Parent 3 commented***, "The SENCo didn't seem like they'd heard of SM at all."*** This systemic knowledge gap delayed identification and reinforced incorrect assumptions. Parent 4 candidly admitted***, "I thought he didn't want to speak and was being defiant. It's hard to admit that I thought that, but I did."***

Such reflections illustrate not only the cognitive dissonance experienced by parents but also the emotional toll of misinterpreting their child's silence. Parent 4 recalled pleading, ***"Why won't you speak?"—***a moment of desperation that highlights the psychological distress parents endure when their efforts to connect are grounded in misunderstanding.

This confusion relates to Attribution Theory (Heider, 1958), which proposes that individuals try to explain behaviours by attributing them to either internal traits or external factors. Initially, parents often made dispositional attributions, such as shyness or stubbornness, because they lacked contextual knowledge about SM. This led to a misinterpretation and confusion about their child's condition.

As parents gradually learned more about SM, their perspectives shifted from frustration regarding their child's silence in certain situations to feelings of empathy and understanding. For Parent 1, discovering the NHS website was a turning point: "***The NHS description finally made me realise what he was experiencing."*** Another parent used a powerful metaphor to express this newfound understanding: ***"Asking her direct questions was like throwing a spider in the face of someone with arachnophobia."*** This insight helped reframe their child's silence as an anxiety-driven response rather than a behavioural choice. This sentiment reflects the empathetic view that parents adopt when they consider the condition to be anxiety, comparing it to phobias that are widely recognised in society, such as arachnophobia.

This shift reflects cognitive reappraisal, a concept from the emotional regulation theory (Gross, 1998), in which individuals change their emotional response by altering the meaning they assign to a situation. As parents reappraised their child's behaviour through the lens of anxiety, they adopted more supportive, flexible approaches—often independently of professional guidance.

Superordinate Theme Two: "It's Not Backed by a Formal Diagnosis"

All parents in the study highlighted the absence of a formal diagnosis for their child's SM. This lack of diagnosis significantly impacted their ability to secure appropriate support and undermined the validity of their concerns. Parent 1 remarked, ***"No, a formal diagnosis hasn't been provided, and I don't know if one will be given in the future."*** Many parents encountered disbelief and dismissal and often felt invalidated and isolated.

A recurring issue parents discussed was the widespread misconception that SM is simply an extreme form of shyness. This misunderstanding was among extended family members, educators, and healthcare professionals. Parent 2 asserted, ***"The first step to support would be simply acknowledging that the issue could be more than shyness."*** Parent 1 observed, ***"There are family members with whom my child struggles to communicate. They label it as shyness, but it's more than that."*** Similarly, Parent 3 encourages others to ***"consider the possibility that a reluctant talker is not reluctant by choice."***

This mislabelling can be understood through Expectancy Violations Theory (Burgoon,2015), which explains how unexpected behaviours—such as a child remaining silent in social contexts—violate social norms and elicit negative interpretations. When children do not conform to expected patterns of verbal interaction, their silence is often interpreted as deviant or oppositional, rather than symptomatic of anxiety. These misconceptions obstruct early identification and prevent the deployment of supportive strategies, perpetuating the cycle of misunderstanding SM.

The lack of diagnostic legitimacy also contributed to a profound invalidation and isolation. Parent 4 stated, "***When we approach these professionals, we come across as overly anxious parents. It's not backed by a formal diagnosis."*** Their concerns were frequently dismissed without formal recognition, compelling parents to become researchers and advocates. Parent 3 shared, ***"I didn't know what I was searching for… but I typed in a few phrases like 'doesn't do this' and 'doesn't do that' and eventually found the Medway page."***

Parent 4 stressed the importance of recognition: ***"Having a label and acknowledging it would be really helpful. It helps to formalise the fact that my child has additional needs."*** Many parents could not navigate healthcare and educational systems without this validation. Parent 4 reflected: ***"I'd given up, which is why I just phoned, and I said I can't get local services without distressing my child. I can't get private speech and language in the area. What can I do?"*** This sentiment highlights how parents can feel isolated when their children do not fit into the system or when the available system is too distressing.

The effort to seek diagnostic validation often brings emotional and logistical burdens, resulting in significant personal sacrifices. For instance, Parent 4 mentioned, ***"I've reduced my work hours on Fridays to be with my child."*** While this commitment is commendable, it highlights an imbalance of responsibility in a system that should offer formal pathways for support.

These findings align with Seligman's Learned Helplessness Theory (1975), which suggests that when individuals are repeatedly exposed to adverse experiences they cannot control, they may eventually stop trying to change their circumstances, believing their efforts are ineffective. For parents seeking a diagnosis of SM, repeated encounters with professionals who dismiss their concerns or downplay their child's symptoms can lead to increasing frustration and helplessness. Over time, these parents may begin to internalise the belief that their advocacy is futile, resulting in emotional exhaustion and disengagement. This highlights the psychological burden faced by families navigating an unresponsive system and highlights the critical need for supportive, informed, and empathetic pathways to diagnosis and intervention.

Superordinate Theme Three: “You’ve Got to Prove That You Need the Help”

This theme highlights parents' heavy burden in advocating for their child’s needs within an under-resourced system. Parent 4 captured this reality: ***“It feels like you have to do a lot of the work before you’re able to get the help. You have to prove that you need the help in the first place.”***

Parents expressed a feeling of having no choice but to advocate for their children, indicating that structured support systems are insufficient. As a result, parents of children with SM often need to become strong advocates for their child's needs. They work to ensure that these needs are recognised, understood, and addressed appropriately. This advocacy role goes beyond providing emotional support; it also involves taking on responsibilities that are typically managed by trained professionals, such as educators and healthcare providers.

Parent 3 emphasised the constant vigilance required, stating, ***“In school, they might go under the radar. So, I want to be quite mindful of that; it is our responsibility to advocate.”*** This points to the systemic invisibility of SM in mainstream settings, where quiet behaviour can easily be misread as compliance rather than a sign of distress or unmet needs. In this context, parents become the primary informants, interpreters, and enablers of their child’s support journey.

The advocacy that parents engage in means they need to educate others. Parents shared examples of how they try to accomplish this. Parent 1 illustrated this point clearly when they discussed how they supported the childminder in understanding SM for their child. They stated, **"I've literally scripted what she needs to say. I told her, 'Don't say this; say this instead, if *you tell people what not to say, they dwell on it. But if you tell them what they should say, then they will do it."*** This demonstrates that parents are working to bridge the gap left by professional services by providing resources and coordinating support for their child.

Similarly, Parent 3 described the creation of pre-drafted email templates that explained the condition and tailored them to their child: ***"Certainly if we e-mail people, we sort of essentially in our drafts forever, we can just copy that over. We formulated this is what selective mutism is and this is how it affects our child, particularly."*** This shows an ongoing effort to educate others and maintain consistency in how SM is understood across different settings—something that would ideally be coordinated by professionals but falls to parents.

Learned Helplessness Theory (Seligman, 1972) may help interpret the emotional fatigue reported by some parents. As parents repeatedly encounter dismissive attitudes or systemic barriers despite their best efforts, they may begin to feel powerless or resigned, which can lead to emotional burnout. Parent 1's reflection—***"I can say that the only thing that's been going well has been the result of my own effort"***—captures this sense of systemic failure and the psychological weight of having no option but to persist.

This superordinate theme emphasises the disproportionate burden placed on families, especially in situations where professional knowledge is lacking. While parents demonstrate remarkable resilience and creativity in their advocacy efforts, their experiences also reveal a critical need for systemic support and formal guidance. This would help alleviate the emotional and logistical challenges they face on their own.

Many parents in the study reported seeking private therapy services out of necessity due to the lack of available support and widespread professional unfamiliarity with SM. Public services, particularly within the NHS and educational systems, were often seen as inaccessible, slow to respond, or incapable of recognising and addressing the complexities associated with SM.

Parent 1 described frustration and helplessness: “***At that point, I went to find a private speech and language therapist.”*** This highlights the reactive nature of help-seeking, where parents felt forced to explore private options as a last resort rather than a choice.
Despite the significant financial burden, private therapy was largely viewed as the most effective and reliable form of support. Parent 3 stated: ***“The main thing that's helped, and we have made progress is the private therapist—they are experts purely in SM. It's all about SM and putting in various different strategies.”*** The parents suggested that private therapists were able to provide targeted, specialist input and filled a critical gap that public services had failed to address.

Parents frequently reported encountering professionals—such as general practitioners and school staff—who lacked basic knowledge of SM. Parent 3 shared: **“*We spoke to the GP. And again, I don't think they were really sure. It didn’t feel that they’d heard—well maybe heard—but they didn’t know much about it.”*** This absence of knowledge left families feeling alone, forced to become the lead experts and advocates for their child in an otherwise disjointed and confusing system.

The widespread reliance on private therapy revealed a more profound structural inequity. Families with financial means could access timely, expert help, while those with fewer resources risked being unsupported. This creates a tiered system of support, where access to appropriate intervention for a clinically recognised anxiety disorder is dependent on socioeconomic status—a reality that contradicts principles of equitable healthcare and education.

Bandura's Self-Efficacy Theory (1977) provides insight into how private support enhances parents' sense of agency and confidence. Working with specialists who understood SM made parents more equipped to implement strategies and advocate effectively. This increased sense of efficacy reduced feelings of helplessness and enabled them to support their child with greater clarity and consistency.

Furthermore, Bronfenbrenner and Morris's Bioecological Systems Theory (2017) helps contextualise these experiences within a broader systemic framework. Interactions across multiple systems (microsystem, mesosystem, exosystem, etc.) shape a child’s development. The bioecological model places particular emphasis on the individual’s biology, such as temperament, genetic predispositions, and developmental stage, and how these characteristics interact with environmental factors. When key systems—such as healthcare, education, and family—fail to coordinate or understand the child’s condition, families are left isolated. In this case, private therapy functioned as a substitute for systemic cohesion, offering a focused and reliable support system that was otherwise missing.

3.11 Findings: Superordinate Themes and Subthemes for Early Years Staff

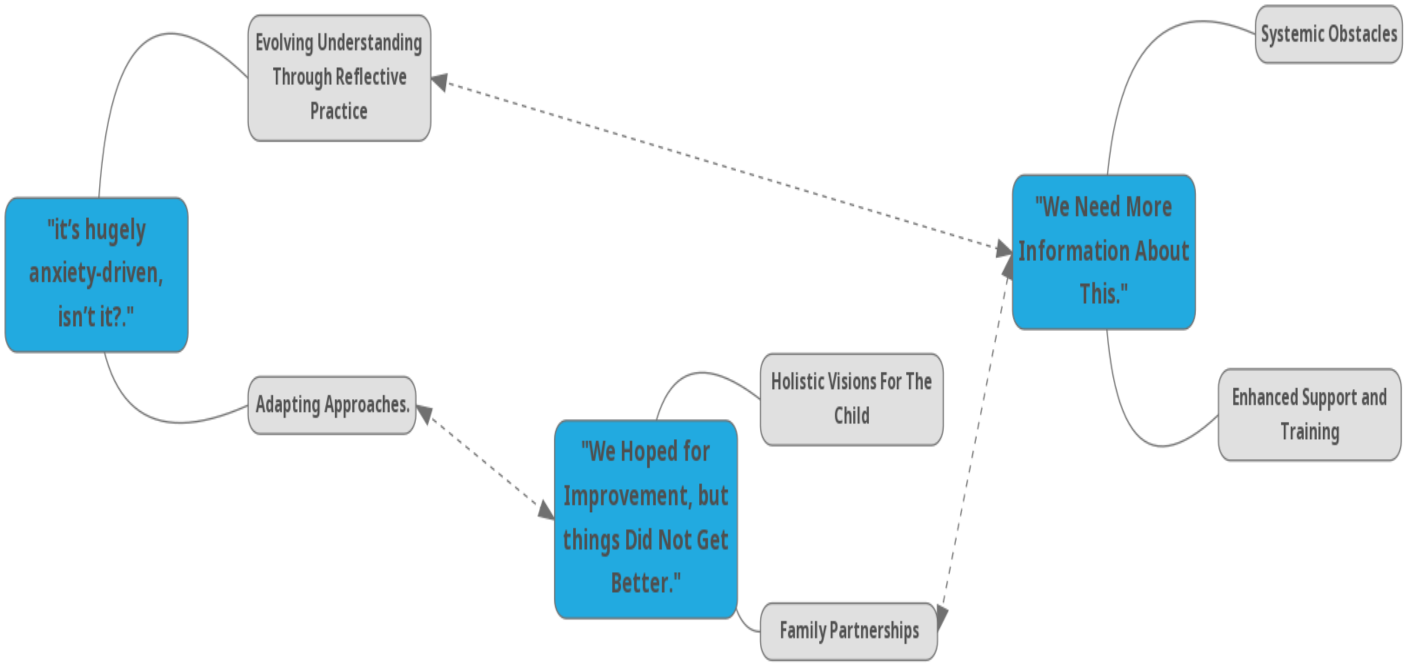


Figure 8- Thematic Map for Early Years Staff

Superordinate Theme One: "It's hugely anxiety-driven, isn't it?"

Early years staff often struggled to understand SM, highlighting the superordinate theme of anxiety's central role in the condition. Through reflective questioning and real-time observations, staff developed a deeper awareness of SM as an anxiety-driven condition. This was evident in Staff Member 2's remark, ***"It's hugely anxiety-driven, isn't it?"*** Although this insight was tentative, it indicated an evolving understanding of SM as staff adapted their approaches over time based on their reflections and the children's behaviours.

Initially, many staff attributed the silence of children to personal choice or traits, with comments like, "***They are choosing not to respond"*** (Staff Member 1) and ***"The child is deciding not to talk"*** (Staff Member 3). These attributions reflected a dispositional interpretation of the children's behaviour, consistent with Heider's (1958) Attribution Theory, which suggests that behaviour is often attributed to internal traits, such as shyness or defiance. Without formal training or diagnostic clarity, silence was commonly misinterpreted as deliberate non-compliance rather than a symptom of anxiety.

However, as staff reflected more on their experiences, their understanding shifted. Staff Member 1 later commented, ***“They’re not controlling it; it’s a physical thing that they can’t control,”*** indicating a move toward a situational attribution of silence. This acknowledgment recognised that the children’s behaviours were driven by anxiety rather than choice. This shift illustrates the process of reflection and learning outlined in Gibbs’ Reflective Cycle (1988), where reflection prompts re-evaluation and changes in practice.

In response to their evolving understanding, staff adapted their approaches to reduce anxiety and create emotionally safe environments. Staff Member 2 shared an example of attempting to engage a child outside the classroom: ***“We tried a staff member going to her home to see if she would talk to them there because it was her familiar setting”.*** The evolving understanding reflects the staff’s willingness to evolve their methods based on experience, even without formal guidance. These efforts align with Basic Psychological Needs Theory (Deci & Ryan, 2000), particularly in the need for relatedness, as staff strive to create emotionally secure environments that foster comfort and communication.

However, the classroom setting itself often complicates matters. Staff Member 3 described how a large, noisy classroom exacerbated the child’s anxiety: ***“It’s hard… she’s in a class of 25. It’s a very small classroom… there are many strong personalities among the children, so it’s difficult.”*** This highlights the tension between the individual child's needs and the broader classroom environment. Bronfenbrenner and Morris’s (2017) Bioecological Systems Theory emphasizes how a child’s biological sensitivity to stress interacts with the dynamics of their immediate environment, potentially reinforcing silence instead of promoting communication.

Despite these challenges, staff began to recognise anxiety as the key driver of SM. Their approaches evolved to meet the children's basic psychological needs better, resonating with Maslow's Hierarchy of Needs (1943). Maslow suggests that foundational needs, such as safety and emotional comfort, must be met before children can engage in higher-order learning. For children with SM, these needs extended beyond speech. As Staff Member 2 noted, "***She will go into the hall, get a lunchbox out, and show us the food, but she won't eat it,"*** illustrating how SM impacts basic routines. Similarly, Staff Member 3 shared their experience with using flashcards: ***"I tried using flashcards for the toilet,"*** emphasising how SM affects communication and fundamental aspects of daily life.

Overall, the staff's evolving understanding of SM was characterised by a process of reflective practice. Lacking formal training or expert guidance, their responses were driven by curiosity and empathy rather than confidence. Staff Member 1's reflection***: "I'm building a relationship with her, and that's I suppose that she needs to be comfortable because sometimes it's hugely anxiety-led, isn't" it?*** Illustrates their ongoing efforts to understand and support the child's inner world. The early years staff transition from dispositional to situational understandings of SM stresses the critical role of reflective practice in fostering more compassionate, anxiety-informed support for children with SM.

Superordinate Theme Two: "We Hoped for Improvement, but Things Did Not Get Better"

This theme demonstrates the quiet tension between hope and reality as Early Years staff supported children with SM. While their efforts were grounded in optimism and a desire to see progress, they frequently encountered emotional fatigue, frustration, and uncertainty. Staff shared how they often hoped things would improve naturally over time, relying on nurturing relationships and the gradual unfolding of confidence. However, their reflections also reveal how these hopeful visions were rarely met with clear or sustained improvement.

Central to this optimism was a holistic vision of the child that extended beyond the classroom. Staff believed real progress could only be achieved by understanding the child's life context. One participant articulated this view: “We need to consider the whole child, which includes their behaviour at home, in various social contexts, and within the school environment.” This perspective echoes Bronfenbrenner and Morris’s Bioecological Systems Theory (2017), which proposes that a child’s development is shaped by interactions across multiple systems—home, school, peers, and community. However, using the bioecological model, SM can be further viewed as being impacted by the interaction between biological characteristics (e.g., temperament, anxiety, or sensory sensitivities) and the environments the child encounters. Staff were hopeful that embracing this holistic approach could support the child’s development more effectively. However, these visions rarely occurred, as the complexities of the child's biological traits and environmental interactions were often not fully understood or supported across all systems (e.g., at school, at home, or in broader community contexts), which limited the practical application of this vision.

Underpinning these efforts for a holistic vision for the child was the belief that meaningful progress required strong partnerships with families. Staff saw collaboration with parents not as optional but as essential. As Staff 1 expressed, ***“Hopefully, this will be a little more meaningful and helpful,”*** referring to Person Centred Planning (PCP) meetings. These meetings aimed to co-create tailored support strategies in line with inclusive education policies such as the Additional Learning Needs (ALN) Code for Wales (2021) and the DfE Special Educational Needs Code (2015). Both frameworks emphasise shared decision-making and proactive planning, encouraging the involvement of parents and educational professionals to support individualised interventions.

However, building these partnerships came with its challenges. Staff often felt that families were willing and concerned but lacked the understanding or tools to contribute effectively. As Staff Member 3 commented, ***“We depend on the parents a lot, but they’re not experts in this area.”*** This created a paradox: staff needed family insight to build their holistic picture of the child, but parents also navigated their learning curve. This gap, while understandable, sometimes became a barrier to progress. Drawing on Vygotsky’s Sociocultural Theory (1978), this dynamic highlights how staff and parents functioned as co-learners rather than a clear, more knowledgeable other—a role traditionally supporting child development. Without formal guidance or expert input, both parties navigated uncertainty together.

Staff also expressed how external structures, such as transition meetings and support plans, while useful, did not always result in meaningful outcomes. As Staff 3 noted, **“We have meetings for when she’s changing year groups,” yet despite these structured efforts, “progress remained limited, and improvement was inconsistent.”** These reflections suggest a disconnect between effort and outcome—a feeling that, despite doing all the right things, staff were left hoping for change that did not always arrive.

This theme reveals how Early Years staff maintained hope through a holistic lens, seeing the child not just as a pupil with SM but as a whole person shaped by multiple systems. Their vision required trust, patience, and deep collaboration with families. However, without adequate external input or consistent progress, their hope was often met with emotional strain.

Superordinate Theme Three: “We Need More Information About This”

This theme highlights the uncertainty and knowledge gaps experienced by Early Years staff when working with children with SM. The staff demonstrated a shared recognition that more information, guidance, and formal training are urgently needed. Staff 3 aptly expressed this sentiment, stating, ***"We need more information about this,"*** which captures both the emotional and professional tension felt by staff caught between their desire to help and their lack of resources.

Despite facing systemic barriers and limited external support, staff demonstrated a strong commitment to understanding SM and improving children's experiences. However, a lack of coordinated pathways, guidance, and specialist input often hindered their efforts. Many staff members reflected that even when signs of SM were identified early, uncertainty about how to proceed led to delays in intervention.

Staff 2 noted, **"It wasn't until well into the academic year that we began our research."** This highlights the reactive nature of current practices, where recognition does not immediately lead to action.

Bronfenbrenner and Morris's Bioecological Systems Theory (2017) helps contextualise these challenges. While staff operate within a child's immediate microsystem—such as the classroom and school—they are also influenced by factors in the exosystem, such as educational policies, healthcare coordination, and professional training structures. The bioecological model emphasises that these systems must be responsive and coordinated to effectively meet the child's needs. However, when there is a lack of alignment and support across these systems, the child's developmental needs—especially for those with SM—remain unmet. This leaves staff feeling isolated in their efforts, as they work within a fragmented system that does not offer sufficient guidance or resources.

A key concern raised was the absence of a designated professional or service to lead SM cases. This lack of ownership creates an accountability gap, resulting in fragmented support. According to Keen et al. (2008), professionals have historically disagreed about who should take the lead in supporting children with SM, with no single agency consistently responsible for managing cases. Staff 3's comment, ***"We require more guidance from experts,"*** encapsulates this challenge and highlights the burden placed on staff to manage a condition often outside their expertise.

Further complicating matters is the perception of SM within broader mental health frameworks. Staff member 2 observed, "***I've been in this school for 15 years, and we've only identified three individuals. For us, social, emotional, and mental health is a priority, which I know is probably linked in some way."*** This suggests that SM is often seen as rare and indirectly associated with broader social, emotional, and mental health (SEMH) needs, leading to its marginalisation in training priorities and resource allocation.

In the face of these obstacles, staff members exhibited agency by engaging in informal learning and self-reflection. The early years staff described utilising their own research, experiences, and peer discussions to improve their practice. Staff 2 explained, "***We engaged in informal discussions and received training recommendations from an educational psychologist, but these exchanges weren’t formalised."*** These grassroots approaches reflect a commitment to improving outcomes, but they also emphasise the need for structured, formal training that recognises SM within professional development agendas.

The desire to act more proactively was a recurring theme. Staff 2 noted, ***"I firmly believe that if concerns already exist, implementing strategies at an earlier age could greatly benefit the child."*** This perspective suggests that equipping staff with the right knowledge—even before a formal diagnosis—could enable them to create psychologically safe, low-pressure environments that reduce communicative anxiety and prevent long-term disengagement. It also speaks to the urgency of incorporating early intervention principles into initial teacher education and ongoing professional development.

Ultimately, these reflections point to a pressing need for systemic change. Without greater recognition of SM as a legitimate and complex mental health issue within early education, staff will continue to feel unsupported, and children may miss the timely and empathetic care they need. While the commitment and compassion of staff are evident, their experiences reinforce the call for formalised training pathways, inter-agency collaboration, and clearer guidance—so that "needing more information" does not remain the norm but becomes the foundation for initiative-taking, informed, and confident support.

3.12 Findings: Superordinate and Subthemes for Parents and Early Years Staff

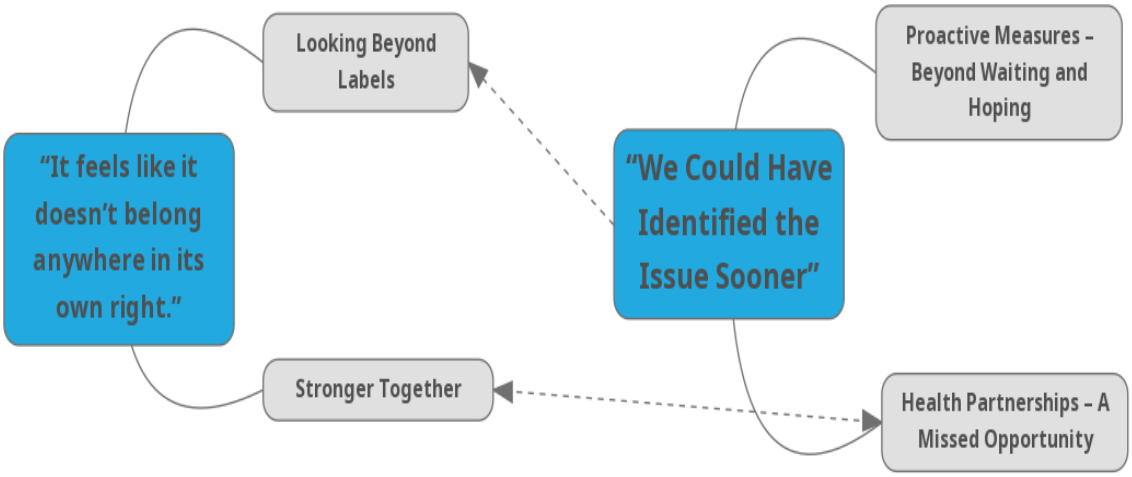


Figure 9- Collective Thematic Map of Parents and Early Years Staff

Superordinate Theme One: "It Feels Like It Doesn't Belong Anywhere in Its Own Right"

This theme sheds light on the uncertainty, frustration, and sense of marginalisation experienced by parents and early years staff when trying to support children with SM. Across the accounts, SM was often perceived as falling between services, with no clear diagnostic route or professional ownership. This lack of clarity left many feeling that SM, while acknowledged in principle, was not adequately addressed in practice.

Parent 4 powerfully expressed the impact of this ambiguity: ***"It's not good enough for speech and language therapy to say it's not us… but then tell me who it is and refer us further. It feels like it doesn't belong anywhere in its own right."*** This quote encapsulates the systemic gap—where neither health nor education services took clear responsibility, resulting in delayed intervention and family uncertainty. Bronfenbrenner and Morris's (2017) Bioecological Systems Theory offers a valuable framework for understanding the interconnected systems that influence a child's development. When family, school, and healthcare systems do not communicate or coordinate effectively, children with social communication challenges, such as SM, risk being overlooked and not receiving the support they need.

This issue is not new. As Keen et al. (2008) noted, professionals have historically disagreed about who should take the lead in supporting children with SM. Now, this study's findings suggest that those disagreements—and the lack of structured pathways—persist. Without formal routes to diagnosis or support, the burden of navigating and making sense of SM frequently falls on parents and early years staff.

Despite these challenges, a strong theme developed around staff and parents seeking to understand the child's needs beyond diagnostic labels. Through reflective observation and experiential learning, they adapted their practices to reduce anxiety and increase comfort. Staff 3 reflected on this process: ***"We learned that this could make her feel anxious because she might think we expect her to respond. So we stopped doing that."*** This demonstrates a move toward more empathetic and child-led strategies. Similarly, parents described scripting social scenarios for teachers and caregivers to reduce unpredictability for the child, making day-to-day interactions more manageable.

These adaptive strategies align with Kolb's Experiential Learning Theory (2014), which asserts that knowledge develops through a cycle of experience, reflection, and adjustment. Without formal guidance, parents and staff engaged in learning by doing—gathering information from resources like SMIRA and the NHS, trialling approaches, and adjusting based on the child's response. This form of learning gave them the confidence to act, even without a formal diagnosis, reinforcing that early support should not be contingent upon one.

A keen sense of collaborative effort also emerged in participants' accounts, as parents and staff worked together to create supportive and consistent environments across home and school. Dialogue and shared understanding formed the foundation of these efforts. Staff 1 commented, ***“Having that conversation with parents… is key to creating that shared understanding.”*** These conversations were not just informative—they were transformative, helping to ensure that support strategies were coherent, individualised, and sustained across settings.

This collective approach can be understood through Wenger’s (1998) Theory of Communities of Practice, which describes how learning is fostered through shared participation and mutual engagement. In this context, staff and parents informally created their communities of practice, exchanging insights, reflecting together, and building strategies rooted in lived experience. While formal systems left much to be desired, these grassroots partnerships enabled real change. Parent 2 reflected on the impact of this collaboration: ***“The school was really proactive in partnering with me to create a safe and supportive environment. It made a huge difference.”***

Systemic gaps have marginalised children with SM, leading to a perception among those who support these children that the condition lacks proper recognition. However, the willingness of staff and parents to look beyond labels and collaborate has been a significant source of strength. Their collective efforts to understand, adapt, and support the child have provided essential backing in the absence of formal resources. This situation highlights the importance of early relational intervention and underscores the crucial role that shared commitment, and grassroots learning can play in fostering inclusive environments.

Superordinate Theme Two: “We Could Have Identified the Issue Sooner”

This theme highlights the shared reflections of parents and early years staff who, with the benefit of hindsight, recognised missed opportunities for the early identification and support of SM. Despite signs being visible in early childcare or preschool settings, systemic gaps—particularly in training, communication, and interprofessional collaboration—often delayed effective intervention. The emotional tone throughout the study conveys frustration and regret, paired with a strong motivation to prevent similar delays for other children.

The experience illustrates how early signs of SM might be overlooked due to a lack of knowledge, training, and proactive engagement. Interactionist Theory (Bruner, 1983) helps explain this phenomenon by stressing the co-construction of meaning through social interaction. When interactions are inconsistent or unresponsive to a child's communicative anxiety, opportunities for social learning can be missed. Additionally, the psychological concept of watchful waiting—observing before acting—presents both a practical and theoretical tension. While this approach can be beneficial in some developmental contexts, it may inadvertently prolong a child's distress and delay necessary intervention in cases of SM.

Parents and staff frequently noted that health professionals, particularly health visitors, were not consistently positioned to identify SM during key developmental checks. Parent 3 remarked, ***"My child wouldn't have passed the two-year check if it relied solely on nursery observations,"*** pointing out that these assessments often lacked contextual nuance. Other parents advocated for the integration of SM awareness into health visitor routines and materials, with Parent 2 suggesting, ***"If there had been more knowledge and resources available, I think we could have identified the issue sooner and supported my child earlier."***

This highlights a broader need for stronger partnerships between health and education services. Bronfenbrenner and Morris's (2017) Bioecological Systems Theory emphasise that a child's development is shaped by the dynamic interaction between their individual characteristics and the multiple systems surrounding them. Health professionals who operate within the exosystem are well-placed to identify early signs of SM. However, their potential is often underused due to limited training and awareness. Bronfenbrenner and Morris's (2017) Bioecological Systems Theory also highlight the importance of proximal processes—regular, meaningful interactions between the child and their environment—which are most effective when supported by knowledgeable and well-coordinated systems. As Staff Member 2 observed, **"We need to ask more probing questions—like, 'Do they talk to**

people outside the family?'" Without targeted awareness and collaboration, early opportunities to identify and support children with SM may be missed.

Parents shared that early childcare providers often noticed differences in their child's behaviour but hesitated to raise concerns, fearing parental distress or lacking confidence in their knowledge of SM. Parent 1 recalled her childminder saying, "***I've thought about reaching out for the last six months, but I didn't want to worry you."*** This delay illustrates the limits of watchful waiting when not accompanied by proactive inquiry or support. While time to settle is important, structured early observation—especially during transitions—was viewed by staff as essential. Nevertheless, concerns were sometimes deferred; Staff 3 noted, ***"Concerns regarding children entering school often went unaddressed until the following school year."***

Conversely, staff who acted early described working without a formal diagnosis. One staff member shared, "***We're still following the plans we had in place as though she is selective mute."*** This indicates that informal recognition can lead to supportive actions, but these efforts may remain isolated without a clear protocol or external guidance. Parents proposed practical solutions to raise awareness, such as posters in GP surgeries and training for health visitors—strategies that align with preventive care models in public health. These measures would empower early years professionals and families to take action sooner.

3.13 Discussion of Findings

This discussion goes beyond the initial reflections in the findings section to provide a more critical and in-depth data analysis, directly addressing the study's core research questions. Drawing on existing literature and psychological theory and guided by a critical realist perspective, this analysis aims to uncover the underlying mechanisms that shape participants' perceptions. In line with qualitative research conventions, participant quotations illustrate key points and ground the analysis in the experiences of parents and early years staff. Specifically, the discussion examines: 1) What barriers hinder effective support during the identification of SM?

and 2) What facilitators enhance effective support during the identification process of SM? By exploring these questions, the discussion provides a deeper theoretical and practical understanding of the factors influencing SM's early identification and support within early childhood contexts.

Question 1: What barriers hinder effective support during the deification of SM?

The Uncertain Nature of SM

The uncertain nature of SM presents a significant barrier to its early identification. Both early years staff and parents often feel unprepared to recognise and address its signs. This uncertainty arises from a lack of specialised training, unclear referral pathways, and fragmented collaboration among agencies. A critical realist perspective suggests that while SM is primarily an anxiety-driven condition, societal systems and institutions significantly influence its understanding and management.

According to Bronfenbrenner and Morris (2017), Bioecological Systems Theory states that a child's development is shaped by interactions between their biological characteristics and the various environmental systems surrounding them. Applying this theory indicates that a lack of coordination between microsystems—such as home and school—and the exosystem, which includes healthcare services, can lead to confusion and delays in a child's development. Parent 4’s remark, ***“It feels like it doesn’t belong anywhere in its own right,”*** illustrates the systemic uncertainty that arises when these interconnected systems fail to communicate and collaborate effectively.

From a social constructionist viewpoint, this uncertainty is influenced by socially constructed norms and expectations regarding silence in children. Disagreements about professional responsibility, as noted by Keen et al. (2008), along with inconsistent referral practices, contribute to delays in intervention. Research by Williams et al. (2021) and Ramon (2018) reveals that educators’ lack of targeted training further complicates early identification. White et al. (2022) also highlighted the absence of SM-specific content in Initial Teacher Training (ITT). These institutional knowledge gaps perpetuate delays in recognising and responding to SM.

Parents often experience significant uncertainty, which is frequently worsened by a lack of guidance. Parent 2's statement, ***"If there had been more knowledge and resources available, I think we could have identified the issue sooner,"*** highlights how the absence of clear information leads to delays in intervention. Kadoma (2023) and Douglas (2021) identify similar concerns within healthcare and educational systems, suggesting that the lack of clear communication pathways increases parental anxiety. Furthermore, the overall uncertainty surrounding the condition—whereby professionals and key stakeholders are unclear about which specialists can provide support—along with a general lack of knowledge in society and insufficient formal training, poses substantial barriers.

Misinterpretation of SM

A significant barrier to the early identification and support of SM is the frequent misinterpretation of its symptoms. Both parents and early childhood staff often view a child's silence as shyness, introversion, or even defiance rather than recognising it as a sign of anxiety. This misinterpretation can be explained by Attribution Theory (Heider, 1958), which posits that individuals tend to attribute behaviours to internal personality traits, often overlooking situational and contextual factors, such as anxiety. From a critical realist perspective, while the reality of SM as an anxiety disorder is evident, societal interpretations of silence—shaped by cultural norms—often obscure this reality.

This misinterpretation is consistent with broader societal patterns highlighted in the literature, where SM is frequently conflated with shyness. As Parent 2 noted**, *"The first step to support would be simply acknowledging that the issue could be more than shyness."*** This statement exemplifies how societal understandings of silence are constructed within a framework that equates it with shyness, leading to a superficial understanding of SM. Research by Kadoma (2023) and Douglas (2021) further supports this view, illustrating how SM is often misunderstood as merely an extreme form of shyness. Kotrba (2015) and Viana et al. (2009) also highlight how children with SM often blend into classroom environments, where their silence is interpreted as harmless or even a positive trait, thereby concealing the underlying anxiety.

From a social constructionist perspective, this highlights how the meanings attributed to silence—rooted in societal expectations of behaviour—lead to a misinterpretation of SM. The lack of a clear understanding of SM means that both parents and staff may overlook the significance of a child's silence, which delays accurate identification and the implementation of appropriate anxiety-driven interventions.

This misinterpretation reflects a broader issue in which societal norms and expectations about shyness shape the interpretation of children's behaviour. Silence, when viewed through the lens of these norms, is often considered non-threatening or even a positive trait, thus obscuring the true nature of the condition. This social construction of silence as harmless may hinder the identification of SM, preventing the necessary recognition of anxiety and delaying targeted interventions.

Lack of formal Diagnosis

The absence of a formal diagnosis of SM appears to present a key barrier, as professionals often dismiss concerns without official confirmation. This lack of a formal diagnosis seems to exacerbate delays in intervention, as professionals may be less inclined to provide support without an official diagnosis. This phenomenon resonates with Seligman’s Learned Helplessness Theory (1975), where repeated failures to secure support foster a sense of parental disempowerment and emotional exhaustion, reinforcing the barrier to timely intervention.

Selective Mutism Information and Research Association (2024) highlights systemic inconsistencies in the diagnostic process for Selective Mutism, including a widespread lack of awareness among referral sources. These findings reinforce the challenges families face in securing formal diagnoses and accessing timely support. Such institutional shortcomings suggest that the development of clearer, more standardised referral pathways is essential. Implementing these improvements could reduce barriers, ensure earlier identification, and promote more equitable access to intervention for children with SM.

Watchful Waiting

The approach of watchful waiting seems to hinder effective support for children with SM. Both early years staff and parents often face situations where passive observation is recommended, under the assumption that the child's difficulties will resolve on their own over time. However, in the case of SM, this approach may unintentionally reinforce the child's anxiety and silence, making the issue more entrenched. For instance, Parent 1 reflects, ***"I've thought about reaching out for the last six months, but I didn't want to worry you,"*** illustrating how well-meaning hesitancy can lead to missed opportunities for early intervention.

Oerbeck et al. (2014) highlight that this delay in action can be compounded by reassurances that children will "grow out of it." This perspective reflects a broader societal tendency to underestimate the persistence of SM, which contributes to postponing necessary interventions. Viewed through a social constructionist lens, this passive approach can be understood as a product of societal norms that favour waiting and observing over early intervention, reflecting a constructed understanding of childhood development.

From a critical realist perspective, however, the underlying reality of SM as an anxiety-driven condition requires timely and responsive support. Bruner's Interactionist Theory (1983) suggests that a lack of intervention during these crucial early stages can prevent vital interactive moments that are essential for the child's communicative development. Consequently, the mechanisms behind watchful waiting seem to stem from a failure to understand the need for early, targeted interventions, as well as a disconnect between the child's actual experiences of anxiety and society's expectations about how children should develop and behave in early childhood.

Question 2: What facilitators enhance effective support during the identification process of SM?

Relational Strategies

Relational strategies, such as creating emotionally safe environments and using low-pressure, child-led play, were identified as important facilitators for recognising and supporting SM. The theme "***It's hugely anxiety-driven, isn't it?"*** highlights the significance of emotionally available adults who can attune to children's needs and reduce perceived social threats, which is crucial for fostering communication. As Staff Member 1 noted, ***"I suppose that's what she needs to feel comfortable…"*****—**this insight captures the understanding that children's ability to communicate depends on feeling emotionally secure.

These relational practices align with Basic Psychological Needs Theory (Deci & Ryan, 2000), which highlights the importance of relatedness in fostering motivation and engagement. Furthermore, the Zone of Proximal Development (ZPD) underscores that sensitive and guided interactions within emotionally safe environments can enhance the development of communication skills (Daniels, 2001, pp. 55–58). By employing these relational strategies, early years staff not only alleviated anxiety but also created developmentally appropriate opportunities for communication.

By creating low-pressure environments sensitive to emotions, early years staff can more effectively identify the subtle and context-dependent signs of SM. This relational approach may facilitate earlier identification and intervention. Understanding SM involves recognising the mechanisms related to actively reducing social threats. When relational safety is established, individuals are more likely to engage freely, which increases the chances that SM will be recognised and supported at an earlier stage.

Self-Directed and Experiential Learning

Self-directed learning is recognised as a crucial factor in addressing the gaps left by a lack of formal training. Both early years staff and parents engaged in independent knowledge-seeking behaviours, utilising resources such as the NHS, Medway, and SMIRA to gain a more nuanced understanding of SM. The informal reflection cycles advocated by Gibbs (1988) had a significant impact on staff, enabling them to critically evaluate their practices and adapt their responses over time. As Staff Member 3 noted, ***“We learned that this could make her feel anxious because she might think we expect her to respond. So we stopped doing that.”*** This highlights how reflective insight can lead to meaningful changes in practice, even without external guidance.

Similarly, parents' proactive search for information allowed them to reframe their child’s behaviours through cognitive reappraisal processes (Gross, 1998). This enabled them to adopt more informed and supportive approaches. Instead of relying solely on professional input, parents drew on their experiences, reflections, and research to construct their understandings, emphasising the socially constructed nature of knowledge development around SM. Parent 3 shared, **“I didn’t know what I was searching for… but I typed in a few phrases like ‘doesn’t do this’ and ‘doesn’t do that’ and eventually found the Medway page.”**

The mechanisms that support self-directed learning involve a continuous cycle of acquiring new knowledge, critically reflecting on that knowledge, and adjusting practices accordingly. These processes could be further enhanced through Continuing Professional Development (CPD) initiatives that include specific content on SM, helping better equip staff and parents with the tools they need for effective support.

Through these processes, self-directed learning is not only viewed as a compensatory mechanism for professional gaps but also as an active means of facilitating earlier recognition and more effective support.

Collaborative Approach

Collaboration between parents and early years staff is essential for effectively identifying and supporting children with SM. This collaboration is particularly valuable when both parties share a clear understanding of the condition. From a social constructionist perspective, knowledge about SM is co-constructed through dialogue and the mutual sharing of experiences. This process allows for a more nuanced and individualised understanding of how SM manifests differently in each child. As Staff 1 noted, ***“Having that conversation with parents is key to creating that shared understanding.”*** This highlights the importance of ongoing, open communication in bridging potential gaps in professional knowledge, ensuring that all aspects of SM-related challenges are recognised and that no child's experience is overlooked or dismissed. In a similar vein, Parent 2 positively reflected on a collaborative approach, stating, ***“The school was really proactive in partnering with me.”*** This emphasises the vital role that partnerships play in ensuring interventions are not only guided by professional expertise but are also informed by parental insights and experiences.

From a critical realist perspective, collaboration is viewed as a relational, dynamic, and context-dependent process. Knowledge about SM is not fixed or universally agreed upon; it emerges through interactions between parents and staff, shaped by broader structural influences such as institutional knowledge gaps, diagnostic practices, and societal perceptions of communication difficulties. In this view, collaboration is more than just exchanging information; it is an active process through which understanding is deepened and negotiated. This perspective features the importance of recognising the complexity of SM and the contextual factors that influence how support is conceptualised and delivered.

Successful models of collaboration, such as those demonstrated in Derbyshire (2020) and St. George’s (Hipolito & Johnson, 2021), illustrate how strong partnerships between parents and staff can improve referral pathways, expedite interventions, and enhance the quality of support provided. These examples reveal that the co-construction of knowledge shared advocacy, and joint ownership of intervention strategies support effective collaboration. From a critical realist perspective, these collaborations exemplify the dynamic interplay between structure (e.g., institutional resources, professional training) and agency (e.g., parent and staff engagement and initiative), facilitating timely, personalised, and impactful support for children with SM.

Discussion Summary

This discussion critically examined the main research questions related to barriers and facilitators for the early identification and support of SM within early childhood settings.

Barriers to Identifying and Supporting Children with SM

Identifying and supporting children with SM faces several challenges:

- The lack of specialised training, unclear referral pathways, and fragmented collaboration among home, educational settings, and healthcare services contribute significantly to the uncertainty and inconsistency in identifying and supporting these children.
- Behaviours associated with SM are often misinterpreted as shyness, stubbornness, or defiance. These misconceptions are reinforced by societal norms and a limited awareness among both the public and professionals.
- Without a timely or formal diagnosis, access to appropriate professional support is frequently delayed. This situation often requires parents to assume the role of primary advocates and coordinators of care for their child.
- The commonly adopted strategy of "watchful waiting" further delays early intervention, which can intensify the child’s distress and diminish the effectiveness of support strategies.

Facilitators for Identifying and Supporting Children with SM

Several factors can facilitate the identification and support of children with SM:

- Utilising relational strategies that create emotionally safe, low-pressure environments aligns with Basic Psychological Needs Theory (BPNT; Ryan & Deci, 2017). This approach supports children's needs for autonomy, relatedness, and competence.

- Self-directed and experiential learning undertaken by both parents and early years staff helps bridge the gap left by limited formal training. This learning process includes reflective practice, proactive information-seeking, and adapting strategies to meet each child's individual needs.
- Collaborative partnerships between parents and early years practitioners enable the co-construction of knowledge, enhance mutual understanding, and promote shared responsibility for the early identification and tailored support of each child.

These findings provide a deeper understanding of the complex and interrelated mechanisms that influence how children with SM are identified and supported. They highlight the importance of relational trust, professional curiosity, and collaborative working in overcoming barriers to timely and effective support. Building on this understanding, the following section will explore how these insights can be applied in EP practice.

3.14 Implications for the Role of the EP

The CARES Model: Foundations and Context

This section introduces CARES, a novel, practice-oriented framework developed by the researcher as an outcome of this empirical study, designed to support children experiencing SM. The model integrates the lived experiences of parents and early years staff with relevant psychological theory to address the barriers and facilitators identified in the research.

CARES was developed to bridge the persistent gap between knowing what needs to happen and understanding how to make it happen, particularly in early years environments where SM often emerges but remains poorly understood. Although best-practice guidance is available (e.g., Keen et al., 2018), professionals frequently report uncertainty and a lack of confidence in responding effectively to these challenges. CARES addresses this by offering a relational, theory-informed model grounded in the realities of early years practice.

Rooted in systemic thinking—specifically the COMOIRA framework (Gameson & Rhydderch, 2017)—CARES promotes collaborative meaning-making, contextualised problem-solving, and joint reflection. It provides a flexible, psychologically grounded structure to guide stakeholders—including EPs, early years staff, ALNCOs, SENCOs, and families—toward inclusive and developmentally sensitive practices.

As a developing model, CARES is introduced here as a starting point for broader application and exploration. While both research and theory inform it, it is intended to evolve through practical use, reflection, and feedback. This section focuses particularly on how EPs might apply the CARES principles within their core domains of practice: assessment, consultation, intervention, and training.

Drawing on Fox's (2003) emphasis on collaborative and iterative approaches to evidence-based practice, the researcher positions CARES as a working framework that invites stakeholders to trial the model, adapt it to their settings, share learning, and contribute to its ongoing development. In this way, the framework offers both immediate relevance and the potential for long-term impact through continued co-construction with its users.

3.15 Purpose and Contribution of the CARES Model

The CARES model—Collaborate, Acknowledge, Recognise, Enable, Strengthen—is a flexible early-intervention framework designed to guide the identification and support of young children experiencing SM. It is intended for use from the moment children enter childcare or preschool through to the primary school years. While it can be adapted for older children, its primary focus is on early identification and support during the early years.

Developed from the findings of this study, CARES bridges the gap between existing best-practice guidance (e.g., Keen et al., 2018) and the practical challenges faced by parents and staff in early years settings, where SM often emerges but is frequently misunderstood. Many participants expressed uncertainty and a lack of confidence in how to respond effectively; CARES addresses this by providing a structured, psychologically informed, and relational model grounded in real-world experiences.

The model's unique contribution lies in its integration of three core dimensions:
Developmental sensitivity: Recognising that SM commonly arises between the ages of 2.7 and 4.1 (Viana et al., 2009; Steffenburg et al., 2018), CARES supports proactive and developmentally appropriate engagement during these critical early years.
Systemic and collaborative thinking: Building on the COMOIRA framework (Gameson & Rhydderch, 2017), CARES encourages shared decision-making, flexible problem-solving, and collaboration among multiple agencies.
Practical accessibility: The model provides early years staff, EPs, SENCOs, ALNCOs and families with a straightforward yet adaptable structure for inclusive and relational practice.

CARES is informed by the lived experiences of parents and early years staff from this study, responding directly to themes such as “You’ve Got to Prove That You Need Help” and “We Could Have Identified the Issue Sooner.” These themes highlight the emotional and systemic barriers families face, which CARES aims to help overcome.

Theoretical Foundations of CARES

The CARES model is informed by four core psychological theories that shape its relational, systemic, and developmental orientation:

- **COMOIRA (Gameson & Rhydderch, 2017):** A decision-making framework that fosters collaborative meaning-making and a non-linear approach. It encourages professionals to build understanding and collaboratively maintain curiosity.
- **Kearney’s Continuum of Communication (2010):** This model reframes SM as part of a broader communicative spectrum. It supports the identification of subtle or non-verbal behaviours and the avoidance of binary "speaking vs. not speaking" thinking.

- **Expectancy Violations Theory (Burgoon, 2015):** EVT explains how silence in expected speaking situations can violate social norms, leading to punitive or avoidant responses. This theory helps professionals reframe silence as emotionally meaningful, rather than deviant.
- **Basic Psychological Needs Theory (Ryan & Deci, 2017):** This theory asserts that children thrive in environments that nurture autonomy, competence, and relatedness. It underscores the importance of emotionally safe spaces for communication readiness and relational trust.

These theoretical frameworks offer a shared language for practice, connecting psychological insight with the nuanced realities described by study participants.

3.16 The CARES Model: Defining Its Five Core Elements

C – Collaborate with Parents as Key Contributors

Parents have a deep and often intuitive understanding of their child's emotional and communicative patterns. However, these insights can sometimes be dismissed or undervalued, particularly when SM has not yet been diagnosed. The theme "You’ve Got to Prove That You Need the Help" highlights the frustration many families experience.

The CARES model encourages professionals to engage in genuine, sustained collaboration with parents, viewing them not as passive recipients of information but as equal partners. Rooted in the social constructionist framework of COMOIRA, this principle highlights that understanding develops through shared dialogue and relationship-building.

A – Acknowledge and Use Uncertainty as a Starting Point

Participants often expressed feelings of uncertainty when it came to identifying or supporting children with SM. Instead of seeking immediate clarity, the CARES model encourages professionals to view this uncertainty as a valuable opportunity for reflection, shared exploration, and flexible thinking.

The subtheme "We Need More Information About This" highlights the ambiguity that frequently accompanies SM in early childhood. Embracing this ambiguity encourages professionals to ask questions and explore the child's experience.

This approach is informed by COMOIRA’s non-linear decision-making model, which promotes an iterative understanding, and Expectancy Violations Theory (Burgoon, 2015), which frames silence as emotionally significant rather than problematic. Tools such as Kearney’s (2010) Communication Continuum and Johnston and Wintgens’ (2016) anxiety-based definition of SM help professionals to reframe silence not as an act of deliberate resistance, but as a fear-based, involuntary response. Through this perspective, uncertainty is seen not as a limitation but as a catalyst for thoughtful, theory-informed engagement.

R – Recognise Communicative Behaviours Across the Continuum

SM does not always manifest as complete silence. Instead, children may communicate in subtle and adaptive ways, such as mouthing, whispering, gesturing, or speaking only to specific individuals. These nuanced behaviours can be easily overlooked if professionals focus exclusively on verbal communication.

The theme “It Takes a Long Time for the Penny to Drop” emphasises that early signs of SM are often misinterpreted or entirely missed. The CARES model encourages professionals to recognise and value all forms of communication, regardless of how minimal or inconsistent they may be, as meaningful expressions of a child's needs and comfort levels.

Kearney’s (2010) Communication Continuum supports this perspective by providing a framework for tracking a child’s communication across various contexts and relationships. This approach promotes early identification and fosters a more accurate and compassionate understanding of how anxiety manifests in speech behaviour.

By adopting a relational and contextual perspective, professionals can better recognise and interpret these subtle signs, which enables earlier and more effective support.

E – Enable Safe, Reflective Spaces for Dialogue

Emotional safety and relational consistency are crucial for children with SM and for the adults who support them. The theme "We Hoped for Improvement, but Things Did Not Get Better" emphasises the need for supportive environments that encourage ongoing conversation, reflection, and adaptation.

Drawing on Edmondson’s (1999) concept of psychological safety and Basic Psychological Needs Theory (Ryan & Deci, 2017), CARES stresses the importance of non-judgemental, collaborative spaces. These environments allow professionals and families to openly discuss their emotional responses, reframe their assumptions, and adjust their support strategies.

S – Strengthen Connections Across Networks

Effective support for children with SM is rarely achieved through isolated efforts. Fragmentation across educational and health systems can delay the identification of issues and weaken consistency in support. The theme “We Could Have Identified the Issue Sooner” emphasises the missed opportunities that occur due to a lack of communication and knowledge.

CARES advocates for stronger collaboration among early childhood settings, schools, families, and health services, guided by Bronfenbrenner’s (1979) ecological systems theory and COMOIRA’s systemic approach. EPs are in a unique position to act as facilitators, promoting alignment, coherence, and mutual understanding across professional boundaries.

3.17 Operationalising CARES: The Role of EPs

CARES can be integrated within the four key domains of EP practice (Fallon, 2010): assessment, consultation, intervention, and training. The following illustrates how each principle can be applied in practice:

- **Assessment:** EPs can conduct holistic, contextual assessments that capture relational and behavioural patterns across time and settings. This includes attuning to non-verbal cues, environmental triggers, and relational dynamics. Using Cline and Baldwin's (2004) concept of overlapping neurodevelopmental profiles, EPs avoid reductionist interpretations and build comprehensive, evolving formulations.
- **Consultation:** EPs can use reflective consultation with parents and early years staff to validate experiences, challenge assumptions, and reframe SM as an anxiety response. Creating spaces where stakeholders feel heard supports collaborative planning and systemic change.
- **Intervention:** CARES-informed interventions focus on the adults who surround the child. According to BPNT (Ryan & Deci, 2017), fulfilling the fundamental needs for competence, autonomy, and relatedness is essential for optimal motivation, engagement, and psychological well-being. EPs can guide adults in creating such environments, thereby supporting children's communication readiness by addressing these core psychological needs.
- **Training:** EPs can design and deliver training based on the CARES model, which helps them develop their knowledge, confidence, and ability to build relationships. By incorporating frameworks such as EVT (Burgoon, 2015), BPNT (Ryan & Deci, 2017), and Kearney's Communication Continuum (2010), EPs can create more nuanced and inclusive responses for supporting SM.

Supporting Implementation and Wider Impact

To support implementation, the following practitioner resources have been developed:

- Appendix 19: A one-page summary table linking each CARES principle to its theoretical basis, practical strategy and illustrative quote/theme. This is designed to be shared across teams and with parents to support consistent understanding.

- Appendix 20: A fictional case study that brings the CARES model to life in a practical, narrative form. This resource aims to illustrate how the model may be applied in everyday practice, helping professionals visualise the journey from concern to coordinated support.

Policy and Systemic Implications

CARES aligns with inclusive educational frameworks, such as the Additional Learning Needs (ALN) Code for Wales (2021). This framework emphasises early intervention, person-centred planning, and collaboration among various agencies. However, applying these frameworks to SM can be challenging due to inconsistent recognition, varied awareness, and a lack of confidence in effectively supporting children with SM.

CARES offers a flexible, practice-based framework that complements existing national guidance, enabling stakeholders to translate inclusive principles into everyday actions. By reframing SM as a communication difference that arises from relational and ecological systems, the model promotes needs-led and developmentally sensitive approaches that facilitate earlier identification and coordinated responses.

To address current gaps in expertise and continuity, it may be beneficial to establish specialist roles for SM, similar to those available for autistic learners. For instance, a Specialist Teacher for SM could provide consistent guidance, contribute to local capacity building, and help integrate practices across educational, health, and care settings.

While grounded in grassroots insights and psychological theory, CARES also emphasises the necessity for broader national coordination, cross-agency training, and investment in cohesive policy responses. In this way, it serves as both a practical tool for immediate use and a platform for fostering long-term systemic improvement.

Conclusion of the CARES model

CARES offers an innovative, relationally attuned, and theoretically informed model for supporting young children experiencing SM. It addresses the urgent need for clear and accessible guidance that translates theory and evidence into everyday practice, particularly during the crucial and often-overlooked early years stage.

The model is built around five core principles: Collaborate, Acknowledge, Recognise, Enable, and Strengthen. CARES offers a practical framework for integrating psychologically informed support throughout early childhood systems. By guiding EPs, ALNCOs, SENCOs, early years staff, and families to engage in systemic consultation, responsive assessment, relational intervention, and capacity-building training, the model promotes a shift from passive observation to active, compassionate, and context-sensitive practice.

Moreover, CARES highlights the broader system in which children develop. It advocates for inclusive, needs-led, and developmentally sensitive approaches, systemic coordination, and a deeper understanding of the emotional needs underlying SM. By doing so, it challenges services to create environments where children with SM are not only recognised and supported but also empowered, understood, and meaningfully included.

3.18 Explore Constructions of the Intentions to Change

Although EPs are well-positioned to support systemic change, gaps in their specialist training often limit their ability to effectively address the needs of children with SM. Edwards (2022) notes that EPs may not always possess the necessary expert knowledge to adequately support this population. This lack of expertise can affect their confidence and perceived ability to lead changes in early years settings.

In addition, the British Psychological Society (BPS) (2024) reported that more than half of EPs cannot support children and young people effectively because of their current workloads. This issue delays essential assessments and interventions, suggesting that EPs may be considered hard-to-reach professionals.

However, EPs who have received specialised training in SM or possess direct experience with the condition can make a significant impact. Their enhanced understanding and expertise enable them to provide targeted support, advocate for necessary changes, and collaborate more effectively with early years settings. With the proper training and resources, EPs can play a crucial role in driving meaningful change, ensuring that children with SM receive the necessary support.

3.19 Future Research Directions on SM Support in the UK

To enhance our understanding of the incidence and needs of children with SM across the UK, conducting audits and small-scale research studies in various regions would be beneficial. Initial audits, such as those by Hipolito and Johnson (2021), emphasise the importance of collaboration among speech therapists, educators, parents, and key workers in identifying SM. Hipolito and Johnson (2021) have already improved the timeliness of referrals; children are now referred between the ages of 2 and 9 years (with a median age of 4), a significant shift from the previous range of 6 to 11 years (with a mean age of 9). This change reflects considerable progress in both awareness and early detection.

Future research should embrace a multidisciplinary approach, akin to the model used in Scotland, to monitor and support children suspected of having SM. The collaborative framework employed by the Royal Aberdeen Children’s Hospital (RACH) incorporates Clinical Psychology, Speech and Language Therapy Services, and Educational Psychology Services, providing a comprehensive method for addressing the increasing number of referrals for children and young people with SM (Aberdeenshire Council, 2020). This approach is informed by The Selective Mutism Resource Manual (Johnston & Wintgens, 2001), which offers critical information, practical strategies, resource lists, assessment tools, and evidence-based intervention guidelines, including the Sliding-in Technique.

Future research has significant potential to systematically evaluate the implementation of these guidelines in early years settings. Studies could investigate how specific elements of the manual—such as environmental adaptations or graduated exposure—are understood and applied by practitioners. This research could also assess outcomes linked to different adaptations of the manual across various school and community contexts, ensuring it is used flexibly and inclusively.

To implement effective support strategies, government entities must adopt guidelines that reflect this multidisciplinary SM approach. For example, Aberdeenshire's staged intervention procedures outline specific steps to assist children showing signs of SM, ensuring they receive appropriate attention within the educational system. The Pathways to Policy document present clear intervention protocols developed in collaboration with parents and caregivers, ensuring that no child falls through the cracks (Aberdeenshire Council, 2020).

However, despite this study's focus on the early years, the perceptions of preschool staff remain largely unheard. This highlights the value of replicating the study to incorporate their voices, thereby enriching the understanding of how SM is identified and supported in early childhood settings. Given their crucial role in the early identification of SM, the insights of preschool staff are essential for informing effective intervention strategies. Future research should prioritise engaging this group, ensuring their perspectives are not only valued but also supported with the necessary knowledge and tools to meet the needs of children with SM effectively.

3.20 Strengths and Limitations of the Research

Table 11- Strengths and Limitations of the Research

Limitations	Strengths
Limited generalisability: The study's findings exhibit limited generalisability due to the absence of participation from preschool staff. This lack of representation may influence the applicability of the results to preschool-aged children, potentially skewing the understanding of this demographic's specific needs and experiences. Further research that includes preschool educators is necessary to enhance the validity and relevance of the conclusions drawn.	**Innovative Focus:** This study highlights a notable gap in preschool staff perspectives on the identification of SM. Future research could address this gap by exploring preschool staff insights, thereby offering a more comprehensive understanding of the identification and support processes for children with SM.
Recruitment Challenges: Difficulty engaging preschool staff led to a small and uneven sample, reducing the potential richness of data.	**Unique Analytical Approach:** Applying the COMOIRA framework adds depth to the analysis and offers specific insights relevant to EPs.
Reliance on Self-Report: Some children were included based on parental reports rather than formal diagnoses, raising concerns about data reliability.	**Timely Contribution:** This empirical study addresses an under-researched area at a critical developmental stage, offering novel insights into the early identification process for SM.
Lack of External Professional Perspectives: The absence of views from external agencies (e.g., EPs, SLTs, health visitors) limits understanding of multi-agency collaboration.	**Inclusive Participant Criteria:** Including children awaiting formal assessment reflects real-world diagnostic delays and gives voice to families often excluded from research.

Potential Researcher Bias: Insider status may introduce subjectivity; reflexivity was employed to address this.	**Insider Researcher Perspective:** The researcher's lived experience enabled more profound empathy and understanding during data collection and analysis.
Small Sample Size: The study recruited only seven participants, which may constrain the breadth and variability of experiences captured. While rich, in-depth insights were obtained, the limited sample size potentially reduces the *study's information power* (Malterud et al., 2016) and may affect the transferability of findings. A larger or more diverse sample could have enhanced the depth and nuance of interpretations, allowing for a wider range of perspectives on the identification and support of SM.	**Methodological Rigor:** Thematic analysis was applied carefully following Braun and Clarke's (2013) guidance for qualitative research. A key strength of the study lies in including participants from both groups—parents and early years staff—which enabled the exploration of multiple perspectives on SM Furthermore, the researcher adopted a reflexive and active role in the analytic process, consistent with RTA and underpinned by a social constructionist stance (Braun & Clarke, 2022). Rather than striving for data saturation—a concept rooted in positivist paradigms—the approach focused on meaning-making and the co-construction of knowledge, enhancing the study's depth and theoretical coherence.

Conclusion

This study explored how parents and early years staff perceive the identification and support of SM in early childhood. The findings highlight the complex challenges surrounding SM during this formative developmental stage, where early intervention is crucial but often delayed. A common narrative emerged across both groups: SM is frequently misunderstood, responses are fragmented, and systemic and conceptual gaps hinder support.

Early years staff demonstrated a strong commitment to child-centred, relational practices; however, their efforts were constrained by limited training, competing priorities within mainstream education, and a lack of structured collaboration. These challenges indicate broader institutional limitations in recognising and addressing early communication differences.

Parents shared emotionally intense accounts marked by persistent advocacy, professional dismissal, and difficulties navigating a system that often requires a formal diagnosis to access support. While their resilience was evident, the undue burden placed on families—often in the absence of consistent professional understanding or clear pathways—signals a pressing need for systemic reform. Families should not bear the primary responsibility for securing recognition and support.

A recurring theme in the accounts was the reactive nature of current systems. Early signs of SM were often observed but not acted upon in a timely or strategic manner. The prevalent “wait and see” approach—rooted in a narrow or incomplete understanding of SM as a complex anxiety condition—risks entrenching difficulties. A shift towards proactive, reflective, and cohesive practices is essential, supported by early intervention, targeted professional development, and inter-agency collaboration.

In response to these findings, this study introduces the CARES model—a practice-oriented, relational framework designed to help professionals respond more effectively to children with emerging SM. CARES is grounded in psychological theory and real-world insights shared by parents and early years staff throughout the study. It draws on several theories, including COMOIRA (Gameson & Rhydderch, 2017), Expectancy Violation Theory (Burgoon, 2015), Basic Psychological Needs Theory (Ryan & Deci, 2017), and Kearney’s Communication Continuum (Kearney, 2010). The model promotes collaborative, emotionally attuned, and systemic responses that reflect the relational and developmental complexities of SM while positioning parents as central partners in the support process.

Although some good examples of practice exist—such as the best practice care pathway proposed by Keen et al. (2008)—further developments include the Derbyshire Selective Mutism Resource Pack (Derbyshire County Council, 2020), the Aberdeenshire Supporting Children and Young People with Selective Mutism Practice Guidelines (Aberdeenshire Council, 2024), and St George’s audit by Hipolito and Johnson (2021). However, access to such provisions remains inconsistent, reflecting an ongoing "postcode lottery." Nationally coordinated, context-sensitive policies—underpinned by relational frameworks like CARES—could help promote more equitable, inclusive, and consistent outcomes for children with SM and the adults supporting them.

Framed through a critical realist lens, this study has illuminated the interaction between individual experiences, institutional practices, and broader sociocultural discourses in shaping how SM is recognised and responded to. Reframing SM not as a marginal or puzzling condition but as a meaningful communication difference shaped by relational and environmental factors creates new opportunities for earlier identification, more coordinated intervention, and truly shared responsibility across services. This perspective encourages a shift away from delay and uncertainty towards a supportive system that is responsive, compassionate, and developmentally appropriate.

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Part 3: Critical Appraisal

"It Feels Like It Doesn’t Belong Anywhere in Its Own Right”: The Challenge of Identifying and Supporting Selective Mutism in Early Childhood

Wordcount: 6,588

Introduction

A fundamental aspect of qualitative research is reflexivity, which requires researchers to actively engage with their subjectivity and the complexities of social phenomena (Olmos-Vega et al., 2023). Reflexivity is not a one-time exercise but an ongoing process of reflection and transparency throughout the research journey (Braun & Clarke, 2022). It involves acknowledging one's assumptions and addressing the challenges encountered during the study (Olmos-Vega et al., 2023). However, it is essential to balance self-awareness with the need to avoid narcissism, which may overshadow participants' voices (Nadin & Cassell, 2006).

This critical appraisal will provide a reflective account of the research process, organised into two sections. The first section, "Development of the Research Practitioner," will discuss my motivations for the study and key methodological decisions. The second section, "Contribution to Knowledge," will explore the study's findings and plans for dissemination. Due to the circular nature of reflection, some overlap between these sections is expected. I will include extracts from my research diary to illustrate key points further. This account will be written in the first person to present myself as an active participant in the research process, highlighting my learning journey (Bourke, 2014; Pellegrini, 2009).

3.21 Part One: Development of the Research Practitioner

Research Positionality and Origin of Research

Acknowledging the researcher's positionality is essential for maintaining ethical transparency and integrity in qualitative research (Hayfield & Huxley, 2015). In this study, my motivation to explore the identification and support of children with SM stems from my personal experiences as a parent of a child with SM, combined with my professional role as a TEP. Parenting a child with SM has significantly shaped my perspective, positioning me as an insider researcher, a concept articulated by Chavez (2008, p. 475). Insider positionality refers to the shared experiences or characteristics between the researcher and the participants, allowing for a deeper understanding of the subject matter. Since several participants were also parents, I was particularly aware of how my identity aligned with theirs, influencing my research approach and interactions with them.

Conducting research as a parent of a child with SM introduces a unique insider-outsider dynamic. As Dwyer and Buckle (2009) described, this duality places the researcher in a "space between," where one must balance personal connection with the subject matter while managing potential biases that may arise from such proximity. In my case, being a parent of a child with SM allowed me to approach the research with a genuine, personal understanding of the difficulties families face when navigating the challenges of identifying and supporting children with this condition. This insider perspective provided me with pre-existing knowledge of the emotional and social complexities involved, enabling me to develop more targeted and empathetic questions.

My journey as a parent further shaped my research focus. As I navigated my child’s experience with SM, I questioned how others, including professionals in early years settings, perceive children with SM. This prompted me to seek out information on SM, and through my reading, I became acutely aware of the ambiguity surrounding the condition and the lack of widespread understanding. I was struck by the gaps in awareness among the public and professionals, including EPs, which sparked my interest in exploring the identification process. As a TEP with limited knowledge of SM, I wanted to understand how other children with SM are identified, particularly given the often-subtle nature of the condition in its early stages.

During my reflective journey, I realised that most of the literature I encountered focused predominantly on the clinical and medical models of SM, emphasising diagnosis and treatment. Very few studies adopted a qualitative lens to explore the early stages of SM or to investigate how parents and professionals first recognise the condition. This realisation marked a "lightbulb moment" for me, igniting my determination to understand the identification process for SM in early childhood.

Theoretical paradigms

Research paradigms serve as fundamental perspectives through which research phenomena are perceived and understood (Cohen et al., 2018). Clarifying the paradigm that underpins this study is essential due to its significant implications for the epistemological foundations of social science and its impact on educational research (Cohen et al., 2018, p. 10).

After thorough consideration, I have adopted a critical realist ontological stance, and my epistemology aligns with a social constructionist approach. A critical realist perspective posits that while reality exists independent of human perception and experience, our social, cultural, and cognitive frameworks inevitably mediate our understanding. This perspective acknowledges the existence of a real-world beyond human thought; however, achieving an objective understanding of it is impossible, as our knowledge is shaped by interpretations and social contexts (Bhaskar, 2014).

This critical realist stance aligns with my position as an insider researcher. SM can be quantified through clinical diagnoses using established guidelines such as the DSM-V and ICD-11, which play a pivotal role in these assessments. By adopting a critical realist approach, I emphasise that SM is a 'real phenomenon.' This understanding supports the premise that anxiety can significantly inhibit children's communication abilities, a view shaped by my personal experiences as a parent of a child with SM.

Based on my reading and literature review, I am also aware that SM has been medicalised with a focus on meeting diagnostic criteria; however, emerging literature highlights the nuances of the condition, and the complexities involved in these processes. Therefore, a critical realist perspective enabled me to distinguish between empirical evidence, such as clinical diagnoses, and the actual lived experiences of parents and early years staff to uncover fundamental causal mechanisms that link these elements.

The social constructionist epistemological stance was chosen to explore how knowledge is co-constructed through social processes (Braun & Clarke, 2013; Burr, 2015). As Burr’s (2015, p. 233) social constructionism advocates for a critical and sceptical examination of our taken-for-granted beliefs about reality. It prioritises understanding how reality is shaped through social interactions rather than the pursuit of an objective truth. My first encounter with social constructionism occurred during my doctoral studies through the Constructionist Model of Informed Reasoned Action (COMOIRA) framework (Gameson & Rhydderch, 2017). This framework enabled me to grasp how groups hold and negotiate various constructions of reality. The social constructionist principles embedded in this framework also guided my decision to apply it in translating the study's findings into meaningful implications for the role of EPs. While I contemplated adopting an interpretivist stance, which, like social constructionism, focuses on understanding participants' meanings and subjective experiences, I recognised that it would emphasise individual perspectives over the co-construction of knowledge. This would have resulted in overlooking the collective reality constructed by parents and early years staffs.

Reflections on the Process of Reviewing the Literature

Engaging in the process of conducting the literature review was, without a doubt, the most challenging aspect of my research journey. I felt a significant amount of pressure to master the various approaches to literature reviews, which resonates with Gergen and Gergen’s (2008) notion of the struggle to write as an authority when one doesn’t feel authoritative. Initially, I believed that a systematic review was an essential component of a doctoral thesis and was often considered the gold standard in research. This belief was not without merit, as systematic reviews have traditionally been viewed as the preferred method by those who value objective, empirical analysis (Creswell, 2014; Greenhalgh, 2019). However, I quickly found myself grappling with the notion of conducting a systematic review for my research, particularly given my epistemological stance rooted in social constructionism. The idea of seeking a singular, objective truth felt misaligned with my goal to explore how meaning is co-constructed across various groups. My intent was to share themes and insights from participants lived experiences, focusing on how these meanings could be interpreted collectively, rather than adhering to a rigid, positivist approach. This tension became particularly apparent when I encountered literature that emphasised the notion of systematic reviews as a means of uncovering objective truths, a perspective that did not resonate with my approach to understanding the fluidity and complexity of human experiences (Flick, 2018; Willig, 2013). Indeed, it felt fundamentally at odds with the Big Q, fully qualitative and social constructionism paradigm that underpinned my research, as it actively resists the concept of absolute truths (Burr, 2015).

I was also acutely aware that research on SM often exists outside the traditional academic literature, being embedded in grey literature such as guidance documents, legislation, materials from the SMIRA charity, and media accounts. These resources are frequently excluded from academic journals and other commercial publications. Given this context, I felt that a narrative review was better suited to my research, as it would allow me to provide a more comprehensive and theoretically grounded overview of the literature. Furthermore, narrative reviews are particularly valuable in offering historical perspectives on how a phenomenon evolves, a characteristic that seemed especially relevant to the field of SM (Siddaway et al., 2019). This approach, in contrast to a systematic review, would enable me to capture the dynamic, evolving nature of SM as a topic and integrate both academic and non-academic sources, offering a richer, more nuanced understanding.

I felt confident in my decision to adopt a narrative review; however, I understood the importance of maintaining a transparent, critical, and evaluative approach to the literature (Carroll & Booth, 2015). To ensure rigor in my process, I implemented a systematic approach to my literature search, focusing on the experiences of individuals involved in the identification process of specific needs, such as parents, early years staff, and other key stakeholders.

I recognised the potential for bias due to my prior knowledge and experience in the field. To address this, I intentionally adopted a comprehensive approach, ensuring that my search and analysis were grounded in the available literature rather than shaped solely by my own preconceptions. This allowed me to engage with the literature more objectively and rigorously, reducing the risk of bias influencing my interpretation of the findings.

My systematic approach was guided by inclusion and exclusion criteria based on the research design, context, sample focus, and publication date relevant to my study. Given the limited research on SM especially in the context I was exploring, the search terms were intentionally broad to capture as much relevant literature as possible. Although my research followed a narrative review strategy, the systematic search was not intended to synthesise all available research in the field; rather, it aimed to provide a thorough exploration of key themes and insights (Siddaway et al., 2019).

As I reviewed the literature, I felt a growing concern upon realising how limited recent research had been regarding the identification process of SM in early childhood, especially from a qualitative perspective. Initially, I saw this as a positive aspect for my research, as it could offer unique insights, but it also presented a significant challenge. The scarcity of studies left me with few resources to construct a comprehensive literature review. This irony led me to reflect on the conventional research aim of identifying gaps in the literature (e.g., Robinson et al., 2011). It prompted me to question the origins of this approach and the difficulties it presents for researchers trying to make meaningful claims when there is limited existing evidence to guide them.

I found reassurance in the work of Braun et al. (2019), who addressed the challenges qualitative researchers face when pressured to present entirely unique findings. They critiqued the positivist assumptions that underpin this pressure, which often overlooks the value of research that contributes to an accumulative understanding of the phenomena being studied. Their perspective helped me realise that, rather than focusing solely on filling a gap in the literature with groundbreaking findings, my work could serve as an important part of a larger, cumulative narrative. This contribution would help to develop a broader, deeper understanding of the identification process for children with SM, and the complexities inherent in that process, ultimately contributing to the growing body of knowledge surrounding this important issue.

Reflections on deciding on a methodology.

The selection of an appropriate research design is a fundamental aspect of any study, and one of the initial decisions I faced was whether to adopt a qualitative, quantitative, or mixed methods approach. After careful consideration, I determined that a qualitative approach would allow me to explore the 'richness' of participants' experiences, as supported by Braun and Clarke (2013). This choice aligned with the ontological and epistemological foundations of my research, which aimed to delve into the data comprehensively rather than merely measuring and testing it—an approach typically associated with quantitative studies (Pyett, 2003).

As I reflected on the theoretical framework for my research, I found myself initially drawn to Interpretative Phenomenological Analysis (IPA) due to its capacity to capture the narratives and lived experiences pertinent to the subject matter. However, I soon recognised the significance of examining the shared meanings among participants. Consequently, I ultimately chose Reflexive Thematic Analysis as my primary analytical approach.

In retrospect, incorporating a critical thematic analysis (Bruan & Clarle, 2019) could have expanded the scope of the study, providing a deeper, more action-oriented understanding of the data. While the main objective was to explore the facilitators and barriers to the support children receive during the identification process for SM, a critical perspective would have highlighted the necessity for structural change to ensure that individuals affected by SM receive the support and resources they rightfully deserve.

Reflections on semi-structured interviews

Reflecting on my decision to use semi-structured interviews as the primary data collection method, I can confidently say several key considerations drove it. I felt that semi-structured interviews struck the right balance between structured questions and the flexibility to explore more profound, personal experiences that could emerge from participants through open-ended questions. Open-ended questions were used to facilitate in-depth responses, as Cohen et al. (2018) note that such questions promote flexibility in exploring areas of interest. Additionally, Kvale and Brinkmann

(2009) emphasise that semi-structured interviews allow for follow-up inquiries based on participants' responses, yielding richer and more nuanced data. This approach aligned well with my aim of capturing the complex and individualised experiences of both parents and staff in relation to SM.

Given the sensitive nature of SM, I recognised that participants might find it challenging to discuss their experiences in more rigid formats. Semi-structured interviews offered the flexibility to create a conversational, empathetic atmosphere, allowing participants to feel heard and validated as they shared their narratives. The choice to conduct the interviews online via Microsoft Teams was also deliberate. As Dörnyei (2007) suggests, online interviews offer participants greater comfort and privacy, allowing them to feel more in control of their environment. Additionally, scheduling the interviews at times convenient for participants added flexibility and demonstrated respect for their time, which I believed would increase their willingness to participate and share personal experiences.

In choosing semi-structured interviews, I was acutely aware of my position as an insider researcher. My prior involvement with SM presented the risk of introducing confirmation bias, where my personal experiences could influence data collection and interpretation. To address this, I engaged in ongoing discussions with my research supervisor and referenced Dwyer and Buckle's (2009) work, underscoring the importance of acknowledging insider researcher bias. I recognised that to maintain objectivity, I needed to actively set aside my assumptions and preconceived notions, ensuring that the voices and perspectives of parents and early years staff shaped the research, rather than my own experiences. I practiced regular reflexivity throughout the research process to manage this potential bias. I kept a detailed research diary, critically examining my role in shaping the interviews and analysing how my personal views may have influenced the interactions and subsequent data interpretation.

In addition to interviewing parents, I wanted to offer a more balanced perspective by including early years staff, as suggested by Dwyer and Buckle (2009). Interviewing both parents and staff allowed me to better understand the broader context of how SM is identified and supported in educational and home settings. This dual approach helped provide a more comprehensive and nuanced understanding of the challenges faced by children with SM while also addressing the potential for bias by incorporating multiple viewpoints.

Reflecting on the experience of conducting the interviews, I believe that the parents I interviewed likely felt a sense of validation and understanding in discussing their experiences with someone who could relate to their challenges. My familiarity with the struggles associated with SM facilitated rapport-building, allowing participants to engage in open and empathetic dialogue about their frustrations, confusion, and the urgent desire for timely intervention. This personal connection provided an environment where participants felt comfortable sharing their stories, knowing their concerns would be met with empathy and understanding.

Looking back on the interview process, I can confidently say that while I found it rewarding, claiming it was without challenges would be misleading. I have gained a much deeper appreciation for the skills required to conduct interviews effectively, such as identifying key points raised by interviewees and responding with thoughtful, unanticipated questions (Seidman, 2013). Throughout the process, I found myself balancing competing demands—building rapport, actively listening, and formulating probing questions—while ensuring that I accurately recorded and adhered to the interview schedule.

Despite these challenges, I am immensely grateful for the experience. I now understand why interviewing is often considered a complex skill. It is an indispensable research tool that allows researchers to engage deeply with participants, providing valuable insights into their lives and social worlds (Silverman, 2016).

One of my key reflections was the decision to disclose my insider-outsider status to participants. By sharing my positionality, I aimed to be transparent, ensuring that participants could give fully informed consent—an essential ethical consideration in qualitative research. Clarke and Braun (2013) emphasise the significance of reflexivity in qualitative research, urging researchers to acknowledge their biases and be transparent about their roles. This transparency addresses ethical concerns and helps navigate power dynamics and participants' autonomy.

However, in hindsight, I wonder whether this disclosure may have unintentionally influenced participants' responses. I question whether revealing my insider researcher status led participants to view me as an expert with prior knowledge, which may have affected how they framed their answers. The extent to which this perception shaped their openness or willingness to share could have influenced the data in ways I did not anticipate. This reflection raises important questions about the balance between transparency and potential bias in qualitative research, especially in sensitive contexts.

That said, I consciously decided to inform each participant at the outset of the research about my background and professional experience. This was intended to promote transparency and build trust. Some parents appeared to feel more comfortable and able to open up, perhaps sensing that I had a genuine understanding of their experiences and challenges. My insider status may have helped foster a sense of rapport and empathy, which can be particularly valuable when researching emotionally sensitive topics such as SM. While this introduces potential bias, it also enriches the data by enabling a deeper, more emotionally resonant dialogue.

Reflections on Recruiting Participants

Reflecting on the participant recruitment process for this research, one major challenge was effectively reaching and engaging parents of children with SM. I consulted with a former TEP who had explored similar topics related to SM and faced significant difficulties in recruiting participants, particularly parents. She shared her insights about the low engagement rates, which led me to carefully consider the best approach for recruitment.

To address this issue, I decided to collaborate with SMIRA, a prominent UK-based national charity and research association relevant to the context of SM. While this provided valuable access to a well-established community of parents and professionals, working through a gatekeeper introduced several logistical and procedural challenges. After obtaining ethical approval, I was required to provide formal documentation to demonstrate this before the gatekeeper allowed me to proceed. There were also delays in communication, as I had to wait for the gatekeeper to respond and give permission to post a recruitment announcement on the SMIRA-associated Facebook parent group. This delay created some uncertainty in the early stages of participant recruitment. Nevertheless, once approval was granted, the Facebook post enabled me to connect with potential participants and invite parents to contact me directly via email. Despite the initial obstacles, the collaboration ultimately helped establish credibility and facilitated access to a hard-to-reach population.

In addition to recruiting parents, I faced the challenge of engaging early years staff, such as preschool educators, who were initially included in the ethical approval process. Initially, I intended to use the gatekeeper model by involving the Principal Educational Psychologists (PEPs), who would share the recruitment information with Early Years Panel leads and Childcare Managers. However, after a limited response, I revised this process and opted to advertise the study further through EPs in LA’s.

Despite my best efforts, recruiting early years staff proved particularly difficult. This is likely due to the challenging working hours and staff-to-child ratios in preschool settings, which differ from school staffing structures. Although I advertised the flexibility of interview times to accommodate preschool staff, this population remained largely unrepresented in my sample. I have considered that future recruitment efforts could involve targeting expanded professional networks that specialise in early years education, such as nursery associations, to enhance participation.

Reflections on data analysis

Braun and Clarke's readings (2013, 2019, 2020) highlight the nuanced nature of RTA. They indicate that RTA does not strictly adhere to inductive or deductive approaches; rather, it often incorporates elements of both (Byrne, 2022). This insight resonates with my experience, as I find it challenging to achieve a purely inductive analysis, particularly within the framework of critical realism.

From a critical realism perspective, the reality we seek to understand is multifaceted and influenced by both observable phenomena and deeper, underlying structures (Bhaskar, 2014). This ontological stance recognises that while we can never fully access the objective nature of reality, we can infer causal mechanisms and structures from the data we collect. Consequently, my analysis included both inductive elements, which allowed themes to develop organically from the data, and deductive components, where I applied existing theoretical frameworks or prior knowledge to interpret the patterns and structures within the data.

Using NVivo as a software tool for coding the data helped facilitate this process. NVivo provided a systematic approach to organising and coding large volumes of qualitative data, ensuring that emerging patterns (inductive) and predefined categories (deductive) could be captured and analysed effectively. The software’s flexibility enabled me to approach the data with an open mind while also checking for alignment with existing literature or theoretical assumptions—reflecting the balance between inductive exploration and deductive confirmation central to critical realism.

Moreover, NVivo not only supported the organisation of data but also allowed me to apply a reflexive approach to my analysis, which is essential to RTA and critical realism. It encouraged me to remain aware of the assumptions I brought to the research. It helped me explore how different layers of reality might develop through participant responses, all while respecting the complexity of the social world I was examining.

Additionally, I recognised that I needed the time and space to conduct a thorough and meaningful analysis. I consciously put aside the pressure of adhering to rigid deadlines to complete the data analysis. Instead, I embraced the deliberate and thoughtful pace of the analytical process, acknowledging that RTA requires a more unhurried approach to interpretation (Braun & Clarke, 2021a).

I have also reflected on my stance regarding Big Q qualitative research and found that Reflexive Thematic Analysis (RTA) aligned well with my data analysis needs. What resonated with me most about this approach was its acknowledgment that analysis may never be entirely “accurate,” but it can still be rich, nuanced, and insightful (Braun & Clarke, 2013; Braun & Clarke, 2022). As a member of the community I was researching, I viewed this approach as facilitating a more authentic, grounded interpretation of the data—allowing my own experiences and positionality to inform my understanding rather than limit it. This approach offered the privilege of engaging with participants' experiences from an insider perspective while recognising the value of reflexivity and self-awareness throughout the research process.

Throughout the study, I remained reflexive and reflective of my positioning as an insider researcher. I made active use of supervision sessions with my research supervisor to explore any personal connections to the data, critically discuss the naming and interpretation of themes, and ensure that I remained aware of how my own experiences might shape meaning-making. I also made a deliberate choice to use an active voice in the thematic maps and theme summaries, aiming to remain close to what the participants were telling me. This was a conscious attempt to centre their voices and reduce the influence of researcher bias, ensuring that interpretations were co-constructed rather than imposed. In doing so, I sought to honour the ethos of RTA while upholding a respectful, participant-centred approach to analysis.

Reflections on Big Q approach

My adoption of a Big Q approach was a pivotal decision within the methodological framework of this research, aligning closely with the values and objectives of qualitative research that I aimed to achieve. Rooted in the critical realist foundations of this study, this choice was essential in shaping my focus on qualitative studies for the critical literature review and guiding my selection of data generation and analysis techniques. I was fully aware of the potential for methodological incoherence in qualitative research, where combining small q (non-positivist) and Big Q approaches could lead to a conceptually disjointed methodology (Braun & Clarke, 2023b, p. 2). This awareness motivated me to ensure that my approach remained consistent and coherent.

Reflecting on this decision, I recognise that more moderate approaches could have been considered, which might have addressed some aspects of conceptual incoherence. However, I resonate with the views of Braun and Clarke (2023b), who advocate for researchers to be thoughtful and deliberate in their methodological choices and to embrace their perspectives (Braun & Clarke, 2021b, p. 44). To avoid a “conceptually messy mash-up,” I decided to fully embrace a Big Q stance for this research, ensuring that all my decisions—from data collection to analysis—were in harmony with the values, assumptions, and ontological orientations of this approach.

This approach aligns well with my critical realist and social constructionist perspectives. From a critical realist standpoint, I acknowledge that while we can never fully access objective reality, underlying structures and causal mechanisms shape the social world. This understanding informed my choice to focus on qualitative methods that allow for exploring participants' lived experiences while still considering the influence of deeper social structures. From a social constructionist perspective, I aimed to understand how knowledge is co-constructed through social processes, emphasising the subjective and contextual nature of reality. Thus, the Big Q qualitative approach facilitated a deeper engagement with these epistemological and ontological assumptions, ensuring consistency and coherence throughout my research design and practice.

I also attended a university workshop by Victoria Clarke in February 2025, where discussions around using a Big Q approach prompted me to consider data saturation. Victoria Clarke suggested that this concept is potentially a positivist trap, and that data sufficiency should be considered instead. This reflection led me to realise that data saturation has many more nuances than I initially thought. In qualitative research, saturation is often associated with the point at which no new themes or information are developed, suggesting that enough data has been collected to address the research questions. However, as I delved deeper into the Big Q qualitative approach—particularly through a critical realist and social constructionist lens—I began to understand that the idea of saturation in these paradigms is more flexible and interpretive.

Rather than adhering to a strict quantitative threshold, the emphasis shifted towards the depth of understanding and richness of insights. Learning from Ian Dey's work (1993), I began to see data saturation not as an endpoint, but as part of an ongoing, iterative process of meaning-making. Dey's constructivist approach taught me that the goal of qualitative research is not necessarily to reach a specific numerical target, but to explore rich, complex experiences and develop deep insights into the phenomena being studied. This insight made me appreciate that saturation could be more about ensuring sufficient depth and diversity of perspectives rather than simply counting interviews or responses.

As I navigated my research, I became more comfortable with the idea that flexibility and interpretation are key components of qualitative analysis. I recognised that, as a researcher, my role is to be thoughtful and reflective in determining when I have gathered enough meaningful data to answer my research questions. This has been an important lesson in understanding that, as a researcher, it is not only about adhering to rigid guidelines but also about engaging deeply with the data and embracing the complexity of the research process.

3.22 Part Two: Contribution to Knowledge

Contribution to existing knowledge

Much of the existing literature on SM focuses primarily on treatment and adopts a medical approach to interventions. However, I have noticed limited research dedicated to the identification process, particularly in early childhood and the initial onset of the condition. To my knowledge, there are no studies that include the perspectives of preschool staff. My study is unique because it enhances our understanding of the identification process for SM in young children. Notably, it is the first research initiative to incorporate the experiences of early years practitioners, including preschool staff and parents, through qualitative interviews. These interviews delve into their perspectives and experiences, providing valuable insights into the identification and support mechanisms for children with SM.

Moreover, I utilised the COMOIRA framework, which supports and clarifies the implications for the role of EPs in practice. The interviews allowed parents and early years staff to reflect on the barriers and facilitators of the support they received during the identification process. A key strength of my study lies in the rich data captured, which would likely have been overlooked had I relied on more positivist, quantifiable measures instead.

Given the lack of research exploring SM in general, this study is a valuable platform for further discussions within the field. I am calling on professionals to engage in additional research to enhance support for children with SM from a multidisciplinary perspective.

A key consideration in this study was the possibility of “false positives”—instances where children are perceived to have SM but may not meet the formal diagnostic criteria. Rather than viewing this as a limitation, I recognised it as an opportunity to engage with the complexity and nuance that characterise real-world identification processes in early childhood settings. From a critical realist perspective, I understood that children’s behaviours exist independently of our interpretations (the real). However, our ability to make sense of those behaviours is shaped by socially constructed understandings and contextual factors (the empirical). This was particularly relevant when working with young children, whose communication difficulties may be fluid, evolving, or inconsistently expressed across different environments.

By adopting this lens, I became increasingly aware that identifying SM is rarely a straightforward process, especially in early childhood. Including children who did not have a formal diagnosis allowed me to give voice to the early stages of concern and inquiry, which are often overlooked in research yet are highly significant in practice. These early signals, whether they ultimately lead to a formal diagnosis or not, frequently trigger the need for reflection, consultation, and responsive support. I believed it was essential to capture and understand how parents and early years staff interpret these initial observations, as this provides valuable insights into how identification unfolds over time.

This approach aligned with the social constructionist aspect of my epistemological stance, which acknowledges that the definition and recognition of SM are not fixed but are co-constructed through interaction, dialogue, and shared meaning-making. My goal was not to clinically validate the presence of SM but to explore how it is perceived, understood, and responded to by those closest to the child. Including children with emerging or uncertain presentations enabled a richer and more authentic understanding of how concerns arise, how decisions are navigated, and how early support is (or is not) mobilised. In this way, the study's design aligned with its philosophical foundations and illuminated the complex, dynamic, and often context-sensitive nature of identifying SM in young children.

Contribution to Future Research

At the conclusion of my research, I identified several areas for future investigation. One of the most important contributions to future research is the need to bridge the gap in the formal recognition and clinical diagnosis of SM. Since SM is often identified in informal settings rather than through formal clinical assessments, this creates significant barriers to early identification and support. To address this, future research should explore ways to streamline the diagnostic process and create clear, accessible pathways for children with SM to receive the support they need.

Another key area for further exploration is developing a more standardised understanding of SM. The varying interpretations of the condition, shaped by different personal experiences and perspectives, highlight the need for a unified definition of SM. Research should focus on establishing clearer, more consistent criteria for diagnosing and understanding SM, which would help to increase awareness and reduce misconceptions about the condition. This could lead to more accurate identification and more effective support for children with SM.

There is also a significant need for research into how EPs and other professionals can be better trained to support children with SM. While some EPs contribute valuable support to children with SM, their lack of specialised training in this area points to an important gap. Future research could focus on developing comprehensive, evidence-based training programs for EPs that incorporate psychological theories and relational approaches. This would ensure that EPs have the knowledge and skills to support children with SM in educational settings effectively.

Moreover, the study emphasises the importance of fostering inclusive educational environments, and this is another area where further research could be invaluable. Understanding how to create supportive, anxiety-reducing environments for children with SM and how to best support teachers in adapting their teaching methods will be essential for improving outcomes for these children. Research into how EPs can guide schools in this process and create systemic changes to address the underlying factors contributing to SM would be highly beneficial.

Lastly, systemic issues, such as the lack of a clear monitoring and support system, are critical barriers to meaningful change for children with SM. Future research should explore developing better systems for monitoring and supporting children with SM, ensuring they receive timely interventions and appropriate services. This could involve examining current systems across different regions and identifying best practices for implementation across educational settings.

In summary, future research should focus on improving the recognition, understanding, training, and systemic support for SM in educational settings. By addressing these areas, we can create a more inclusive, supportive environment for children with SM and ultimately improve their educational experiences and outcomes.

Dissemination of Research

This research captures a specific moment in time and reflects the participants' perspectives within a particular context. However, sharing these findings can significantly influence real-world practices and contribute to transformative processes (Flick, 2018). I feel a strong responsibility to ensure this research is disseminated as widely as possible. To achieve this, my priority will be to provide the participants with a complete copy of the thesis as a gesture of gratitude for the time they generously dedicated to the interviews. By sharing the full thesis, I hope to allow participants to reflect on the research findings in relation to the broader literature and consider any potential implications relevant to their experiences.

Piloting the CARES Model

As part of my ongoing development of the model, the next phase of my research will involve piloting CARES in collaboration with early years settings. My goal is to explore how the framework can be integrated into real-world practice, assess its feasibility and acceptability, and gather feedback from key stakeholders, including EPs, early years staff, ALNCOs, and parents.

This piloting phase will employ a participatory approach, reflecting the values of community psychology and the principles of evidence-based practice as outlined by Fox (2003). In this approach, I aim to co-construct knowledge through collaboration with researchers and practitioners. Through cycles of implementation, reflection, and adaptation, I hope to gain deeper insights into how the model operates in various contexts and how it can be refined to better meet the needs of children with SM.

Opportunities for joint reflection with practitioners will be central to this phase, helping me evaluate the utility of the CARES principles in practice and further explore how EPs can support systemic, relational, and developmentally sensitive approaches in early years environments. Insights from this pilot will inform future iterations of the model. They may contribute to the development of more formalised training materials, implementation guidance, and potentially a validated tool to support early identification and intervention planning.

I welcome collaboration with local authorities, early years teams, and EP services interested in further exploring the CARES model. This next stage represents a significant opportunity to bridge the gap between theory and practice, contributing to a more inclusive, compassionate, and responsive system of support for children experiencing SM.

I am eager to share my research with the local authority, where I will begin working in September 2025. I hope this opportunity will spark meaningful discussions about SM at the local authority level, particularly concerning its implications for teachers, early years staff, and EPs practices. Additionally, I would like to collaborate with preschools through consultations and, if possible, joint research projects to further explore awareness and understanding of SM within this professional sector.

Furthermore, I am interested in disseminating this research more widely within the EP and education community, both in the context of Welsh education and across the broader field of SM. My goal is to encourage greater reflection on SM and its implications for practice, facilitating ongoing consideration of how best to support children with SM. To achieve this, I plan to explore various peer-reviewed journals and submit my research for publication.

In addition to academic dissemination, I am keen to develop SM-specific training resources tailored to the needs of professionals working in early years and educational settings. I aim to make this training accessible by offering flexible formats, including webinars, recorded sessions, and interactive online workshops. A central focus of this training would be to promote relational and proactive approaches to support—emphasising the importance of building trusting relationships, reducing anxiety, and fostering emotionally safe environments for children with SM. By equipping professionals with practical, theory-informed strategies grounded in empathy and early intervention, I hope to contribute to more inclusive, supportive practice that helps children with SM to thrive.

Reflections for EP Practice

Reflecting on the role of EPs in facilitating change for children with SM, I recognise that EPs play a crucial role in supporting these children's emotional and educational needs. Although EPs may not always have specialised training in SM, their expertise in emotional health—particularly with anxiety disorders—positions them as valuable contributors within educational settings. Importantly, their professional obligations, as outlined by the Health and Care Professions Council (HCPC), reinforce their suitability for this role. For example, EPs are required to uphold the rights, dignity, values, and autonomy of every service user (HCPC, 2023), a principle that is especially significant when working with children with SM, whose voices are often unheard and who may be particularly vulnerable. Additionally, EPs are expected to apply psychological models in developing and implementing interventions that promote psychological well-being and social inclusion. This aligns closely with the potential of EPs to foster inclusive environments, reduce barriers to participation, and support the emotional needs of children experiencing SM through proactive, holistic approaches.

Training is a key area where EPs can make a significant impact (Fallon, 2010). I see the importance of EPs training educators and other professionals to build a network of support around children with SM. Incorporating relational approaches into training is critical, as studies show that positive, informed responses from staff can reduce anxiety and foster a supportive environment for children with SM. By using psychological theories like Self-Determination Theory (Ryan & Deci, 2017) and Basic Psychological Needs Theory, they can help staff better understand and meet the emotional needs of children with SM, promoting a more inclusive and empathetic educational setting.

At the same time, I acknowledge the gap in specialised training for EPs in SM. For me, this suggests the need for greater support and resources, such as a clear position paper on SM and practical tools to identify the condition. Collaborating with other services and exchanging best practices could further strengthen the ability to support children with SM. As part of a broader system, EPs can advocate for systemic changes that create inclusive environments and focus on anxiety management rather than viewing SM as a solely within-child issue.

Additionally, EPs’ consultation skills are pivotal in fostering inclusive environments. Through thoughtful and context-specific questioning during consultations, I can better understand how SM manifests in individual children, ensuring tailored support strategies are implemented. This involves adjusting teaching methods, content delivery, and encouraging non-verbal participation, all of which can contribute to a more inclusive and supportive atmosphere.

Looking ahead, I see the importance of further research to improve the early identification and support for children with SM. By advocating for a multidisciplinary approach, I believe EPs can collaborate more effectively with other professionals to enhance intervention strategies. These efforts, grounded in evidence-based practices, will help address the systemic barriers currently in supporting children with SM, ultimately improving outcomes for these children in educational settings.

In conclusion, the role of the EP in supporting children with SM is multifaceted. EPs are well-positioned to lead efforts in training, advocacy, and consultation while also contributing to a more inclusive, supportive educational environment. However, to effectively meet the needs of children with SM, EPs must have access to specialised training, resources, and a collaborative framework that encourages continuous improvement and innovation.

Concluding Reflections on the Research Journey

This research has been an incredibly fulfilling journey, offering me valuable insights both professionally and personally. On a personal note, juggling the demands of my doctorate, writing my thesis, and being a proud mum to three beautiful little girls has certainly come with its challenges. Nonetheless, this experience has instilled in me a deep sense of gratitude and resilience, qualities that will serve me well as I move forward in my career as an EP. It has also ignited a new passion for research, further cementing my commitment to staying engaged in the educational research community.

What has been particularly meaningful to me is the opportunity to gain a deeper understanding of SM, especially in relation to my own child. Being a parent to a child with SM has given me a unique perspective on the condition, and I feel an immense sense of pride and privilege in supporting her. This experience has only strengthened my determination to advocate for children with SM and has deepened my commitment to ensuring that others in similar situations receive the understanding and support they truly need.

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List of Appendices

Following an initial scoping exercise, the search terms depicted were used for the initial systematic literature review. The inclusion criteria for this initial search specified that the research had to be related to SM in the context of identification and support, capturing the experiences of families and early years.

Appendix 1- Initial Search Terms

Search Terms	
"selective* mut*" OR "elective* mut*" OR "situational mut*"	teacher* OR parent* OR father* OR mother* OR guardian OR "primary caregiver" OR "primary carer*" OR "foster carer*" OR "early years" OR "pre school" OR preschool

Notes:

- The asterisk (*) serves as a truncation used to search for alternative letters at the end of words. For example the use of mut* would enable searches for 'mutism' and 'mute'.
- The search was conducted within the TITLE, ABSTRACT, and KEYWORDS fields (TITLE-ABS-KEY).
- Boolean operators (OR/AND) were utilised to logically combine search terms.

These search terms were combined into the PsycInfo®, Medline, SCOPUS, Proquest Dissertations, and Theses Global databases. Retrieved articles were screened to ensure they met the inclusion criteria of being peer-reviewed and published after 2013. This initial search revealed that no research articles had specifically examined SM in preschool or early years settings. Furthermore, very few studies focused on the role of preschool staff in supporting children with SM. As a result, the decision was made to broaden the search terms to include a broader range of key stakeholders involved in identifying and supporting SM in early childhood (see Appendix 2 for the final key search terms used)

Appendix 2- Subject Mapping Terms, Keyword Searches and Rationale

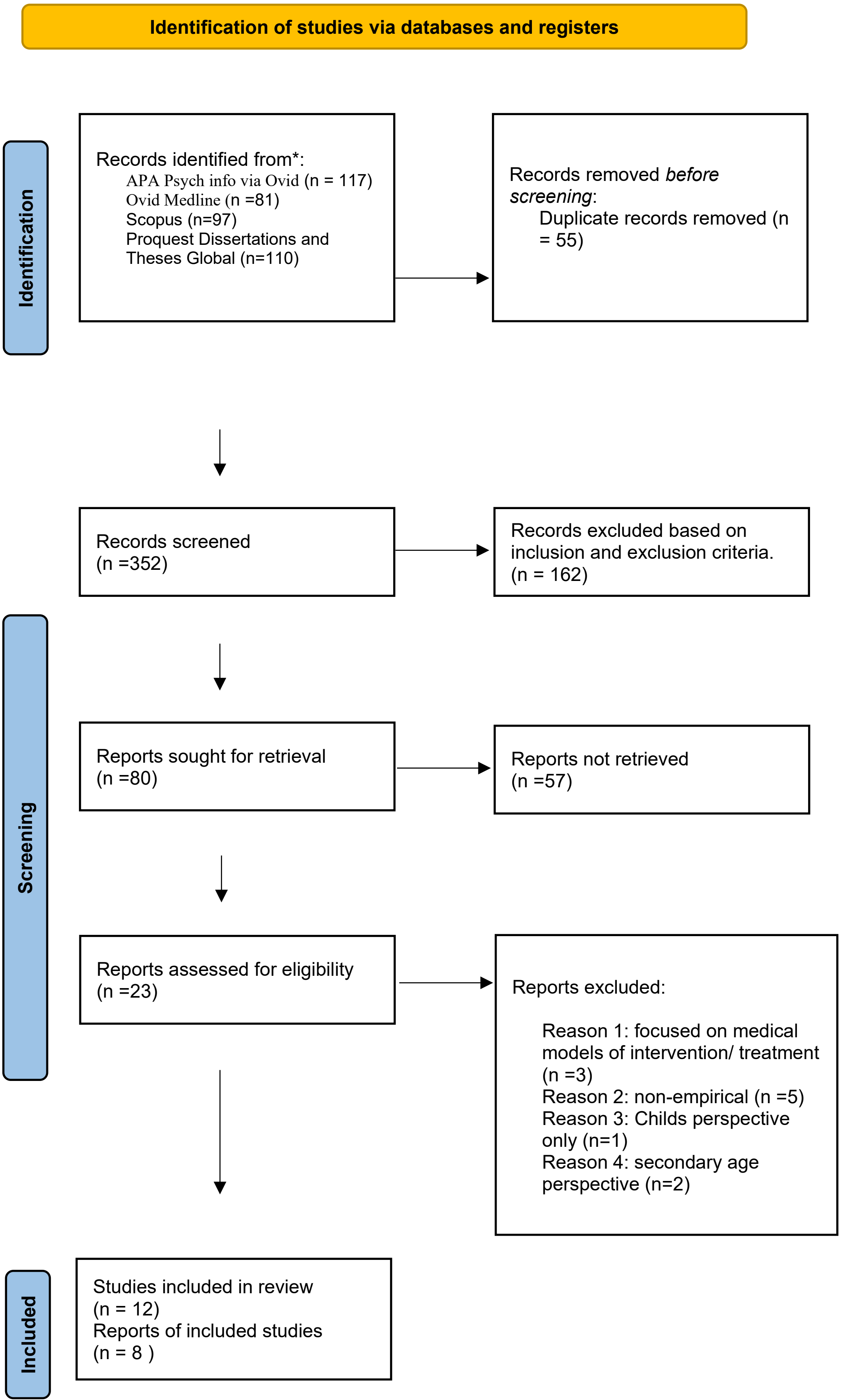
Category	**Terms**	**Rationale**
Subject Mapping Terms	"selective* mut*" OR "elective* mut*" OR "situational mut*"	To comprehensively capture all terminology used to describe Selective Mutism across different contexts and disciplines.
Keyword Search: Stakeholders	teacher* OR parent* OR father* OR mother* OR guardian* OR "primary carer*" OR "foster carer*" OR professional* OR stakeholder* OR "language therapist" OR nurs* OR "health visitor*" OR gp OR doctor OR psychologist*	To explore literature reflecting the perspectives and involvement of all key stakeholders (educational and health professionals, parents, carers) supporting children with SM. This ensures a broad understanding of the multidisciplinary environment influencing early childhood support.

The search strategy was designed to examine the literature on SM in early childhood by considering research from various key stakeholders. Incorporating perspectives from education, healthcare, and caregiving allows for a comprehensive understanding of how children with SM are identified and supported across different systems and settings. This approach highlights the multidisciplinary nature of early intervention and support for SM.

Appendix 3- Database Rationale for Inclusion

Database	Rationale for Inclusion
PsycINFO	PsycINFO is the most comprehensive database for psychology-related research, providing access to a wide range of peer-reviewed articles, books, and dissertations. It was essential for capturing psychological research relevant to the understanding, identifying, and supporting SM in early childhood.
OVID	OVID provided access to various medical and health-related databases, including psychology resources. It was included to ensure that research from both health (e.g., speech and language therapy, paediatrics) and psychological fields informing SM practice was captured.
ProQuest	ProQuest offers many sources, including dissertations, theses, and peer-reviewed journals. It was selected to supplement the search with grey literature and lesser-known studies on SM, which is important given the niche focus on early childhood and preschool settings.
Scopus	Scopus is one of the largest abstract and citation databases, covering a broad range of disciplines such as psychology, education, and health. Its inclusion ensured access to high-quality, multidisciplinary peer-reviewed research crucial for understanding the complex, cross-sectoral support required for children with SM.

Appendix 4- PRISMA- Identification of Studies



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

Appendix 5- Research Gathered for Critical Literature Review- Parent Perspectives

	Author	**Type of publication**	**Detail of Study**	**Audience targeted**	**Context of findings**	**Location**	**Limitations**
Parents Perspectives	Kadoma 2023: “Navigating the Needs of Children with Selective Mutism: A Qualitative Examination of Parent Experiences Through	Dissertation	This phenomenological study examined the lived experiences of 14 parents of children with SM, utilising the bioecological model (Bronfenbrenner, 2005) and the seven essential needs of	Parents	Few studies explore or expand on the experience of parenting a child with SM. This study examined the lived experience of parentin	USA (California)	The study is not based in the UK, so the generalisability of its results to other countries cannot be assumed. One limitation of this

	a Bioecological Lens”		children (Brazelton & Greenspan, 2000) as its theoretical frameworks.		g a child with SM using a tightrope metaphor to illustrate the complex and challenging journey that parents face. The findings revealed that SM significantly affects a child's ability to form relationships and meet their needs. Parents often		study is the lack of diversity in the family structures of the participants.

					encounter barriers in understanding and addressing the condition, primarily due to professionals lacking firsthand experience with it. Key factors that facilitate support include personal experience and professional backgrounds in child		

					development or psychology. Additionally, cultural and systemic issues, such as the stigmatisation of mental health and individualistic societal beliefs, were identified as major obstacles to accessing treatment and services.		
	Douglas (2021):	Thesis	The study aimed to	Parents	Four parents	United Kingdo	Limitations

	What are the lived experiences of parents in understanding and supporting their child with selective mutism? An exploratory study.		empower parents to share their perspectives on the potential causes of their child's SM and its impact on their child, themselves, and the broader family. Additionally, the study examines how parents cope with and maintain their own emotional well-being. Ultimately, the research aimed to increase the understanding of SM among		believed genetic factors played a role in their child's SM, citing a history of anxiety and mental health issues in the family. Two parents mentioned their own struggles with anxiety, and one speculated the child's father may have	m (London)	include how the research was conducted during Covid-19, when various national lockdowns, including school closures, were enforced. This significantly impacted the research process and likely affected the findings.

			health and educational professionals, including EPs. Six parents participated, and Interpretative Phenomenological Analysis (IPA) was used to analyse the data.		experienced SM. Five parents reported that their child's SM negatively impacted their emotional wellbeing, with feelings of stress, worry, frustration, helplessness, and depression. One parent even experienced a mental		

					breakdown. Parents' experiences of accessing support for their child with SM varied greatly, depending on the resources available in the educational setting and local authority.		
	Keville et al (2024). Parent perspectives of	Journal	Twelve parents from the UK participated in semi-structured interviews,	Parents	This study is the first qualitative research explorin	United Kingdom (University of Hertfordshire)	The study did not explore parental experiences of

	children with selective mutism and co-occurring autism		all reporting that their children had a formal clinical diagnosis of SM and either autism or were in the process of diagnosis. The study highlights the challenges parents face when managing both SM and autism, including communication freezes, sensory overload, and advocacy in environments that often misunderstand their children's		g parental experiences of caring for a child with both SM and autism. Parents described the significant impact of these conditions on their child's ability to form relationships, communicate, and engage in activities, as well as the		SM and autism within other demographic populations, which could limit the findings' applicability to other groups. Diagnoses were self-reported by parents, which could introduce bias or inaccuracies. Additionally, some children were still

			needs. It emphasises the struggle for access to timely assessments and support, and the importance of recognizing early signs of SM as potential indicators of neurodevelopmental conditions. The study advocates for a more personalised, parent-centred approach to diagnosis and intervention, stressing the role of parental advocacy in		broader effects on siblings. Many parents had to adapt their lives or give up careers to advocate for their child's independence. The study also highlighted the interaction between SM and autism-related symptoms, including		in the process of being diagnosed with autism, affecting the clarity of the findings related to autism diagnosis.

			shaping policies and support. Top of Form Bottom of Form		anxiety and sensory challenges, leading to communication difficulties. Some children experienced communication freezes and shutdowns due to sensory overload at school.		

Appendix 6- CASP Checklists for the included Parent Studies

CASP Qualitative Studies Checklist

Keville et al. (2023)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes.
3.)	Was the research design appropriate to address the aims of the research?	Yes, Interpretative Phenomenological Analysis (IPA) provides a detailed and in-depth analysis and exploration of lived experiences.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes, the purpose sampling method was used to recruit parents of children with a diagnosis of SM and possible autism through SMIRA.
5.)	Was the data collected in a way that addressed the research issue?	Yes
6.)	Has the relationship between researcher and participants been adequately considered?	The authors report no conflict of interest; however, there was no further discussion highlighting the relationship between the researchers and participants.
7.)	Have ethical issues been taken into consideration?	Yes, the University of Hertfordshire Health, Science, Engineering, and Technology Ethics Committee with the delegated authority granted ethical approval

8.)	Was the data analysis sufficiently rigorous?	Yes, the second and third authors carefully reviewed each transcript several times. Throughout this process, reflexive conversations were held with the first and last authors to ensure adherence to quality guidelines for Interpretative Phenomenological Analysis (IPA). Triangulation was achieved through consultations with clinicians and individuals who have lived experiences.
9.)	Is there a clear statement of findings?	Yes, Four main themes emerged, each accompanied by several related subthemes.
10.)	How valuable is the research?	This is the first qualitative study exploring parental experiences of caring for a child with co-occurring SM and autism.

Kadoma (2023)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes.
3.)	Was the research design appropriate to address the aims of the research?	Yes, a hermeneutic, phenomenological study was selected/

		Kadoma discarded approaches that highlight the singular nature of SM such as narrative or case study, as these would reinforce the rare nature of SM, and were contrary to the goal of demonstrating that a sizeable subset of sufferers do exist and would greatly benefit from more attention and research.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes, participants were recruited through social media platform Facebook and the groups “Parents of Children with Selective Mutism” and “Selective Mutism Support California”
5.)	Was the data collected in a way that addressed the research issue?	Yes.
6.)	Has the relationship between researcher and participants been adequately considered?	Yes.
7.)	Have ethical issues been taken into consideration?	Yes, ethical approval was granted through Fielding Graduate University’s Institutional Review Board (IRB)
8.)	Was the data analysis sufficiently rigorous?	Yes, Kadoma used frequent member checks—pausing to clarify meaning—throughout each interview (Saldaña, 2011). Ensuring accuracy with participants’ responses increased the trustworthiness of the data, which is indicative of the study’s credibility (Treharne & Riggs, 2015).

9.)	Is there a clear statement of findings?	Yes, however due to the nature of the hermeneutic, phenomenological design. The findings section was lengthy and included a lot of rich data, which can be difficult to clearly summarise and interpret.
10.)	How valuable is the research?	This research project was the first study to examine parent perspectives for children with selective mutism. Using a hermeneutic, phenomenological approach and framing questions through a bioecological lens

Douglas (2021)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes.
3.)	Was the research design appropriate to address the aims of the research?	Yes, an interpretative phenomenological approach was chosen.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes.
5.)	Was the data collected in a way that addressed the research issue?	Yes.

6.)	Has the relationship between researcher and participants been adequately considered?	The researcher considered how the study might impact participants' well-being. A risk assessment indicated a low risk to the researcher's emotional health. However, the researcher was aware that conversations with participants could evoke strong memories from their own childhood experiences related to the subject of study. To address this, the researcher ensured there were regular opportunities for participants to reflect on their thoughts and feelings.
7.)	Have ethical issues been taken into consideration?	Ethical approval was granted by the University of East London.
8.)	Was the data analysis sufficiently rigorous?	Yes, the researcher used Lincoln and Guba (1985), who espouse that four criteria determine the rigour and trustworthiness.
9.)	Is there a clear statement of findings?	Yes.
10.)	How valuable is the research?	This research is valuable as it provides insight into parents' perspectives on the causes and impact of their child’s SM and how they cope with the emotional challenges it presents. By focusing on parents' experiences, the study enhances understanding of SM and offers valuable information for health and educational professionals, including EPs, to better support families and improve interventions.

		The use of Interpretative Phenomenological Analysis (IPA) strengthens the depth of the findings.

Appendix 7- Research Gathered for Critical Literature Review- Teachers' Perspectives

Teachers' perspectives	Author	Type of publication	Detail of study	Audience targeted	Context of findings	Location	Limitations
	Williams et al. (2021): Primary teachers' experiences of teaching pupils with selective mutism: a grounded theory study	Journal	In this study, grounded theory methods enabled the systematic collection of teachers' experiences in their own words and guided the exploration of narratives to develop a	This study interviewed 11 teachers and used qualitative methods to develop an explanatory framework representing the lived	The findings highlighted a connection between teacher categorisation of students with social anxiety and the support provided to these pupils. This framewor	United Kingdom (Brighton and Hove)	Opportunity sampling led to participants who were motivated but may not represent the entire population of teachers working with pupils with selective

			theoretical representation of this experience.	experiences of teaching pupils with selective mutism.	k has implications for guiding both research and educational practices aimed at supporting pupils with social anxiety.		mutism (SM). To enhance the generalisability of the findings, recruiting from a broader and more diverse group is recommended
	Ramon (2018) Thesis Breaking the Silence: An IPA study exploring the experiences, thoughts,	Thesis	Perspectives from five teachers were gathered through semi-structured interviews, analysed using Interpretative Phenomen	Teachers	The six key themes identified from the teachers' contributions are: Creating an inclusive environment – Efforts to accommodate the	United Kingdom (Essex)	The study's limitations include a small sample size of only five teachers, which may limit the generalizability of the findings.

	feelings and perspectives of teachers working with Selectively Mute children.		ological Analysis.		selectively mute child. Taking ownership – Teachers' responsibility in helping the child speak. Using support – Relying on colleagues and specialists for assistance. Experiencing challenges – Difficulties faced in managing selective mutism.		The experiences described are unique to this group and may not fully represent the experiences of all teachers working with children with Selective Mutism (SM). Additionally, the study relies on self-reported data, which could be influenced by

					Frustration – Feelings of frustration due to lack of communication. Need for training – Desire for more professional development and guidance.		teachers' emotional responses or biases, and some teachers were unfamiliar with sharing such responses. The diversity of backgrounds among teachers, while offering varied perspectives, also introduced potential differences in approac

							h to teaching SM. Lastly, the research is based on a single local authority, which may not reflect the broader context of SM in other areas.

Appendix 8- CASP Checklists for the included Teachers Studies

CASP Qualitative Studies Checklist

Williams et al. (2021)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes.
3.)	Was the research design appropriate to address the aims of the research?	Yes, in this study, grounded theory methods facilitated the systematic collection of teacher experiences in their own words and guidance.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes, through opportunity and snowball sampling, where a teacher identified additional potential participants.
5.)	Was the data collected in a way that addressed the research issue?	Yes, the researchers used a semi-structured interview to provide a basic framework for discussion, allowing teachers to steer the conversation toward issues most relevant to their experiences.
6.)	Has the relationship between researcher and participants been adequately considered?	I'm not certain. The author(s) did not report any potential conflicts of interest.
7.)	Have ethical issues been taken into consideration?	Yes, the authors adhered to the guidelines set by the British Psychological Society as of 2009. Ethics approval for the study was

		granted by the School of Psychology ethics committee and the University Research Governance.
8.)	Was the data analysis sufficiently rigorous?	Yes
9.)	Is there a clear statement of findings?	Yes
10.)	How valuable is the research?	The development of this theoretical framework offers new insights into the experiences of teachers working with students who have SM, an area where existing literature is limited. This framework can be utilised by teachers, education practitioners, and EPs to reflect on their experiences and to consider strategies for improving outcomes for students with SM in schools.

Ramon (2018)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes
3.)	Was the research design appropriate to address the aims of the research?	Yes
4.)	Was the recruitment strategy appropriate to the aims of the research?	While the method is effective for a focused study, its limitations may impact the breadth and

		generalisability of the findings due to the participation of only two schools.
5.)	Was the data collected in a way that addressed the research issue?	The researcher conducted semi-structured interviews to gather detailed data and utilised interpretative phenomenological analysis (IPA) methodology.
6.)	Has the relationship between researcher and participants been adequately considered?	Not sure.
7.)	Have ethical issues been taken into consideration?	Yes, the researcher consulted with the Principal Educational Psychologist in the EPS and obtained consent to conduct the research project within the local authority. The project was supervised by an EP from Tavistock, and approval was also granted by the ethics committee at the university.
8.)	Was the data analysis sufficiently rigorous?	Yes, the researcher used Yardley's (2000) framework to demonstrate the rigour of the data.
9.)	Is there a clear statement of findings?	Yes
10.)	How valuable is the research?	This research is valuable because it offers a detailed understanding of the challenges involved in teaching students with SM. It highlights the essential role teachers play in recognising and supporting these students. Moreover, it emphasises the need for specialised training and

		supervision to better prepare educators, ultimately helping to prevent feelings of isolation and inadequacy among them.

Appendix 9- Research Gathered for Critical Literature Review- Stakeholders' Perspectives

Stakeholders Perspectives	**Author**	**Type of publication**	**Detail of study**	**Audience targeted**	**Context of findings**	**Location**	**Limitations**
	White et al. (2022). An exploration of how selective mutism training informs teachers understanding and practice	Journal	This small-scale research project explored the perceived impact that SM training, delivered by an EP, had on school practitioners'	Three participants from a mainstream primary school were self-selected in response to a call for participation	This study used a qualitative research design to capture participants' views through small-group interviews. As the present study sought to explore the	United Kingdom (Manchester)	Whilst this piece of research is a qualitative exploration of participants' views and perceptions around SM training,

			understanding of the condition and their subsequent professional practice.	circulated within an identified school where staff had recently received SM training.	perceived impact of SM training among participants, a qualitative approach was deemed to be most appropriate.		the experiences of three teachers in one school may not be generalised to a broader population
	Edwards (2022) “It’s the fact they’re no trouble to anybody. That’s the problem, isn’t it?”:	Thesis	The study aimed to explore parents' and EPs perceptions of SM. It was divided into two parts: Parents' Perceptions via a quantitati	Parents and EPs	This research aimed to explore whether the characteristics identified by Johnson (2017) are present in individuals with SM from a parental	United Kingdom (Wales)	The qualitative aspect of this project was completed with three EPs who all had personal interest and persona

	An exploration of the characteristics of Selective Mutism and their applicability for the role of the Educational Psychologist.		ve method and EPs' Perceptions via a focus group. A semi-structured focus group with EPs to explore their views on SM and evaluate the potential usefulness of a checklist for supporting children with the condition.		perspective, and to assess the usefulness of Johnson's checklist in supporting EPs with hypothesis building. The findings highlight parents' perceptions of their child's condition, the role of EPs in supporting SM, and the additional support needed for EPs when working		l connections with the condition, possibly suggesting a high chance that the sample is biased.

					with the condition. Both qualitative and quantitative data were collected to enhance the quality of results. The study also revealed that participants had personal connections to SM, suggesting a homogenous group.		
	Huey et al. (2024): Unlocking voices:	Journal	This case study aims to report on the	MK is a 4-year-old Malay girl	This case study highlights the importance of a	Aisa (Malaysia)	The study relies heavily on the clinical

	a multifaceted approach in assessing and managing a preschooler with SM.		psychological assessment and intervention for a 4-year-old preschooler with SM. A comprehensive assessment that involves parents and teacher interview, classroom observation, Seguin Form Board Test (SFBT), Vineland Adaptive Behavio	from a middle-class family. She was selected for this case study via purposive sampling as she met the criteria for selective mutism, and her parents and teachers were actively involve	comprehensive approach to addressing SM, A collaborative model involving parents, teachers, and peers is essential. Psychoeducation sessions, as outlined by Zakszeski et al. (2017), were conducted for both MK's parents and teacher, enhancing their understan		records and observations of a single psychologist in training. While the clinical psychologist's training ensures a certain level of expertise, the subjectivity inherent in qualitative data collection—such as interpreting behaviour

			ur Scales Third Edition (Vineland-3), Behaviour Assessment System for Children, Third Edition (BASC-3), Childhood Autism Rating Scale, Second Edition Standard Version Rating Booklet (CARS 2-ST), and School Speech Question	d and committed to the treatment.	ding of her struggles and the support required. The initial meeting, which included MK's teacher, provided valuable insights into her speech abilities and challenges.		during classroom observations or drawing conclusions from parent and teacher interviews—may introduce bias. Moreover, the reliance on the perspectives of MK's parents and teachers, who are invested in the child's success

			naire were conducted.				, may result in overly positive assessments of the intervention's effectiveness.

Appendix 10- CASP Checklists for Stakeholders' studies.

White et al. (2022)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes, questions were asked that provided context on how SM training has informed their practice.
3.)	Was the research design appropriate to address the aims of the research?	Small-scale interviews were conducted to gather the perspectives of teachers.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes, three participants from the same school took part in the research.
5.)	Was the data collected in a way that addressed the research issue?	Yes.

6.)	Has the relationship between researcher and participants been adequately considered?	No.
7.)	Have ethical issues been taken into consideration?	Yes, ethical approval was granted for the study.
8.)	Was the data analysis sufficiently rigorous?	The researchers did not employ a specific framework to emphasise the trustworthiness of the data process; however, they were transparent about the transcription and anonymisation of the interviews. The data analysis followed the framework established by Braun and Clarke (2006), which was both inductive and data-driven. This approach ensured that the study's findings accurately represented the participants' views concerning both research questions.
9.)	Is there a clear statement of findings?	Yes.
10.)	How valuable is the research?	Although this research is limited in scope, it highlights the positive impact that training provided by an EP can have on practitioners' understanding of SM and their professional practices. At the same time, it emphasises the limited knowledge that school staff seems to have regarding SM. This finding is consistent with international research and explains why children with this condition face barriers in obtaining diagnosis and support.

Edwards (2022)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	Yes
2.)	Is a qualitative methodology appropriate?	Yes, this research also utilised quantitative data. The quantitative and qualitative aspects were conducted separately, with the results merging in the overall interpretation, chosen to improve the quality of the outcomes.
3.)	Was the research design appropriate to address the aims of the research?	Yes
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes
5.)	Was the data collected in a way that addressed the research issue?	Yes
6.)	Has the relationship between researcher and participants been adequately considered?	Yes, the researcher explained their positionality and motivations for the research topic.
7.)	Have ethical issues been taken into consideration?	Yes
8.)	Was the data analysis sufficiently rigorous?	Yes
9.)	Is there a clear statement of findings?	Yes
10.)	How valuable is the research?	During the focus group, participants suggested that a checklist of characteristics could be helpful for

		assisting EPs in building hypotheses, especially if it includes specific features of the condition. However, they noted that a checklist alone may not be sufficient. This highlights the need for additional training, position papers on working with the condition, consultation protocols, and easily accessible, freely available, and well-researched resources.

Huey et al., (2024)

	Checklist Question	**Details**
1.)	Was there a clear statement of the aims of the research?	The researchers briefly outline the aims within the research design section, but I'm not entirely sure about the details.
2.)	Is a qualitative methodology appropriate?	Yes
3.)	Was the research design appropriate to address the aims of the research?	Yes, several instruments were required to analyse the data.
4.)	Was the recruitment strategy appropriate to the aims of the research?	Yes, purpose sampling was used.
5.)	Was the data collected in a way that addressed the research issue?	Yes.
6.)	Has the relationship between researcher and participants been adequately considered?	I'm not certain; this issue was not addressed directly.

7.)	Have ethical issues been taken into consideration?	No
8.)	Was the data analysis sufficiently rigorous?	It is unclear what data analysis methods were applied or how the analysis was conducted.
9.)	Is there a clear statement of findings?	Yes
10.)	How valuable is the research?	This case study emphasises the significance of a comprehensive approach to addressing SM. A collaborative model that includes parents, teachers, and peers is essential.

Appendix 11- Participant Information Sheet

School of Psychology
Participant Information Sheet
Version: 01 Date: 11/01/24

School of Psychology

What are parents' and early-year staff's perceptions of the support they receive during the identification process of Selective Mutism (SM) in early childhood?

You are being invited to take part in a research project. Before you decide whether to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with others, if you wish.

Thank you for reading this.

1. What is the purpose of this research project?

The purpose of this research project is to interview parents and early years staff. It is hoped that the interviews will explore the facilitators and barriers to the support received during the identification process of SM in early childhood. The research will aim to provide an understanding of what helps and hinders when identifying a child with SM.

2. Why have I been invited to take part?

You have been invited because you are parent/ early years lead staff member who has supported a child with SM.

3. Do I have to take part?

No, your participation in this research is entirely voluntary and it is up to you to decide whether to take part. If you decide to take part, we will discuss the research project with you and ask you to sign the consent form that is attached with this information sheet. If you decide not to take part, you do not have to explain your reasons and it will not affect your legal rights.

You are free to withdraw your consent to participate in the research project at any time, without giving a reason, even after signing the consent form.

4. **What will taking part involve?**

   You will be asked to take part in an interview to discuss your perceptions on the support you received when identifying SM, including the characteristics that you experienced. The interview will take approximately 60 minutes of your time. The interview will take place via Microsoft Teams/ Zoom. The interviews will be audio recorded for research purposes; you will be anonymised using pseudonyms for confidentiality purposes in the write up of the research.

5. **Will I be paid for taking part?**

No, you will not be paid or offered any incentives for taking part.

6. **What are the possible benefits of taking part?**

There will be no direct benefits to you from taking part, but your contribution may help Educational Psychologists support parents and early years staff during the identification of SM.

7. **What are the possible risks of taking part?**

There are no possible risks of taking part in this research.

Will my taking part in this research project be kept confidential?

Yes, all information collected from and about you during the research project will be kept confidential and any personal information you provide will be managed in accordance with data protection legislation and stored on university data facilities. All interview data will be anonymised using pseudonyms and no participants will be identifiable in the write up of the research including the researcher's submission of an anonymised empirical paper inline with the university DEdPsy requirements. The researcher will also submit a summary of the research to the local authority. Please see ‘What will happen to my Personal Data?’ (below) for further information.

8. **What will happen to my Personal Data?**

9.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University’s Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner’s Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

Cardiff University (the researchers) will need to share names, email addresses and school contact details with the Local Authority for the purposes of this research project. After data collection in Jan/Feb, the researcher will anonymise all the personal data that has been collected from and about you in connection with this research project. This is except for your consent form which includes personal data which must be retained. Your consent form, which includes personally identifiable information, will be retained until July 2024 and may be accessed by members of the research team and, where necessary, by members of the University’s governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 6 months but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Data collected will be anonymised and confidential and participants and schools will not be identified or identifiable. Data from the transcripts will be stored on a password encrypted and protected computer. It will not be possible to withdraw any anonymised data that has already been published or in some cases, where identifiers are irreversibly removed during a research project, from the point at which it has been anonymised.

10. What happens to the data at the end of the research project?

Anonymised Data from the research could be made publicly available (anonymised) and/or shared with Local Authorities for future development of supporting children with SM.

What will happen to the results of the research project?

It is the researcher's intention to publish the results of this research project in academic journals and present findings at conferences. Participants will not be identified in any report, publication, or presentation.

Your anonymised data may be stored in a data repository as part of Cardiff University's commitment to Open Science.

11. What if there is a problem?

If you wish to complain or have grounds for concerns about any aspect of the way you have been approached or treated during this research, please contact Dr Victoria Biu Biuv1@cardiff.ac.uk or the School of Psychology Research Ethics Committee, Cardiff University at School of Psychology Research Ethics Committee, Cardiff University. Secretary of the Ethics Committee, School of Psychology, Cardiff University, Park Place, Cardiff, CF10 3AT. Tel: 029 2087 0707 Email: psychethics@cardiff.ac.uk.

If your complaint is not managed to your satisfaction, please contact the Information Commissioner's Office should you wish to complain, can be found at the following: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, you may have grounds for legal action, but you may have to pay for it.

12. Who is organising and funding this research project?

The research is organised by Danielle Hackett and Dr Victoria Biu. There is no funding being received for this research project.

13. Who has reviewed this research project?

This research project has been reviewed and given a favourable opinion by the School of Psychology Research Ethics Committee, Cardiff University. Secretary of the Ethics Committee, School of Psychology, Cardiff University, Park Place, Cardiff, CF10 3AT. Tel: 029 2087 0707 Email: psychethics@cardiff.ac.uk.

14. Further information and contact details

Should you have any questions relating to this research project, you may contact us during normal working hours:

Danielle Hackett (hackettda@cardiff.ac.uk) -Researcher

Dr Victoria Biu (biuv1@cardiff.ac.uk)- Research Supervisor

Thank you for considering taking part in this research project. If you decide to participate, you will be given a copy of the Participant Information Sheet and a signed consent form to keep for your records

Appendix 12- Participant Consent Form

School of Psychology
Consent Form
Version: 01 Date: 14/01/24

What are parents' and early-year staff's perceptions of the support they receive during the identification process of Selective Mutism (SM) in early childhood?

Name of Chief/Principal Investigator: Danielle Hackett

Please
initial
box

I confirm that I have read the information sheet dated / version 01 for the above research project.	
I confirm that I have understood the information sheet dated / version 01 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw at any time without giving a reason and without any adverse consequences I understand that if I withdraw, information about me that has already been obtained may be kept by Cardiff University.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research	

project. I give permission for these individuals to have access to my data.	
I consent to the processing of my personal information (name, email address and name of primary school) for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to my personal information, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify me from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I consent to being audio recorded for the purposes of the research project and I understand how it will be used in the research.	
I understand that anonymised excerpts and/or verbatim quotes from my focus group may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree to take part in this research project.	

Name of participant (print)

Date:

Signature:

Name of person taking consent (print)

Date:

Signature:

Role of person taking consent

(print):

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

Appendix 13- Interview Schedule

Interview Schedule

The questions for the interview scheduled have been adapted from Edwards's (2022) research, the previous research questions were developed for a focus group of EPs which included the following.

"1) What does the term Selective Mutism mean to you? 2) What are your experiences of working in relation to Selective Mutism? 3) What are your expectations when you hear the word Selective Mutism? 4) What would you deem are the characteristics of Selective Mutism? 5) Is Selective Mutism an area you are confident in? 6) If answered no to the top question, what do you think could help you become more confident in your hypothesis building and working with Selective Mutism? … Would a checklist of characteristics be helpful?"

The researcher has now developed questions to explore their research question of "What are parents and early years staff's perceptions of the support they receive during the identification process of Selective Mutism (SM) in early childhood?" Questions have been developed for both the staff and parents in the early years.

Early Years Staff Questions:

Hello, thank you for agreeing to participate in the interview today; the purpose of this interview is to discuss your perceptions of the process of identifying children with SM, which includes discussing your experiences and how these experiences may have helped or hindered the identification process of SM. Today's interview will be audio recorded online and will not include any video recordings; the audio recordings will be destroyed when transcription has been completed (within two weeks), and pseudonyms will then be used, so you will not be identifiable from then on. All information will remain confidential. I have received your informed consent to take part prior to this interview and I would like to remind you of your right to withdraw from the research at any point up until the final transcriptions are complete (in two weeks' time).

- What does the term SM mean to you?

-How many children have you supported with SM

- Tell me about how you identify children who display the characteristics of SM.

- How confident do you feel when identifying children with SM?

-

- Can you tell me about what professionals you work with when identifying the characteristics of children with SM, if any, and what this involves?

- What support would you like to see from other professionals, such as Educational Psychologists and Speech and Language Therapists?

- Tell me about how you work with parents when identifying SM.

- In your experience, did you make parents aware of SM, or did the parents approach you with queries about SM?

- What works well when identifying children with SM?

- What do you feel could work better to identify children with SM?

- If you could give any advice for early years staff about identifying SM, what would it be?

Questions- Parents

Hello, thank you for agreeing to participate in the interview today, the purpose of this interview is to discuss your perceptions of the process of identifying your SM for your child which includes discussing your experiences, and how these experiences may have helped or hindered the identification process. Today's interview will be audio recorded online, and will not include any video recordings, the audio recordings will be destroyed when transcription has been completed (within two weeks) and pseudonyms will then be used, so you will not be identifiable from then on. All information will remain confidential. I have received your informed consent to take part prior to this interview and I would like to remind you of your right to withdraw from the research at any point up until the final transcriptions are complete (in two weeks' time).

- What does the term selective mutism mean to you?

-Does your child have an official diagnosis of SM?
-How old was your child when you first became aware of their SM

- Tell me about how you first became aware that your child was experiencing SM

- Tell me about your experiences if any of the support you received from your child's early year setting when identifying your child with SM.

- What services/ professionals have been involved if any, and what did that experience involve?

- What did you feel worked well when identifying your child with SM?

- What could have worked better when identifying your child with SM?

- What support would you like from other professionals such as Educational Psychologists and Speech and Language Therapists?

- If you could give any advice to other parents when identifying SM, what advice would that be?

Appendix 14- Debrief Form

What are parents' and early-year staff's perceptions of the support they receive during the identification process of Selective Mutism (SM) in early childhood?

Debrief

Thank you for taking part in this study, your participation is appreciated. The aim of the study is to explore the support received during the identification process of SM in early childhood. It is hoped that this research will be able to share some of the barriers and facilitators when identifying a child with SM. The information gained from the semi-structured interviews will be used to inform the researchers thesis project, as part of the Doctorate in Educational Psychology.

The anonymised results may be published and used in presentations. It is hoped that findings may provide local authorities with an insight into identifying children with SM in early years settings. This is a reminder that the semi-structured interview recording, and subsequent transcripts will be kept confidentially in a secure location only accessible to the researcher and translator if appropriate. The semi-structured recording will be kept confidentially up to the point of transcription, at which point it will be deleted, and all transcribed information will be anonymised, and pseudonyms will be used.

You have the right to withdraw your data up to two weeks after the interview, as beyond this point there will be no identifiable link between yourself and your responses. If the conversation within the semi- structured interviews has brought up any worries or if you are concerned about your wellbeing, you may wish to contact: www.mind.org.uk https://www.educationsupport.org.uk/helping-you

If you have any further questions or comments about the research, please contact:

The researcher: Danielle Hackett hackettda@cardiff.ac.uk,

The research supervisor: Dr Victoria Biu (biuv1@cardiff.ac.uk)

Cardiff University's Research Ethics Committee:
School of Psychology, Cardiff University, Tower Building, 30 Park Place, Cardiff, CF10 3EU; email: psychethics@cardiff.ac.uk

Privacy Notice: *Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. The University has a Data Protection Officer who can be contacted at inforequest@cardiff.ac.uk. Further information about Data Protection, including your rights and details about how to contact the Information Commissioner's Office should you wish to complain, can be found.*

Appendix 15- Gatekeeper Letters

FAO: Early Years Panel Leads

Address: EPS

Date:19th June 2024

Dear Sir/Madam,

I am a Trainee Educational Psychologist studying within the School of Psychology at Cardiff University. I am seeking to conduct research into

I am writing to enquire whether you would be willing to give permission for me to recruit participants from preschools in your Local Authority who are supporting children with Selective Mutism (SM) and share the attached information (a recruitment poster, participant information sheet and consent form) with them on my behalf. This would mean acting as my gatekeeper for this research project.

Inclusion Criteria

- Must be a member of staff working within an early year setting with children aged 2-7.
- Must be a staff member with at least one month's experience of working with children with a clinical diagnosis of SM or with children who display the same characteristics as the diagnostic criteria, which include the following:
- A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home).
- This pattern has continued for over a month, not including the first month of a new environment such as school.
- The lack of speech impacts the individual's education, work, or social interactions.

- The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.

Participation will involve semi-structured interviews online via Microsoft Teams or Zoom, answering questions related to their experiences identifying children with Selective Mutism. The semi-structured interviews will take place at a time convenient for the individuals and will last for approximately 60 minutes. All information will be kept confidential and anonymised using pseudonyms for the final report.

To indicate your consent for acting as a gatekeeper for our research project, or for further information, please reply to this email contacting Danielle Hackett hackettda@cardiff.ac.uk. or to speak with my research supervisor Dr Victoria Biu (biuv1@cardiff.ac.uk).

Thank you for taking the time to consider my request, I would be very grateful for your support.

Kind Regards,
Danielle Hackett
Trainee Educational Psychologists of Psychology, Cardiff University Tower Building,
30 Park Place, Cardiff, CF10 3EU.

FAO: Childcare Team Managers

Address: Childcare Team

Date:14th January 2024

Dear Sir/Madam,

I am a Trainee Educational Psychologist studying within the School of Psychology at Cardiff University. I am seeking to conduct research into the identification process of Selective Mutism in early childhood (aged 2-7).

I am writing to enquire whether you would be willing to give permission for me to recruit participants from preschools in your Local Authority who are supporting children with Selective Mutism (SM) and share the attached information (a recruitment poster, participant information sheet and consent form) with them on my behalf. This would mean acting as my gatekeeper for this research project.

Inclusion Criteria

- Must be a member of staff working within an early year setting with children aged 2-7.
- Must be a staff member with at least one month's experience of working with children with a clinical diagnosis of SM or with children who display the same characteristics as the diagnostic criteria, which include the following:
- A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home).
- This pattern has continued for over a month, not including the first month of a new environment such as school.
- The lack of speech impacts the individual's education, work, or social interactions.

- The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.

Participation will involve semi-structured interviews online via Microsoft Teams or Zoom, answering questions related to their experiences identifying children with Selective Mutism. The semi-structured interviews will take place at a time convenient for the individuals and will last for approximately 60 minutes. All information will be kept confidential and anonymised using pseudonyms for the final report.

To indicate your consent for acting as a gatekeeper for our research project, or for further information, please reply to this email contacting Danielle Hackett hackettda@cardiff.ac.uk. or to speak with my research supervisor Dr Victoria Biu (biuv1@cardiff.ac.uk).

Thank you for taking the time to consider my request, I would be very grateful for your support.

Kind Regards,
Danielle Hackett
Trainee Educational Psychologists of Psychology, Cardiff University Tower Building,
30 Park Place, Cardiff, CF10 3EU.

FAO: Principal Educational Psychologist

Address: EPS

Date:19th June 2024

Dear Sir/Madam,

I am a Trainee Educational Psychologist studying within the School of Psychology at Cardiff University. I am seeking to conduct research into the identification process of Selective Mutism (SM) in early childhood (aged 2-7).

I am writing to enquire whether you would be willing to give permission for me to recruit participants from early years settings in your Local Authority who are supporting children with Selective Mutism (SM) and share the attached information (a recruitment poster, participant information sheet and consent form) with them on my behalf. This would mean acting as my gatekeeper for this research project.

Inclusion Criteria

- Must be a member of staff working within an early year setting with children aged 2-7.
- Must be a staff member with at least one month's experience of working with children with a clinical diagnosis of SM or with children who display the same characteristics as the diagnostic criteria, which include the following:
- A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home).
- This pattern has continued for over a month, not including the first month of a new environment such as school.
- The lack of speech impacts the individual's education, work, or social interactions.

- The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.

Participation will involve semi-structured interviews online via Microsoft Teams or Zoom, answering questions related to their experiences identifying children with Selective Mutism. The semi-structured interviews will take place at a time convenient for the individuals and will last for approximately 60 minutes. All information will be kept confidential and anonymised using pseudonyms for the final report.

To indicate your consent for acting as a gatekeeper for our research project, or for further information, please reply to this email contacting Danielle Hackett hackettda@cardiff.ac.uk. or to speak with my research supervisor Dr Victoria Biu (biuv1@cardiff.ac.uk).

Thank you for taking the time to consider my request, I would be very grateful for your support.

Kind Regards,
Danielle Hackett
Trainee Educational Psychologists of Psychology, Cardiff University Tower Building,
30 Park Place, Cardiff, CF10 3EU.

FAO: SMiRA

Address: SMiRA

Date:14th January 2024

Dear Sir/Madam,

I am a Trainee Educational Psychologist studying within the School of Psychology at Cardiff University. I am seeking to conduct research into the identification process of Selective Mutism in early childhood (aged 2-7).

I am writing to enquire whether you would be willing to give permission for me to recruit parents who are part of the association and share the attached information (a recruitment poster, participant information sheet and consent form) with them on my behalf. This would mean acting as my gatekeeper for this research project.

- Must be a parent/guardian of a child who has a clinical diagnosis of SM **or**
- Must be a parent/guardian of a child who displays the characteristics of the diagnostic criteria for SM, which include the following:
    - A consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home).
    - This pattern has continued for over a month, not including the first month of a new environment such as school.
    - The lack of speech impacts the individual's education, work, or social interactions.
    - The failure to speak is not due to the limited knowledge of, nor discomfort with, the spoken language required in the specific social situation. Nor is it better accounted for by a communication disorder or condition resulting in transient mutism such as separation anxiety, schizophrenia, or a psychotic episode.
    - Must have a child aged between 2 and 7, and the child must attend an early year setting.

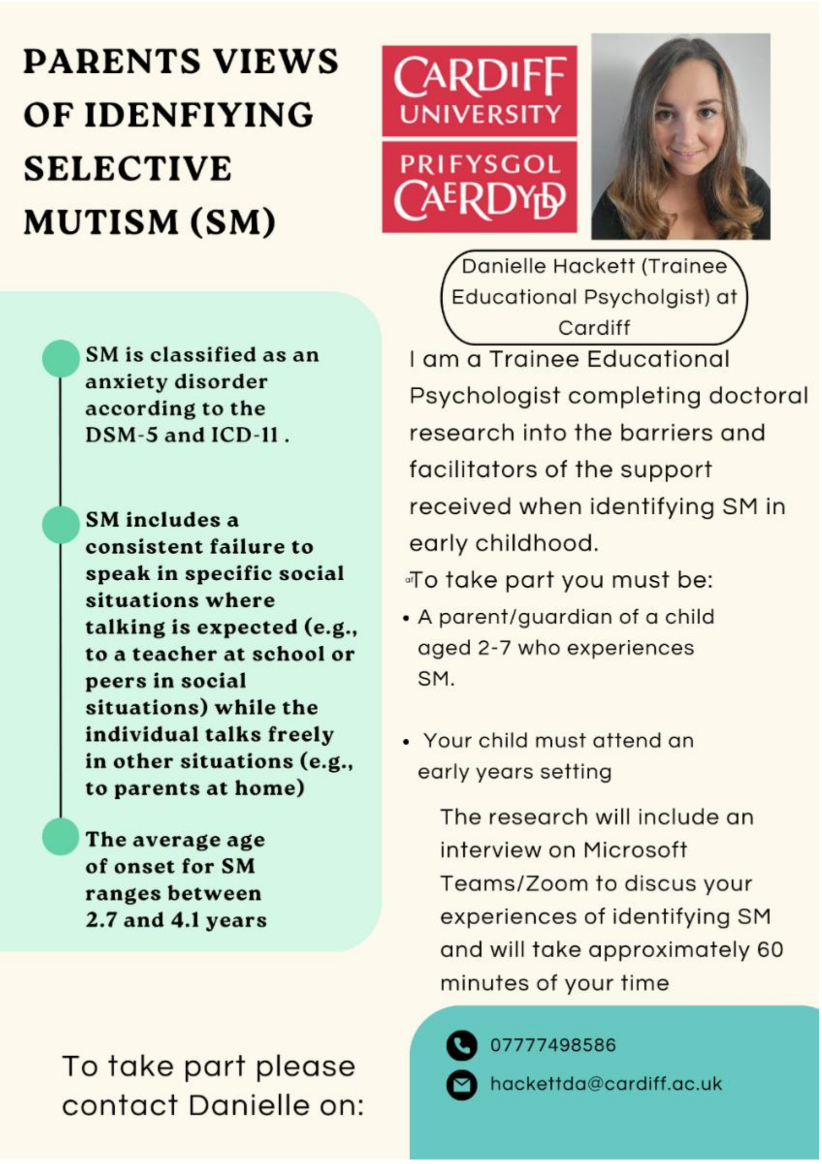
Participation will involve semi-structured interviews online via Microsoft Teams or Zoom, answering questions related to their experiences identifying children with Selective Mutism. The semi-structured interviews will take place at a time convenient for the individuals and will last for approximately 60 minutes. All information will be kept confidential and anonymised using pseudonyms for the final report.

To indicate your consent for acting as a gatekeeper for our research project, or for further information, please reply to this email contacting Danielle Hackett hackettda@cardiff.ac.uk. or to speak with my research supervisor Dr Victoria Biu (biuv1@cardiff.ac.uk).

Thank you for taking the time to consider my request, I would be very grateful for your support.

Kind Regards,
Danielle Hackett
Trainee Educational Psychologists of Psychology, Cardiff University Tower Building, 30 Park Place, Cardiff, CF10 3EU.

Appendix 16- Recruitment Posters



PARENTS VIEWS OF IDENFIYING SELECTIVE MUTISM (SM)

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Danielle Hackett (Trainee Educational Psycholgist) at Cardiff

- **SM is classified as an anxiety disorder according to the DSM-5 and ICD-11 .**
- **SM includes a consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home)**
- **The average age of onset for SM ranges between 2.7 and 4.1 years**

I am a Trainee Educational Psychologist completing doctoral research into the barriers and facilitators of the support received when identifying SM in early childhood.

To take part you must be:

- A parent/guardian of a child aged 2-7 who experiences SM.
- Your child must attend an early years setting

The research will include an interview on Microsoft Teams/Zoom to discus your experiences of identifying SM and will take approximately 60 minutes of your time

To take part please contact Danielle on:

☎ 07777498586
✉ hackettda@cardiff.ac.uk

EARLY YEARS AND SELECTIVE MUTISM (SM)

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Danielle Hackett (Trainee Educational Psycholgist) at Cardiff

- SM is classified as an anxiety disorder according to the DSM-5 and ICD-11 .
- It includes a consistent failure to speak in specific social situations where talking is expected (e.g., to a teacher at school or peers in social situations) while the individual talks freely in other situations (e.g., to parents at home)
- The average age of onset for SM ranges between 2.7 and 4.1 years

The research will include an online individual interview via Microsoft teams/ zoom and will take approximately 60 minutes of your time.

I am a Trainee Educational Psychologist completing doctoral research into the barriers and facilitators of the support received when identifying children with SM.

To take you must:

- Work in an early years setting (with children aged between 2 and 7)
- Have at least one months experience of supporting children experiencing SM.

To take part please contact Danielle on:

☎ 07399642055
✉ hackettda@cardiff.ac.uk

Appendix 17- Research Journal Excerpts

October 2024- Example of Journal regarding Interviewing Parents

Initial Thoughts

Before the interview, I believed parents might define SM differently than early years staff. I thought parents might use the term situational rather than selective. I perceived that parents could struggle with the label of SM, possibly becoming emotional or frustrated when discussing their experiences with involved services.

Suprises

It seemed challenging to identify what changes needed to be made. When asked to define SM, the parent replied, “I wouldn't say I attribute much meaning to it. It's a label I try not to use.” She preferred the term "selective talking," stating, “I don’t like the connotation behind mutism.” The parent first learned about selective mutism through her sister, who is an EP. When she approached the childminder, the childminder revealed they had wanted to mention this for months. The parent’s journey to identifying SM relied on her advocacy, stating, “I have gone with the combination of my sister's professional opinion and a private speech and language therapist.” Additionally, she discovered a SEN (Special Educational Needs) playgroup that was already working on identifying SM, which she was initially unaware of. Despite having a referral and evidence from the SEN playgroup knowledgeable about SM, the referral was not accepted due to systemic issues and not meeting criteria. The parent attempted to seek support from a GP, but the GP suggested exploring a different avenue, which she refused, as it would be too distressing for her child. Consequently, the parent feels stuck regarding how to pursue a diagnosis. She commented that early year’s providers need training in SM, stating, “I would expect a professional childcare provider to at least have knowledge of it. It seems to be something that is not even known by people you’re supposed to trust to be highly qualified with your children.”

Own Reflexive Thoughts

As a parent of a child with SM, I empathise with the uncertainty surrounding the term SM: what it means and how to explain it. The training I have completed, and my experiences support the view of SM as a phobia—a learned response that a child cannot control. Even with personal experience and research on SM, I often grapple with how to explain the term in an accessible manner and question its effectiveness. Given the knowledge gap, I wonder how many children are affected by SM. I am curious about how early years staff can begin to identify children displaying symptoms of SM and how they can create a safe environment for all children who struggle to speak. I ponder whether focusing on reducing anxiety and the pressure to communicate across different settings could make a difference. Children with SM often face challenges attending settings where they cannot meet their basic needs, which is heart-wrenching for parents. Many children cannot use language for various reasons; thus, a systemic shift is needed to understand why speech is not used.

<u>December 2024- Example of Journal regarding Interviewing Early Years Staff</u>

Surprises

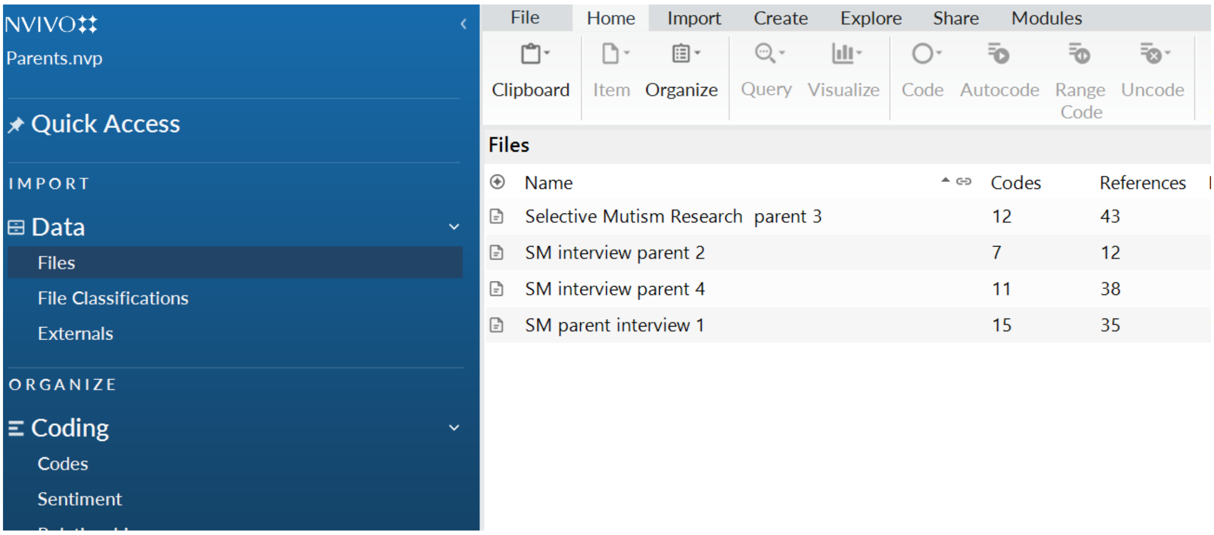
The staff defined SM in relation to the pupil (context specific) “she is speaking in the majority of other situations, but not in school.” The staff like participant 1 suggested that they needed to do their own research “I did my own research into what it could be, and selective mutism came up”. Unlike Participant 1, this school appears to be at a different stage with knowledge “And so what we've learned is that we've had another child with mutism, and we were thinking, well, how do they control it? You know, they look so happy. They look bubbly in their enthusiastic. How are they managing to control it, not to let anything out. But with the research we've done, we've learned that they're not controlling it, its that they physically can't talk” This school has the awareness that for children with SM they are not controlling it, they physically ‘can’t’. This school had one previous child with SM but many years ago. There was an awareness that the child wouldn’t speak to the childminder prior to starting school. However, they suggested, “we were hoping that maybe a new situation, a new setting things would be better”. The school then gave time for the child to settle but took a while to start to do their research further.

Curious Questions

“Progress kind of stopped or was really really slow” at this point the school requested educational psychologist involvement, I’m wondering if there had been advice/ strategies upon starting school if the outcome could be different. I am curious about EPs knowledge of SM, how much training have they had, how do EPs consider neurodiversity and/or SM. The staff was very interested in what can make a difference for people with SM. “Was there anything that helped them or was it just a natural progression?” I’m curious about how we find the difference that makes the difference, how do we consider the ripple effect, and will sharing the knowledge of SM to the adults that know that child make a difference. “I can understand why people say, well, they're too young”, We don't want to diagnose when they're too young, but I just think if there are those concerns, if there are strategies put in place so much sooner, maybe that would help the child” – how do we shift this narrative of ‘holding off’ or being “too young” and how do we support schools and EY settings to become more inclusive and offer early interventions.

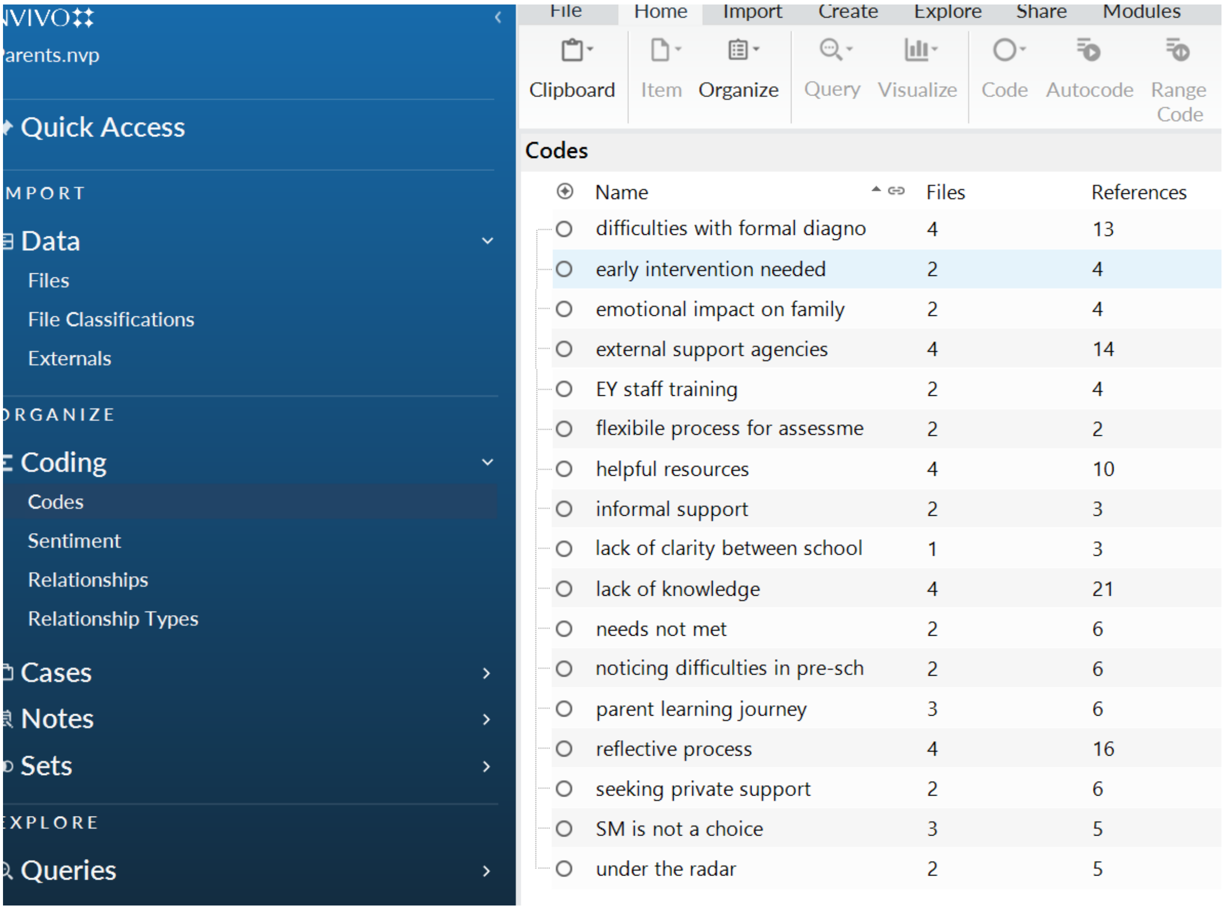
Appendix 18- An Overview of the Data Analysis Process

Generation of codes during Reflexive Thematic Analysis – Parents



Files

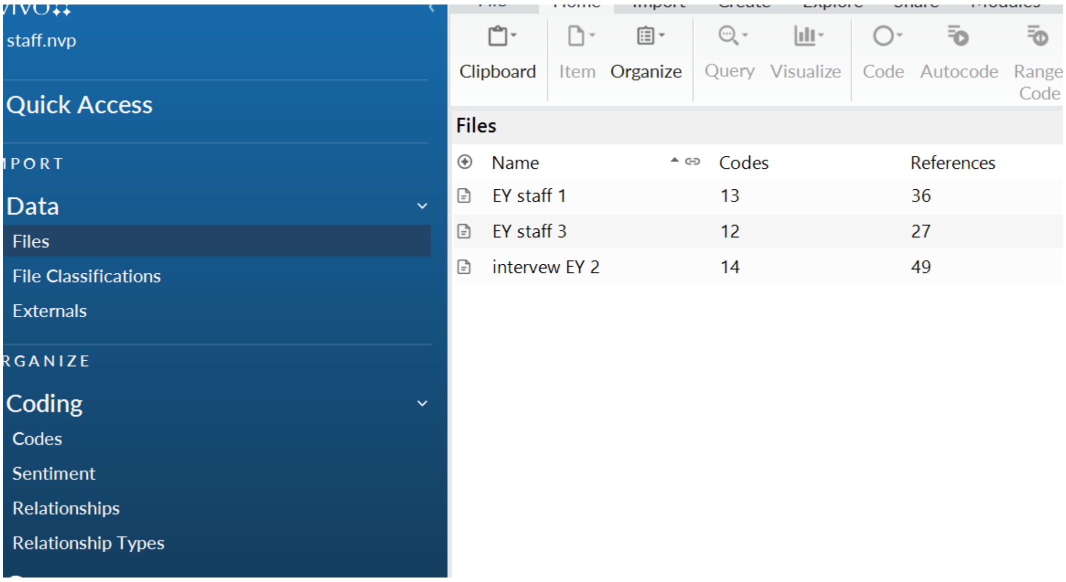
Name	Codes	References
Selective Mutism Research parent 3	12	43
SM interview parent 2	7	12
SM interview parent 4	11	38
SM parent interview 1	15	35



Codes

Name	Files	References
difficulties with formal diagno	4	13
early intervention needed	2	4
emotional impact on family	2	4
external support agencies	4	14
EY staff training	2	4
flexible process for assessme	2	2
helpful resources	4	10
informal support	2	3
lack of clarity between school	1	3
lack of knowledge	4	21
needs not met	2	6
noticing difficulties in pre-sch	2	6
parent learning journey	3	6
reflective process	4	16
seeking private support	2	6
SM is not a choice	3	5
under the radar	2	5

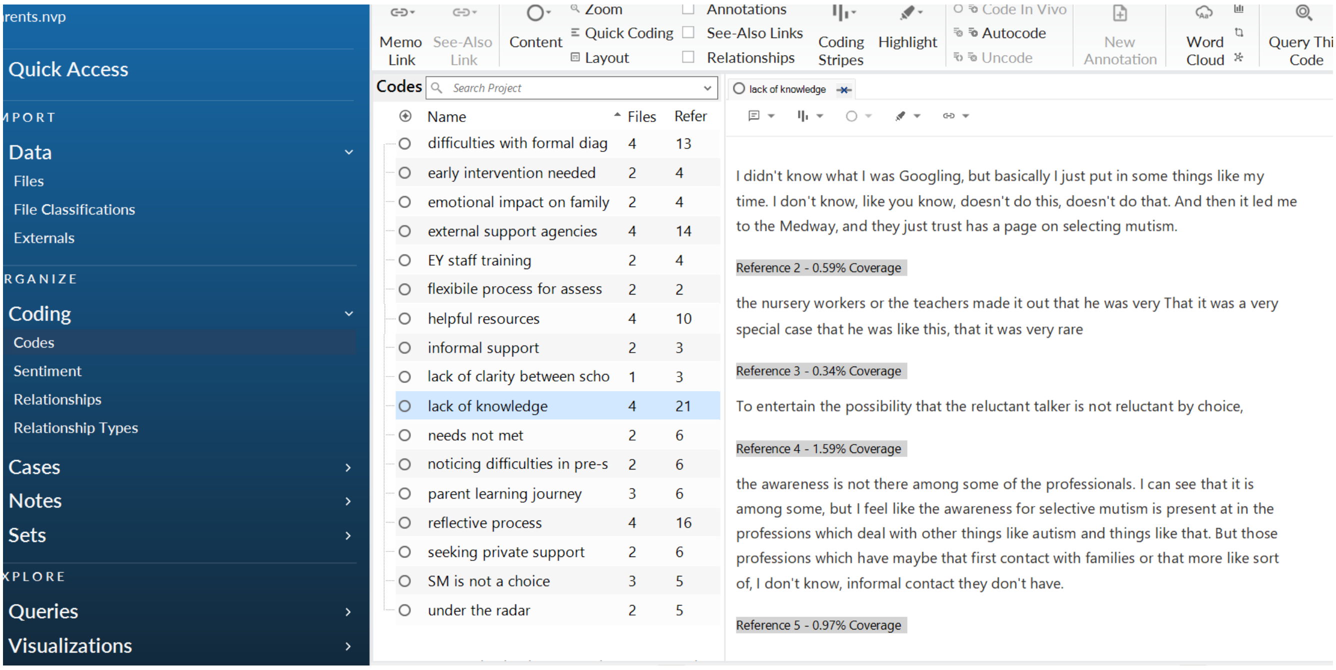
Examples of codes during Reflexive Thematic Analysis for Parents



Files

Name	Codes	References
EY staff 1	13	36
EY staff 3	12	27
interverw EY 2	14	49

Example of “lack of knowledge’ code and subsequent parents quotes



Name	Files	Refer
difficulties with formal diag	4	13
early intervention needed	2	4
emotional impact on family	2	4
external support agencies	4	14
EY staff training	2	4
flexibile process for assess	2	2
helpful resources	4	10
informal support	2	3
lack of clarity between scho	1	3
lack of knowledge	4	21
needs not met	2	6
noticing difficulties in pre-s	2	6
parent learning journey	3	6
reflective process	4	16
seeking private support	2	6
SM is not a choice	3	5
under the radar	2	5

I didn't know what I was Googling, but basically I just put in some things like my time. I don't know, like you know, doesn't do this, doesn't do that. And then it led me to the Medway, and they just trust has a page on selecting mutism.

Reference 2 - 0.59% Coverage

the nursery workers or the teachers made it out that he was very That it was a very special case that he was like this, that it was very rare

Reference 3 - 0.34% Coverage

To entertain the possibility that the reluctant talker is not reluctant by choice,

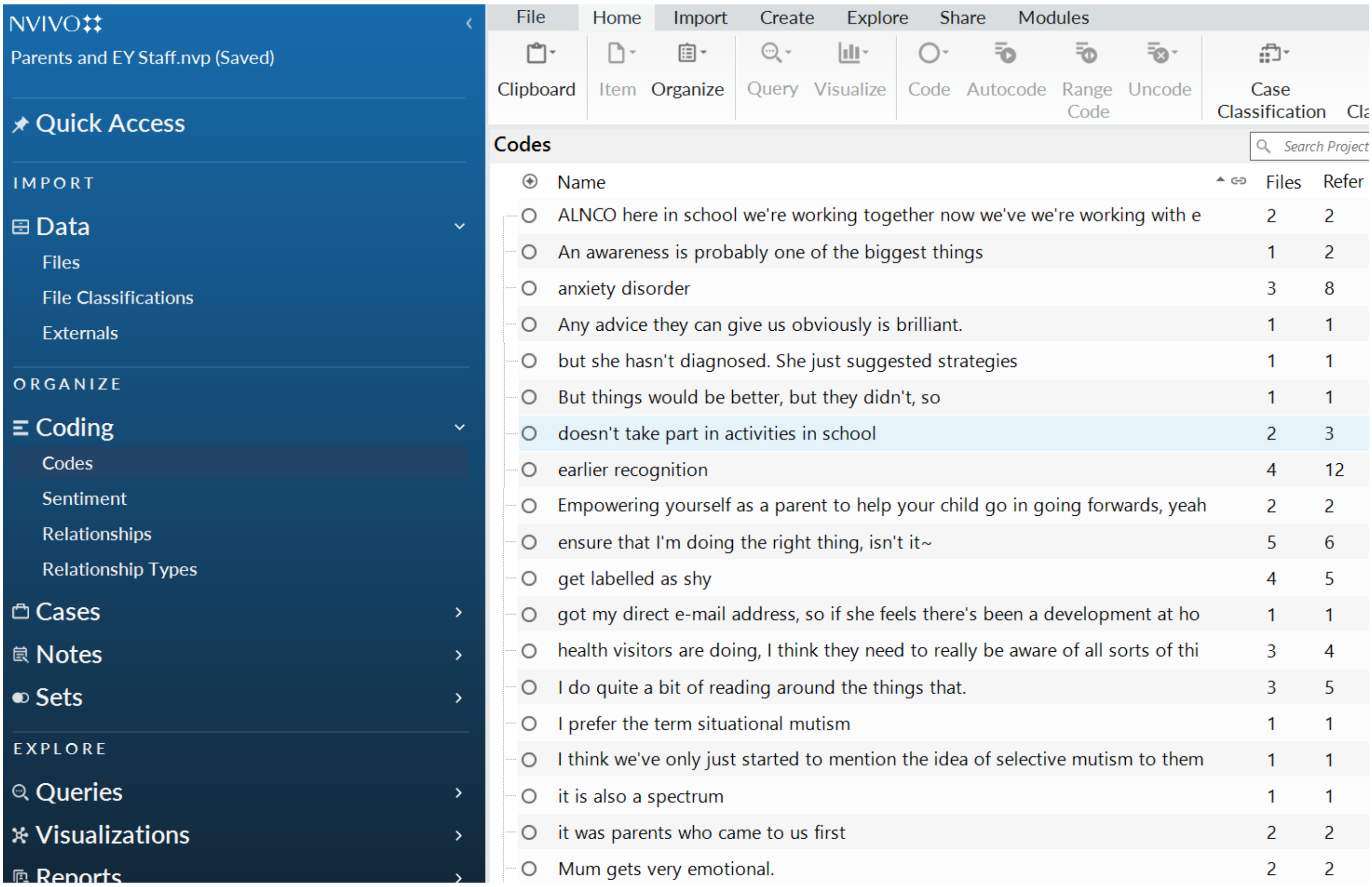
Reference 4 - 1.59% Coverage

the awareness is not there among some of the professionals. I can see that it is among some, but I feel like the awareness for selective mutism is present at in the professions which deal with other things like autism and things like that. But those professions which have maybe that first contact with families or that more like sort of, I don't know, informal contact they don't have.

Reference 5 - 0.97% Coverage

Generating codes for the Early Years Staff

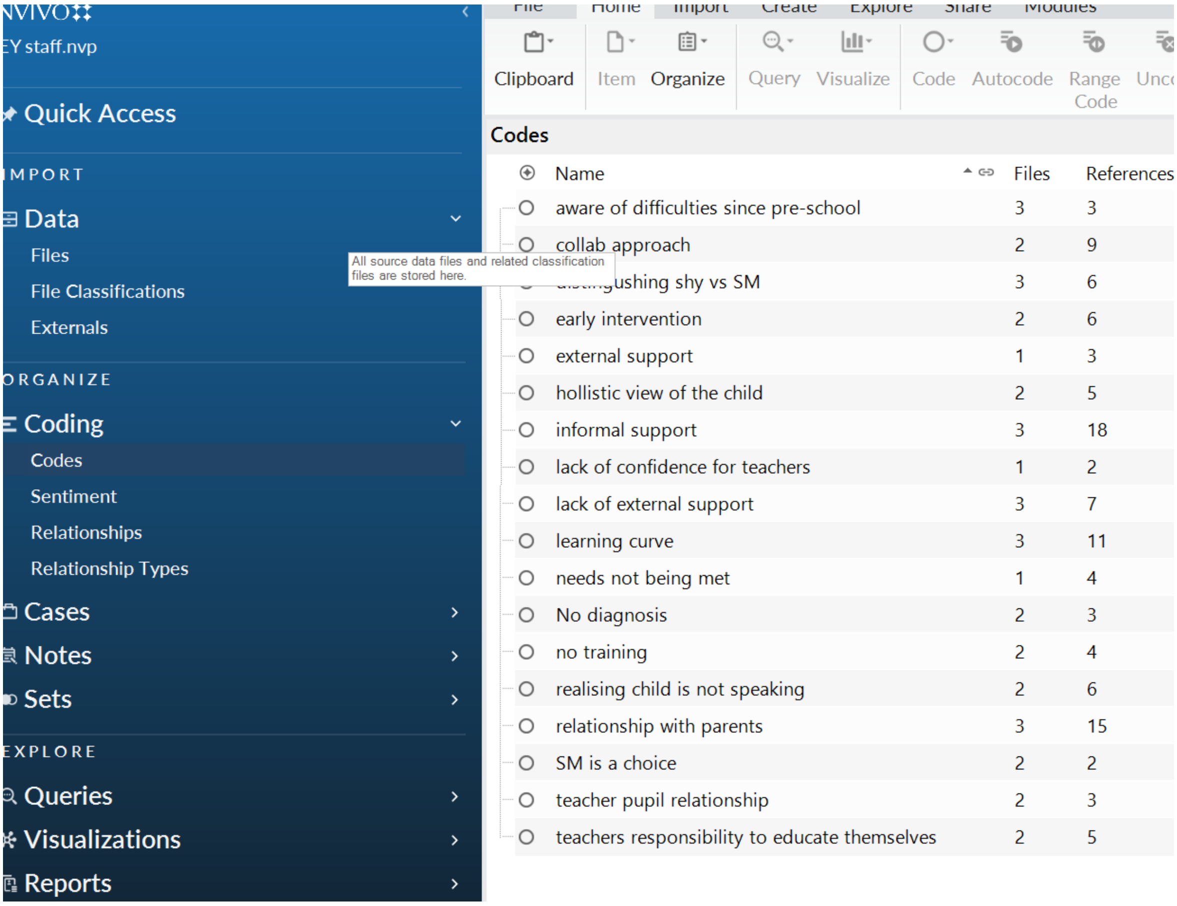
Examples of codes generated for Early Years Staff



Codes

Name	Files	Refer
ALNCO here in school we're working together now we've we're working with e	2	2
An awareness is probably one of the biggest things	1	2
anxiety disorder	3	8
Any advice they can give us obviously is brilliant.	1	1
but she hasn't diagnosed. She just suggested strategies	1	1
But things would be better, but they didn't, so	1	1
doesn't take part in activities in school	2	3
earlier recognition	4	12
Empowering yourself as a parent to help your child go in going forwards, yeah	2	2
ensure that I'm doing the right thing, isn't it~	5	6
get labelled as shy	4	5
got my direct e-mail address, so if she feels there's been a development at ho	1	1
health visitors are doing, I think they need to really be aware of all sorts of thi	3	4
I do quite a bit of reading around the things that.	3	5
I prefer the term situational mutism	1	1
I think we've only just started to mention the idea of selective mutism to them	1	1
it is also a spectrum	1	1
it was parents who came to us first	2	2
Mum gets very emotional.	2	2

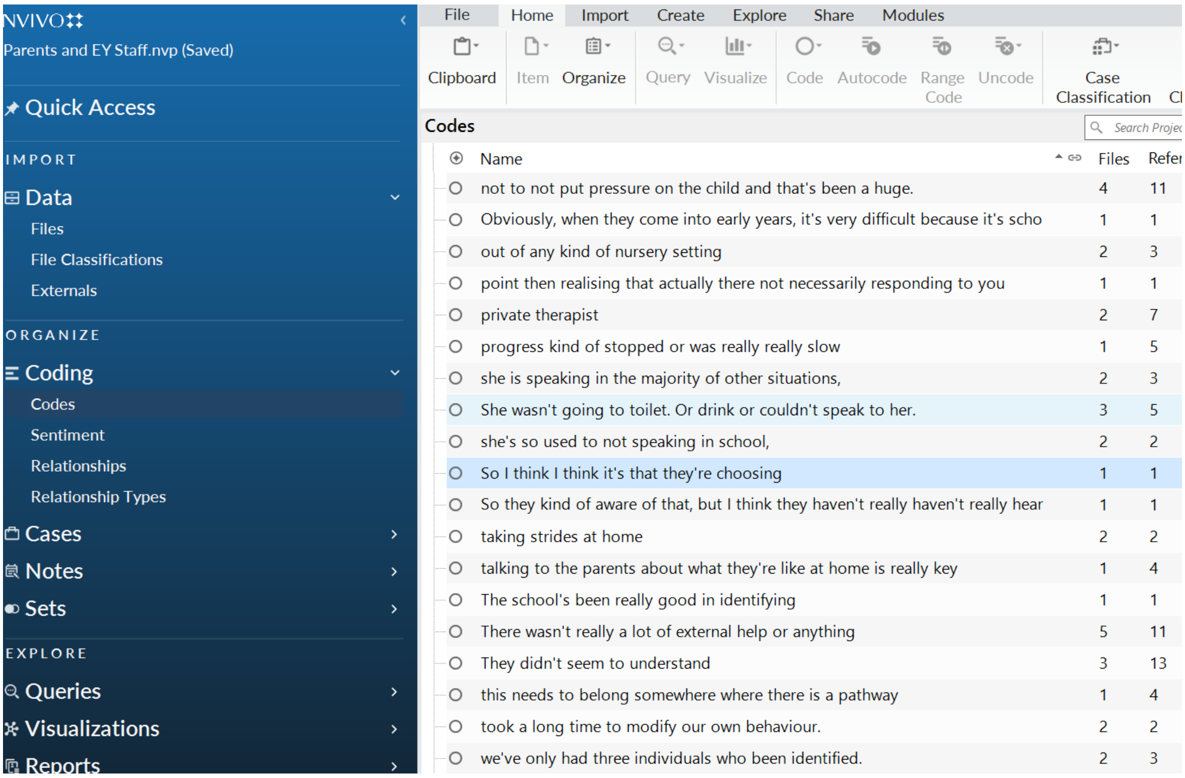
Examples of generating codes collectively for Early Years Staff and Parents



All source data files and related classification files are stored here.

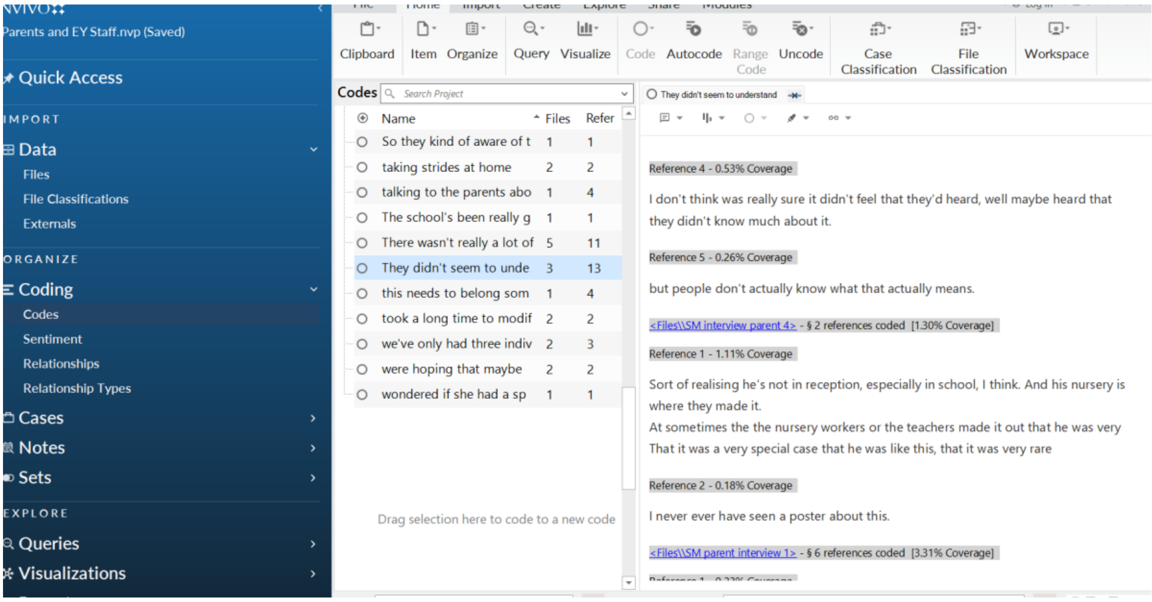
Codes

Name	Files	References
aware of difficulties since pre-school	3	3
collab approach	2	9
ushing shy vs SM	3	6
early intervention	2	6
external support	1	3
hollistic view of the child	2	5
informal support	3	18
lack of confidence for teachers	1	2
lack of external support	3	7
learning curve	3	11
needs not being met	1	4
No diagnosis	2	3
no training	2	4
realising child is not speaking	2	6
relationship with parents	3	15
SM is a choice	2	2
teacher pupil relationship	2	3
teachers responsibility to educate themselves	2	5



Codes

Name	Files	Refer
not to not put pressure on the child and that's been a huge.	4	11
Obviously, when they come into early years, it's very difficult because it's scho	1	1
out of any kind of nursery setting	2	3
point then realising that actually there not necessarily responding to you	1	1
private therapist	2	7
progress kind of stopped or was really really slow	1	5
she is speaking in the majority of other situations,	2	3
She wasn't going to toilet. Or drink or couldn't speak to her.	3	5
she's so used to not speaking in school,	2	2
So I think I think it's that they're choosing	1	1
So they kind of aware of that, but I think they haven't really haven't really hear	1	1
taking strides at home	2	2
talking to the parents about what they're like at home is really key	1	4
The school's been really good in identifying	1	1
There wasn't really a lot of external help or anything	5	11
They didn't seem to understand	3	13
this needs to belong somewhere where there is a pathway	1	4
took a long time to modify our own behaviour.	2	2
we've only had three individuals who been identified.	2	3



Codes

Name	Files	Refer
So they kind of aware of t	1	1
taking strides at home	2	2
talking to the parents abo	1	4
The school's been really g	1	1
There wasn't really a lot of	5	11
They didn't seem to unde	3	13
this needs to belong som	1	4
took a long time to modif	2	2
we've only had three indiv	2	3
were hoping that maybe	2	2
wondered if she had a sp	1	1

○ They didn't seem to understand

Reference 4 - 0.53% Coverage

I don't think was really sure it didn't feel that they'd heard, well maybe heard that they didn't know much about it.

Reference 5 - 0.26% Coverage

but people don't actually know what that actually means.

<Files\\SM interview parent 4> - § 2 references coded [1.30% Coverage]

Reference 1 - 1.11% Coverage

Sort of realising he's not in reception, especially in school, I think. And his nursery is where they made it.
At sometimes the the nursery workers or the teachers made it out that he was very
That it was a very special case that he was like this, that it was very rare

Reference 2 - 0.18% Coverage

I never ever have seen a poster about this.

<Files\\SM parent interview 1> - § 6 references coded [3.31% Coverage]

Examples of quotes taken from the code "they didn't seem to understand" for parents and early years staff.

Appendix 19- CARES Table

CARES Element	**Theoretical Basis**	**Practical Strategy**	**Illustrative Quote / Theme**
C – Collaborate with Parents as Key Contributors	COMOIRA (Social Constructionism) [Gameson & Rhydderch, 2017]	Joint planning, validating lived experience, shared formulation	*“You’ve got to prove that you need the help.”*
A – Acknowledge and Use Uncertainty as a Starting Point	COMOIRA (Flexible Decision Points) [Gameson & Rhydderch, 2017], EVT [Burgoon, 2015]	Open discussion of ambiguity, reflective inquiry, and creating a chance for curious questions	*“We need more information about this.”*
R – Recognise Communicative Behaviours Across the Continuum	COMOIRA (Informed and Reasoned Action) [Gameson & Rhydderch, 2017], Kearney’s Communication Continuum [Kearney, 2010]	Notice non-verbal cues, interpret subtle signals, and avoid binary thinking	*“It takes a long time for the penny to drop.”*
E – Enable Safe, Reflective Spaces for Dialogue	COMOIRA (Enable Dialogue) [Gameson & Rhydderch, 2017], BPNT [Ryan & Deci, 2000]	Create trust-based, emotionally safe consultation spaces.	*“We hoped for improvement, but things did not get better.”*
S – Strengthen Connections Across Networks	COMOIRA (Systems Thinking) [Gameson & Rhydderch, 2017]	Collaboration among multiple agencies and consistent messaging across systems.	*“We could have identified the issue sooner.”*

Appendix 20- Fictional Case Study applying CARES

Fictional Case Study: Maya (4 years old, nursery setting)

Background:

Maya is a bright and playful child who speaks confidently and frequently at home. However, at the nursery, she has not spoken for several months. Staff are uncertain whether this is typical shyness or something more significant. Parents express frustration, saying, “She talks non-stop at home!”

Application of CARES:

- **Collaborate with parents as key contributors:**
  Stakeholders—including EPs, parents, and nursery staff—come together to facilitate a meeting that prioritises giving parents a voice and valuing their unique insights. Parents share home videos of Maya’s speech and interaction, helping staff gain a more comprehensive understanding of Maya’s communication strengths and building trust between the home and the nursery.

- **Acknowledge and use uncertainty as a starting point:**
  The nursery uses uncertainty as a starting point, engaging in reflective discussion and applying Kearney’s (2010) Communication Continuum to consider Maya’s communication across different contexts. This phase is also an opportunity to explore and describe SM thoughtfully. Stakeholders can refer to Johnston and Wintgens’ (2016) definition of SM, which describes it as a neuropsychological fear response whereby a child experiences intense anxiety to direct questions, leaving them ‘frozen’ and unable to speak. This understanding helps the nursery to reflect on and reframe SM not as a deliberate choice or defiance, but as a complex anxiety-driven response.

- **Recognise communicative behaviours across the continuum:**
  The nursery setting carefully observes and records Maya’s nonverbal communication—such as mouthing words and smiling at peers—and considers where she sits on Kearney’s Communication Continuum to understand her communicative behaviours better.

- **Enable safe, reflective spaces for dialogue:**
  The nursery will first foster an anxiety-reducing environment by supporting Maya’s autonomy, competence, and relatedness (Basic Psychological Needs Theory; Ryan & Deci, 2017). Staff then use the lens of Expectancy Violation Theory (EVT; Burgoon, 2015) to reflect on their interactions and reactions, ensuring their verbal and nonverbal behaviours are positive and do not increase Maya’s anxiety. This approach aims to foster a shift from passive, watchful waiting to mindful observations. Monthly reflective meetings with stakeholders (EPs, SENCOs/ALNCo’s, nursery staff) review Maya’s progress and communicative profile. This is followed by holistic, formal planning meetings, such as Person-Centred Planning (PCP), to support Maya’s evolving needs further.

  Strengthen connections across systems:
  Supporting a child with SM necessitates a coordinated, multidisciplinary approach. After thoroughly reviewing Maya’s communicative profile and considering her holistic needs, the EP can convene a multidisciplinary meeting involving key professionals, such as Speech and Language Therapists, health services, and other relevant external agencies. These collaborative forums enable an in-depth exploration of Maya’s needs, including the possibility of co-occurring neurodevelopmental conditions, such as Autism Spectrum Disorder (ASD) or Developmental Language Disorder. Such meetings help determine appropriate next steps, which may include referrals for formal assessment or diagnosis, and collaboratively designing tailored, child-centred interventions that align with Maya’s strengths, needs, and context. This coordinated effort ensures consistent, integrated support across all settings to maximise positive outcomes for Maya.