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Research Paper

Professionals' experiences of selective mutism in children: An interpretative phenomenological analysis

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Abstract. Selective mutism (SM) in children occurs when children experience verbal difficulties in social situations outside their natural environment. Research in the field of SM tends to focus on specific treatment-related interventions and their efficacy. In contrast, this qualitative study investigated the lived experiences of professionals who worked directly with children who have SM, in order to understand what it was like for them to engage with these children and the meaning(s) they attached to their experiences. The study's aim was to consider the professionals' beliefs regarding this disorder and how it impacted their practice. Six practitioners from various areas of specialisation working in Malta were interviewed, including two speech and language pathologists, one counsellor, one clinical psychologist/ psychotherapist and two educational psychologists. Data was analysed using Interpretative Phenomenological Analysis (IPA) and four superordinate themes were identified. Findings indicated that clinical practice in this area was a complex endeavour. Participants referred to the need to be 'self-sufficient' as professionals, by engaging in reflexivity, independent study and supervision related to the disorder. Future research may consider a deeper exploration into the emotional reactions and discomfort experienced by professionals in response to children's silence. Furthermore, research regarding the aetiology, symptomatology and prevalence rates of SM in Malta is needed, together with related professional development opportunities for professionals who work with children in their practice.

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1. Introduction

1.1. Selective Mutism

Selective mutism (SM) in children is when children struggle to "speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations" (American Psychiatric Association [APA], 2013, p.195). SM is more commonly found in children aged between four and six years old (Muris & Ollendick, 2015; Ponzurick, 2012). Children with SM tend to be verbal at home but encounter difficulties when they are required to speak in other contexts (Muris & Ollendick, 2015). Their interaction with peers can include verbal and nonverbal communication, such as nodding and writing (Kovac & Furr, 2019). Disruptions in social interaction are usually characterised by high social anxiety (World Health Organization [WHO], 2004).

The diagnosis of SM often includes the diagnosis of another anxiety disorder, usually social anxiety disorder (APA, 2013). Diagnosis is made more complex due to the overlap between SM and comorbid disorders (Sluckin & Smith, 2015). For example, Vogel et al., (2019) observed that some children with SM might have "language impairments", which in turn can produce language-related fears (p.1177). In their retrospective study on children with autism spectrum disorders (ASD) and SM, Steffenburg et al., (2018) argued that practitioners need to be aware that features of SM can be found in ASD, noting "the risk of overlap" (p.1163). In the US, SM in children is a relatively rare disorder, with a point prevalence ranging between 0.03% and 1% (APA, 2013).

A Turkish study found a prevalence rate of 0.033% amongst kindergarten, first, second and third grade students (Karakaya et al., 2008).

SM prevalence rates in West Jerusalem immigrants were reported at 2.2% (Elizur & Perednik, 2003). Maltese prevalence rates for the disorder are currently unrecorded.

1.2. Interventions

According to McInnes et al., (2004), children with SM should ideally be assessed and diagnosed by a multidisciplinary team, where psychiatrists, psychologists and speech-language pathologists can attend to "communicative and psychiatric issues" when structuring interventions (p.313). Clinical assessment of the disorder usually includes collecting information from the child's parents/carers and school personnel, in order to understand and recognise where and when the child is less likely to speak; furthermore, assessment of the child's speech, language and cognition by psychologists and/or speech language pathologists is often undertaken (Johnson & Wintgens, 2016; Sluckin, 2011).

Practitioners require parental collaboration, as parents play a critical role in assessment and diagnosis (Bergman et al., 2013; Hung, Spencer & Dronamraju, 2012; Mayworm, et al., 2014; Omdal, 2008). Omdal (2008) recommended that professionals assess the relationship between the child and the adults who they do not speak to. Professionals further need to harmonise treatment and coordinate with school staff in the classroom setting, given that children with SM tend to stop talking at school (Bergman, 2013; Kovac & Furr, 2019). Sluckin (2011) also noted that it is important for children with SM to sense that their parents/carers and teachers share a good relationship with one another.

Professionals frequently work with the child directly in the various environments that are impacted by the SM, such as in the classroom or home (Kearney, 2010; Manassis, 2009; Shaughnessy, 2012; Sluckin & Smith, 2015; Zakszeski & DuPaul, 2017). Imich (1998) warned that interventions held in unfamiliar settings are likely to make the child feel uncomfortable, thus hindering the development of a trusting relationship. Research seems to suggest that school-based interventions generated encouraging results in speech initiation, possibly because the treatment specifically occurs in the environment where the child is silent and involves individuals who are central to the child's life (Zakszeski & DuPaul, 2017).

Traditionally, psychodynamic therapies were the preferred professional intervention, where the aim here was to 'unmask' the event that 'caused' the child to stop speaking (Busse & Downey, 2011; Krysanski, 2003). Subsequently, behavioural interventions and modification began gaining recognition. Muris and Ollendick (2015) noted that Cognitive Behavioural Therapy (CBT) and pharmacological interventions are currently favoured.

For professionals, the ultimate goal is to increase the child's verbal communication (Camposano, 2011); according to Camposano (2011), in the early stages of therapy, decreasing the child's anxiety and adopting alternative healthy coping mechanisms are addressed prior to increasing speech. Facilitating the child in enhancing his/her self-confidence is another goal identified by Sluckin and Smith (2015). Here, therapeutic goals and the involvement of other people in the treatment (such as teachers) should be communicated to the child, thus allowing the child to feel involved and supported, rather than pressured to talk (Sluckin & Smith, 2015). Professionals often use a range of techniques that motivate and engage the child, including rewards and play activities (Bergman, 2013).

1.3. Professional Dilemmas

SM presents diverse challenges for practitioners (Bergman et al., 2013; Khan & Renk, 2018).Children with SM often fail to be verbal in the first few sessions with professionals (Bergman et al., 2013). This silence is documented as being one of the most difficult obstacles in this work, leading professionals to experience feelings of frustration (Anagnostaki, 2013; Kearney, 2010; Sluckin & Smith, 2015). Efforts to convince the child to speak may be more damaging to the treatment, as constantly

encouraging a child with SM to talk may result in a reinforced unwillingness to speak (Kearney, 2010; Sluckin & Smith, 2015). Removing the pressure to be verbal can enhance the professional-child relationship (Hung, Spencer & Dronamraju, 2012; Sluckin & Smith, 2015). However, presenting no opportunities to talk can in turn also strengthen the child's lack of speech (Bergman et al., 2013; Cleave, 2009).

1.4. Research Aims and Objectives

This study explored the following research question: "What are the lived experiences of Maltese professionals who have worked with children with SM?" Research in the field has been predominantly treatment-focussed, overlooking what it *is actually like* for professionals who work with this disorder. Therefore, this study sought to understand the experiences of professionals in their clinical practice with this specific client group.

2. Method

2.1. Design

A qualitative approach was selected in order to focus on the participants' detailed and context-based retellings (Langdridge, 2007; Willig, 2008). In contrast to quantitative methodologies, the scope of qualitative inquiry is not to predict but rather explore and describe (Willig, 2008). Thus, a qualitative approach promotes subjectivity and in-depth analysis of each individual account (Langdridge, 2004).

The qualitative methodology adopted for this study was Interpretative Phenomenological Analysis (IPA). IPA is informed by the philosophical branch of phenomenology, which "focuses upon the content of consciousness and the individual's experience of the world (Willig, 2001, p.52). This methodology acknowledges that researchers can never have direct access to the participants' individual accounts (Willig, 2001). Furthermore, researchers cannot completely suspend their own biases and presuppositions, hence the analysis is coloured by the researcher's own world view and interpretation of the participants' accounts (Smith, Flowers, & Larkin, 2009).

Smith and Osborn (2009) noted that IPA involves a "two-stage interpretation process", often referred to as "a double hermeneutic" (p.54). Here, the researcher strives to gain access into the participants' personal experiences (thus highlighting IPA's interpretative position) as the participants too engage in *their owns* ense-making (Smith & Eatough, 2008; Smith, Flowers & Larkin, 2009). IPA adopts an idiographic approach, where the analysis of individual cases allows the researcher to make specific inferences about the participants (Smith, Harré & Langenhove, 1995). It is only from a detailed and systematic analysis that the researcher can then generalise inferences, therefore, IPA studies generally consist of small participant samples (Smith, Flowers & Larkin, 2009).

A qualitative methodology known as Thematic Analysis (TA) would have been appropriate had the focus of study been the participants' *perspectives* of *their clients'* experiences (Braun & Clarke, 2006). However, the basis of our study was specifically how professionals *themselves* experienced working with SM in children; IPA thus allowed for a better understanding of the participants' *own* subjective experiences, as well as the individual value they placed on their practice.

2.2. Recruitment and Participants

IPA studies use purposive sampling, where researchers intentionally select participants who fit predefined criteria (Smith, Flowers & Larkin, 2009). Participants were required to share an experience with the central phenomenon: working with SM in children. No exclusion criteria were made for demographic characteristics such as age, gender or years of practice.

Professional organisations and associations related to child therapeutic services were identified, contacted by email and asked for permission to recruit participants. Following ethical clearance, these were asked to forward an information sheet to registered members. Interested participants were invited to contact the first author via email to schedule an interview.

Six professionals were recruited and interviewed, including two speech and language pathologists, one counsellor, one clinical psychologist/ psychotherapist and two educational psychologists. Five of the participants identified as female and one identified as male. Years of practice ranged from one year to thirteen years and most professionals fell within the '25 – 34 years' age bracket.

2.3. Ethical Considerations

Ethical clearance (Reference Number SWB 008/2017) was granted by the Faculty for Social Wellbeing Research Ethics Committee (FREC) and the University of Malta Research Ethics Committee (UREC).

Each participant was provided with a detailed consent form to read and sign. Participants were free to withdraw from the study at any point. Identifying details pertaining to the participants, their clients and work place were omitted or altered. Participants were all given pseudonyms.

2.4. Research Tool and Data Collection

Data was gathered through semi-structured interviews (Langdridge, 2007; Smith, Flowers & Larkin, 2009; Willig, 2008). Such interviews are widely-used in IPA and are described as a "conversation with a purpose" (Smith, Flowers & Larkin, 2009, p. 57). For this study, interviews were held at a mutually convenient and confidential setting. On average, each interview lasted forty-two minutes.

An interview schedule with eleven questions was used as a guide. Questions included probes to delve deeper into the participants' accounts. A small notebook was used by the first researcher during the interviews to aid in the recall of salient points raised by the participants, which could then be probed further. Interviews were recorded and transcribed verbatim. On average, transcripts were fifteen pages long with a word count of 5600 words.

2.5. Data Analysis

The aim of IPA research is to provide an in-depth discovery of meaning from the participants' narrations of their personal and social worlds (Smith, Flowers & Larkin, 2009). Firstly, each participant interview was transcribed verbatim and transcripts were formatted with large margins on either side of the text. Then, the first transcript was read repeatedly and notes were made in the left-hand margin (Willig, 2008). These notes included paraphrasing, associations, initial thoughts on the participant's experiences, particular usages of language, contradictions, repetitions and anything else deemed salient (Smith & Osborn, 2009). At this stage the participant was the focus of analysis (Smith, Flowers & Larkin, 2009).

After comments were made in the left-hand margin of the whole transcript, the right-hand margin was used to note emerging theme titles (Smith, Flowers & Larkin, 2009). These titles attempted to present and provide a balance between "psychological terminology" at a more "abstract" level with the true nature of the participant's recollections (Smith & Osborn, 2009, p. 68). The next stage involved listing the themes from the right-hand margin on a separate paper and making associations between them (Smith, Flowers & Larkin, 2009). This resulted in the clustering of some themes and the emergence of other subordinate concepts.

Once the connection of themes was completed, these were then compared and checked repeatedly with the transcript in order to ensure that the themes reflected the true essence of the participant's experience. This reflects the iterative process of IPA, which is the continuous interaction between reader and text (Smith, Flowers & Larkin, 2009). Names were then assigned to the clusters of themes, characterising their nature.

This process was separately repeated for each transcript (Langdridge, 2007). The final themes from each transcript were amalgamated in a write-up, presenting the gist of respondents' experiences. Here, a distinction needs to be made between repeated themes and new themes that give rise to novel areas. The structure of the write-up is in the form of a narration which includes the participants' direct quotes (Smith, Flowers & Larkin, 2009).

2.6. Validity and Reflexivity

The subjective nature of qualitative research makes it complex to assess through standardised scientific measures generally used in quantitative studies (Yardley, 2017). Yardley (2017) grouped the elements that enrich validity in qualitative research into four concepts: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to context means that researchers are aware of how participants are influenced by their worldview and environment, which in turn influences the researcher's interpretation (Yardley, 2017). The authors conducted a thorough review of empirical work pertaining to SM. This was important to secure an accurate understanding of the phenomenon (Yardley, 2000).

Yardley (2000) emphasised that the researcher should be engaged with the data and have a sound

understanding of the methodology adopted. The authors closely attended to IPA's philosophical underpinnings and outlined the study's design, data collection and data analysis.

This study recognised that the complete suspension of a researcher's personal beliefs is impossible. Questions in the interview schedule were open-ended and non-leading. A process of self-reflection was adopted throughout. The first author was reading for a Higher Diploma in Psychology and the second author served as research supervisor. Several of the first author's personal beliefs and assumptions were revealed, including the view that children with SM do not effectively communicate with professionals. These assumptions were discussed with the second author during research supervision. This process is referred to as bracketing, whereby researchers challenge their prejudices and explore their assumptions (Langdridge, 2007). The second author also reviewed the participant transcripts and gave feedback throughout the stages of data analysis, providing written and oral guidance on preliminary drafts of the write-up. The findings include direct quotes from the participants and disconfirming cases, in order to ensure that the participants' lived experiences and associated interpretations remained grounded in the data.

Impact and importance entail that the researcher promotes the study's relevance (Yardley, 2000). This study contributed to existing literature in the field of SM by focussing specifically on practitioners with professional experience of this condition. Furthermore, to date no studies have investigated SM within the Maltese context.

3. Results

Data analysis generated four superordinate themes. The first superordinate theme, '*A Child who has SM*', features the participants' descriptions of their clients. This is followed by '*It's a Challenging Experience*', where reference is made to SM's comorbidity with other disorders and the participants' perceived lack of training in this area. The superordinate theme, '*The Therapeutic Relationship*', attends to how the professional-child bond affected the participants, including the social and physical environment. The final superordinate theme '*Self-Sufficiency*', depicts the ways in which the participants used reflexivity and supervision. Direct quotes are included within quotation marks.

Table 1. Superordinate and respective subordinate themes, including the frequency of the subordinate theme occurrences across the data set

Superordinate Themes	Subordinate Themes	Subordinate Theme Frequency
"A child who has SM"	"They're very different"	3
	"Slow to warm up"	6
"It's a challenging experience"	Comorbidity	4
	The systems around the child	6
	Lack of training, lack of practice	5
The Therapeutic Relationship	Frustration and insecurity	4
	Comfort and understanding	6
Self-Sufficiency	Silent reflections	5
	Self-care through supervision	4

3.1. "A child who has SM"

3.1.1. *"They're very different"*

The participants emphasised the individuality of clients with SM. Carol explained that "(she) *wouldn't go about generalising*." Joanne expressed that, "*the two children I had were very different from each other*." Pam noted that one of her clients tended to be more of a follower, whereas her other client was determined and directive. Joanne observed that therapeutic work with SM is "*not one size fits all…there isn't a magic potion and you can use it with everyone…you have to take each child in his own individuality*," suggesting that clients may vary in their personality and manner.

3.1.2. *"Slow to warm up"*

John reflected on "*the root of the issue*," noting that "*we do not have direct feedback from the child because the child cannot explain what they experience*." This makes it complex to identify a specific, clear 'cause' of the disorder.

Most of the participants described their clients as "*extremely shy children*" (Kelly). John maintained: "*when the child is in an unfamiliar setting, for some reason, a considerable amount of anxiety kicks in.*" Kelly illustrated how much of "*a real anxiety-causing situation*" SM can be by explaining how a situation can be "*blown out of proportion*" in the child's mind. Joanne described her client's "*negative thoughts that he's going to fail if he gets something incorrect*." However, Alice shared "*if I find them talking to their parents and they're not aware…I am surprised by how much they actually shout*."

Carol reflected that these children are "*very cautious and you need the time to help them warm up to the situation*." Kelly emphasised that "*you start small.*"

According to Joanne, the relationship builds "*slowly, slowly.*" Alice echoed that "*progress is very slow*". Professionals need "*to give them space*" (Pam).

3.2. "It's a Challenging Experience"

3.2.1. *Comorbidity*

Joanne referred to SM's comorbidity with other difficulties or disorders. Joanne's client "*used to go to (her) for other problems*", namely articulation difficulties and language delay. John described that "*there could be a little bit of a speech difficulty as well, the one doesn't exclude the other*." Alice reflected that "*there are other factors to take into consideration…if there are learning difficulties or mental health conditions.*"

John and Alice noted that the co-occurrence of autism and SM is not uncommon. Kelly explained "*very often, selective mutism is considered part of the Autism spectrum because it co-occurs so often with Autism.*"

3.2.2. *The systems around the child*

Carol expressed that "*one does not work with the child in a lacuna*." Alice advised other professionals "*not to work with children in isolation*." Carol highlighted the importance of communicating effectively with teachers and hearing their concerns. John held that the input of the teachers is important "*because we see it a lot occurring in schools.*" However, Pam described complex experiences of working within a multidisciplinary team. She maintained that "*in multidisciplinary teams there are a lot of dynamics*", reflecting that "*my personal experience is that it doesn't always happen to the benefit of the client*" because the client might become 'lost' in the system.

All of the participants mentioned work with the family. Kelly shared that "*it is always important to involve the family…*" Carol needed to engage in intensive work with the child's parent when she felt that the SM was not being addressed, recounting that "*it was extremely important to explain to the mother that we couldn't ignore this anymore*."

Kelly explained "*if needs be we move around with the child, where the problem is, because if there's no problem in the clinic then I have to tackle the problem where it's happening in situ.*" Joanne too maintained that clinical interventions need to happen in other environments "*because it is useless bringing her to the clinic when she talks to me in the clinic…there's no point*."

3.2.3. *Lack of training, lack of practice*

All of the participants expressed dissatisfaction with the amount of training they received about SM. John observed "*obviously it's not easy considering, in the context as it is, it is not a major…you know, disability*." Carol explained, "*I do feel that there was a bit of a lack in my training…not on a theoretical level more on a practical level on how to actually work with them*." John too felt that his training was "*very little*." Kelly's training "*was very minimal.*"

3.3. The Therapeutic Relationship

3.3.1. *Frustration and insecurity*

The participants reflected that working with silence took a toll. Pam's first client with SM left her "*confronted with a lot of silence*." She became increasingly frustrated and "*used to dread sessions*", mainly because "*you feel that you're not good enough.*" Alice described feeling "*frustration and tension,*" reflecting that the silence could sometimes elicit self-doubt: "*you feel a little bit like you don't know what you're going to do.*" Joanne worked with her client for over a year yet he still was not talking in school. She disclosed "*I feel frustrated because I'm used to having results.*" Kelly paralleled this by saying: "*refusal to talk and to participate, it makes it obviously hard.*"

3.3.2. *Comfort and understanding*

The participants emphasised maintaining a professional approach that placed no or minimal pressure on the child. However, this presented the conundrum of "*how am I going to get this child to speak spontaneously without creating the pressure of having to speak?*" (Kelly).

The process of slowly growing comfortable with one another was reflected in the participants' understanding and caring stance.

John maintained, "*what I give a lot of importance to is that the child has to make himself understood.*" Similarly, Pam reflected this understanding and compassion when she described "*it's even just being able to be yourself with someone...just to understand what they need and to try to provide that to them.*" Joanne recounted how she used to "*encourage him in a more, sort of, comfortable way*" because if she put pressure on the child "*he'll sort of shutdown.*"

Joanne recalled how she used to go to her client's class just so he could know that she was present for him "*not only in the clinic*." The participants reflected on the importance of being 'relatable.' In their practice, they used play, humour and attended to the client's interests "*trying to find something that they like*" (Kelly). Alice said: *I am a bit silly during the counselling intervention or for example whilst we walk to the counselling room I go and hide somewhere and she will try and find me*.

These interventions appeared to be a common way of helping the child feel more at ease. Joanne maintained that "*you have to adapt to the child's level*" linking this with maintaining an equal physical level, such as by working on the floor and sitting down with the child.

3.4. Self-Sufficiency

3.4.1. *Silent reflections*

The participants spoke about the importance of self-reflection in their work with SM and the insights this elicited in them. Joanne observed: "*you have to stop and think.*"

Pam came to realise that "*the aim wasn't to help her speak.*" She narrated: *"Once I said,''Listen, you don't need to talk, I can be comfortable with silence,' and I realised it was my own issue with the silence. And I relaxed*."

Kelly adjusted her demeanour in order to release tension: "*I usually calm myself down.*" Alice considered that "*there will be sessions where it's just silence. And I think that, at the same time that is necessary.*" Referring to her clinical work, Alice shared that one needs to "*feel okay with ambiguity, that you don't know where you're headed.*"

3.4.2. *Self-care through supervision*

The participants emphasised the importance of supervision, noting that it helped them manage the complexity of their work. Pam maintained that "*it was both peer supervision with colleagues and as well supervision of another professional where [she] could explore [her] frustration.*" Carol also confirmed this:

> *...I had to find creative ways also through my supervisor because I felt the need to go to supervision (...) I was treading on ground where I wasn't using standardised means of assessing the child (.) I wanted to double check that there weren't alternative ways where I could get a more accurate picture of her abilities.*

Joanne too shared that *"If you get stuck somewhere there's always a point of reference to help you, to share your experiences."* Pam described her clinical work as gradually becoming "*less challenging*" and other participants noted that their self-confidence increased as they familiarised themselves with SM.

4. Discussion

The study's participants described clinical progress with SM clients as slow. SM is a disorder which develops gradually. This in turn is reflected in improvement and behaviour change that occurs over a lengthy period of time – in some cases, even years (Harwood & Bork, 2011). Therefore, professionals may "become overwhelmed or disheartened" over the course of their work (Khan & Renk, 2018, p.363). Low practitioner motivation can potentially have a negative impact on the professional-child relationship and the efficacy of any interventions adopted.

The participants experienced strong emotional reactions when confronted with their client's silence. The child's lack of speech appeared to make sessions difficult and elicited feelings of doubt and frustration in some of the professionals. Most of the participants in this study encountered moments when they felt at a loss and out of ideas on how to proceed with treatment. Pozzi Monzo, Micotti and Rashid (2015) observed that this work can elicit frustration and a sense of inadequacy in practitioners. Feelings of incompetence and uncertainty generated by the client's silence were also noted in Anagnostaki's (2013) case study. The importance of self-awareness and reflexivity was emphasised in the participants' accounts, as this in turn helped them to accept the silence in a productive manner.

Scott and Beidel (2011) referred to SM as "vexing" (p.251). In our study, the participants described their surprise when they saw their clients communicating with family members; this appeared to be the complete opposite of how they presented themselves to the professionals. This suggests that professionals find it baffling to harmonise the personalities of their clients described at home as chatty, loud and overbearing with the inhibited, stiff personalities that are presented in clinical practice, as noted by Pozzi Monzo, Micotti and Rashid (2015).

SM features differ from child to child, including severity (Kovac & Furr, 2019). While some children may present with temperamental issues, others experience SM as a result of trauma and yet other children feel frozen and genuinely cannot express themselves verbally. Sluckin and Smith (2015) reflected that children with SM are individuals with different hopes and aspirations. The participants in our study emphasised the importance of respecting each and every client's own individuality. The uniqueness of children with SM was recognised by the participants and they thus felt the need to consider the subjectivity of each child and modify treatment accordingly. In their review on SM, Muris and Ollendick (2015) emphasised that professionals need to be aware of the "multifaceted nature of this disorder" (p.166). Furthermore, Khan and Renk (2018) urged professionals to consider "their own clinical judgement" regarding what they believe would be helpful for each client (p.363).

The participants in this study emphasised the importance of communicating with the child at his/her level and removing any pressure from the child, as this may reinforce the child's unwillingness to speak. Hung, Spencer and Dronamraju (2012) too advised reducing pressure on the child to speak, increasing trust and safety between child and professional by getting to know the child's interests and creatively incorporating the child in any interventions. Participants in our study preferred to engage playfully at first because this seemed to ease the child and balance the power differential between child and professional. Therefore, practitioners need to be creative and make use of play to build a relationship with the client, as this can be a crucial component in gaining insight to the child's inner world (Bergman, 2013; Camposano, 2011).

The participants mentioned their efforts to generalise interventions to other environments, especially in the environment predominantly affected by the SM – the school (Harwood & Bork, 2011; Kovac & Furr, 2019). The participants inferred that both parents and teachers are involved in the children's everyday lives and thus should also be involved therapeutically. In their review of SM interventions, Zakszeski and DuPaul (2017) highlighted that treatment needs to be held in a context that is of relevance to the child and should include other adults who are involved in their care. Ultimately, both the participants and literature emphasise a holistic approach rather than solely child-practitioner based interventions (Kearney, 2010; Manassis, 2009).

The participants shared their belief that SM is a rare disorder. According to Kovac and Furr (2019), low SM prevalence rates means that few professionals have experience in this area. Our participants in fact spoke about their lack of experience and believed that their training did not equip them to work with this disorder. Increased training can have a positive impact on professionals by enhancing knowledge and providing a supportive professional environment (Dean, 2012; Harwood & Bork, 2011). The importance of self-awareness and reflexivity featured in the participants' accounts. Reflexive attunement to practitioner responses can

potentially provide insight regarding how a child might be feeling and what they might be communicating through that silence (Anagnostaki, 2013).

4.1. Limitations

Participants from a range of professional groups were invited to participate in this study. Therefore, their experiences might be shaped by different professional training, theoretical influences and aims.

Nevertheless, this study's findings revealed many similarities in the participants' accounts, despite their diverse practitioner orientations and backgrounds. It is worth noting that no local research was found regarding SM. Although this study's findings strongly complemented international research, the literature presented may still lack cultural relevance regarding how SM is diagnosed and assessed locally; the aetiology and symptomatology of SM and targeted interventions might also differ cross-culturally. Additionally, certain participant quotes were translated from Maltese to English, which might result in some of the meaning being lost in translation.

The participants were asked to articulate what it was like to work with nonverbal clients and hence had to access inner feelings and experiences related to a 'silent' relationship, rather than recounting direct verbal narratives. This might have made it complex for them to actually 'put into words' what they went through.

4.2. Implications for Practice and Research

Any research in the local context with regards to SM would be beneficial. Maltese practice could be informed by locally-based studies that take into consideration this country's culture, child policies (especially with regards to education), SM prevalence rates and current support services/interventions offered.

Considering that SM is uncommon and training specifically on SM is limited, the participants expressed that most of their knowledge was gained through practice. It is recommended that professional entities provide training that addresses clinical work in this field.

The interviews also indicated that both peer and professional supervision prevent the accumulation of distress when working with complex disorders like SM. Strengthening a supervisory plan in which professionals can share their frustrations, explore alternative methods of assessment and creative interventions could be beneficial.

5. Conclusion

Professionals working with SM need to be patient and comfortable with silence in the first few sessions, being mindful of the non-verbal behaviour that the child may be exhibiting. Accepting feelings of frustration, self-doubt and being able to tolerate feelings of powerlessness can be harnessed into recognising what the child might be experiencing but unable to communicate directly. Finally, practitioners who seek out supervision and value reflexive practice may learn much about themselves professionally, thus strengthening their confidence and further enhancing effective work with these children.

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Conflicts of interest

The authors report no conflicts of interest.

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