ANGLIA RUSKIN UNIVERSITY

FACULTY OF ARTS, HUMANITIES AND SOCIAL SCIENCES

EVALUATING A THEORETICAL FRAMEWORK FOR THE USE OF MUSIC THERAPY IN THE TREATMENT OF SELECTIVE MUTISM IN YOUNG CHILDREN: A MULTIPLE CASE STUDY

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A thesis in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Doctor of Philosophy

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This PhD is dedicated to the memory of Alice Sluckin OBE, the founder member and Chair of the UK charity SMIRA, who worked tirelessly throughout her life to help children with Selective Mutism and who died on 15th February 2019 aged 99 years. Alice took a keen interest in my research inviting me to write a chapter in the book 'Tackling Selective Mutism' (2015). Rest in Peace Alice.

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ABSTRACT

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Selective Mutism (SM) is an anxiety disorder that affects some children when they begin school. If left untreated the long-term impact can include complex, debilitating mental health conditions. The usual presentation is a lack of speech in the education setting, contrasting with confident speech at home. Incidence rates are estimated at around 0.7% but can be three times higher for children with immigrant backgrounds. A review of Music Therapy case studies suggests Music Therapy is helpful but a deeper understanding is needed. This study asks: Does a theoretical framework, developed in single-case study research (Jones 2012), explain the process of Music Therapy across a number of cases of children with SM? If not, how can the framework be revised to reflect improvements proposed as a result of the study?

A pragmatic mixed methods approach is used. A survey of Music Therapists (n=75) identifies the range of Music Therapy practice for SM in the UK. Six semi-structured interviews with Music Therapists explore this practice in more depth. The main investigation is multiple case studies (n=6) of Music Therapy for children with SM aged 3-5. An abductive template analysis approach is used to synthesise data sets and revise the theoretical framework.

The survey describes Music Therapy with a range of ages and presentations of SM. The interviews highlight how improved understanding of SM would enhance Music Therapy practice. The six case studies describe Paths into Speech that confirm, reconfigure and expand the theoretical framework. Music Therapists bring many useful skills, with musical communication established as an invaluable, empowering tool for alleviating SM.

The revised theoretical framework provides the evidence base for comprehensive guidance for Music Therapy with young children with Selective Mutism. An open, flexible, multi-modal approach, integrating teamwork and considering transdisciplinary practice, is indicated. The need for improved training for Music Therapists and the potential role of Music Therapy on the Care Pathway for Selective Mutism is demonstrated.

Selective Mutism; Children; Music Therapy; Multiple Case Study Research; Pragmatism; Transdisciplinary Practice

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Chapter 1 - Introduction

1.1 Motivation and aim of the study

The main aim of this study is to investigate how and why the ingredients of Music Therapy may have therapeutic benefits for children with Selective Mutism. The thesis is born out of a deep conviction and clinical experience that Music Therapy can be extremely helpful for young children suffering from the debilitating and isolating condition known as Selective Mutism. It is part of a learning journey that I began as an inexperienced clinician working in inner London schools and noticing that Music Therapy appeared to help children who were 'very quiet' or 'not talking'. Many of the children referred were also learning English as an additional language (EAL). As a Music Therapist I often look out for quieter children who can get overlooked in a noisy classroom environment but who frequently respond positively to the opportunity for musical self-expression that also naturally encourages vocalisation. After discovering that there was a diagnostic label for children who were quiet at school but not at home I pursued my clinical interest further by reading all available literature on the matter. On attending an evening conference on the topic of Selective Mutism at the Association of Child and Adolescent Mental Health (ACAMH) I was encouraged to develop my enthusiasm for this topic by undertaking research. This thesis is an account of my ongoing investigation and personal journey of clinical discovery into how and why Music Therapy might be helpful for children with Selective Mutism.

In this introductory chapter I begin by giving a brief overview and history of Selective Mutism. This is followed by a summary of the literature on interventions for SM including care pathway research. I then explain what is understood by the term Music Therapy. The study builds on my MA research and so a description of this and the resulting theoretical framework is given. I then outline my main research aims and questions, and the overarching structure of the thesis.

1.2 What is SM?

Selective Mutism (SM) is an anxiety disorder experienced when people are consistently unable to speak in specific situations (American Psychiatric Association 2013). The full definition from the Diagnostic and Statistical Manual, fifth edition,

is given below (1.2.2). SM was previously categorised as a disorder of early childhood as it most commonly affects children when they first enter the school system. Children with SM often use their normal speech at home but find it difficult or impossible to speak in school due to anxiety about speaking in that setting. Awareness and understanding of this potentially debilitating condition is poor (Kopp and Gillberg 1997) with children and adults with SM often being misunderstood as stubborn or controlling. However, charities such as the Selective Mutism Information and Research Association (SMIRA) are dedicated to raising awareness and supporting people with SM. SMIRA's website and social media groups provide invaluable information and support forums for professionals, parents and young people and adults with SM. For those with SM social media groups also provide an invaluable source of social interaction which otherwise may be very limited.

1.2.1 History of terminology for Selective Mutism

The current diagnostic label, Selective Mutism, has caused much controversy and debate as to whether it is an accurate description of the condition. Earlier terms for the condition have been similarly problematic. Originally named 'Aphasia Voluntaria' (Kussmaul 1877) it was renamed 'Elective Mutism' by Swiss psychiatrist Moritz Tramer in 1934. Tramer felt that there was an element of choice, albeit perhaps unconscious, in who the person is able to talk to. From 1967, academic writers (Reid et al.1967) gradually started using the term 'Selective Mutism', though without a specific explanation, and it was formally adopted by the American Psychiatric Association in 1994. We now understand that the suggestion of choice implied by this terminology is misleading as many, if not all, children and adults with SM are desperate to speak.

1.2.2 Definition of SM

The 5th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) was published in May 2013. In this edition the definition of Selective Mutism remained the same but it was reclassified as an anxiety disorder, having previously been classified as a disorder that is first diagnosed in infancy, childhood or adolescence. The definition of Selective Mutism is as follows:

A. Consistent failure to speak in specific situations (at which there is an expectation for speaking, eg, at school), despite speaking in other situations.

B. The disturbance interferes with educational or occupational achievement, or with social communication.

C. The duration of the disturbance is at least one month (not limited to the first month at school).

D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in a social situation.

E. The disturbance is not better accounted for by a communication disorder (eg, stuttering) and does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder.

Source: Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V)

1.2.3 Etiology

As suggested by the reclassification (1.2.2), anxiety about speaking in certain settings is understood to be the most prominent causal factor in the development of SM (Anstendig 1999; Cohan et al., 2008). However, other factors play a key role in contributing to the current conceptualisation of SM as having a multifactorial etiology (Cohan, Chavira and Stein 2006). A family history of shyness, SM, anxiety or social phobia is thought to be a potentially influential factor (Brown and Lloyd, 1975). Communication issues and developmental delay are also considered to be risk factors for SM (Kristensen 1997; Manassis et al. 2003). The stress of being an immigrant second language learner may contribute significantly to the development of SM for some children (Elizur and Perednik 2003). (See 1.7.5).

1.2.4 Prevalence

Prevalence rates for SM were previously thought to be relatively low, however more recent studies indicate a range between 0.7% (Bergman, Piacentini and McCracken 2002) and 1.9% (Kumpulainen 1998). Rates given vary depending on whether studies gather data from across a wider school population or focus on early years where SM usually first occurs. Carlson, Mitchell and Segool (2008) noted higher

estimated prevalence rates for SM (<1%) than the more widely recognised condition Autism Spectrum Disorder (ASD) (0.5%) although this is an entirely different condition. Baron-Cohen et al. (2009) estimated prevalence rates of ASD at 1.57% in Cambridgeshire in the UK.

It has been highlighted internationally that SM often remains hidden owing to poor awareness of this condition (Kopp and Gillberg 1997). This is also the case within the UK (Keen, Fonseca and Wintgens 2008) although awareness is increasing through the work of the UK charity SMIRA.

Accumulated statistics show prevalence rates are higher amongst girls than boys at a ratio of approximately 3:2 (Steinhausen and Juzi 1996; Kopp and Gillberg 1997). The higher risk of SM for children learning English as an Additional Language is discussed in the next section.

1.2.5 Second language learners

Working in an inner London borough, I notice that many children referred to Music Therapy with SM are also learning English as an additional language (EAL). Elizur and Perednik (2003) noted prevalence rates for SM of 0.76% in the general child population which increased three-fold to 2.2% in children with immigrant backgrounds. Other studies have noted that relatively high proportions of children presenting with SM come from immigrant backgrounds (Bradley and Sloman 1975; Cline and Kysel 1987/88; Steinhausen and Juzi 1996).

An obvious point of contention is that some of the EAL children who are not speaking when they first attend school simply do not have a strong enough grasp of the language yet. This has been conceptualised within the literature on second language acquisition as the ‘silent’ or ‘non-verbal’ period. In a survey of 47 children learning English as an additional language, Gibbons (1985) showed that the mean length of the silent period was just over 2 weeks, but with great variation. He also surmised that the silent period probably marks a lack of comprehension and if prolonged may indicate psychological withdrawal rather than a failure of language acquisition. Other research challenges the evidence for the existence of a specific ‘silent period’ in language acquisition stating that there is ‘limited empirical support’ for this stage (Roberts 2014).

1.2.6 Local EAL policy

Within the inner-London borough where this study is based, acknowledgement of the link between language fluency and attainment was investigated through case study research of primary schools with a record of high attainment for EAL pupils (Demie, Bellsham-Revell 2013). Examples of strategies used to support EAL pupils include giving first languages a high profile and encouraging their use, close engagement with families and employing a diverse, multi-ethnic workforce.

1.2.7 Differential diagnosis of SM in Bilingual Children

Toppleberg, et al. (2005) examine second language acquisition and the non-verbal period in relation to the diagnostic criteria given for SM in DSM-IV (now DSM-V). Criterion D (1.2.2) is key as it prevents 'the incorrect diagnosis of SM in normal immigrant children traversing the silent period' (Toppleberg et al. 2005 p.593). The phases of second language acquisition are described as being:

1) Persistent silence
2) Repeating words
3) Practising the words and phrases in the second language quietly and non-communicatively
4) "going public" with the new language.

Toppleberg et al. (2005) suggest that children with SM get "stuck" in phases 1-3 and summarise that:

> "SM in children learning a second language can be suspected when mutism is prolonged, disproportionate to second language knowledge and exposure, present in both languages, and/or concurrent with shy/anxious or inhibited behaviour." (2005 p.594)

They then highlight the key issues which are essential for diagnosis of SM in second language learners and suggest allowing 6 months for second language acquisition. Cline and Baldwin (2004) also suggest 6 months as sufficient to describe a child as being Selectively Mute. Six months is used as a minimum timeframe for the inclusion of SM children with EAL in the present project.

1.3 Overview of Treatments for SM

A range of interventions have been used in the treatment of SM. Cohan, Chavira and Stein (2006) evaluated 23 peer-reviewed studies of interventions for SM published between 1990-2005. They found 10 behavioural or cognitive behavioural studies, one behavioural language study, one family systems study, five psychodynamic studies and six multimodal studies.

The present overview of treatments builds on that review adding a further 33 treatment studies from 2005-2014. Psychinfo, Medline and Cinahl databases were searched with the search terms; Elective Mutism OR Selective Mutism OR Mutism; and Child OR Children OR Childhood; and treatment OR intervention OR early intervention OR therapy OR therapeutics. The search found 17 behavioural or cognitive behavioural studies, five behavioural plus pharmacological studies, two pharmacological, one family therapy, five multi-modal, one dramatherapy and one Music Therapy study. One study described international care pathway research for SM. These studies are described below organised by setting and treatment approach.

1.3.1 Diagnosis and early intervention

Early diagnosis of SM (Schwartz, Freedy and Sheridan 2006) along with provision of effective early intervention is highlighted as a priority (Bergman, Piacentini and McCracken 2002; Busse and Downey 2011; Hung, Spencer and Dromanraju 2012). This is important because SM can become increasingly entrenched as a child gets older and may evolve into generalised anxiety disorder and social phobia (Cline and Baldwin 2004; Forrester and Sutton 2015).

1.3.2 Behavioural/cognitive behavioural interventions

Selective Mutism can be viewed as speech anxiety or a phobia of speaking. A behavioural perspective views the failure to speak as a way of avoiding the anxiety connected with speaking. In their earlier review Cohan, Chavira and Stein (2006) concluded that behavioural techniques were successful interventions for SM. They described studies that employed a range of techniques such as:

1. *contingency management and shaping* whereby all communication, for example pointing or nodding and then vocalisations or speech, is encouraged through positive reinforcement. This may be provided through positive

communicative responses or a pre-determined reward system (Amari et al. 1999; Porjes 1992).

2. *stimulus fading* (1.3.3) may be added to these techniques to generalise the speech (Masten et al.1996; Watson and Kramer 1992).
3. *systematic desensitisation*, involving relaxation skills and increasingly anxiety-provoking tasks or 'exposures' (Rye and Ullman 1999)
4. *social skills training and modelling or self-modelling* using video or audiotapes of the SM child speaking in situations where they were previously mute (Blum et al. 1998; Kehle, Owen and Cressy 1990).

A retrospective follow-up study of 25 children showed improved speech for children receiving combined behavioural techniques compared to a control group (Sluckin, Foreman and Herbert 1991).

Since Cohen, Chavira and Stein's review (2006) behavioural methods continue to be the dominant approach for treating SM with further studies demonstrating their value (Vecchio and Kearney 2007; O'Reilly 2008; Beare, Torgerson and Creviston 2008; Vecchio and Kearney 2009; Lang, et al. 2011; Baylot Casey 2012; Ale, et al. 2013; Howe and Barnett 2013; Jacob, Suveg and Shaffer 2013; Mitchell and Kratochwill 2013).

Three studies describe how cognitive behavioural therapy (CBT) employing techniques such as psychoeducation, relaxation techniques, exposure and cognitive restructuring, has been successfully used to treat SM (Fung et al. 2002; Reuter et al. 2011, Ooi, et al. 2012). Two of these interventions are provided online (Fung, et al. 2002 and Ooi, et al. 2012). Another case study describes group CBT for five children with a parallel psychoeducation group for parents (Sharkey, et al. 2008).

Involving parents in their children's treatment has evolved as a key ingredient in some behavioural strategies. Vecchio and Kearney (2009) described the use of exposure-based practice such as shaping, modelling or prompting and contingency management whereby parents reward speech or punish lack of speech. These interventions resulted in positive end-state functioning for 8 out of the 9 children with SM with a bias towards exposure-based practice. Ale, et al. (2013) describe two detailed case studies using systematic graduated exposure with parents as the main therapists delivering the exposure tasks. Ponzurick (2012) advocates that school

nurses are ideally placed for implementing a school-based behavioural strategy. Bergman, et al. (2013) undertook a pilot randomised controlled trial investigating the use of Integrated Behaviour Therapy for SM that resulted in increased speech at school for participants. In an investigation of a conjoint behavioural consultation (CBC) framework, involving parents as active participants, Kratchowill and Mitchell (2013) concluded that a manualised approach would further assist in supporting school-based approaches for SM.

Internationally there are some notable variations in the way behavioural approaches are delivered. Intensive SM 'bootcamps' in the US (The Selective Mutism Center 2018) and online cognitive behavioural therapy in Australia (Spence et al. 2008) address some of the practical geographical demands of travelling to therapy sessions. Research on more intensive methods from the US shows significant gains in communication (Klein et al. 2016).

1.3.3 UK behavioural approach

Within the UK a comprehensive manualised approach written by Speech and Language therapists Johnson and Wintgens (2001) is grounded in behavioural principles. Their Selective Mutism Resource Manual is a practical guide for assessment and treatment that is widely recommended in the UK. Johnson and Wintgens' approach is also recommended by the UK charity SMIRA. SMIRA also provide leaflets such as 'Planning and Managing a Small Steps Programme' (Johnson and Wintgens 2015), which succinctly describe behavioural methods such as stimulus fading, shaping and desensitisation to help parents and professionals work together to develop confident speech across all areas of a child's life. The Johnson and Wintgens approach has informed my personal practice over the years. The following is an overview of the key techniques.

1.3.3.1 Stimulus fading -also known as 'sliding in'- is when a trusted conversational partner, such as a parent, shifts speech into a situation where it is absent. This is done in small steps by slowly introducing a manageable amount of anxiety represented either by a new person or space. For example, a child may be talking freely in a room with their conversational partner, usually a parent, and a key worker could make themselves visible outside of the room whilst the speech continues. Gradually the key worker makes themselves more present to the child or 'slides-in' to the room at a pace that the child can cope with without stopping speaking. The key worker would

gently become involved in the conversation with the child. Further details are available in Johnson and Wintgens (2001).

1.3.3.2 Shaping is the technique whereby speech is slowly elicited with a key worker using suggested activities such as 'non-verbal communication and action-rhymes, to sound-making, singing, humming, speech sounds and words' (Johnson and Wintgens 2015). With awareness and development, Music Therapy provision could neatly fulfil the role of a 'shaping' programme as the aims and techniques are similar.

1.3.3.3 Desensitisation is a technique for getting used to the idea of doing something previously deemed unmanageable. For children with SM this might mean deciding to share a video of themselves talking at home with a key worker at school. Other activities such as using telephones to talk to a friend or member of staff from another room are also helpful (Johnson and Wintgens 2015).

1.3.3.4 Generalisation The aim of all these techniques is to develop confident speech across all settings. This is called 'generalisation' of speech and occurs more easily if the school setting has a good working understanding of SM and creates a 'pressure-off', enabling environment around the child. Awareness raising presentations to give information about SM along with preparatory information sheets from the Selective Mutism Resource Manual (Johnson and Wintgens 2001) and regular discussions can help class teachers to develop a positive environment around their child with SM and monitor progress within the classroom.

1.3.4 Pharmacological intervention

Selective Serotonin Reuptake Inhibitors (SSRIs) commonly used to treat anxiety disorders have also been used to treat SM, however this is more common in the US than the UK. There is some evidence to suggest that SSRIs may be helpful for persistent or severe SM that has not responded to other treatment but further research is needed (Manassis and Tannock 2008; Carlson, Segool and Mitchell 2008; Kaakeh and Stumpf 2008; Manassis and Avery 2013; Smith and Sluckin 2015 ch 8).

1.3.5 Mixed behavioural and pharmacological treatments

Pharmacology is sometimes recommended (Kaakeh and Stumpf 2008) and then employed in treatment resistant cases (Manassis 2007; Manassis 2008) or when progress with behavioural techniques has stalled (Lescano 2008). Others such as Ooi, et al. (2012) used online cognitive behavioural therapy concurrently with

pharmacology.

1.3.6 Family therapy

A single case study of systemic family therapy is described by Sloan (2007). The therapy process was two years in length and addressed a range of complex factors at home and within school. Some of the strategies employed were behavioural techniques such as 'sliding in' and systematic desensitization, however positive reinforcement appeared to have the greatest impact.

1.3.7 Dramatherapy

Dramatherapy employs a creative medium to express and explore inner feelings. A single dramatherapy case study (Oon 2010) describes offering alternative ways of encouraging spontaneity, opportunities for externalising inner conflict and experiencing different aspects of a personality. The therapy process required the integration of the behavioural technique 'shaping' in order to 'warm-up' the voice and move into speech in the sessions (Oon 2010).

1.3.8 Multi-modal interventions

Six multi-modal interventions, combining two or more approaches, are described by Cohan, Chavira and Stein (2006). Play therapy or art therapy offers emotional support in combination with behavioural techniques such as stimulus fading, contingency management, shaping or self-modelling (Powell and Dalley 1995; Moldan 2005; Jackson, Allen, Boothe, Nava and Coates 2005). Later studies continue to show promising outcomes for multi-modal approaches combining behavioural strategies with bilingual counselling (Elizalde-Utnick 2007) and play therapy (Hung, Spencer and Dronamraju 2012). Sharkey and Nicholas (2006) describe an intervention with identical twins that involved non-directive play with art, music and board games. This first stage of therapy was unsuccessful, however the follow-up group work with a parallel psychoeducation group for parents and teachers achieved greatly increased communication with peers. In a study of seven children with SM, Oerbeck, et al. (2012) employed behavioural techniques such as stimulus fading by engaging in 'joyful activities' with the children. Six out of the seven children achieved speech across all settings after 14 sessions. One child with developmental delay achieved speech in some settings only.

1.3.9 Care pathways for SM

Lack of awareness means children with SM are at risk of receiving poor treatment or no treatment by healthcare professionals. In 2008 Keen, Fonseca and Wintgens published international consensus-based research in an attempt to define principles of care and support for this clinical population. Johnson (2015) responds to the consensus research by outlining recent developments in the UK towards establishing effective local care pathways for SM, summarising the research into five key recommendations.

- A multi-modal and multi-agency approach to assessment and intervention with local agreement on the first point of contact for those seeking advice and support.
- Provision of training to educate all involved in identifying and supporting children with SM.
- Access to an individualised intervention programme as soon as SM is identified, with an emphasis on parental involvement in real-life settings.
- Progress determined by improved social functioning.
- Access to a dedicated support group or organization such as the Selective Mutism Information and Research Association (SMIRA).

Johnson (2015) provides local examples of how these principles have been implemented around the UK. The importance of recent awareness raising measures in the UK such as the inclusion of SM on the NHS Choices A-Z of conditions (NHS 2016) and a reference to SM in the National Institute for Health and Care Excellence guidelines (NICE CG159 2013) is also highlighted (Johnson 2015).

1.3.10 Music Therapy

Music Therapy, like Dramatherapy, employs a creative medium to express and explore inner feelings. Cline and Baldwin (2004) state that Music Therapy 'could have much to offer' but note 'the literature is sparse'. The database search described above (Section 1.3) revealed one case study detailing the use of Music Therapy for Selective Mutism (Amir 2005). 'Shiran' has an unusual presentation of SM whereby she stops speaking in nursery several weeks after her brother is born. Amir (2005) describes a 'music psychotherapy' approach which investigates a client's inner

world. The sessions build in musical intensity culminating in expressive, loud drumming and a scream. Later in the process singing plays an important role leading eventually into talking.

An extensive search of all Music Therapy literature -including non-peer reviewed literature- using hand sorting and 'snow ball' techniques such as reference list checking is presented in chapter two.

1.4 What is Music Therapy?

The World Federation of Music Therapy provides a broad definition stating that:

> Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts (WFMT, 2011).

When explaining to non-Music Therapists about our profession, people usually express an immediate sense of comprehension of the healing properties of music. Since training as a Psychodynamic Music Therapist (Sobey and Woodcock 1999; Hadley 2003) I have greatly valued being reminded of this universal notion of the therapeutic value of music and keep an open approach to what Music Therapy can be. There are many excellent histories, definitions and evolving explanations of Music Therapy (Bruscia 1998; Darnley-Smith and Patey 2003; Edwards 2008; Bunt and Stige 2014) that chart the journey from our innate human appreciation of the health benefits of music to a structured, theory-based profession. I will present a succinct introduction to the recent history and main features of the profession as a prelude to an in-depth investigation of the topic of enquiry.

1.4.1 Recent history of Music Therapy

In a review of early literature on music in healthcare settings, Edwards (2008) cites an article in the Lancet from 1891 which cautions 'reserve' about the therapeutic use of music in London hospitals. In 1903, the American singer Eva Vescelius created the National Therapeutic society of New York stating 'the object of music therapy

was to return the sick person's discordant vibrations into harmonious ones' (Bunt and Stige 2014). Music Therapy developed further during World War 2 with the increasingly therapeutic use of music in medical settings with formal training courses opening in the US in 1944 (Darnley-Smith and Patey 2003). Within the UK Music Therapy appeared in the 1950s with the pioneering work of Juliet Alvin who subsequently established the first Music Therapy training course in 1968 at the Guildhall School of Music and Drama. At this time three main approaches dominated Music Therapy thinking: the 'free improvisational model' (Alvin 1975), Analytical Music Therapy (Priestley, 1975) and Creative Music Therapy (Nordoff and Robbins 1977). More recently, Darnley-Smith and Patey (2003) defined Music Therapy as having evolved 3 main strands:

1. Community Music Therapy (Ansdell 2002) - a psychosocial model
2. Guided Imagery in Music (GIM; Goldberg 1995) - uses a specific schedule of recorded music
3. Improvisational Music Therapy - employing a more music-oriented or Psychodynamic stance.

Music-centred Music Therapy is acknowledged as the original Nordoff and Robbins approach.

1.4.2 Music Therapy theory

Music Therapists practice across a wide range of clinical areas, for example; with children with Autism Spectrum Disorder (Gold, Wigram and Elefant 2006); in forensic mental health settings (Dickinson, Odell-Miller and Adlam 2012); with people with acquired brain injury (Bradt et al. 2010); in palliative care (Aldridge 1998). Theoretical approaches have evolved in varied ways reflecting the perspectives afforded by our intersubjective experiences as therapists working in hugely varied work environments. I have found that a 'Magpie' approach to theory through selecting the most personally relevant ideas enriches and expands our own therapeutic thinking. Certain theories resonate strongly with my current practical and theoretical journey as a therapist, others touch the fringes but might take greater prominence were I practising in a different context.

An awareness of the social and political power structures that surround any therapy context is important to my practice. Noticing where therapeutic music making exists

beyond traditional Music Therapy boundaries is key to the debate within Community Music Therapy -CoMT- (Pavlicevic and Ansdell 2004). Foregrounding context Ansdell suggests that:

> "the Community Music Therapy movement has successfully advocated a broader social practice supported by a psycho-social cultural theory on music and well-being". (Ansdell 2014 p.18)

Stige (2002), also a recognised Community Music Therapist, describes Music Therapy as "situated health musicking in a planned process of collaboration". His recent 'practice turn' theory defines Music Therapy practice as 'bundles of activity' within spatial, temporal and social contexts which are sites of knowing rather than just the application of knowledge (Stige 2015).

Addressing female inequalities Hadley (2006) shares Feminist perspectives on Music Therapy practice within our 80% female profession. Kenny's 'Field of play' (2006) sits within this Feminist framework providing a general theory for Music Therapy centred around being rather than doing. Based on her indigenous experience Kenny describes seven energy fields: the aesthetic; the musical space; the field of play; rituals; a particular state of consciousness; empowerment and the creative process.

Other Music Therapy theories include: Biomedical (Taylor 1997); Neurologic (Thaut 2009); Aesthetic (Lee and Khare 2001); Music-Centred (Aigen 2005); analogy based (Smeijsters 2005); dialogical (Garred 2006); Resource-oriented (Rolvsjords 2010); humanities oriented (Ruud 2010). Resisting having to fit into a particular theory or model of Music Therapy practice is also a feature of recent thinking (Stewart 2004).

1.4.3 Early communication theory and music therapy

Theories originating from outside the Music Therapy profession have deeply influenced Music Therapy practice. In the 1970s, studies observing mother-infant interaction began to challenge previously held notions of a primarily physiological mother-infant relationship, recognising instead the sophisticated nature of early communication (Stern 1974; Trevarthen 1979) termed 'protoconversations' (Bateson 1971). Scientists noticed that infants were far more interested in people than objects (Papousek and Papousek 1974) ultimately establishing evidence of our innate capacity for intersubjective functioning (Trevarthen 1974, 1979, 1998a). These protoconversations were named 'motherese' or 'infant-directed speech' (IDS) and

noted for their musical qualities. Elements such as rhythm, melody, voicing, repeated phrases and slowly changing narratives of emotion led researchers to identify this as pre-verbal or sub-verbal musicality used to convey motives and emotions (Malloch 1999; Papousek 1996). Stern (2010) describes how these feeling qualities are evoked through this musical communication's dynamic shape, for example, exploding, pulsing or fading. Other studies demonstrated reciprocity and similarities in contour and timing between mother and infant (Malloch 1999).

Stern (1985) explains how cross-modal sharing of an affective state is indicative of a deeper level of mutual understanding and intimacy. This is demonstrated when a feeling is expressed perhaps through an arm movement but reflected back musically by following the timing and quality of this movement. Stern called this more sophisticated communication "affect attunement" (Stern 1985).

Acknowledging the potential healing properties of this knowledge Trevarthen and Aitken suggest 'what we have learned about fundamental intersubjective processes in infancy can be applied to benefit the wellbeing and development of children with developmental disorders and improve motivation and emotional wellbeing' (2001 p 29). Malloch and Trevarthen (2010) describe how musical and dance forms can usefully progress from 'regularity and predictability to novelty and surprise and back again' creating a safe structure for children for whom communication may be challenging.

Understanding the musical foundations of early relationships has resulted in fruitful theoretical collaborations and an 'elegant synthesis' (Pavlicevic and Ansdell 2009) between developmental scientists and Music Therapists (Pavlicevic and Trevarthen 1989; Pavlicevic, Trevarthen and Duncan 1994). In a paper entitled 'The dance of wellbeing: Defining the Musical Therapeutic Effect' Trevarthen and Malloch explicitly state that 'communicative musicality is the source of the music therapeutic experience and its effects' (Trevarthen and Malloch 2000 p3).

Emphasising the particular role of Music Therapy for people with communication issues Ansdell and Pavlicevic (2005) write that:

> 'In our culture, where it is seemingly always "good to talk", disorders or failures of communication stand out… Amongst the approaches treating such

"pathologies of communication" music therapy is increasingly acknowledged as being especially successful' (2005 p. 193).

1.4.4 Music Therapy Terminology

Within Music Therapy discourse aspects such as timing, mirroring, turn-taking and affect attunement are seen as the technical building blocks of the developing music therapeutic relationship in a similar way to the parent-infant relationship. I now offer explanations of some of the terms used in Music Therapy sessions relevant to this investigation and approach.

Mirroring or matching can simply mean imitating or closely following the actions of another person. Within a therapeutic relationship the therapist may take the lead from the action, however small, of the client. However, the client may also mirror or match the therapist.

Affect Attunement - cross-modal attuning is a more complex version of mirroring or matching. It demonstrates to the person or client that you comprehend how their experience feels without directly copying them. It often happens automatically in human relationships but is employed in Music Therapy through responding to the intensity, timing and shape of behaviours or musical expression. The best example outside of the Music Therapy session is when a child goes down a slide and you exclaim "weeeeee" mimicking the feeling quality of the experience through the timing, prosody and intensity of your vocal expression.

Turn-taking borrows from the natural 'protoconversation' patterns whereby someone might 'say' or communicate something –e.g using an instrument, a vocalisation, words or a gesture- and the conversational partner responds; this then repeats forming a turn-taking pattern.

Containment – a term coined by Wilfred Bion (1959) to mean providing a safe space or container for the expression of feelings. The parent or therapist takes in the feeling expressed by the child or client, processes it and offers it back in a more manageable form. In Music Therapy elements such as a Hello and Goodbye song/music, structures, rhythm, predictability, tonality, harmony and timbre can all help to offer a sense of containment. Musical self-expression from the client is heard and responded to by the therapist and processed through the musical therapeutic relationship.

Psychodynamic therapy is a way of attending to and exploring feelings and events in the therapeutic relationship to facilitate understanding of other personal relationship dynamics. Two main concepts within this are;

> *Transference* is the phenomenon of the client unconsciously redirecting feelings from childhood onto the therapist.
>
> *Countertransference* - is the phenomenon of all of the therapist's conscious or unconscious feelings or attitudes towards the patient. These may be the therapist's response to the patient's *transference* or the therapist's own separate *transference* feelings towards the patient (Darnley-Smith and Patey 2003).

In order to process these feelings, the therapist should spend time discussing the sessions with an experienced supervisor, which is an essential part of any therapy practice (Odell-Miller and Richards 2009).

1.5 Music Therapy and Selective Mutism – MA case study

> *The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications. (Moustakas 1990 p.27)*

My experience as a Music Therapist has been that Music Therapy can be a highly successful intervention for SM, with children engaging enthusiastically and often speaking in sessions within a few weeks (Jones 2012). These positive outcomes suggested that Music Therapy should be carefully evaluated as a potential intervention for this clinical population.

My initial investigation was a single case study, as part of Masters level research, from which I developed a theoretical framework for the use of Music Therapy with a child with SM and English as an Additional Language (EAL) (Jones 2010). A paper based on this research describes the parallel layers of musical, physical and social/emotional communication available in each session and the overarching therapeutic process (Jones 2012). A book chapter in 'Tackling Selective Mutism' (Jones 2015) describes case material and the potential role of Music Therapy as an intervention for SM.

1.5.1 Summary of MA research

The process of researching this clinical area began with an MA investigation of a single case study describing psychodynamic music therapy for a young child with SM and EAL. The study employed a heuristic approach with six stages: Initial Engagement, Immersion, Incubation, Illumination, Explication and Creative Synthesis, (Moustakas 1990) and utilised the dual role of being therapist and researcher.

The study found that music could be used to facilitate 'sliding in' to speech within the therapy room whilst acknowledging the emotional component and the need for self-expression. A subsequent article (Jones 2012) aimed to raise awareness and invite dialogue and responses to this subject area.

1.5.2 Theoretical Framework

Figure 1.1 is a distilled, skeleton version of the theoretical framework that was developed from my single-case study research. I describe the main elements of the framework in turn below. Original language from the dissertation will be preserved where possible to enable critical comparison with data arising from the current study. For the full version please see Appendix 1.1.

Figure 1.1 Theoretical Framework from single case study research

Therapeutic process / **Parallel layers of communication**	1. Offering a potential space	2. Manifesting anxiety – having it contained and processed	3. Gradual build-up of trust and contact through listening and accepting – 'no pressure approach'	4. Gradual development of shared, meaningful communication and 'playing'	5. Need to end therapy – healthy, confident separation
a) Musical	Musical conversations – parallels spoken conversations – 'sliding in'				
b) Physical	Control and expression in the physical realm lead to control of the voice				
c) Emotional/ social	Therapeutic relationship parallels mother/ infant interaction = emotional/ social communication				
	TIME IN THERAPY ➔				

Parallel layers of communication

a) Musical conversations - parallels spoken conversations - 'sliding in'

Musical communication is the unique tool that Music Therapists are trained to utilise within a therapeutic context. Our specialist skills in this area enable us to attune to the sensitive and careful development of a musical relationship. We are also aware of the parallels to spoken conversations and the related theory in this field. Music Therapy provides an invaluable version of the 'sliding in' technique (1.3.3) by developing musical conversations using resources such as oral instruments, vocalisations and singing to provide a clear path into speech. Each child creates their own path at a pace that respects their emotional needs. Offering a space in which to make sounds and be heard is the first step down this path. The release of being heard and being 'loud' after an extended period of silence is intrinsic to the success of this process.

That the children often head for the louder instruments is also reflected in the work of Roe (1993). The path for some can be quite short and they quickly move through from oral instruments to vocal sounds or singing and then words. Another child will 'slide in' by playing very loud sounds and use the volume to cover initial attempts at speaking. Other children will use different barriers such as playing under a table or using words with their back turned. In these situations it is possible for a child to gradually move into speech whilst the therapist is apparently focussing on the musical communication, thus taking the pressure off the efforts at speech.

b) Control and expression in the physical realm lead to control of the voice

It is common for a child with SM to present as 'frozen' and sometimes to have additional problems engaging with activities such as PE (Physical Education) (Cline and Baldwin 2004). In such cases, controlling the physical therapy space and perhaps using 'dancing' as another means of expression may be helpful in the therapy process. Selective Mutism can feel like a physical problem. Children report later that they felt as if there was a physical constriction in their voices and throats. It was important to Luis (the subject of the case study) to feel that he could own these instruments in some way.

By piling up the musical instruments and saying "Mine, all mine" he was owning the means of communication and the therapy process.

c) Therapeutic relationship parallels mother/infant relationship = emotional communication

The literature on mother/infant interaction describes the function of early communication as primarily social and emotional (Schaffer 1977; Stern 1985). This literature provides a theoretical foundation for Music Therapy practice. The therapeutic relationship parallels this mother/infant relationship and can be used to revisit and rework issues that arose at key developmental stages. In the case of Luis I believe that the original mother/infant relationship was strong and healthy as Music Therapy provided the means to confidently develop another language. Initially this language was musical and then it moved into speech. The focus on emotional communication is particularly relevant for SM (which is sometimes referred to as speech anxiety) as the therapeutic relationship can 'contain' some of this anxiety.

Emotional processing

This is the whole of the emotional process as manifested by the client in any combination of the different realms of physical, musical and emotional self expression, as described above.

1. Offering a potential space

This simply means being able to offer the therapy space that the child is able to access. In most cases the actual therapy room will be in the school and should be emotionally accessible and fairly familiar to the child.

The development of rapport in the transition to and from the therapy space can be crucial. Luis and I spent a lot of time exploring frost, snow and puddles on our journeys to and from the music room. Ultimately, the therapist's goal is to offer a potential space to play.

2. Manifesting anxiety - having it contained and processed-

The therapy space also needs to be offered on the same day and at the same time each week. This helps to facilitate the containment necessary for emotional processing.

Once the therapy space is emotionally available the client then manifests their emotional being within this space. It is the therapist's responsibility to listen to this emotional communication and respond accordingly. Musical 'containment' offers an acknowledgement of the anxiety without the therapist being overwhelmed by it. This then allows the child to move on in the therapeutic relationship.

In considering the data from the case study it felt important to explore the origins and nature of the anxiety of SM. The process of separating from the primary social relationship with a parent into the social world of nursery school can be intense without the additional need of learning another language. There is a sense of a double loss here, that of the mother and the mother tongue, and perhaps also the loss of a sense of self. Is the anxiety of SM an extension of this separation anxiety that has not been processed in the usual way by verbal self-expression and socialization in the nursery setting?

Does the pressure of meeting educational targets create additional anxiety for the teachers of a child with SM? Is the anxiety purely connected to the process of communication, so that when communication is expected this creates an anxious response? This view is widely suggested in the SM literature (Cline and Baldwin 2004; Johnson and Wintgens 2001). Toppelberg (2005) says that "shy, anxious, and/or inhibited children expected to function in a second, unfamiliar language may be more prone to reacting with mutism". This remark suggests that the anxious personality is a potential factor in creating SM rather than just integral to the mutism. However, Toppelberg also suggests that not treating SM can result in 'emergent anxiety disorders' (p.593).

3. <u>Gradual build up of trust and contact through listening and accepting - 'no pressure' approach</u>

Carl Rogers (1951) describes the importance of 'unconditional positive regard' and accepting the negative, defensive and abnormal feelings as well as the good in order to help facilitate change. This approach is completely congruent with the 'no pressure' approach as described by Johnson and Wintgens (2001) but allows it to be effective at a deeper, emotional level.

Mahns (1999) also embraces the idea that children should have a therapeutic space in which to make progress 'while still not reconciling with the public'. In behavioural approaches to SM much emphasis is given to the progression into normal confident speech, whereas Mahns protects the individual's need for emotional growth first.

With regard to this case study, this acceptance was important for Luis not only to process the anxiety but in order to develop a therapeutic relationship which facilitated further meaningful communication and change.

4. Gradual development of shared meaningful communication and 'playing'

Once the child has experienced this 'acceptance' they can move on to own and increase their participation in the therapeutic relationship. The therapy setting should enable them to express themselves in a variety of different ways. These can be musical, physical, symbolic and verbal.

The shared experience of 'humour' always seems to have significance in the therapy and this occurred at a time of intense 'playing' and before the separation phase.

5. Need to end therapy - healthy, confident separation

This process of separation and ending was perhaps important in that it reworked some of the difficult separation Luis had experienced when first attending the nursery. In this separation there is a clear sense of a healthy child who is confidently wanting to go back to class to generalize the verbal communication skills developed within Music Therapy.

If a therapist is working within a school setting generalisation can be supported by the transition from the therapy room back into the classroom. However, if a child finds it difficult to 'slide' the speech back into the classroom then choosing a friend to attend a few therapy sessions can help facilitate this process.

1.6 Aims and Research Questions

The overarching aims of this study are:

> To critically examine, develop and refine a theoretical framework for the use of Music Therapy with young children with Selective Mutism.
>
> To raise further awareness of Selective Mutism and the potential role of Music Therapy in this area.

The primary research question is:

> Does a theoretical framework, developed in single-case study research, explain the process of Music Therapy across a number of cases of children with SM?

In order to address the primary research question the study will seek to answer a number of focussed secondary questions. Secondary questions a)-d) will address the wider context in which the study takes place. The secondary questions e) and f) are specifically focussed on the framework. Question g) situates the findings back into the wider context:

a) *What are the current treatments for SM? -Addressed above-.*
b) *What is the evidence for the use of Music Therapy as a treatment for people with SM?*
c) *Has Music Therapy been used as an intervention for people with Selective Mutism in the UK?*
d) *How do experienced UK based Music Therapists describe their practice of working with children with Selective Mutism?*
e) *What are the main ingredients of Music Therapy that appear useful for children with SM?*
f) *How do the therapy narratives from the multiple case studies enrich or challenge the theoretical framework?*
g) *Where does Music Therapy fit on the care pathway for children with SM?*

1.7 Outline of the thesis

This section provides a brief overview of the chapters in the thesis. Specific secondary research questions will be answered within the separate chapters.

Chapter two - SM and MT literature review

Chapter two asks whether Music Therapy has been used as an intervention for SM by conducting a scoping literature review (Question b). The rationale for this is based on the paucity of literature in the initial review of databases.

Chapter three - Methodology

Chapter three describes how the methodology for this study is built on prior research. I summarise basic epistemological concepts that are important to consider in planning any research study and explore their relevance for this investigation. 3rd paradigm approaches are then outlined and the stance for this study established.

Chapter four- Survey chapter

This chapter builds on the historical evidence of chapter two and uses a survey to ask whether Music Therapy has been used as an intervention for Selective Mutism within the UK (Question c).

Chapter five- Interview chapter

Chapter five builds on the information from the survey (Chapter 4) and uses semi-structured interviews with individual UK Music Therapists to gain rich qualitative data about their Music Therapy practice with children with Selective Mutism (Question d).

Chapter six- Case study methods and setting

This chapter describes case study theory, methods and the local context for the multiple case studies.

Chapter seven- Results

This chapter presents evidence of the 'path into speech' for each of 6 cases of Music Therapy for young children with SM.

Chapter eight- Analysis and discussion

In chapter 8 thematic analysis of the cases is presented and compared to the original theoretical framework (Questions e and f).

Chapter nine- Conclusions

Chapter nine synthesises data from across the study to answer the primary research question and evaluate the original theoretical framework. Insight gained from the research is explored and distilled into key outcomes. The implications of the research for practice, theory, policy (including Question g) and future research are considered.

Chapter 2 - Music Therapy and Selective Mutism literature review

2.1 Background

This chapter considers the historical practice of Music Therapy for people with SM and addresses the question: What is the evidence for the use of MT as a treatment for people with SM?

A pilot search in three databases (Psychinfo, CINAHL, Medline,) revealed insufficient literature to conduct a formal systematic review of Music Therapy intervention for people with SM. The two peer-reviewed papers (Amir 2005; Shultz 2011) and one thesis (Seidl 1995) found in this way describe detailed case reports. However, the Music Therapy profession has a strong tradition of sharing knowledge through case narratives, some of which do not reach peer reviewed or indexed journals, but could nevertheless be valuable to this study.

2.2 Case studies as a clinical evidence base

Case studies in books are a vital resource to practising Music Therapists (Bruscia 1991; Hadley 2003). However, it is only in the last 20 years that the difference between clinical case studies and case study research has been more clearly defined by the profession. Smeijsters (1996) describes non-scientific or traditional case studies as having unreliable data collection and selection methods which are difficult to independently verify. He defines scientific case studies as being more reliable and systematic with sound construct validity and internal and external validity. Aldridge's (2005) book, Case Study Designs in Music Therapy, helpfully surveys a broad spectrum of research techniques from varied aspects of Music Therapy practice. Aldridge connects Music Therapists' need to tell stories from clinical practice with a rationale for more formalised rigorous presentation of our work as case study research. He references Yin (1994) as a key source of information and guidance on case study research design and methods.

Looking outside our profession, at case study researchers such as Yin (2009), helps us to formulate and strengthen our own ideas as Music Therapy researchers. McLeod (2010) examines the historical development of case study research within the Psychotherapy profession. He begins with Freud's famous case study of 'Dora'

which highlights the pitfalls of traditional case studies and their lack of reliable evidence or system of checking the interpretation. It is interesting to note that subsequent rechecking of the 'Dora' case from Freud's clinical notes suggest that she was the victim of sexual abuse and that her experience with Freud was a 'great psychotherapeutic disaster' (Mahony 1996: 148-9).

Throughout the 20th century there has been valid criticism of the clinical or traditional case study (Spence 1989, 2001). One of the most important early examples of more rigorous case study research took place at the Menninger foundation in Kansas, USA. 42 cases of Psychoanalysis or Psychoanalytical Psychotherapy research were analysed using session notes, psychological tests and interviews, with some patients followed up for 30 years (Wallerstein 1986). This unique study resulted in a significant shift in Psychoanalytical theory and practice towards more collaborative and supportive ways of working with clients. From the 1960's onwards there has been much greater rigour and rapid methodological development within case study research in Psychotherapy (McLeod 2010). Case study design is explored in more detail in chapter 6.

2.3 Scope of the review

The specific aims of the review are:

a. To identify and document the history of Music Therapy engagement in this clinical area.

b. To explore features of Music Therapy practice with people with SM including:

   - clinical presentation: age, gender, languages spoken;
   - frequency/length and amount of therapy;
   - therapeutic effect;
   - therapeutic approaches;
   - attitudes and understanding of Selective Mutism;
   - therapy phenomena and themes.

c. To provide an external evidence base from which to view and scrutinise the theoretical framework as described in chapter one.

2.4 Review method

This review included all literature describing Music Therapy as an intervention for Selective Mutism such as: peer reviewed articles, book chapters, unpublished/non peer reviewed reports, PhD theses or Masters dissertations, and conference presentations. There were no limitations on the earliest date of publication but the review finished at the end of 2015.

Online searches were undertaken of the databases CINAHL, Medline and Psychinfo using the search terms Selective/Elective Mutism/Mutism/Mute and Music/Drama/Art therapy. Other search methods included: Google searching, national request to all UK members of the British Association for Music Therapy, hand searching of the British Journal of Music Therapy and extensive checking of reference lists.

2.4.1 Inclusion criteria

Literature was included if it described Music Therapy as the main method of treatment for an individual or a group including people with Selective/ Elective Mutism. All ages and presentations of SM including adults with comorbid mental health issues and children and adults with learning difficulties were included in this review.

2.4.2 Exclusion criteria

Literature was excluded if the client was not clearly described as having Selective Mutism or the focus was not specifically on Selective Mutism.

2.4.3 Study selection

Where title and abstract met the inclusion criteria, the full texts were read and included in the review.

2.4.4 Restrictions

Only studies in English or German were accepted for the review. This was because articles in other languages were not found as part of the search and because translation was available for German articles.

2.4.5 Data extraction

Data were extracted from included papers into a table (Appendix 2.1) that reflected the aims of the review, specifying:

1. Client details: gender, age, SM presentation
2. Therapy details: frequency, length, duration, number of sessions, location of sessions.
3. Therapeutic effect: generalised speech, speech in sessions, emotional improvement.
4. What was the understanding of SM within the historical context?
5. What were the main features and approach of the therapy?
6. How does the therapy relate to the theoretical framework being examined in this study?

For the purposes of this literature review I distinguish clinical case studies from case study research which describes clear and systematic methods of data collection and analysis.

2.5 Results

17 items were identified, all reporting single case studies, of which there were 8 peer reviewed journal articles, 5 book chapters, 1 conference paper, 1 PhD thesis and 2 MA dissertations. Of these, 14 are clinical case studies and three are case study research as defined in the background to the chapter. No other types of study were found in the review.

2.5.1 Age, gender and presentation including language presentation (bilingual or second language learners)

The client's ages across all the reviewed studies were between 4 and 37 years old with 3 teenagers (Castellano 1970; Davies and Mitchell 1990; Trondalen 2001) 3 adults (Aigen 1990; Whelan 2007; Esa Ala-Ruona 2014) and 11 children aged 4-12 (Monti 1985; Johns 1986; Seidl 1995; Sekeles 1996; Lutz-Hochreutener 1998; Katz 2002; Mahns 2003; Amir 2005; Moreau 2008; Vogel 2009; Schulz 2011). This reflects both the Music Therapy profession's tendency towards working with children and the increasing awareness of SM in early years settings.

9 clients were female and 8 male. In the general SM literature a review of 98 cases of SM gave a ratio of 57% of girls to 43% boys (Cline and Baldwin 2004).

8 case studies describe SM, 3 describe SM with additional mental health issues, 2 describe SM and learning difficulties, 3 have bilingual clients and 1 a client with additional physical health needs (see table 1 below). The people with SM and mental health issues are adolescents or adults, which reflects the fact that SM becomes more entrenched and complex if left untreated, with the risk of generalised social anxiety and depression (Cline and Baldwin 2004; Forrester and Sutton 2015). The 2 studies of children with SM and learning difficulties (a group less mentioned within general SM literature) reflect the clinical population that Music Therapists work with.

2.5.2 Frequency/ length/ duration/no of sessions and location of therapy

11 studies state the frequency of therapy, which ranges between once (5 studies) and 5 times per week (Johns 1986). Frequency of sessions is a point of interest for this clinical area. Johns dramatically changes from 1 session per week to 5 in order to help break the non-active, non-speaking pattern.

7 studies state the length of sessions, which range between 15 minutes (Monti 1985) and 60 minutes (Seidl 1995). When stated, the length tends to broadly reflect the age of the client with shorter sessions for the youngest children (Monti 1985).

14 studies state the duration of the treatment period which ranges between 5 weeks (Castellano and Wilson 1970) and 3 years (Ala-Ruona 2014). Briefer therapy often has specific limits due to being a research study participant (Seidl 1995) but therapy may also be brief if it rapidly reaches a successful conclusion (Trondalen 2001). Longer-term therapy is often with adolescents or adults with mental health issues where the SM is more entrenched and complex (Ala-Ruona 2014).

7 studies state the number of sessions, which range from 9 (Castellano 1971) to 120 (Amir 2005).

13 studies state the location of sessions. 4 were in the client's schools, 5 in clinic settings, 2 at the client's home, one in a psychiatric hospital and one in a private practice setting. This perhaps reflects the historical tendency to favour a clinic setting whereas the current recommendation is to work in the school or setting where the SM occurs (Keen, Fonseca and Wintgens 2008).

2.5.3 Therapeutic effect/ change

All studies report the therapeutic benefits of the therapy. 6 studies report emotional improvements without speech, 3 report speech in therapy sessions and 8 report speech in therapy which is then generalised outside of the sessions to school or social settings. 2 studies describe emotional improvements for adults with mental health issues (Aigen 1990, Davies and Mitchell 1990). 1 study of a child was quite a complex case which seemed nearly successful (Seidl 1995) and another was nearly successful (Vogel 2009).

Of the 3 studies where speech was achieved in the therapy sessions only, 1 describes possibilities for generalisation of speech into school or other settings, 1 brings a friend into the therapy sessions and 1 does not mention generalisation.

2.5.4 Understanding of SM

The Music Therapy literature in this chapter either questions or reflects historical understandings of SM and this section explores the therapeutic impact of this thinking. The studies combine references to SM, either outmoded or contemporaneous, and insight gained from clinical experience. These sometimes 'fit' but are often conflicting.

2.5.4.1 Early Descriptions of anxiety

Despite the relatively recent acknowledgement of the role of anxiety in SM (APA 2013) many early MT studies vividly describe the anxious and frozen presentation typical in SM (Castellano, 1970; Monti, 1985; Johns, 1986). Castellano (1970) presents the '"rigid", robot-like, perspiring,' of his client but then uses a harsh behavioural approach which was typical of the time to treat the SM. Monti (1985) describes her client's 'withdrawn affect characterized by a mask-like expression. He was never seen smiling, appeared fearful beyond appropriateness, did not interact with the other children and exhibited little or no interest in toys and materials available for play' (Monti 1985, p.24).

2.5.4.2 Practice-based concepts of SM

Aigen's approach (1990) of setting aside theory and writing honestly and descriptively about the therapy experience is helpful as he questions contemporaneous understandings of SM, then known as Elective Mutism, that do not

fit his clinical experience. 'Is she really choosing – as the word elective implies – not to talk to me in person, or is this something beyond her conscious control?'(1990, p. 49). Aigen's critical approach to SM, informed by his clinical experience, highlights the debate around terminology that continues to this day. Aigen values laughter in the sessions and clearly describes what we might now term 'social phobia' with the desperate need but also fear of connecting with other people. Similarly, Lutz-Hochreutener (1998) describes her client's 'silent scream', evoking the frustrated emotional quality of SM and wonders whether her client often feels this way, wanting to express herself but it being impossible.

2.5.4.3 Psychodynamic understanding

Davies and Mitchell's study (1990) published in the same year embraces a psychoanalytical stance and describes how 18 year old Robert 'refused to speak' and had a 'determined silence', evoking a now outdated conceptualisation of SM but reflecting the attitude of that time. Robert's 'need to control' the therapy door and 'resistance' to being tape-recorded would now perhaps be interpreted as anxiety about being heard. Davies concludes that there are issues in the mother-child relationship but without providing evidence from the client's history. There is no mention of Robert beginning to use his voice again which suggests that perhaps the therapy was not successful in this respect.

Although a psychodynamic approach has been justifiably criticised as being unhelpful in looking for a cause for SM (Cline and Baldwin, 2004), countertransference can provide insight into how the client may be feeling. Davies and Mitchell (1990) state the therapist's feeling of helplessness perhaps reflected the client's communication issues and that the therapist may have taken on the client's need for control by insisting on the use of the tape recorder.

Katz (2002) describes the loss of the music in therapy process and how she, the therapist, experienced a loss of confidence and sense of worth. This was not linked to how the client might be feeling, perhaps due to an outmoded understanding of SM. Katz cites Meijer's (1979) view that the need to maintain a family secret and a 'weak mother' are the 'passive aggressive' roots of the silence of SM.[1] In spite of this

[1] This misunderstanding is reminiscent of the historical 'refrigerator mother' concept used to explain the cause of Autism (Kanner 1949, Bettelheim 1967).

potentially damaging understanding of SM, Katz recounts an instinctive and effective therapeutic relationship.

2.5.4.4 Outmoded conceptualisations

One PhD thesis (Seidl, 1995) provides a single case study examination of Music Therapy for a young girl with SM. The concept of a child refusing to speak pervades much of the thesis and is accepted rather than critically examined, despite the reference to the then new definition (APA 1994) which uses 'failure to speak' rather than refusal.

Seidl (1995) provides reasons for SM that are now discredited in current literature such as trauma, abuse and the need for control, stating that 'Faye (aged 8) controlled when and to whom she spoke to at all times'. Ala-Ruona (2014), similarly states that her client was 'not willing' to speak.

2.5.4.5 Mixed understanding

Sekeles (1996) similarly describes her client's 'persistent refusal to talk' but combines outmoded concepts with sound therapeutic insight. She uses contemporaneous causal explanations of SM such as 'oral trauma, early hospitalisation and bilingual conflicts' but cites symptoms such as social isolation, passive aggression and fear of change which, apart from passive aggression, might be recognised as contributing factors today. In contrast, she then suggests that the child's 'negative trends and the mutism are generally directed at the parents even though the silence is expressed away from home' (pp. 125-142).

Sekeles (1996) understands SM as a symptom of deep anxiety and employs the novel approach of forbidding her client to talk in the therapy room. Supportive acceptance and 'holding' by assuming the role of the 'good enough' mother are embedded in her approach, and her description of her client's brief, subdued speech 'as if he had a lump in his throat' reflects the physical sensation reported by some SM sufferers.

Vogel's MA study (2009) makes outdated observations such as 'choosing not to speak was Anne's defence' and 'refusing to play', but sets appropriate therapeutic goals such as a pressure-free musical environment for non-verbal creative expression.

2.5.4.6 Contemporaneous conceptualisations

Mahns (2003) and Amir (2005) provide in depth informed descriptions of SM based on contemporaneous understandings, explaining that the earlier term of 'chosen silence' is misleading. Mahns describes the complex factors involved in his client's mutism including his immigration status, social isolation and abusive family dynamics. Amir (2005) also gives comprehensive detail about the potential causes of SM highlighting the central role of anxiety. Shultz (2011) describes an informed understanding of current treatment practice for children with SM.

2.5.4.6 Other understandings

Whelan (2007) describes a diagnostically ambiguous case lying between Traumatic Mutism and SM. Exploring successful therapy for a woman with learning difficulties, she thoroughly investigates the literature on trauma and silence although reference to SM literature is comparatively light.

The therapist's conceptualisation of SM can have a profound impact on the outcome of the therapy depending on the accuracy or otherwise of the conceptualisation and the emphasis placed upon it. There is, in many of the studies considered, a mismatch between various theoretical understandings of SM and descriptions of broadly similar phenomena in Music Therapy for people with SM. Although the understanding of SM has a potentially huge impact on treatment outcomes there are many common features that emerge in the Music Therapy process across these various studies.

2.5.5 What were the main features of the therapy?

This section explores common themes emerging from the studies and highlights other features that were novel or interesting.

2.5.5.1 Loud playing

Descriptions of an initial frozen or rigid presentation contrast strikingly in many studies with a later need to play loudly (Monti 1985, Aigen 1990, Davies and Mitchell 1990, Seidl 1995, Sekeles 1996, Lutz-Hochreutener 1998, Katz 2002, Mahns 2003, Amir 2005). Very forceful playing is a feature that I have also experienced a lot in my own therapy practice. Children with SM often seem to head quickly towards the louder instruments (Roe 1993) in an attempt perhaps to express

some of the frustration and anxiety of SM and to be heard in the context in which they are usually silent. The quality of this loud playing and the meaning ascribed to it varies between studies but the main sense of freedom of expression is clear.

This is seen with 'David' (Monti 1985, p.25) whose 'piano improvisations suddenly escalated into random banging involving his whole hands and at times his arms and elbows on the keyboard'. The therapist encouraged him to express his frustration and set up floor toms so that he could make 'a great deal of noise'. Aigen (1990) describes the more powerful and forceful playing with his client as strong and assertive. Davies and Mitchell (1990) mention 'very forceful or energetic playing' which seems to express frustration and anger for their client.

A sense of urgency in the need for self-expression is seen in 6 year old 'Pia's' drumming (Lutz-Hochreutener 1998) as she moves quickly from quiet to strong drumming lasting for 20 minutes and causing blisters on her hands. These contrasts between frozen silence and loud playing are sometimes reflected in the wider context of the school and home environment where parents may report the SM child's need to 'let off steam' at home possibly as a consequence of not being able to speak all day at school. This urgent need for self-expression is encapsulated dramatically and poignantly in Pia's 'silent scream' (Lutz-Hochreutener 1998).

Another scream highlights this acute need for 'Shiran', also 6 years old (Amir 2005). Shiran is so anxious in her first therapy session that she is barely able to enter the therapy room. However, in her 40th session she moves from quiet to loud and aggressive drumming and then screams, cries and is hugged by the therapist. This transition through drumming into vocal sounds was then repeated in each session to help facilitate this emotional release.

Loud drumming or playing combined with physical activity such as dancing is an important activity for both 'Faye' in Seidl (1995) and 'Alon's' "jungle" phase' (Sekeles 1996).

2.5.5.2 Physical features

It is difficult to separate this phenomenon of loud playing from the physical self-expression it necessitates and they share the same therapeutic function (Monti 1985, Amir 2005). However, many of the studies describe the specific use of physical self-expression, physical relaxation techniques and the use of physical space.

Aigen (1990) encourages the use of physical movement to support the integrative potential for his client with schizophrenia and SM. He describes how Ariane's swaying and rocking to her piano playing transforms her being. Sekeles (1996) develops an approach with the aim of building physical strength and confidence. The 'Jungle' phase describes strong aggressive drumming and dancing to 'stimulate spontaneous movement'. This, perhaps instinctive, focus on physical energy connects to the physical self-expression of the theoretical framework under scrutiny in the present study. Seidl (1995) describes her client's use of physical energy through her cartwheels and dancing.

Many physical aspects of the studies are linked to musical aspects, however some are not. Katz (2002) describes the replacement of music with football which undermines the therapist's confidence and sense of identity. Playing football in a music therapy space involves an element of risk and unpredictability that perhaps shifts the therapy out of a comfort zone towards speech. Physical risk-taking in Mahns (2003) suggests that the trusting therapeutic relationship was paramount, as highlighted by 'Osman' jumping from a high cupboard into his arms.

Physical relaxation techniques to reduce anxiety are described by Seidl (1995) and Trondalen (2001). Seidl (1995) uses taped background music and specific relaxation exercises that are also used by the special education teacher with her client, noting that Faye's physical presentation on the walk to the sessions reflects her anxiety levels. Trondalen (2001) describes 'body-activities' undertaken on the floor involving being rocked and held, shaken and nudged and rolled forward and backward while wrapped in carpets and music. Johns (1986) uses various techniques including a maracas dance to 'loosen bodily tensions'.

Davies and Mitchell (1990) give examples of how the physical space plays a role in therapy: the 'need to control' the therapy door; creating a 'barricade of instruments'; playing back to back; constantly rearranging instruments; wanting to play behind a barrier. These are all examples of a physical manifestation of the anxiety that underlies SM and the need for protective defences against the anxiety of close communication or unwanted contact. This links directly to creating a private, safe, space (discussed below).

2.5.5.3 Creating a safer space

Many studies describe the need for an additional layer of protection, or defensive barrier to augment the client's sense of safety and ease the facilitation of the anxiety-provoking task of communicating. Sekeles (1996) provides a tent-like structure to create a 'lair of the beast' representing an intermediate area or refuge from which to move into the room and try new experiences. 'Osman' builds a cave that seems to provide a safe space in which to work through some inner conflicts by drawing (Mahns 2003).

Aigen's client (1990) wears sunglasses in the therapy sessions to protect herself from invasive eye contact. Lutz-Hochreutener's eyes are covered when the client vocalises whilst playing 'blind man's buff' (1998). Not being able to see the client when they are vocalising perhaps provides this additional layer of protection and safety.

Davies and Mitchell (1990) describe Robert continually checking the door to the therapy room. Although this isn't an additional layer of protection it is perhaps the most significant physical boundary in a therapy room that possibly didn't feel safe enough for Robert. The potential to be heard by someone outside of the therapy space or for someone to come in to the therapy space can be extremely significant, and used either positively or negatively, for someone with SM (See 'Stimulus fading' 1.8.4). Davies interprets Robert's door checking as a need for control and goes on to describe how Robert builds a 'barricade of instruments' around himself. In the third therapy session Robert opens up the partition in the room and plays on the other side of this barrier. It is interesting to consider whether if these activities had been conceptualised differently by the therapist, perhaps less about a need for control and more about creating a safe space, the outcome for Robert would have been different. Perhaps if the therapist had accepted these activities and explored them with him she could have helped to build the safer space that Robert needed.

Vogel (2009) also describes how Anne builds a circle of instruments around herself which helps facilitate the free improvisation that she had previously found challenging. Von Moreau (2008) intuitively offers an imaginative layer of protection for her anxious client by creating 'mole holes' where both client and therapist slowly and playfully negotiate contact. Later, in group therapy, Von Moreau describes how

made-up language provided protection for first attempts at speech. Katz (2002) removes the front of the piano so that her unresponsive and 'petrified' client can look inside and then later play together under the keyboard like twins in the 'protective womb'.

In Psychodynamic thinking these examples might be considered additional layers of 'containment'. Music can also be used to create a sense of safety and security and the loud drumming described above could also be thought of as providing either a barrier or a protective space. Additionally, microphones and kazoos placed in front of or in the mouth can be both another layer of protection and enabling (Davies and Mitchell 1990, Von Moreau 2008).

2.5.5.4 Humour and laughter

Humour and laughter are important themes in many studies, demonstrating how laughter simultaneously relieves anxiety and creates audible vocalisations sometimes propelling people into speech.

Trondalen (2001) describes how her client responds to her laughter with a giggle and thereafter often responded with laughter to changes in the music. Laughter and humour play a central role for Lutz-Hochreutener (1998) when she impulsively decides to play the clown to fill a silence. She plays the trumpet the wrong way round and, sensing a giggle ready to burst out, continues clowning until her client laughs out loud. The clown appears to provide light relief and momentum in the therapy by mirroring the feelings of the client playing the timpani, who then engages in a dramatic fashion.

Johns (1986) also actively encourages humour after hearing a giggle from her client that sounds like 'held back' laughter. Johns invents musical games and tickles Tamara to increase the giggling until 'full laughter' occurs. Johns then increases the amount of sessions per week as perhaps the laughter makes speech seem quite close.

Vogel (2009) describes Anne initially responding to humour with a silent laugh, putting her hand in front of her mouth. -This is reminiscent of Pia's 'silent scream' (Lutz-Hochreutener 1998)-. Vogel later actively elicits laughter by changing the registers on the keyboard to make unusual sounds. They both laugh out loud and Anne initiates repeating this activity in each session.

In Katz (2002) a particular note is 'stuck' on the piano and 'Adam' finds Katz's frustration at not being able to unblock it very amusing. 'Adam' also finds it very amusing when the note becomes unstuck and Katz acknowledges the symbolism of this process. Aigen (1990) describes the poignant sound of laughter and also crying for his adult client who sadly doesn't move into speech.

2.5.5.5 Playfulness and play

Playing is an intrinsic part of childhood and the ability to play is a sign of good mental health for children. Children with SM are extremely anxious and sometimes find it difficult to engage initially in Music Therapy sessions. Developing playful interactions and exchanges seems to be an important part of the Music Therapy process and therapists choose to develop this in a number of different ways. Play can be a part of musical interaction but can also exist without music as part of a Music Therapy session.

As discussed above, playfulness can sometimes be naturally linked to humour and laughter but may also form an essential part of the therapist's approach to therapy. 5 studies employ play techniques, 3 of which use intuitive, playful ideas to initially reach out to anxious, frozen clients. Von Moreau's (2008) 'mole hole' game doesn't achieve any response from her client for the duration of the first session. In subsequent sessions however, the mole theme engages the child and develops imaginatively and musically within the therapeutic process. Lutz-Hochreutener (1998) reaches out in the first session by 'playing the clown' and this circus theme is continued together when they pretend to be snorting horses and Pia becomes a small whining dog.

Playful provocation and teasing is successfully employed by Lutz-Hochreutener (1998) when she says that Pia has to be quiet. This results in Pia speaking for the first time and saying and then shouting 'no'. Lutz-Hochreutener repeats this game and 'no' is used many times with more words following in subsequent sessions. This sensitive, intuitive use of playful provocation appeared to be key in the development of speech.

Katz (2002) intuitively develops rapport and breaks the silence with her client by offering to look inside the piano. Being able to use intuition and then follow the client's lead created a space in which confident speech was developed. However,

playing football becomes the dominant medium of the therapy and Katz reflects that the loss of music, particularly when she is shouted at to be silent, is a form of projective identification. Sometimes it is important to understand how it feels to lose our main means of self-expression in order to understand Selective Mutism.

Sekeles (1996) appears to embrace aspects of drama and play therapy as part of her approach. The therapy follows dramatic 'jungle', 'recording studio' and 'royal palace' phases, which represent a psychoanalytical working through of anxieties and family issues.

Working in a therapeutic nursery, Monti (1985) affords play a central role in her approach to Music Therapy, describing the function of play as relieving anxiety, experimenting with reality and mastering skills. These functions all seem particularly pertinent in helping a child with SM. Monti cites Winnicott's (1971) 'facilitating environment' for play as providing a theoretical model for the role of Music Therapy.

Seidl (1995) describes the use of playful structures such as copying the other person's beat then swapping roles and leading. 'Faye' particularly enjoyed it when Seidl pretended to get behind her beat and she laughed out loud. Similarly, Vogel (2009) hoped that her fearful, anxious client would become more silly and playful, releasing tension through engaging in humorous rhythmic games.

2.5.5.6 Risk taking/ craziness/ spontaneity.

Therapeutic play can help facilitate spontaneous acts and risk taking which seems invaluable in the therapeutic process for some clients with SM. Katz (2002) describes the importance of safely letting go into 'chaos and vitality' through a game of football that quickly results in speech. Mahns (2003) states that 'responding to the spontaneous, unplanned and unforeseen' is the special value of Music Therapy, allowing 'Osman' to jump from cupboards and light matches in the therapy room. These risk-taking activities are seen an important part of the therapeutic journey and part of the developing trust between the client and therapist.

Seidl (1995) describes 'Faye's' brief ability to speak when she gets stuck inside her own coat. This speech continues when her father is in the room at the end of the session but then stops in subsequent sessions. However, it is in Faye's exuberant

physical behaviour, cartwheels, dancing and spinning that there seems to be an element of spontaneity and freedom that has potential to move towards speech.

Davies and Mitchell (1990) state how important it can be to 'take risks' within the safety of the therapeutic environment in order to explore significant relationships. Sekeles (1996) describes 'dancing to stimulate spontaneous movement' as being helpful. Vogel (2009) shows how progress is made with Anne laughing out loud when there is an 'unexpected, fun, rude sound' on the keyboard.

Spontaneity and intuition on the part of the therapist are also important for Von Moreau's playful mole (2008) and Katz' looking inside of the piano (2002). Sekeles (1996) and Lutz Hochreutener (1998) also tell their clients that they have to be quiet which appears unusual or risky but provides the provocation which results in speech.

2.5.6 Oral instruments, microphones, vocal sounds

Oral instruments emerge in the practice literature as a key resource for supporting the active use of the voice. Many studies show a clear understanding of this process (Von Moreau 2008, Johns 1986, Amir 2005, Trondalen 2001) whilst other studies simply describe the use of oral instruments as part of the case study narrative.

Von Moreau (2008) states the importance of oral instruments, placing 'blowing' instruments near the 'mole holes' in her game and describing the 'musical dialogue, vocal exchanges and language' that follow. The subsequent group therapy process uses kazoos, a Jew's harp and pan pipes alongside humour and laughter to develop vocal confidence. Additional vocal ideas such as blowing raspberries, games with microphones and made up languages were also part of the group activities.

Amir (2005) describes how oral instruments and playful vocal experimentation offers a healthy 're-experiencing' of early oral development. The physical component is emphasised suggesting that wind instruments can prepare for the voice to be released by using and strengthening the mouth muscles. 'Shiran' uses a slide whistle and kazoo prior to a pivotal therapy session in which she screams out loud. After this point Shiran slowly progresses through humming, singing and finally speaking in the sessions.

Johns (1986) provides a succinct depiction of 'Tamara's' path into speech. After relaxation exercises she uses oral instruments requiring increasing amounts of breath such as the 'duck call'. 'Tamara' then manages to sing through a kazoo, a

microphone and eventually shouts out of the window “listen to me!” Her speech is then carefully generalised back into the classroom setting.

Bird calls and kazoos also feature in Trondalen (2001) prior to the development of whispering, singing and finally spoken language. Lutz-Hochreutener (1998), Katz (2002) and Mahns (2003) describe how the voice is gradually developed within the sessions but don’t mention oral instruments except for Lutz-Hochreutener’s trumpet which she pretends to play the wrong way round. ‘Pia’ laughs and later makes animal noises such as a horse snorting and a ‘silent scream’.

In Katz (2002) the vocal path into speech is very clear. Laughter (see above) is followed by ‘scary’ vocal sounds to surprise the therapist when entering the room, vocal sounds to accompany the football game and then word sounds such as “boo” to make the therapist jump. Whispering, speaking and shouting all follow in relation to the football game.

Similarly to ‘Adam’ above, ‘Osman’ (Mahns 2003) directs a range of vocal activities on his path into speech which the therapist follows and supports. This begins with using the microphones in the sessions and continues with the therapist following Osman outside the school where he examines a rubbish heap and whispers the names of different objects. Osman instinctively initiates behavioural techniques, using a space where he feels less pressure to speak, -outside the school- and undertaking a speaking activity which is easier to perform than free speech -naming objects-. In a later session Osman uses telephones in different rooms to speak to the therapist, which is a ‘desensitisation’ technique. In the final sessions he gives loud orders to a friend in the room and sings.

Ala-Ruona’s 17 year old client (2014) speaks first through discussions about music as this topic is a particular interest for the client. Later, microphones help the client use singing to further develop her confidence and musical identity.

Schulz (2011) describes Orff Music Therapy and a step by step use of ‘provocation’ to elicit vocal sounds and speech with a child with SM. This approach appears closer to speech and language therapy with musical elements added in the form of a Hello song and Goodbye music at the piano. Techniques include the use of vocal warm up exercises and a marble run game to encourage specific words and sounds. Although the therapy is described as sensitive there are ‘increasing demands’ on the client to

speak, with questions repeated several times. Shultz shows awareness of the effect of these demands and describes how choices may be given to ease this speech. The client responds positively to this intervention with increased speech in the therapy sessions. However, elements of conventional Music Therapy such as the use of musical sounds, oral instruments and freedom of expression that can be invaluable for a client with SM are absent.

2.5.7 Theoretical approaches

10 studies state a formal Music Therapy approach. Of these studies, 3 state that they use a Psychodynamic approach (Davies and Mitchell 1990; Whelan 2007; Katz 2002). Other stated approaches are: Psychodynamic and eclectic (Ala Ruona 2014); Psychoanalytic (Von Moreau 2008); Analytical Music Therapy (Mahns 2003); Music Psychotherapy (Amir 2005); Developmental Integrative Therapy (Sekeles 1996) and Orff Music Therapy (Schultz 2011).

5 studies stated a specific therapy approach in the case study that may have been part of a broader approach. These were: play based (Monti 1985); experimental (Seidl 1995); object relations (Trondalen 2001); being with (Aigen 1990); contact and awareness (Johns 1986). 3 studies did not state a specific approach but it could be inferred from the descriptions of the therapy. These were: Psychodynamic (Lutz-Hochreutener 1998, Vogel 2009) and Behavioural (Castellano 1970).

2 studies adopt elements of behavioural approaches (1.8.4). In Mahns (2003) behavioural techniques are initiated by the client and supported by the therapist. Johns (1986) uses a ‘generalisation’ technique that is used to help the client speak to more people.

2.6 Comparison to theoretical framework

The external validity of the theoretical framework under examination in this study was tested by comparing it to see if it broadly matched with the evidence described above. Reasons for any perceived mismatching are reported and explored to see if revision of the theoretical framework is required.

Themes and features from the studies were placed on the framework with an indication of the importance of the topic throughout the literature. It was found that topics were balanced quite evenly across the framework without any mismatching.

However, interesting therapeutic detail regarding particular features such as ‘protective layers’ may warrant deeper exploration. The features were also often relevant to more than one aspect of the framework and this was indicated on the diagram with arrows. Arrows were also used to suggest possible changes to the stages of the therapy process along the top of the diagram. Some new themes such as a ‘history of misunderstanding’ did not have an obvious location and so were placed on the left-hand side of the framework as a potential location.

Figure 2.1 Themes from Music Therapy case study literature placed on theoretical framework

History of misunderstanding.	**Therapeutic process** **Parallel layers of communication**	**1. Offering a potential space** Amount of sessions per week Facilitating environment (Monti)	**2. Manifesting anxiety – having it contained and processed** Mole holes. Tents, caves, mics, sunglasses, blindfolds	**3. Gradual build-up of trust and contact through listening and accepting – 'no pressure approach'** Humour & laughter Clown. Tickling	**4. Gradual development of shared, meaningful communication and 'playing'** Playfulness & play Provocation, teasing Animals Games Structures	**5. Need to end therapy – healthy, confident separation**
Need to ground MT practice in recent research	**a) Musical**	Self-expression. Musical voice first. A musical bridge (Mahns & Aigen) **Musical conversations – parallels spoken conversations – 'sliding in'** Loud powerful playing. Screaming. Aggression. Blistered hands. Forceful. Powerful. Risk-taking craziness and **spontaneity** **Oral instruments Kazoos. Bird calls. Microphones and vocal sounds. Scary sounds. Boo.**				
and look outside of the MT box	**b) Physical**	Links to space Cartwheels. Football. Jumping off cupboards. –stimulating spontaneous movement Doors, barricades, inside/underneath the piano. Barriers partitions **Control and expression in the physical realm lead to control of the voice** Relaxation through body activities. Dance. Swaying.				
Recording and consent	**c) Emotional/ social**	Made up language **Therapeutic relationship parallels mother/ infant interaction = emotional/ social communication** (I think that this perhaps should be underneath the musical layer so that connections can be more easily made and physical at the top to link to the physical space etc)				

2.7 Conclusion

In summary, Music Therapy literature describing treatment of clients with SM is limited to case studies with very few constituting true case study research. They outline a broad range of presentations in which clients are predominantly younger children. Music Therapy provision could be brief or extended with evidence of some outmoded contemporaneous ideas about SM informing the therapy. Rich descriptions of the therapy narratives provide detail on therapeutic phenomena such as loud playing and the role of oral instruments. The literature is useful in confirming the validity of the framework and adding further detail to aspects of the therapeutic process.

Chapter 3 - Methodology

Chapter 2 highlighted a gap in the literature on Music Therapy and Selective Mutism which this study aims to address. My main research question is:

> Does a theoretical framework, developed in single-case study research, explain the process of Music Therapy across a number of cases of children with SM?

Chapter 3 describes the methodology for this study. I summarise basic epistemological concepts that are important to consider in planning any research study and explore their relevance for this investigation. Third paradigm approaches are outlined and the stance for this study established.

3.1 Prior research

This PhD study builds on prior research and aims to evaluate the theoretical framework from my MA investigation for the use of Music Therapy in the treatment of SM in young children (1.10). I aim to address more fully, with contextual breadth and deep analysis of the Music Therapy processes, the question of the application and potential usefulness of Music Therapy for children with Selective Mutism. Because this PhD study is both developing and testing theory, a method is needed that blends inductive and deductive approaches and which uses new data to critique or support and enrich the theoretical framework. The original framework will have a dual function as both an analytical tool for processing data sets and as the focus for theory evaluation and development.

3.2 Ontology, Epistemology and Paradigms

Ontology is the theory of being and existence. Our epistemology is our philosophical position on knowledge; what we believe it is possible to know and how we can know it. A paradigm is our viewpoint on the world and our research paradigms are often positioned on an epistemological spectrum between positivism and interpretivism or constructivism (Sommer Harrits 2011; Tashakkorie and Teddlie 2010). For this inquiry it is important to explore and describe specific research paradigms in order to help define the stance for this investigation. Below I consider in turn the main research paradigms and their appropriateness for addressing my research question.

3.2.1 Positivism

Positivism is the assumption that reality is out there and knowable, and that you simply need the tools to be able to discover that knowledge. It also assumes that it is possible to take an independent, objective view on the subject matter we are studying. Auguste Comte was the first philosopher to define a positivist epistemology in his series of literary texts between 1830 and1842 (translated Martineau 1853). Positivist research is usually associated with quantitative methods such as Randomised Controlled Trials (RCT) which determine the efficacy of an intervention in highly controlled experimental settings. This is often considered the gold standard in health science research. Over the last 20 years there has been an increase in the use of RCTs of Music Therapy for children with a variety of needs such as anxiety disorders (Goldbeck and Ellerkamp, 2012) and emotional neglect (Jacobsen et al., 2014). RCTs have also been used in Music Therapy research for patients with depression (Erkkila et al., 2011), dementia (Ridder et al., 2013) and schizophrenia (Ulrich, Houtmans and Gold, 2007) amongst others.

Ultimately quantitative research in the form of an RCT would be needed to test the hypothesis that Music Therapy helps children with Selective Mutism, but there is not currently a fully evaluated framework from which to derive a hypothesis to test with this population. Therefore this study aims to collect and evaluate data in order to develop and articulate knowledge about Music Therapy and SM which will contribute to a rationale for larger RCT trials.

3.2.2 Post-positivism

Post-positivism critiques the notion of absolute truth and believes instead that our perceptions of truth evolve and are continually revised and modified. However, like positivism it does hold with the existence of a ‘mind independent’ reality that we are able to get closer to and know imperfectly through research. Post-positivism is mainly associated with quantitative research methods (Bradt, Burns and Creswell 2013) which are located in naturalistic, real world rather than laboratory settings (Cohen 1993; Cohen 2016). Pragmatic RCTs measure effectiveness and take context into consideration (Streiner 2002). Funded health research RCTs on complex interventions now typically include qualitative questions to help unpack the ‘active ingredients’ of the intervention (MRC 2006). In this study identifying and refining

the ‘active ingredients’ is the main focus. A future RCT of Music Therapy for children with Selective Mutism would, however, also need to include consideration of the setting in which therapy is delivered.

3.2.3 Interpretivism

Interpretivism is the belief that knowledge is influenced and shaped by our perspective and understanding of the world. Baker and Young (2016) have since described interpretivist research as providing ‘rich descriptions of Music Therapy practice as it occurs in real-world contexts’ (p106). My single case study of Music Therapy with a child with Selective Mutism, undertaken explicitly from the perspective of ‘being a music therapist’ could be described as interpretative research (Jones 2012) as could Rolvsjord’s multiple case study investigating clients’ perspectives on their agency and involvement in Music Therapy (Rolvsjord 2015). Both of these studies also embrace a qualitative approach.

In this study I am mainly testing the utility of a theoretical framework against different data sets and case studies rather than only exploring my own and other writers’ perspectives on Music Therapy and Selective Mutism. However, there is a distinct interpretative aspect to some of the research questions within the survey and interviews which are used to explore other Music Therapists’ experiences of undertaking therapy with people with SM.

3.2.4 Constructivism

Constructivism is the belief that reality is constructed by humans as they engage with the world they are interpreting (Bradt, Burns and Creswell 2013). Constructivists suggest there is no objective reality as reality is always influenced by a person’s values and social context. Interpretations and understandings of reality are multifarious and research should aim to investigate this complexity. The constructivist paradigm is again mainly associated with qualitative research methods. O’Callaghan (2009) highlights the relevance of a constructivist approach for investigating the experience of Music Therapy for cancer patients in palliative care. She found investigating and interpreting many different perspectives was key to developing an understanding that could be generalised to patients in similar situations.

While it could be argued that through developing a theoretical framework this study is offering a 'construction' of Music Therapy and Selective Mutism, I am not primarily concerned with exploring children's understandings of their therapy experience. The focus will be a more pragmatic investigation into the use of Music Therapy to help children with SM.

3.2.5 3rd paradigm research

In the past there has been much debate around the 'paradigm wars' or 'false dualism' that existed between the positivist and interpretivist, and quantitative and qualitative schools of research (Bryman 2006, Badley 2003). However, 'paradigm peace' has now allegedly been declared and some researchers suggest that the debate between qualitative and quantitative approaches is a technical research question (Bryman 2006) and that we no longer need to stick to 'methodological orthodoxy' (Glogowska 2011). Bradt, Burns and Creswell (2013) suggest that paradigms can shift within a study according to the procedures and phases of the research. Multiple philosophical stances and approaches may be incorporated within this 3rd paradigm (Onwuegbuzie 2012). Having explored the potential relevance of different research paradigms, aspects of all of which had some utility, it is helpful to now consider third paradigm approaches. The main tenets of realist evaluation, critical realism and pragmatism are discussed in consolidating the design for this study.

Realist evaluation

Realist evaluation sits within the 3rd paradigm. Its aims are mainly concerned with improving aspects of our lives and inequalities within society. Realist research interrogates and evaluates a vision for change through an intervention or 'programme' to improve society (Pawson and Tilley 2004).'Programmes' are sophisticated social interactions set amidst a complex social reality. Realist evaluation has four main distinguishing features:

1. a plan or theory;
2. an intervention or programme that is 'embedded' in society and evaluated as such within its wider context.
3. it is 'active'- meaning that the intervention or programme requires the active interpretation and engagement of individuals.

4. It is open and responsive to change.

Four linked concepts are key to realist evaluation and these are the context mechanism outcome configuration or CMOC. The CMOC is analogous to a recipe where different ingredients need to be blended to suit the specific consumers. A realist evaluation of an intervention programme for Music Therapy for children with SM would be highly valuable in terms of addressing the wider systems around the Music Therapy provision that impact on the outcome of the therapy such as the relationships with children's services, school staff teams and parents. However, at this stage I am primarily concerned with unpacking the components of the Music Therapy process itself rather than the mechanisms of its implementation as an intervention.

Critical realism

Bhaskar's 'A Realist theory of science' (1975) became the foundation of the critical realist movement. His philosophy was concerned with the nature of reality and what it must be like in order for science to be possible. Clark and colleagues describe the relevance of Bhaskar's critical realism in relation to research in nursing practice (Clark, Lissel and Davis 2008), a practice underpinned by both natural science and the key role of human relationships. They outline how Bhaskar criticized both positivism and relativism and posited a middle ground in which a 'mind independent' reality can be 'fallably known' by humans through observation or research and that things exist whether or not they are known or recognised by individual humans. He criticized the interpretivist perspective that ontology and epistemology are one and the same as being 'an epistemic fallacy', maintaining that these two aspects are crucially different.

Bhaskar defined reality as having 3 domains of 'the real', 'the actual' and 'the empirical' (Clark, Lissel and Davis 2008, Parr 2013). Our experience of the world is 'the empirical' domain and this may or may not include experience of 'the actual' which are the events and actions that are likely to be observed. These events are driven by underlying mechanisms or causal powers which constitute 'the real'. Social science informed by this philosophy is concerned with how these 'real' mechanisms create our lived experience. Bhaskar suggests that through our research efforts we are able to gain insight into our 'partially patterned' world (Clark, Lissel

and Davis 2008). To be 'partially patterned' means that our perceptions and attempts to understand reality are always imperfect and limited and that a theory that fits for most things will always have exceptions and require revision.

A critical realist approach is helpful for this study as it is investigating and hoping to explain a causal relationship between a specific human issue, Selective Mutism, and a potentially helpful intervention, namely Music Therapy, and the mechanisms that underpin this relationship (Parr 2013). Critical realist research tends to use qualitative methods to investigate complex relationships and processes within complex, 'open systems' contexts where real world environments may change and affect the investigation (Clark, Lissel and Davis 2008). In this study I am also paying close attention to the context surrounding this phenomenon, since SM literature highlights the influence of the environment around the child (Johnson and Wintgens 2001).

Pragmatism

A pragmatic approach to research challenges the notion that it should fit either a positivist or constructivist paradigm. Pragmatism suggests that research requires different tools to investigate different aspects of the world (Badley 2003). In his article on educational research Badley suggests that pragmatism offers a way forward as a 'working point of view', but that this 'fuzzy perspective' does not make specific claims or offer specific outcomes but instead provides 'possible lines of action' and is always self-reflective. Pragmatist researchers do not view truth and knowledge as an independent reality waiting to be discovered but more as a consensus constructed by a community of inquirers that requires constant reappraisal (Badley 2003).

A pragmatist philosophy is similar to realist evaluation and critical realism in its aims of social improvement, greater happiness and a utopian future (Cherryholmes 1998, Badley 2003). Many researchers now use a 'pragmatic' approach and methodological pluralism when choosing the most appropriate methods to answer their research question (Barbour 1999, Glogowska 2011). This pragmatist philosophy often underpins a 'mixed methods' approach which uses both qualitative and quantitative methods (Bradt, Burns and Creswell 2013, Bryman 2006) or a 'toolkit approach' (Ritchie and Lewis 2003). As such, pragmatism is particularly relevant for this study

in supporting the use of different research methods to answer a logical sequence of questions.

3.3 Study Methodology

3.3.1 Epistemological stance

The main aim of this study is to evaluate a theoretical framework for the use of Music Therapy for foundation stage children with Selective Mutism. The implication of this is that there may be a 'usefulness' to the research that improves outcomes for children with Selective Mutism through the use of Music Therapy as an intervention. As a researcher I also have a sense that there is more information or data about this phenomenon or aspect of reality that is 'out there' but that needs to be gathered together to form a comprehensive and cohesive argument or thesis.

This research epistemology does not fall neatly into a positivist or interpretivist paradigm but sits firmly within third paradigm research, blending a critical realist philosophy (Bhaskar 1975) with a pragmatic methodological approach (Badley 2003, Bryman 2006, Glogowska 2011).

I share the critical realists' philosophy of a 'mind independent reality' that can be fallibly known rather than reality being a human construction and this perspective shapes aspects of the research design. A critical realist approach is also helpful for this study in that it is concerned with the power of human agency to change and improve society (Clark and Lissel 2008). The study is also investigating a complex topic where understanding and explanation is not straightforward and formulaic (Clark and Lissel 2008).

Pragmatism is perhaps the most relevant approach for this study as it thoroughly embraces a 'tool-kit', pluralist methodology using a variety of methods to suit specific research questions (Ritchie and Lewis 2003). A philosophical and epistemological position for critical realism within pragmatic mixed methods research is explored in depth by Maxwell and Mittapalli (2010) who state that:

> 'critical realism retains an ontological realism while accepting a form of epistemological relativism or constructivism' (2010 p 9).

I accept that my view of the topic under investigation is inextricably bound to my interpretive perspective as a Music Therapist and that it will therefore necessarily be

limited. I hope that this study will provide a helpful contribution to knowledge on the topic of Music Therapy and Selective Mutism but acknowledge that it is just one piece of the puzzle and an accumulation of ideas that form part of a wider, evolving reality. Therefore I feel that it is not incongruent to have both a critical realist view of reality and a pragmatic approach to research.

3.3.2 Mixed Methods research

Mixed methods designs allow the researcher to explore a complex phenomenon from multiple perspectives in order to produce a more complete story (Burns and Masko 2016). Tashakkori and Teddlie (2010) describe the nine characteristics of Mixed Methods Research as being:

1. Methodological eclecticism
2. Paradigm pluralism
3. Diversity at all levels of the research enterprise, from the broader, more conceptual dimensions to diversity in the range of confirmatory or exploratory questions asked
4. Continua or a range of methodological options rather than 'either-or' dichotomies
5. An iterative, cyclical approach using deductive and inductive logic
6. A focus on the research question in determining methods
7. 'Signature' qualitative - quantitative designs (alongside acceptance that the mixed methods community is still emergent and not yet ready for a design consensus)
8. A tendency towards balance and compromise in the 3rd methodological community.
9. A reliance on visual representation such as figures and diagrams.

Mixed methods have been employed to evaluate Music Therapy interventions for a range of populations. McFerran, Roberts and O'Grady (2010) used questionnaires and small focus group interviews to investigate the impact of Music Therapy with groups of bereaved teenagers. An exploratory randomised controlled trial with additional content analysis and patient interviews was utilised by Carr et al. (2011) to

assess the feasibility of group Music Therapy for people with persistent post-traumatic stress disorder.

This study predominantly employs qualitative methods with one quantitative method embedded within the research design (Burns, Bradt and Creswell 2013). The study uses a multiphase mixed methods design whereby each new phase builds on what was learned previously to address a central objective (Creswell and Plano Clark 2011). These phases may be concurrent or, as in this study, sequential. The methods employed all test the existing framework by analysing each data set and revealing ideas and themes that critique or expand the theoretical framework.

3.3.3 Synthesising multiple data sets using template analysis

In chapter one, a broad range of research questions were identified that will require different methods to address. Employing a mixed methods research design necessitates synthesising the various data sets. In this study a form of thematic analysis (Braun and Clarke 2006; Boyatzis 1998) called template analysis (King 2012, Brooks et al., 2015) is used as a tool to interrogate, interpret and integrate multiple data sets. Template analysis deliberately blends inductive and deductive methods to create a hybrid (Fereday and Muir-Cochrane 2006) or abductive approach (Burns and Masko 2016). It is therefore useful to briefly define inductive, deductive and abductive analysis.

Inductive analysis- this is a methodological approach where the analysis is driven by the data. This is also referred to as a 'bottom up' approach.

Deductive analysis- this is research that is driven by the researchers theoretical or analytical interest. It can also be called theoretical analysis.

Abductive analysis- moves between inductive and deductive reasoning in order to build theory.

Template analysis (TA) has particular utility for this study as it consciously foregrounds the role of prior knowledge, theory or ideas as a guide in the research. In TA a coding frame or template is created from an initial list of themes developed from the data. This coding template becomes the main tool in the analysis process but should evolve and allow for multiple revisions to encompass new themes emerging from the data. Brooks et al. 2015, describe a process of template analysis as having 6 stages:

1. Familiarisation with the data
2. Preliminary coding of the data
3. Organising themes into meaningful clusters
4. Define an initial coding framework
5. Apply the framework to further data and modify as necessary
6. Finalize the framework and apply it to the full data set.

However, in this study stage 1-4 have been completed through prior research (Jones 2012) and we already have a theoretical framework that provides the coding template for the analysis of the data sets. Therefore the steps of template analysis that will be applied in each stage of this study are:

1. Creating a framework (achieved)
2. Coding the data
    a- Familiarisation with the data
    b- Generating initial codes
    c- Identifying themes
    d- Reviewing themes
    e- Placing the themes on the Theoretical Framework
    f- Noting where themes do not fit.
    g- Identifying potential modifications to the Theoretical Framework
3. Repetition of the coding process for each data set.
4. Interpreting and integrating the data sets in a meaningful redevelopment of the Theoretical Framework.

The theoretical framework[2] is a point of both collection and connection between contextual data (chapter two -literature review, chapter four –survey, and chapter five- interviews) and the main data of the multiple case studies (chapters seven and eight) towards which the analysis will be weighted. It is also the vehicle for theory

[2] The term 'theoretical framework' is used throughout the thesis to mean the original theoretical framework from the MA single case study research

development. A modified version of this analysis method is applied to each stage of the research process and described in detail at the beginning of chapters four, five and six.

3.3.4 Methods

As this study is using multiple methods, rather than presenting the operational methods for each stage of the research process- survey, interviews and case studies- in this section of the thesis, methods for each chapter will be described at the beginnings of chapters four, five and six respectively. This is so that the method and results for each stage remain together for ease of reading. The template analysis (3.3.3) is the process through which the different data sets are compared and finally synthesised in chapter nine.

3.4 Conclusion

This chapter appraises a range of research paradigms and selects a pragmatic third paradigm approach as the most appropriate for this study. Following a pragmatic approach, multiple methods will be employed reflecting the range of research questions to be addressed. Template analysis will be used to analyse and synthesise the various data sets in order to critique and refine the theoretical framework. The specific methods for each stage of the research will be introduced at the beginning of relevant chapters.

Chapter 4 - Survey of UK Music Therapists

4.1 Background

This chapter builds on the review of Music Therapy and SM literature by asking the question: Has Music Therapy been used as a treatment for people with Selective Mutism in the UK? A range of different methods were considered including interviews and focus groups but as there was no definitive information about MTs practising in this area it was decided that a survey was the best initial method. If a significant amount of Music Therapy practice was found through the survey then MTs engaged in this work would be asked to participate in a semi-structured interview (5.3.2).

Surveys have been used extensively within the Music Therapy profession to gain descriptive statistics on a range of topics such as the use of Music Technology (Hahna, Hadley and Miller 2012), song-writing practice (Jones 2006) and Music Therapy education (Wheeler 2000, Gardstom & Jackson 2011). They have also been used to investigate specific clinical areas such as adult mental health (Odell-Miller 2007) hospice work (Hodkinson, Bunt & Daykin 2014) and Autism Spectrum Disorder (Kern et al 2013). Wigram (2005) describes how surveys can provide part of a hierarchy of evidence and explains the potential function of surveys to: provide descriptive statistics; explore clinical activity, attitudes and perceptions; investigate the potential of MT for a specific population; provide supportive evidence to underpin the future deployment of MT services. These are all key functions that this survey aims to elicit and explore.

4.2 Survey rationale and aims

Informal discussions with Music Therapy peers and insight from the Music Therapy literature review (Chapter 2) suggested that there may be a wealth of knowledge about UK Music Therapists providing interventions for people with SM, which could be gathered and systematically analysed and categorised. The survey is designed to elicit comprehensive data evidencing and exploring the practice of Music Therapy for people with SM. Although the main research investigation is concerned with early intervention for young children with SM, the survey asks questions about the wider SM population. This is a similar approach to the Music Therapy literature review in chapter 2 and allows the inclusion of adolescents and adults with SM and

clients with complex or comorbid diagnoses. The aim of this approach is to maximise the opportunity to begin to develop a broad, rich evidence base and map out a clinical area that is little described in the Music Therapy literature. It also provides further understanding of how early years work fits within this broader context.

The main aims of the survey are to find out:

- If Music Therapy is/ has been used as an intervention for SM in the UK and for whom?
- What are therapists' experience of this?
- How is it being used, what are the techniques and approaches?
- How does the Music Therapy process, as described by survey respondents, reflect the theoretical framework under scrutiny in this study?
- What was the impact of the therapy?

4.3 Survey method

4.3.1 Population

The population for the survey was all 835 therapists registered with the British Association for Music Therapy (BAMT) at the time of the survey (2014).

4.3.2 Survey questions

The questions were designed to elicit general information about Music Therapists' experience of this client group and then to focus on recent therapy practice (in the12 months prior to the survey), exploring the approaches and techniques employed within this clinical work. Questions were developed around the main aims as described above and moved from broad questions about the Music Therapist to specific questions about therapy practice and the relevance of the theoretical framework under scrutiny in this study. The survey begins with background questions about the therapist's career (Q1) and general levels of experience with various ages and presentations of people with SM (Q2). 'SM alone' is the term used throughout the chapter when discussing children presenting with SM and no other comorbid conditions. Other categories discussed cover a range of other comorbid conditions or presentations. The terms learning difficulties and learning disabilities

were used to differentiate between people with a specific learning difficulty or global learning disability.

Question 3 asks for further quantitative detail regarding the numbers of different clients with SM that the respondent has seen over the last 12 months. This is an attempt to explore the current picture of Music Therapy practice for people with all presentations of SM.

Questions 4 asks about the type of therapy (individual, pair, group or a combination), question 5 about the location of therapy and question 6 about the source of referral to Music Therapy.

Question 7 asks about the therapist's theoretical and general approach to therapy using an adapted version of categories developed by Odell-Miller (2007). The additional categories of interactive, systemic and medical were added to the original nine, acknowledging recent developments in Music Therapy thinking within children and family work. The medical category acknowledges the potential for Music Therapists to work alongside drug-based treatments and medical models which are more widely used in the US but also sometimes in the UK for people with SM.

Question 8 asks which techniques the respondents utilised in the sessions using a modified version of Odell-Miller's (2007) Music Therapy techniques. Odell-Miller's survey was originally designed for adult psychiatric services and so 'Receptive techniques using live music' was removed as this was unlikely to be available to a mainly school based clinical population. An 'other' category was added for respondents to specify additional techniques.

Question 9 aims to elicit detailed information about which instruments were important in the therapy sessions with clients with SM. The range of instruments given was designed to cover the broad range generally used in Music Therapy sessions but also to find out whether specific categories of instruments were useful. These categories were based on my prior case study research on Music Therapy and SM (Jones 2012). The categories of particular interest were oral instruments and large percussion. An 'other' category and comments box was provided to highlight any novel or interesting instruments and invite explanations about why particular instruments appeared important.

Question 10 builds on the information sought in question 9 and was concerned with the features and themes of the therapy. The categories were again based on my prior case study research experience (Jones 2012) with a specific focus on different aspects of vocalisation, volume, anxiety and the use of dance or physical movement.

Question 11 is designed to elicit specific information about the relevance of different elements of the theoretical framework under scrutiny in this study (see fig 1.1 in chapter 1). Respondents are requested to indicate whether these aspects are highly relevant, relevant or of low relevance for the different ages ranges as given in question 3.

Question 12 provides an opportunity to gather more detailed quantitative and qualitative information. Respondents are asked to indicate their agreement with the statement "In my experience Music Therapy has a positive effect on clients with SM" on a five point Likert scale. Respondents are also asked to indicate the outcomes for various age groups -as in Q3 and Q11- and the length of therapy for all age ranges. Finally, the respondents are asked to 'summarise the main therapeutic effect of Music Therapy for this client group'.

The survey questions use drop down menus to gain numerical information and comments boxes to offer opportunities for qualitative detail. The full set of questions as set out in the survey can be seen in Appendix 4.1.

Respondents were also asked if they would be willing to be interviewed about their clinical experience. Details of the interviews conducted can be found in the following chapter.

4.3.3 Data collection approach

The survey was designed and set up using Survey Monkey software (www.surveymonkey.com) and sent out via an emailed link to all registered members of BAMT by their administrative team. The email invited Music Therapists who had worked with people with SM to complete the survey and gave a description of SM (Appendix 4.2).

Reminders were sent to members one and two weeks after the original email. The survey opened in the middle of June 2014 and closed in the middle of July 2014. Data were stored and used in an anonymised form.

4.3.4 Analysis

Descriptive statistics from the survey were used to portray the clinical picture of UK Music Therapists working with people with SM. Where comments boxes were used to collect 'other' options in addition to existing categories, these are simply listed or summarised (Qs 7, 8, 10). Where open questions and comments boxes were used to elicit more in-depth responses to the questions of Music Therapy and SM (Qs 9, 11, 12) these are analysed using a modified form of template analysis (King 2012, Brooks et al., 2015). This version of Template Analysis adopts the original theoretical framework, created through prior research (Jones 2012), as the main template of comparison. The stages follow the process as described in chapter 3 (3.3.3) but include an additional content analysis. Open responses to question 12 (Appendix 4.1) were coded and sorted into similar groups that became categories. The number of times a category occurred was counted and placed on the Theoretical Framework. In the final discussion the results from both the structured and open questions will be explored in relation to the theoretical framework.

4.3.5 Ethical considerations

Potential risks for the survey are very low, however respondents should be informed about how the information about themselves and their clients will be used. The purpose of the survey was outlined in an email to BAMT members (Appendix 4.2). The first page of the survey explained that the data would be securely stored, analysed and reported anonymously (Appendix 4.1). Personally identifiable data, in this case emails, were stored separately from the survey data and linked to participant identifier codes. This information was used to follow up positive responses to the request for interviewees. Ethical approval for this study was given on 8th November 2013 by the Music and Performing Arts Departmental Research Ethics Panel at Anglia Ruskin University.

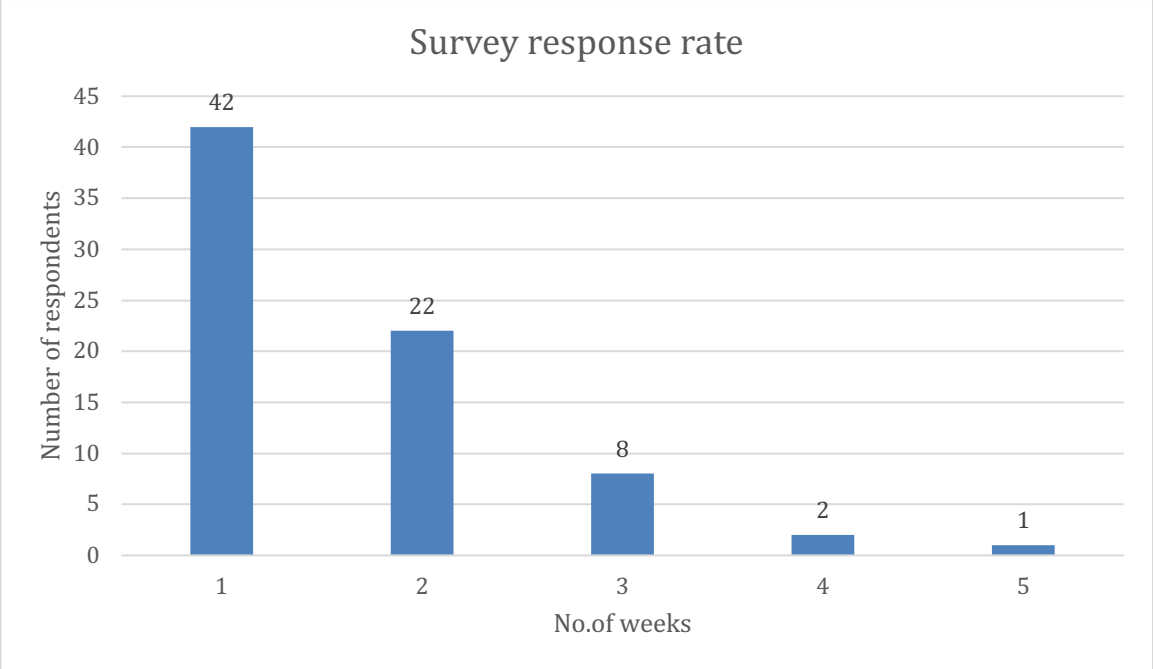
4.4 Results

4.4.1 Return rate

The survey was sent out to 835 members of BAMT. 75 members -approximately 9%- returned the survey (see figure 4.1 below). On the face of it this appears to be a low response rate, however, given that the survey was directed at Music Therapists that had worked with a specific clinical population we cannot surmise whether this

response was either high or low (i.e. many Music Therapists may not have worked with people with SM).

Figure 4.1 Survey response rate

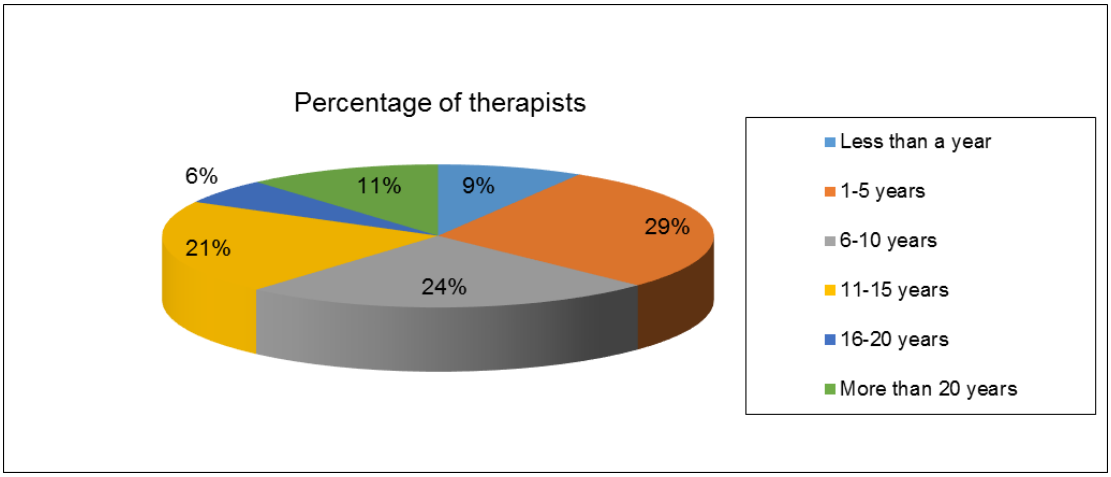


No. of responses = 75

4.4.2 Respondent characteristics

Q1 How many years have you been working as a Music Therapist?

Figure 4.2 Years working as a Music Therapist



No. of responses = 70

The number of years working as a Music Therapist was spread across the full range of options but with a concentration of responses between 1-15 years in work (83%).

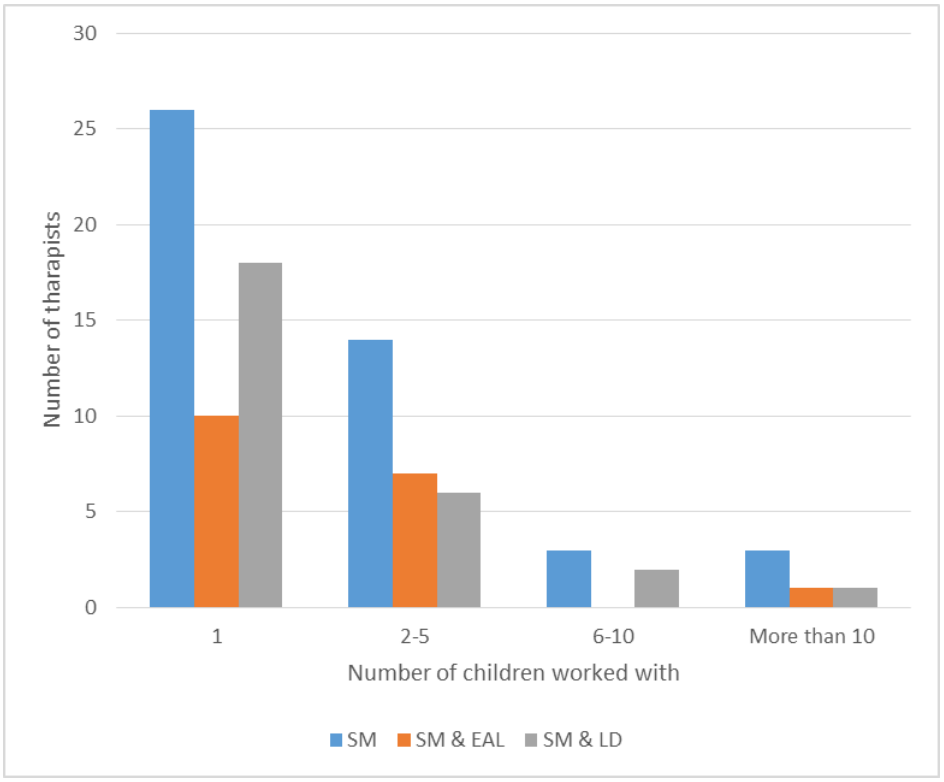
In the percentage response for each year of work there is a clear drop off in responses in the 15 year and above range. This could perhaps indicate an increased awareness of Selective Mutism among more recently qualified therapists but could also be partly due to the increasing numbers of Music Therapists practising in recent years.

Q2 Over your career as a Music Therapist, approximately how many children and adults with Selective Mutism have you worked with?

Responses to this question were broken down into broad categories to get a general overview of how many UK Music Therapists have worked with which types of presentations and ages of clients with SM over their whole career.

Respondents were able to tick different boxes to signify the number of clients within each presentation type they had worked with. Respondents gave 152 responses which indicates that some have worked across a number of different categories. Across all the separate categories the highest number of survey respondents have worked with children with SM alone (N=46).

Figure 4.3 Music Therapy over career as a Music Therapist with children with SM

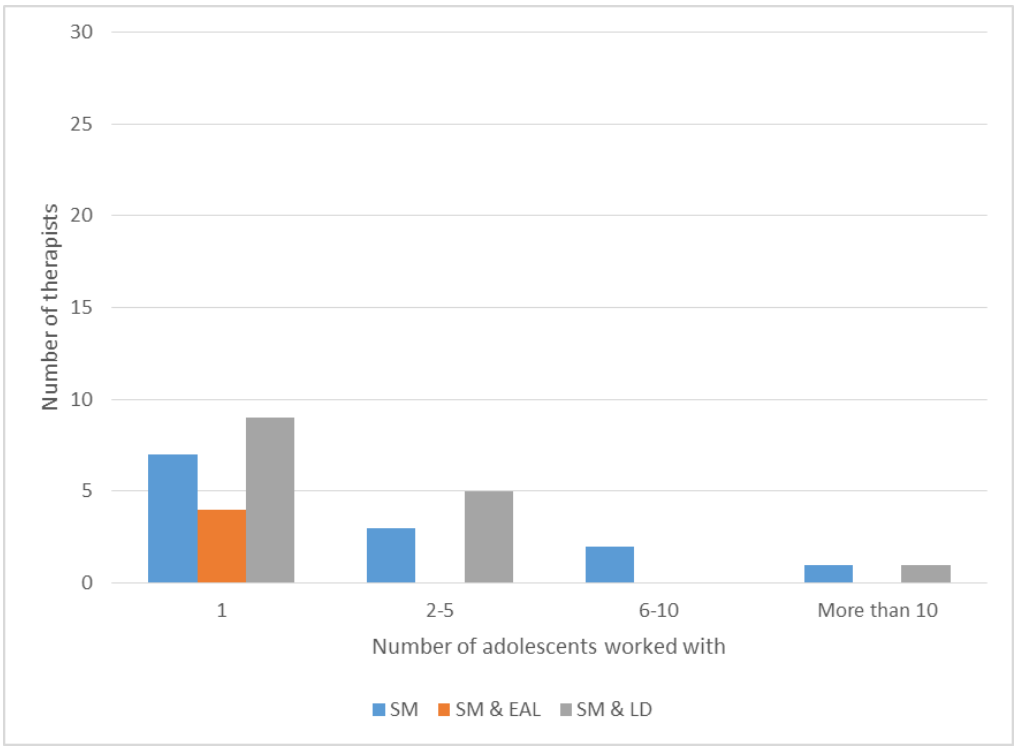


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LD - *Selective Mutism & Learning Disability*

No. of responses = 73

More respondents indicated that they have worked with more children with different presentations of SM (N=91) than adolescents (N=32) or adults (N=29) (see figures 4.4 and 4.5).

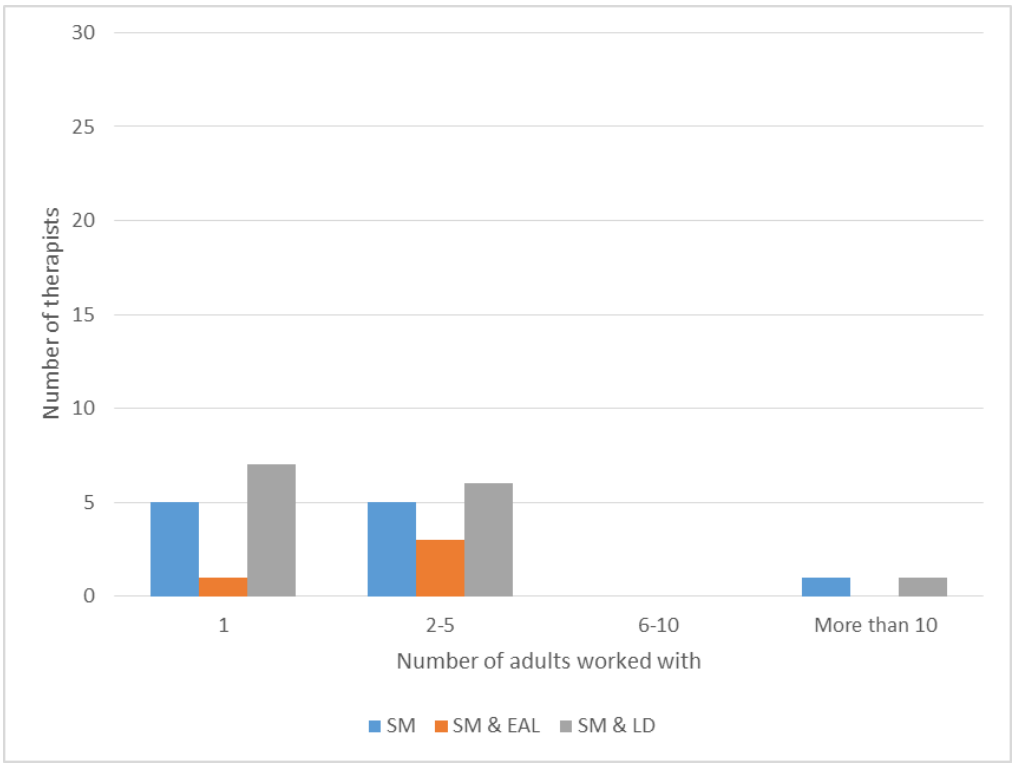
Figure 4.4 Music Therapy over career as Music Therapist with adolescents with SM



Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LD - *Selective Mutism & Learning Disability*

No. of responses = 73

Figure 4.5 Music Therapy over career as Music Therapist with adults with SM



Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LD - *Selective Mutism & Learning Disability*

No. of responses = 73

Respondents that had worked with people with English as an additional language were lower (N=24) but this remains a significant proportion of those respondents that answered this question (N=73) and an important aspect of work with SM clients.

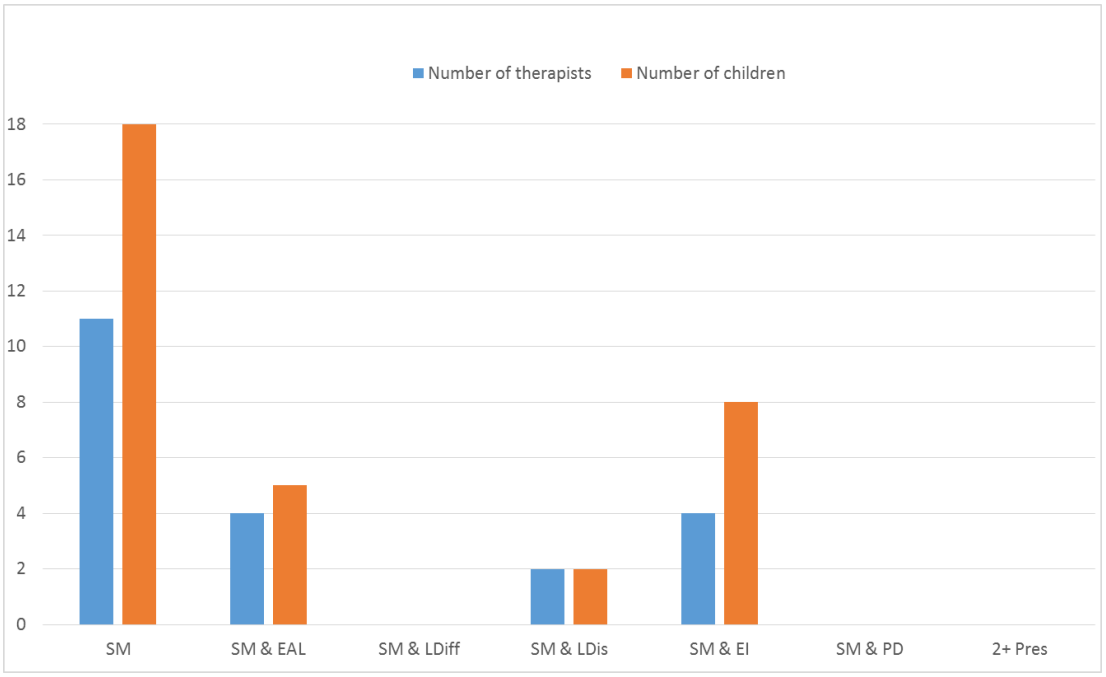
Across all age groups, most respondents have worked with people with SM on it's own (N=70), followed by SM and a learning disability (N=56).

4.4.3 Current practice data

Q3 Over the last 12 months, how many children or adults with Selective Mutism have you worked with?

46 people answered this question with 29 skipping it. Overall, the total number of people that respondents had worked with over the 12 months prior to the survey was 119.

Figure 4.6 Music Therapy in the previous 12 months with children aged 2-4 years with SM

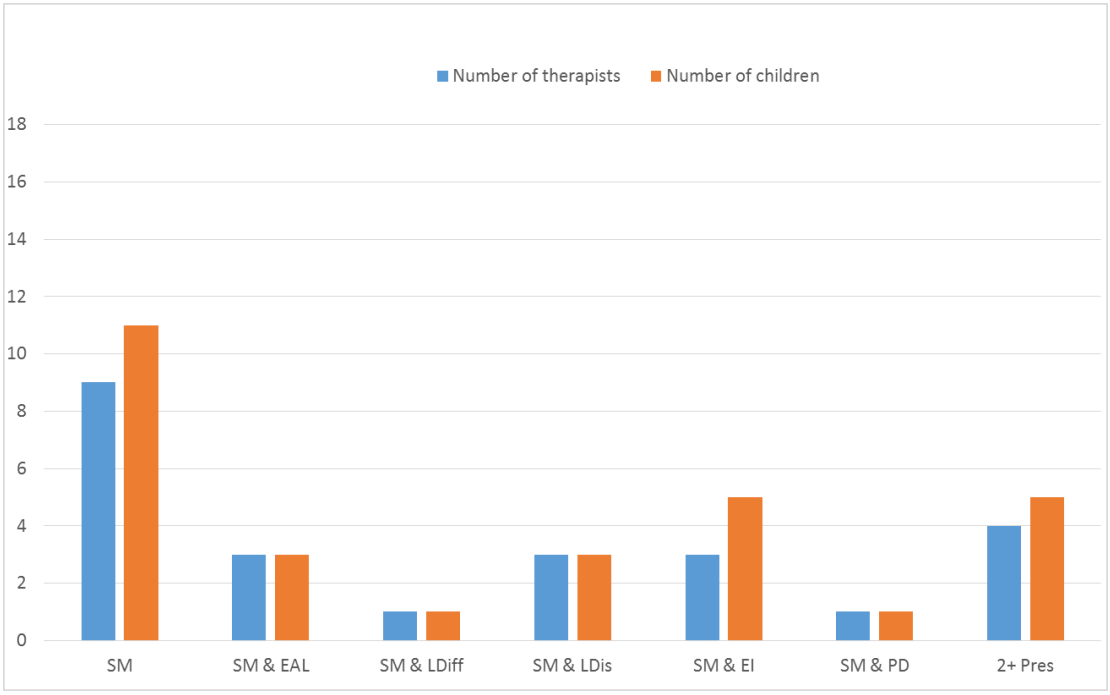


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

Respondents worked with 33 children in this age range over the 12 months prior to the survey (see figure x below). 11 respondents worked with 18 children with SM alone and 4 respondents worked with 8 children with SM and emotional issues with fewer responses to the other categories.

Figure 4.7 Music Therapy in the previous 12 months with children aged 5-7 with SM

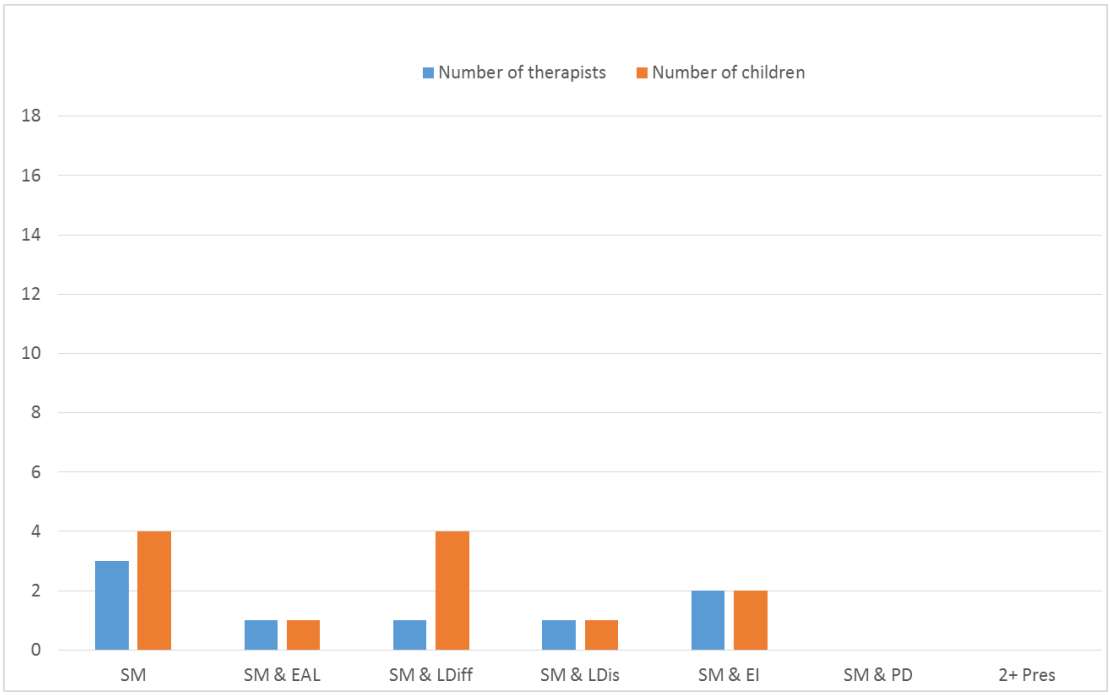


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

More respondents (9) worked with children with SM alone (11), with smaller numbers of therapists working with children in other categories. The total number of children in this age range is 29.

Figure 4.8 Music Therapy in the previous 12 months with children aged 8-10 with SM

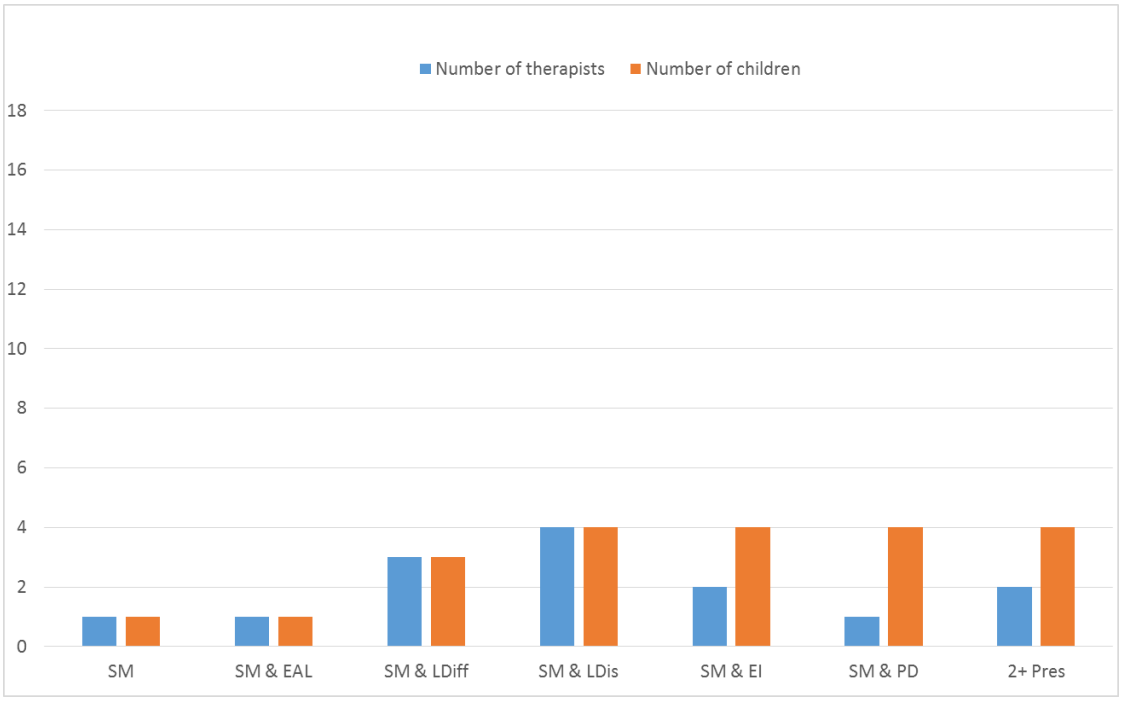


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

Three respondents worked with four children with SM alone, one respondent worked with four children with Selective Mutism and Learning Difficulties , with less in the other categories. Overall respondents worked with 12 children in this age range.

Figure 4.9 Music Therapy in the previous 12 months with children aged 11-13 with SM

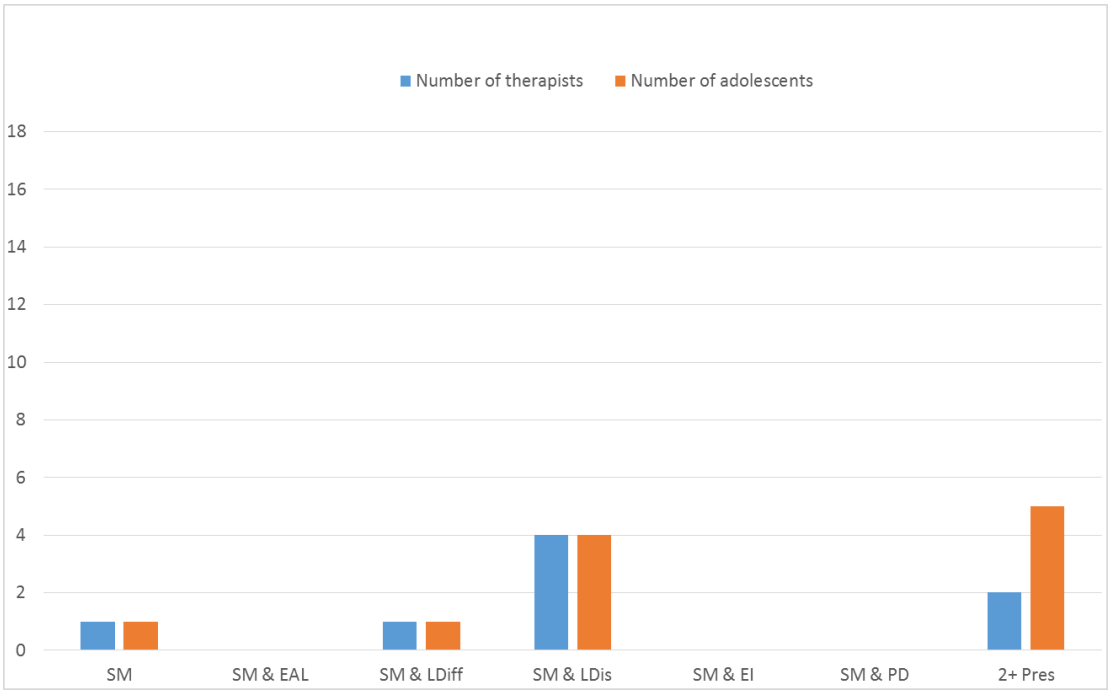


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

Overall respondents worked with 23 children in this age range. Respondents worked less with SM alone or SM with EAL and more with children with complex presentations or special educational needs and SM.

Figure 4.10 Music Therapy in the previous 12 months with adolescents aged 14-17 with SM

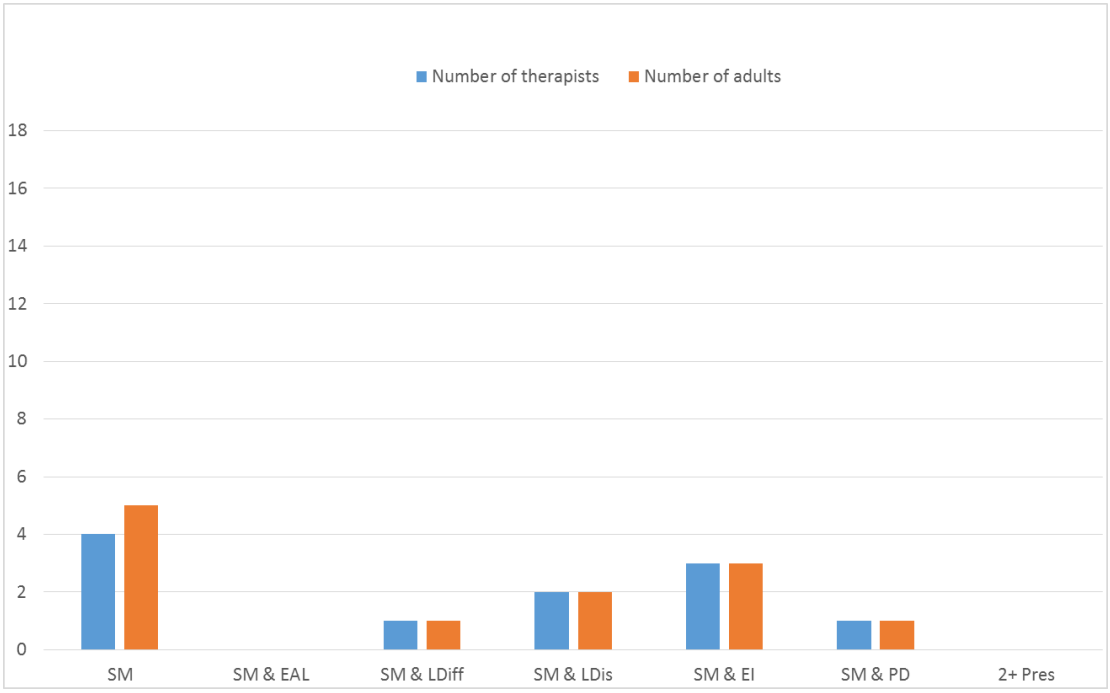


Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

One respondent worked with an adolescent with SM. One worked with an adolescent with SMLD. 4 respondents worked with 4 adolescents with SMLDis. 2 respondents worked with 5 adolescents with SM with complex presentations. Overall respondents worked with 11 adolescents in this age range.

Figure 4.11 Music Therapy in the previous 12 months with adults with SM



Key: SM – *Selective Mutism*; SM & EAL – *Selective Mutism & English as an Additional Language*; SM & LDiff - *Selective Mutism & Learning Difficulties*; SM & LDis - *Selective Mutism & Learning Disability*; SM & EI - *Selective Mutism & Emotional Issues*; SM & PD - *Selective Mutism & Physical Disability*; 2+ Pres – *Selective Mutism & two or more other presentations*

No. of responses = 46

4 respondents worked with adults with SM alone. One with a person with SMLD and 2 with 2 people with SMLDis. 3 respondents worked with 3 people with SM and emotional issues and one with a person with SM and physical disabilities. Overall respondents worked with 11 people in this category.

Characteristics of people receiving Music Therapy for SM

Table 4.1 Age ranges of people receiving Music Therapy for SM

Age	2-4 yrs	5-7 yrs	8-10 yrs	11-13 yrs	14-17 yrs	18+ yrs
Total no	33	29	12	23	11	11

No. of responses = 46

Over half (N=62) the children being seen are in the 2 youngest age ranges which suggests a pattern of early intervention that is highly recommended for SM.

Table 4.2 Presentation of people receiving Music Therapy

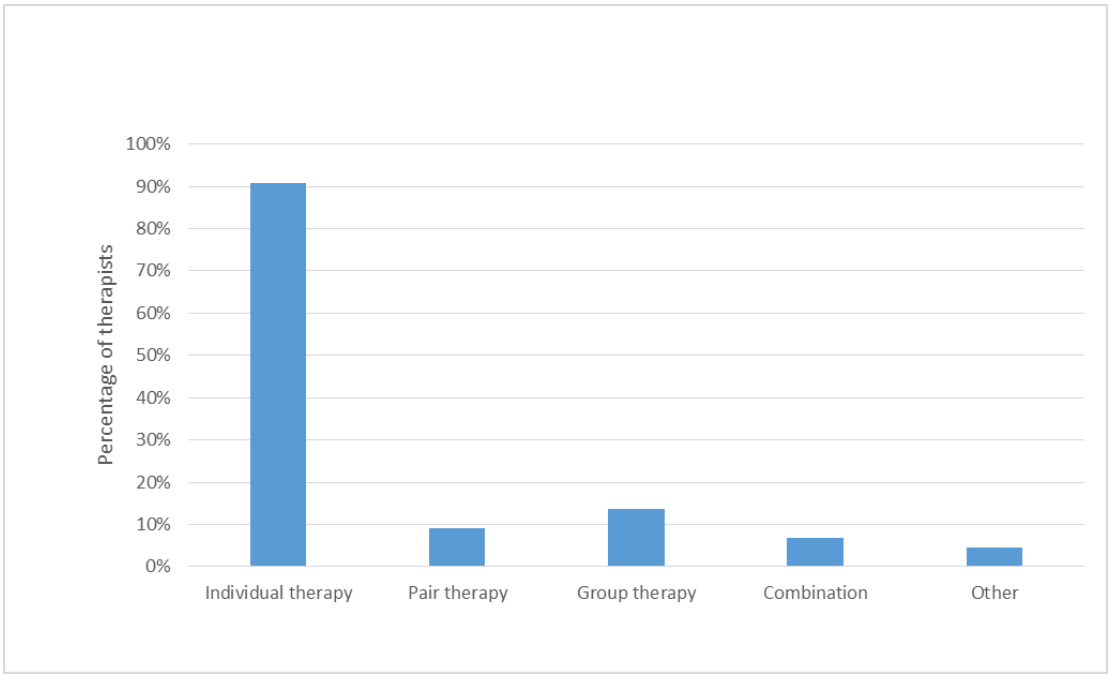
Presentation	SM alone	SMEAL	SMLDiff	SMLDis	SM and EI	SMPD	Complex
Total no.	41	10	10	16	22	6	14

No. of responses = 46

Total numbers of people in different categories are represented in table 4.2. Most people were in the 'SM alone' category (N=41) with SM and additional emotional issues being next highest (N=22). People with SM are generally recognised to have issues with anxiety and so it would be logical to describe them as also having emotional issues, therefore there may have been some clients who would fit into either SM alone or the SM and additional emotional issues category.

Q4: Over the last 12 months, was this work: (individual, pair, group, a combination)?

Figure 4.12 Modality of Music Therapy in the previous 12 months



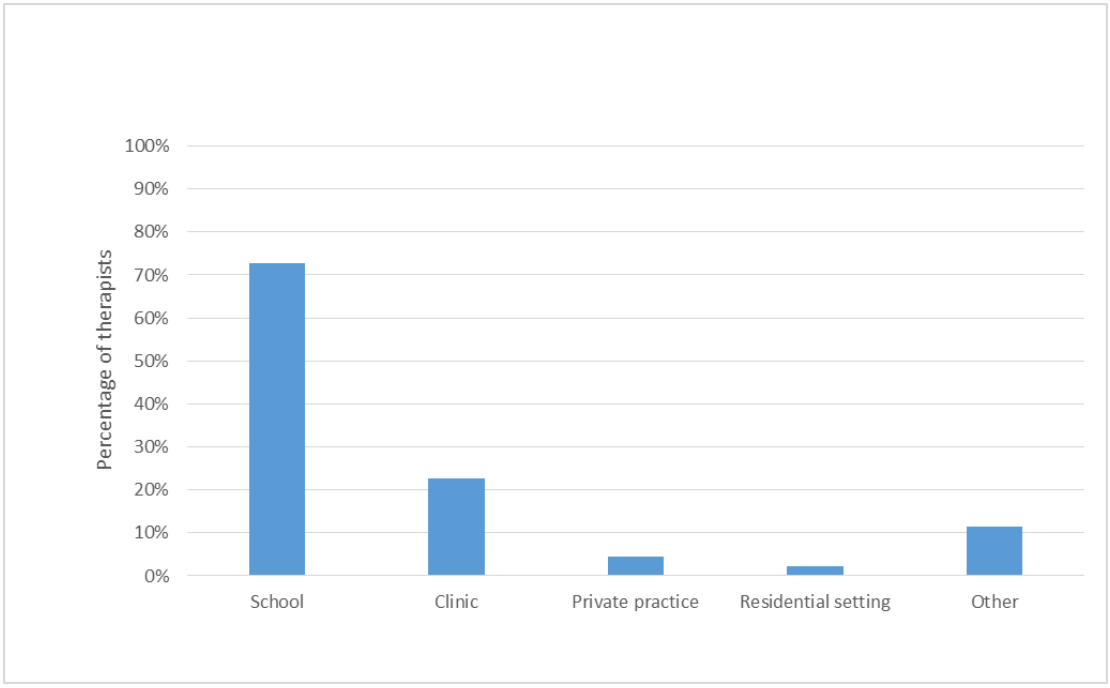
No. of responses = 44

90% therapists undertook individual therapy with a small number of therapists undertaking pair, group or combinations of the above. Combination therapy may be an area that requires more consideration for this client group because generalisation of speech to other settings is key to the success of the therapy and often requires

involving other people (see chapter one ‘generalisation’). One comment in the ‘other section’ was family therapy with child, mother and grandad.

Q5: Over the last 12 months, where did the therapy take place?

Figure 4.13 Location of Music Therapy in the previous 12 months

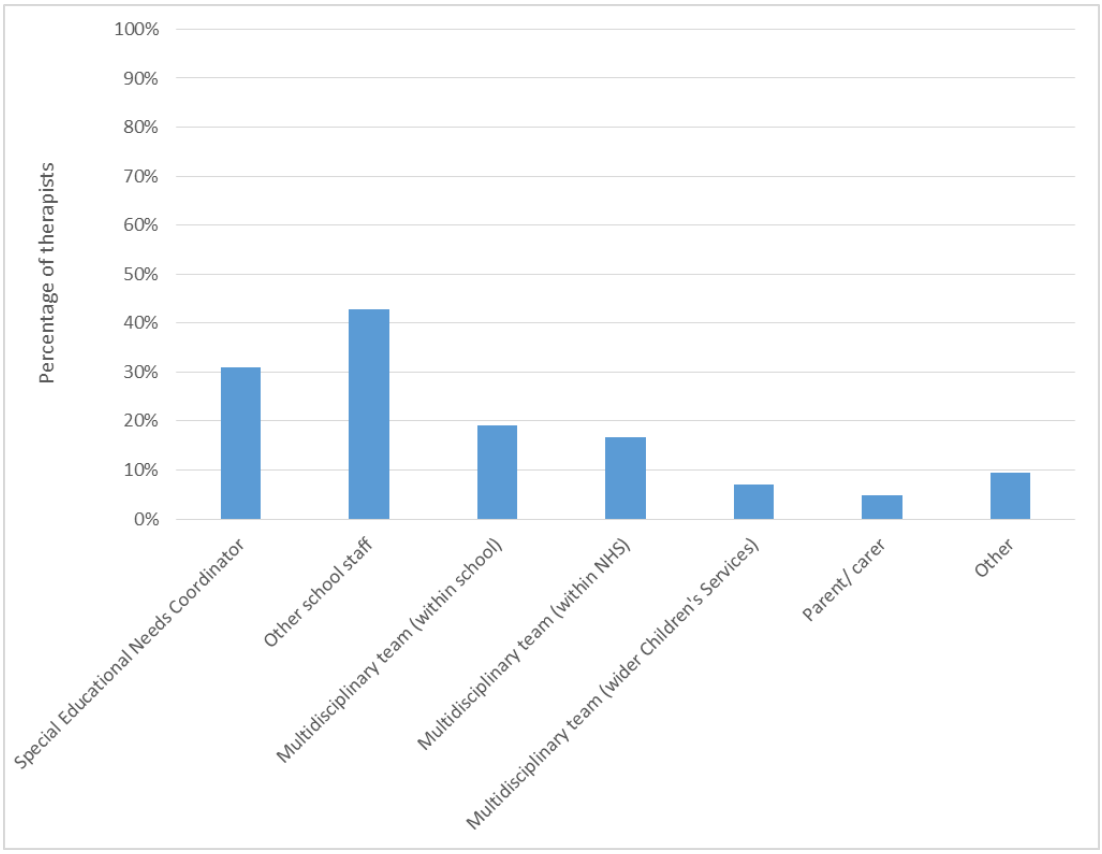


No. of responses = 42

73% of respondents undertook the therapy work within school settings reflecting where the issue is often recognised and from where referrals are made. School is usually recommended as the best location for therapy. Some responses in the ‘other’ category were: a sure start children’s centre, clients home and day centre.

Q6: Over the last 12 months, how were these clients with SM referred to you?

Figure 4.14 Referral source of clients with SM in the previous 12 months

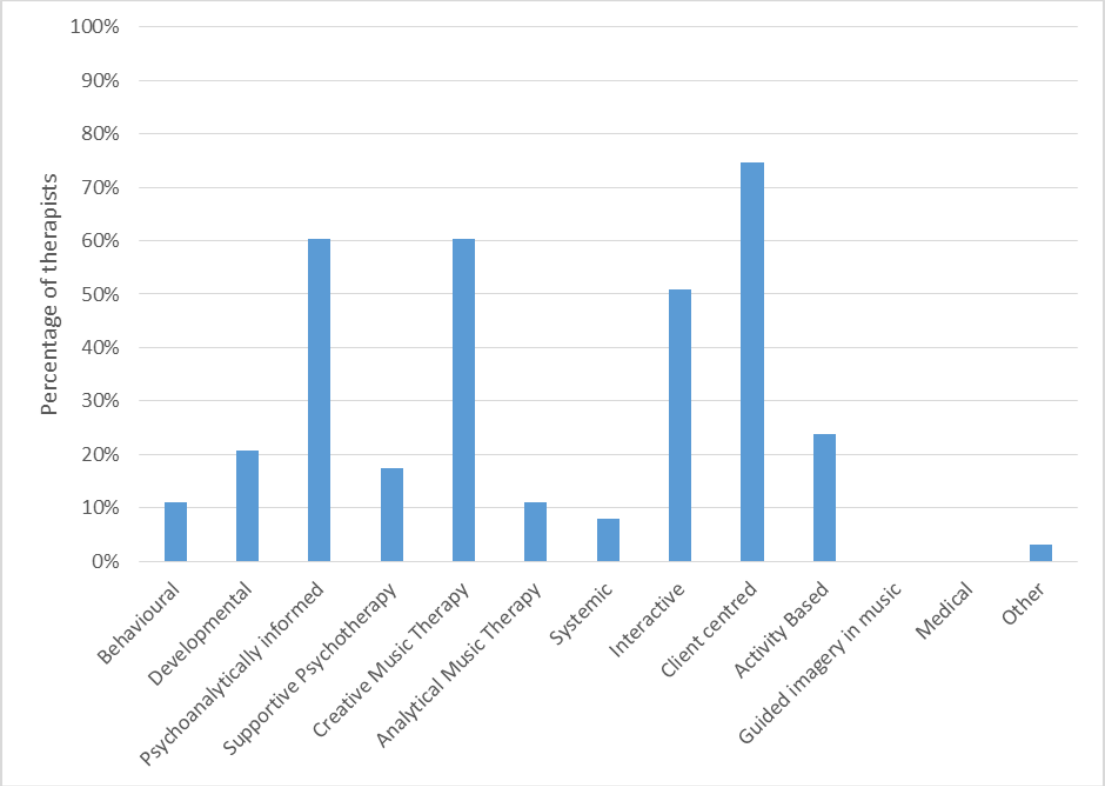


No. of responses = 42

Responses to this question reflect that most clients referred are school-aged children with a mix of referrers from within the school environment (93%). Other referrals included: multidisciplinary team within local council's adults with learning difficulties department, private provider to NHS, Multidisciplinary team Local Authority, and a Day Centre Keyworker.

Q7: Which way of working best describes your approach with all the clients with SM that you have seen?

Figure 4.15 Approach to Music Therapy with clients with SM



No. of responses = 63

The responses to this question broadly reflect the training backgrounds of UK music therapists. Many respondents have ticked a range of different boxes, (63 respondents ticked a total of 216 boxes) which indicates the broad mix of skills and approaches typical of our UK MT profession. Client-centred has the highest score (75%) reflecting an approach that would encompass a range of trainings and therapy techniques. A behavioural approach, which is the main approach in Psychological and SLT treatments for SM, is very low at 11%. This is probably due to the lack of training in behavioural methods within the UK Music Therapy profession as Music Therapy has traditionally provided an alternative to behavioural approaches.

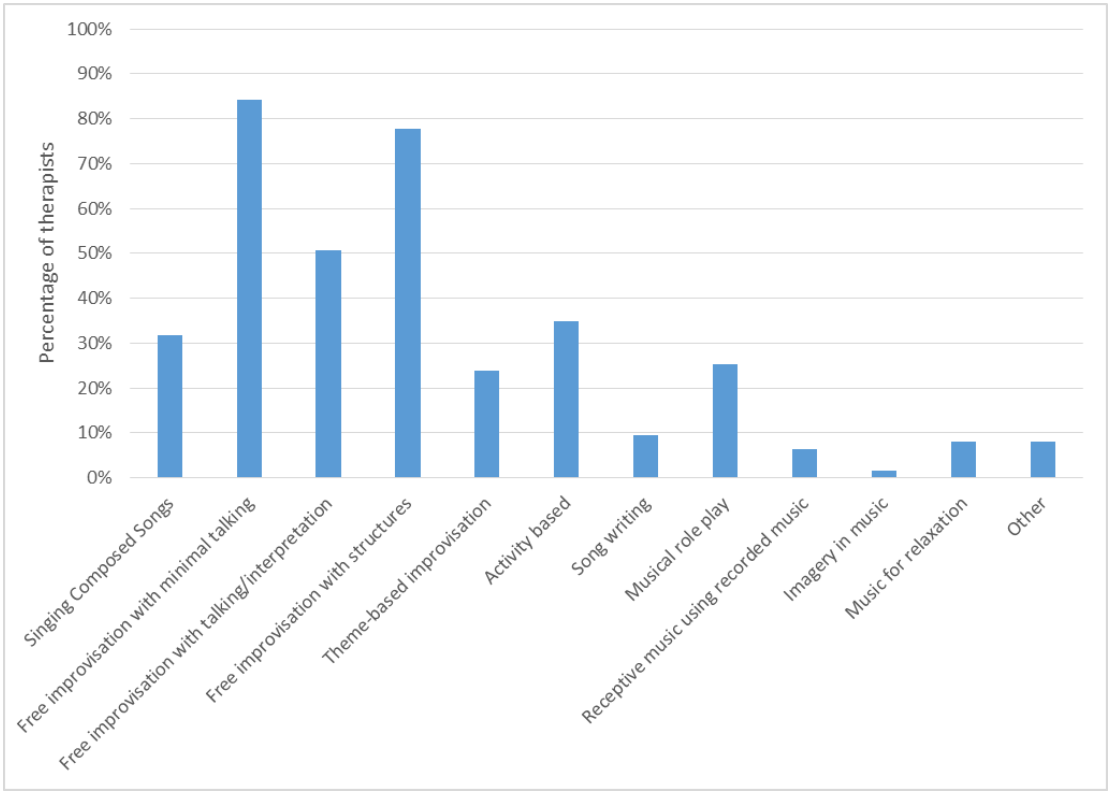
In the 'other' category respondents wrote about:

- Incorporating the concept of the 'sliding in' approach into the work
- Combined methods, changing according to the immediate situation
- Attachment theory informed

- Developmentally informed MT using play and other expressive arts
- Group work with 2 other children using traditional MT games and structured activities
- Puppets and toys to facilitate play and enrich symbolic expression
- Psychoanalytically informed, music focussed
- Directive grounding and mindfulness at points to reduce anxiety

Q8: Which Music Therapy techniques have you used with clients with SM?

Figure 4.16 Which Music Therapy techniques have you used with clients with SM



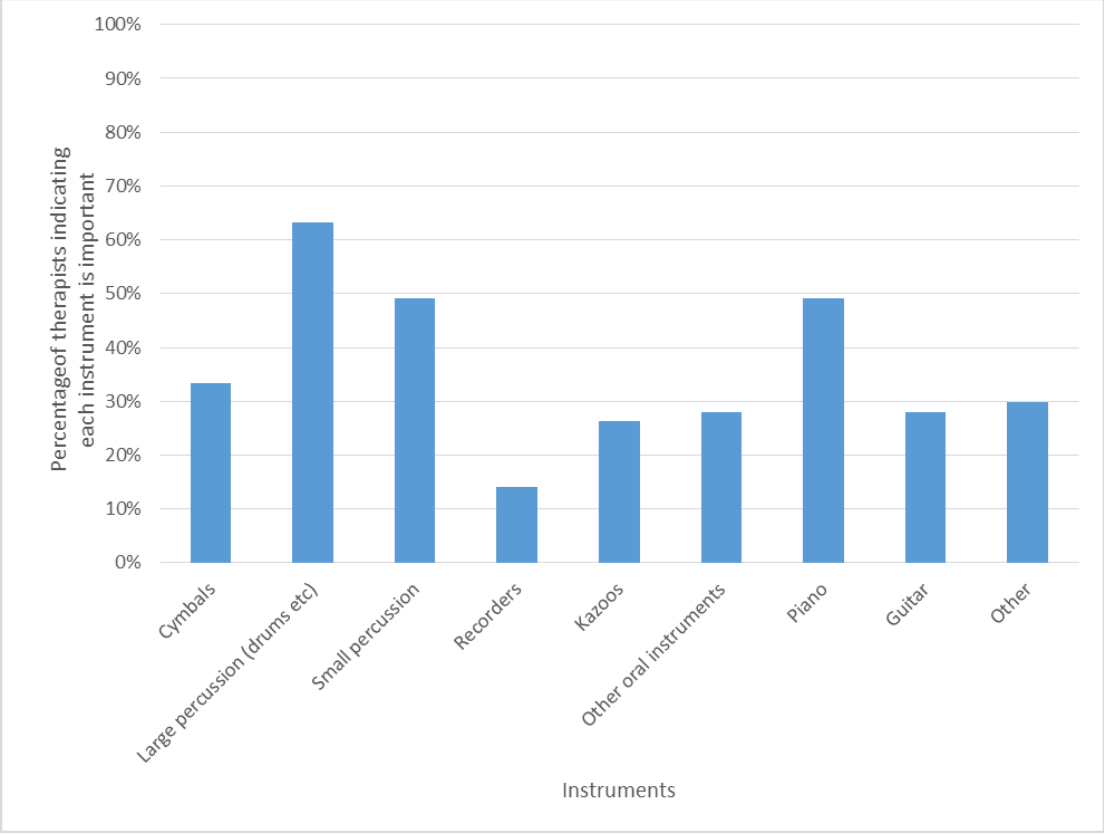
No. of responses = 63

The total number of responses (N=228) suggests that therapists use a variety of techniques in their sessions. However, most of the responses are focussed in the area of free improvisation of some kind (N=134). As this number is more than double the total number of respondents (N=63), this suggests that therapists use more than one kind of free improvisation in this work. Activity based work, singing composed songs, musical role play and theme-based improvisation also received a significant number of responses.

The written responses in the 'other' section of this question included: drawing (to music), talking with minimal improvisation, playing music based on the client's art work, symbolic/imaginary play, puppets, art, Ipads as instruments, call and response, narrating actions, affect attunement, toys, playdo and choosing CDs were all examples of different techniques used in sessions. One respondent commented that clients often found composed songs less stressful than free improvisation. Details about the use of special toys or puppets to speak for the child perhaps provide another useful tool and link to the voice through play.

Q9: Were any of the following instruments, played by clients with SM, important in your work?

Figure 4.17 Importance of instruments played by clients with SM



No. of responses = 57

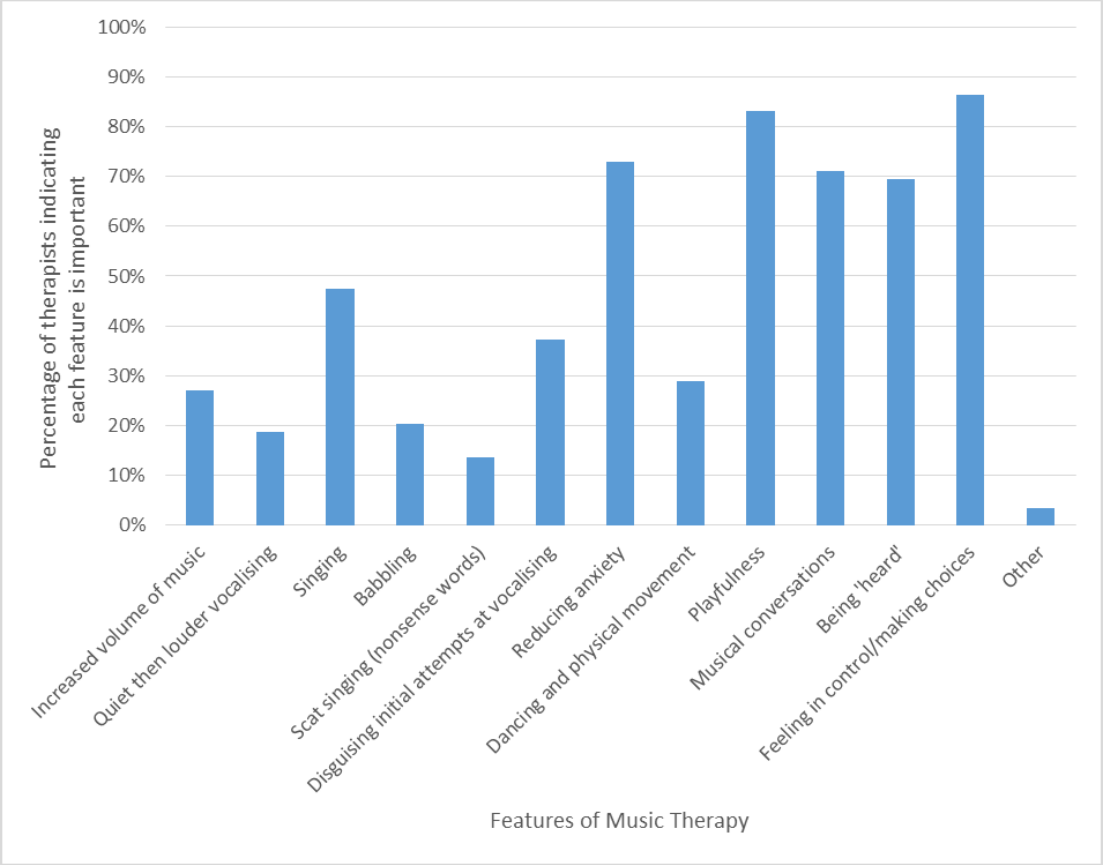
57 respondents gave 183 responses to this question. Oral instruments were divided into three categories, including 'other oral instruments', for greater definition of an area of key interest. Cymbals and large percussion were also divided for this reason. The sum of all the oral instruments together has a large number of responses (N=39). However, large percussion (N=36) combined with cymbals (N=19) has the greatest

response. This is followed by small percussion (N=28) and piano (N=28). These results appear support the theory that the potential for loud self-expression and the use of oral instruments are important for clients with SM in Music Therapy.

In the comments box people were asked to explain why specific instruments were important. 17 respondents gave detailed reflections on a wide range of topics. Oral instruments were mentioned 19 times and were considered significant because they encouraged greater vocal confidence, created an opportunity for vocal 'conversations' and provided a connection with and process towards to using the voice. Being able to play loudly, very loudly or extremely loudly was another common theme that people felt was important and was mentioned 8 times. Other explanations of why instruments were important describe the key ingredients and essence of most Music Therapy practice such as the opportunity for musical self-expression (N=11), and developing a musical (N=15) and emotional (N=12) relationship. This seems to suggest that these more general components of Music Therapy are also important for people with SM as opportunities for self-expression, relating and communicating are inevitably hugely impaired for people with this disorder.

Q10: Were any of the following features important in your work with clients with SM?

Figure 4.18 Importance of features of Music Therapy with clients with SM



No. of responses = 59

59 respondents made 342 responses to this question giving an average of 6 responses each. This seems to indicate that a range of features are important in this work. Feeling in control/making choices was the feature with the highest number of responses (51), followed by playfulness (49) and reducing anxiety (43). Features key to Music Therapy practice also receive high numbers of responses: 'musical conversations' (42); 'being heard' (41); singing (28). These features also seem particularly closely linked with the nature of SM. It was also interesting that the very specific category of 'disguising initial attempts at vocalising' received quite a few responses (22).

Respondents were asked to describe other features that were important in their work with clients with SM. Responses made were:

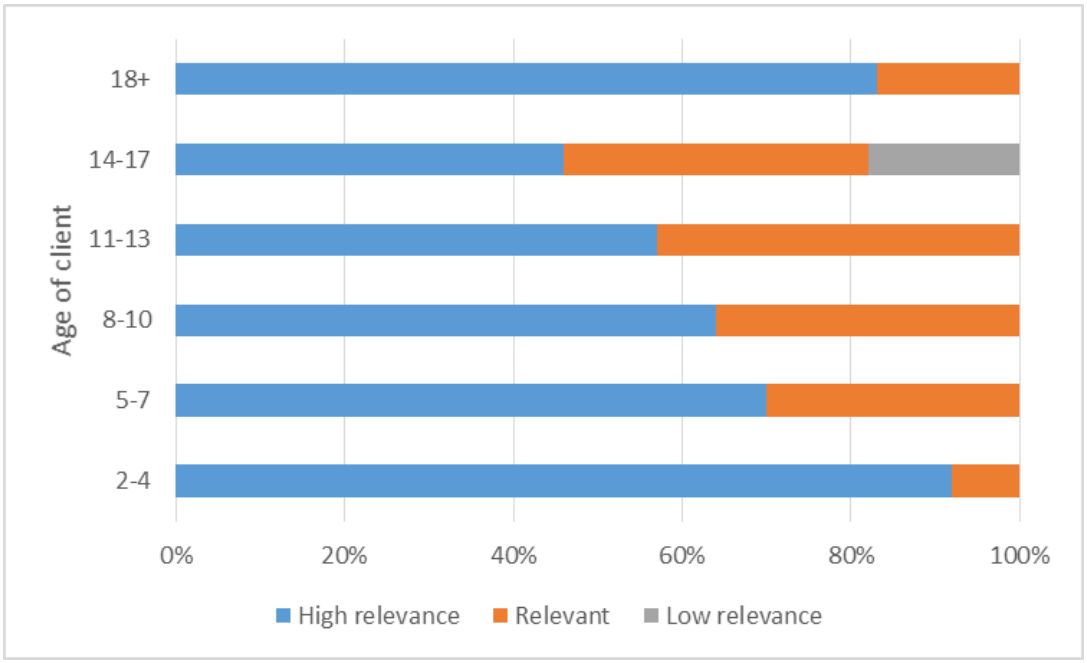
- pre-composed familiar children's songs;

- exploring the room and a sense of distance/hiding;
- peek-a-boo style;
- looking out of the window;
- view boxes;
- using the slightest noise they made to begin a musical interaction;
- eye contact;
- no-pressure time but to explore how the client feels, or how they understand themselves in relation to their speaking issues;
- self-awareness and self-confidence;
- Musical play and freedom to do anything;
- A group environment;
- musical games and structures activities:
- be a sense of fun and no pressure;
- rhythmical movements on the creaky floorboards!;
- we worked with the parents too;
- Playing back some of the video of the sessions;
- Symbolic play; instruments as objects;
- Musical stories 'Once upon a time';
- chaotic music-making; fragmentation; musical; overwhelm; rigidly controlled music-making; free music-making;
- talking with CDs playing;
- being very calm and relaxed.

Some of these features can perhaps be grouped with other features but it is interesting to note some of the novel aspects such as the use of video or CDs in the sessions.

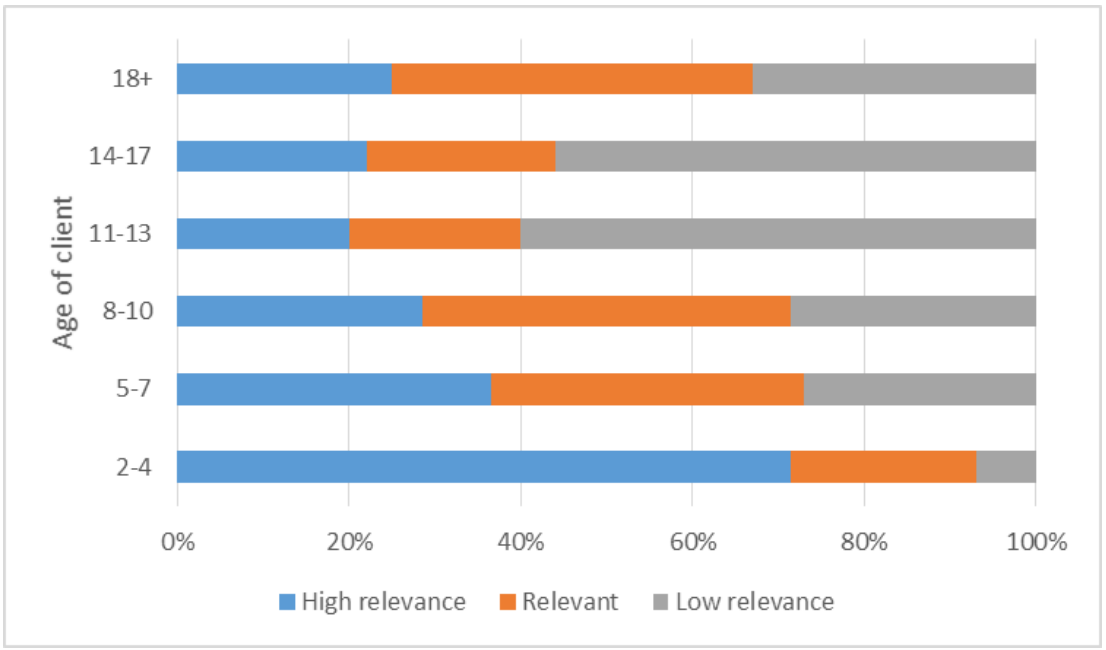
Q11: Please indicate the relevance of the following aspects of Music Therapy intervention for all clients with SM that you have worked with over your career.

Figure 4.19 Relevance of musical elements of Music Therapy to clients with SM



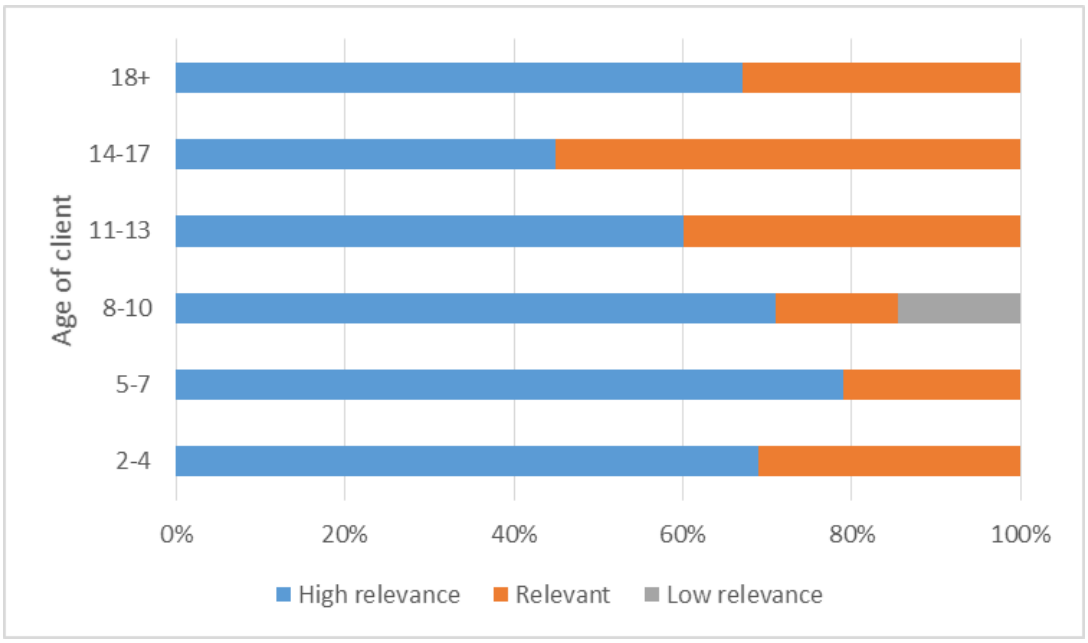
No. of responses = 57

Figure 4.20 Relevance of physical elements of Music Therapy to clients with SM



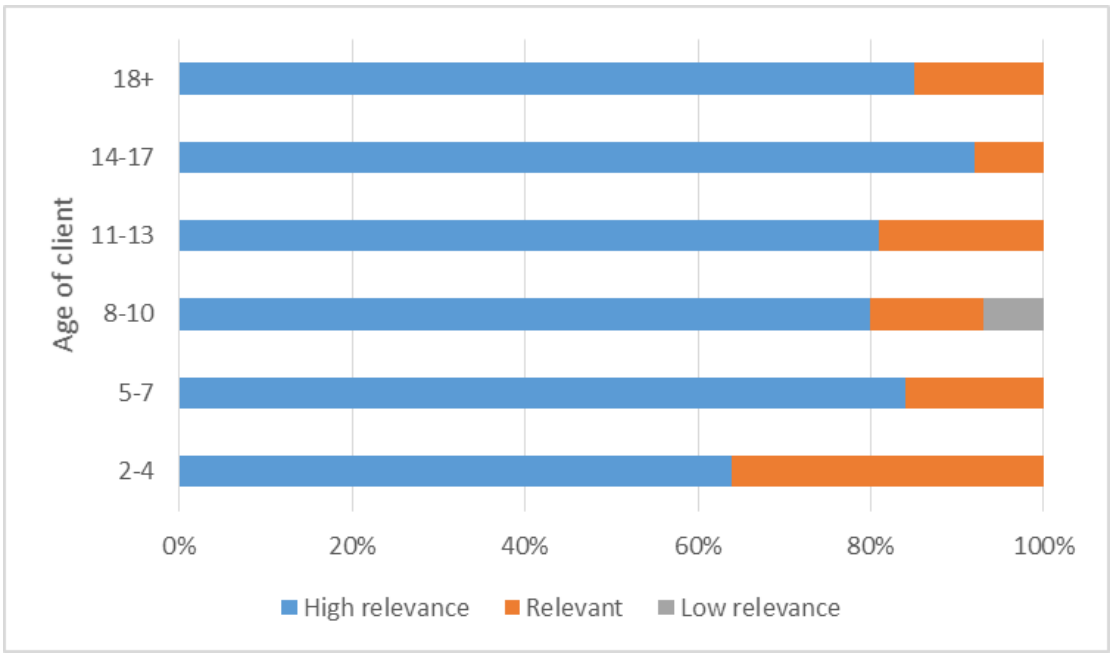
No. of responses = 57

Figure 4.21 Relevance of social interaction to clients with SM



No. of responses = 57

Figure 4.22 Relevance of therapeutic relationship to clients with SM



No. of responses = 57

Musical elements appear to be relevant across the age ranges but especially for the 2-4 year age range. Physical elements appear to be highly relevant for children aged 2-4 years old, less relevant for 11-17 year olds but then an increase in relevance again for adults with SM. Social interaction is of high relevance or relevance for all clients

with two exceptions in the 8-10 year old range. The therapeutic relationship was given high relevance for all age ranges.

In the comments box 30 respondents added comments on what they thought was important about Music Therapy for this client group. The comments largely reflected elements of the categories in the main question with most responses (n=22) relating to musical components such as musical communication or the musical relationship and how this gave people a musical 'voice' or means of expressing themselves and relating. The importance of play and playfulness was also mentioned (N=5).

The therapeutic relationship was mentioned 14 times and details were specified such as containment, developing trust, sharing difficult feelings, developing confidence and a stronger sense of self. Respondents also indicated the importance of employing a 'no pressure' approach (N=9) and of using sensitivity, time and patience (N=4). Additional aspects included early intervention, communicating with classroom staff and parents in sharing information and including staff in sessions (N=3). Physical aspects were only reflected upon twice in this comments section.

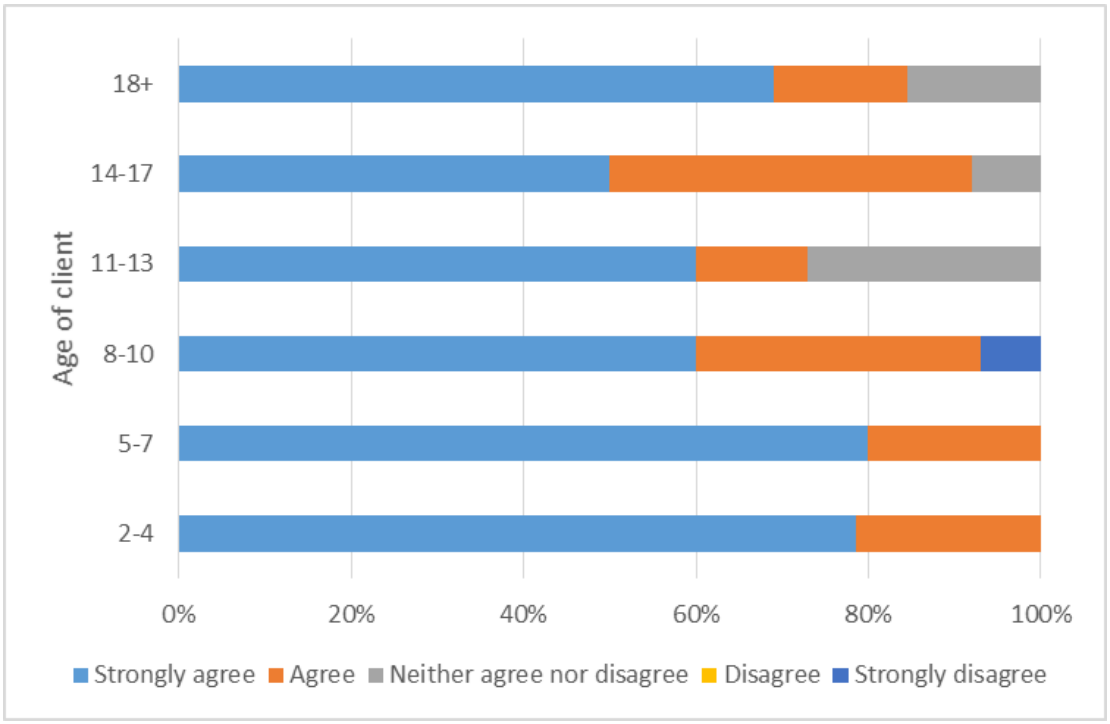
Once again, the overall importance of the role of music as a means of expression, enabling communication and the possibility of a therapeutic relationship was strongly emphasized. Indications of possible adaptations of the framework might include the addition of the role of staff and parents in the therapy.

Q12: Please indicate your response to the statement below relating to all those clients with SM that you have worked with. If you have worked with more than one person from each age group please indicate the most typical response for that age group.

"In my experience Music Therapy has a positive effect on clients with SM"

Please also indicate the main therapeutic effect and typical length of therapy for each age group that you have worked with using the drop down menus.

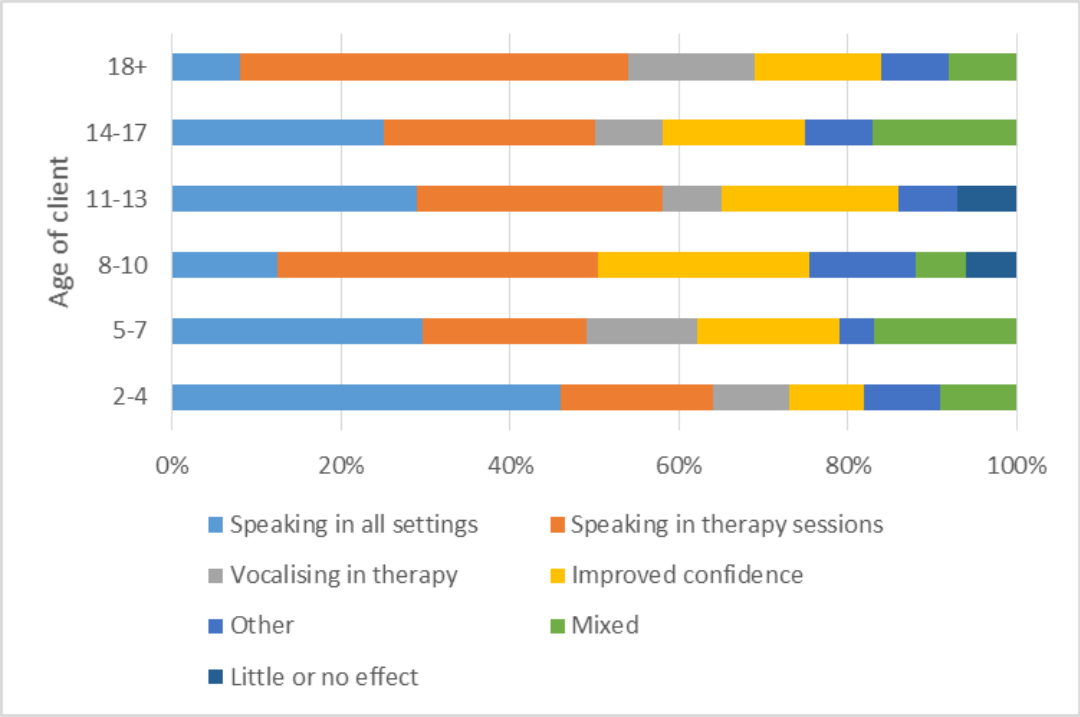
Figure 4.23 Music Therapists' agreement with the statement: "In my experience Music Therapy has a positive effect on clients with SM"



No. of responses = 54

For all age groups respondents mostly strongly agreed with the statement that Music Therapy had a positive effect on clients with SM. There were particularly high levels of strong agreement with respect to work with the younger age ranges. Within the older children and adult age ranges 7 respondents indicated that they neither agreed nor disagreed with the statement regarding the postive effect on clients. There was one negative response to the statement and that was strong disagreement for 1 child in the 8-10 year old range.

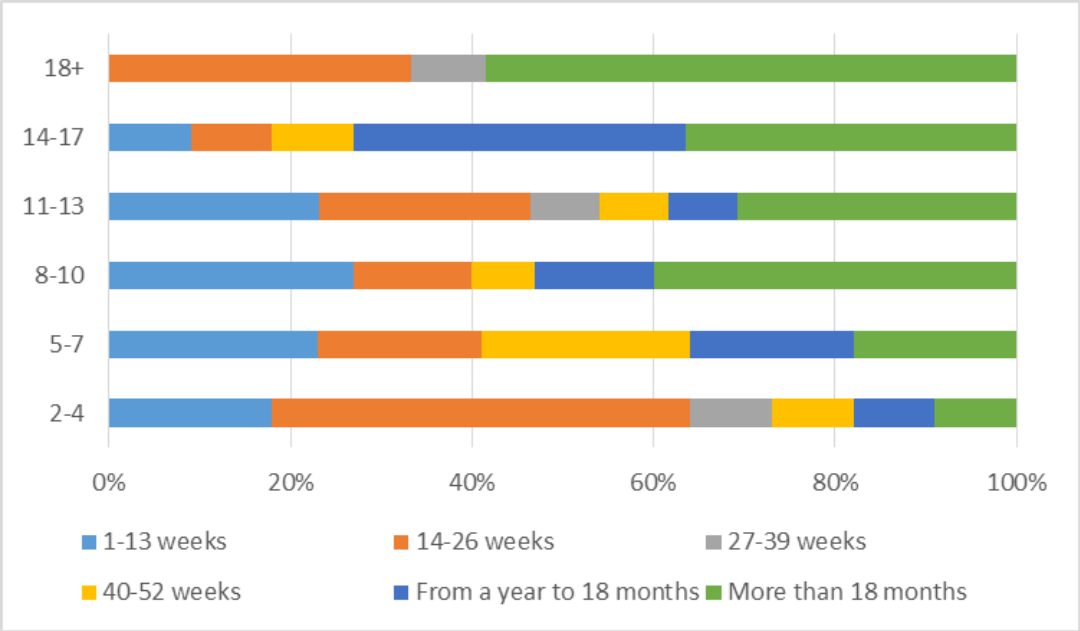
Figure 4.24 Main effect of therapy



No. of responses = 54

In the 2-7 year old age range the main therapeutic effect was speaking in all settings followed by speaking in the therapy room. In the 11-17 year old age range these remain the dominant effects but are split equally between speaking in all settings and speaking in the therapy room. For ages 8-10 years and 18+ years the main effect is speaking in the therapy room.

Figure 4.25 Length of therapy



No. of responses = 54

Overall there was a wide range of responses for the length of time in therapy across the age ranges but with a general pattern of short-term therapy for the youngest age group and longer-term therapy for older children and adult clients. For children between 5-13 years old there was an even spread from short-term to longer-term therapy. This appears to indicate that early intervention is highly recommended when using Music Therapy for children with SM and that the anxiety disorder rapidly becomes more entrenched for some children who are not treated before the age of 5. However, there are still strong positive benefits of longer-term Music Therapy for older clients.

Respondents were then asked: *'Please summarise in 1 or 2 sentences the main therapeutic effect*[3] *of Music Therapy for this client group.'*

Categories generated using content analysis are represented in figure 4.26 with numbers indicating each reference to a specific category. This is followed by a discussion of each category. The theoretical framework with the categories positioned on it can be seen in appendix 4.3.

[3] 'Effect' in this case does not imply a statistically significant effect but rather a perceived impact or benefit.

Figure 4.26 Main therapeutic effects with numbers of comments within each category

Approach (N=19)

These comments were ideas linked to the no pressure approach (N=11), communication with staff/parents/multi-disciplinary team (N=7) and early intervention. These were collected together as they represent good practice for any professional working with a person with Selective Mutism. Examples of responses in this category were "providing a space where clients can simply 'be' and communicate and play in their own way, without having demands placed on them to speak" and "a place where he was free from the pressure to speak".

Non-verbal/musical self-expression (N=35)

This category seemed to emphasise the hugely therapeutic effect of offering a space where an alternative, primarily musical, means of expression is used. Codes that were grouped under this broad category included musical communication and musical conversations, making sounds and being heard. Physical self-expression was also mentioned (N=3). Some comments that perhaps best exemplify this category are

'playing the instruments and singing with the hand puppets', 'sounds were received and reflected back without overemphasis and wild celebration' and 'to behave conversationally through using drums'. Other pertinent comments were: 'experiencing themselves as sound-making without talking'; 'the chance to play with sound that is not the voice'; 'to practice dialogue and sound exchange'; 'MT enables clients to be heard and seen'.

Playing (N=11)

Playing could perhaps be a sub-category of non-verbal self-expression but seems to have gathered enough data to become a category on its own. Instruments are always 'played' and so a stronger link to playfulness was required to become part of this category. Playing, play and being playful overlaps with other categories and is rarely mentioned without linking it to another aspect of Music Therapy such as in the example above. Other examples given were: 'to play with sound-making in an interactive way'; 'to use the music to communicate playfully'; 'play incorporating other forms: movement, dance, poetry/ song creation, story-making'.

Interaction (N=16)

This is difficult to distinguish from non-verbal expression and is similar to play but is given a category of its own because it seems to underline the essential role of communication for a person with SM. Typical examples linking to the therapeutic relationship are 'to experience interactions as a sympathetic reciprocal experience' and 'it allows the client to enter into an interactive relationship'. Other comments were: 'offers a less anxiety provoking way of communicating and interacting' and 'a space to explore interaction and develop relationships'. Musical communication and musical conversations could perhaps have been subsumed by this category as 'non-verbal/musical expression'.

Emotional expression/relationship (N=25)

Although closely linked to the previous category this category groups together responses which highlight the importance of emotional self-expression or the emotional, therapeutic relationship. Included within this category were comments regarding trust and safety in the relationship, relaxation and anxiety reduction, and verbally processing and understanding the experience of having Selective Mutism.

Examples of more general comments are: ‘it provided a safe space….in which the client built up the courage to try out speaking’ and ‘they were able to be heard and express feelings’. One interesting example was ‘assessing the distress caused by the mutism’. Another comment alludes to SM causing emotional issues and links the whole therapeutic process stating that ‘finding a voice through musical play, vocalising etc which contributes towards emotional well-being, increased self-confidence and decreased anxiety levels’. Both these latter examples reflect a clear view that SM in itself causes anxiety and distress. That SM is both caused by and causes anxiety is a perspective that particularly resonates with my past clinical experience of children with SM.

Raising confidence and self-esteem (N=23)

Many respondents stated that Music Therapy resulted in improved confidence and self-esteem. For some this was the main outcome of the therapy and for others this was a step on the path towards speech. Examples of comments are: ‘increased confidence and motivation to interact’; ‘generally increased confidence has been evident’; ‘increased confidence within the school setting’; ‘increased self-esteem’. If SM is perhaps seen to cause emotional distress and anxiety then general improvement in confidence and self-esteem are crucially important outcomes for some clients.

Vocalisation (N=10)

We can see from the main survey that for some clients vocalising in therapy is an important therapeutic outcome. For some it may also be a step in the therapy process towards speech. These comments describe some of this experience of vocalisation and the special value that Music may have in connecting with the voice: ‘music can encourage a vocal response’; ‘provides ways to gradually find a voice without the pressure of using words’; ‘ways to explore use of voice without using words’; ‘use of voice (vocalising not talking) in sessions’. In summary Music Therapy can help enable the expressive, musical aspects of the voice which is perhaps slightly different from the more functional voice or speech that is required at other times in our lives.

Verbalisation (N=20)

Once again, as in the main survey question many respondents cited verbalisation of some kind as a positive outcome of the Music Therapy. These examples give us an

idea of the types of comments that were typical in this area; ‘spoke to his teacher’; ‘now talks in all settings’; ‘doing something enjoyable with another person seemed to provoke spontaneous use of speech’; ‘increasing the number of people she was able to speak to at school’.

4.5 Discussion

The survey showed that there are at least 75 other UK Music Therapists working with people with SM and that in the 12 months prior to the survey (2014) respondents worked with 119 people with SM. There is an emphasis on early intervention with younger age children with SM alone but there is also evidence of work generally across all the ages and presentations. A number of therapists had worked with people with SM and learning disabilities. This is a population that is known about both anecdotally within the MT profession and in the grey literature (Whelan 2007) but they do not receive significant attention within mainstream SM literature. This could be because the MT profession often specialises in intervention with children and adults with learning disabilities and perhaps has a specialist role to play with this hidden population. It is also important to note that more respondents worked with adolescents and adults with learning disabilities and SM than adolescents and adults with SM alone. There is perhaps potential for misdiagnosis of SM in this population but they may also be under-represented within the SM literature. This could indicate an important area for future investigation.

Clinical work is primarily on an individual basis within schools with referrals made by school staff. Respondents blend a broad range of approaches in their clinical work reflecting the different training courses and openness within the profession but say that they are mainly client-led. Free improvisation is a key technique being used in sessions amongst some other creative and novel ideas.

Questions then relate more directly to the theoretical framework. Question 9 considers instrument usage and shows that oral instruments and large percussion appear important for clients with SM. Respondents cite the link with the voice and the opportunity for loud playing as reasons for these preferences. Responses to question 9 appear to support and fit the theoretical framework of why Music Therapy is helpful for people with SM.

Question 10 asks which features of the therapy were important. The responses give dancing and physical movement a lower score (29%) than other elements of the framework such as musical conversations (71%) and reducing anxiety (73%).

The relevance of physical elements of the framework is again scrutinised in question 11. The results appear to confirm the importance of physical elements for 2-4 year olds with a quick levelling out of relevance and then reduction in relevance for older children and adults. This could indicate that the framework is relevant for early years but requires some modification for older children and adults. The relevance of other aspects of the framework: musical; social interaction; the therapeutic relationship remain consistently high for other age groups with the possible exception of 14-17 year olds. For this age group the relevance of the therapeutic relationship seems much higher than the musical or social interaction elements; the physical aspect is again low as for the other age groups. From the qualitative results a clear sense of the importance of the approach and process of therapy with different elements seeming important at different times was particularly strong.

Question 12 provided detailed quantitative data about: whether Music Therapy has a positive effect on clients; the nature of that effect; the length of therapy; and additional qualitative detail through comments on the main therapeutic effect. The strong agreement with the statement that music therapy has a positive effect was a very heartening result which was further strengthened by the main effect of the therapy being given as 'speaking in all settings' for the 2-7 year old age range. It might perhaps be common for a clinician to perceive general positive benefits for their own specific therapeutic intervention but for this to be clearly linked to a concrete outcome that mirrors the expectations of other interventions for this client group – for example, Speech and Language therapy- is very encouraging. That early intervention also appears to be more effective in achieving wide-reaching benefits than later intervention again mirrors recommendations for SM within other professions.

Explanatory detail given about the positive effect of Music Therapy illuminates the various potential stages of the Music therapeutic process for a wide variety of clients and the key elements that are the corner stones of provision for clients with SM. The essential and perhaps obvious role of sound and music for people with SM cannot be emphasised enough and is strongly reinforced by the survey data.

Figure 4.27 Template analysis of survey data (wider clinical population)

Therapeutic process / **Parallel layers of communication**	1. Offering a potential space **School or** Clinic **Psychoanalytically informed** **Creative** **Interactive** **Client centred** Early intervention Safe space	2. Manifesting anxiety – having it contained and processed Anxiety reduction Relaxation	3. Gradual build-up of trust and contact through listening and accepting – **'no pressure approach'** Feeling in control. Making choices. Sensitivity/time and patience	4. Gradual development of shared, meaningful communication and 'playing' Play and Playfulness Musical conversations	5. Need to end therapy – healthy, confident separation Positive effect (esp. younger children) Speaking in therapy and across all settings
a) Musical	Musical conversations – parallels spoken conversations – 'sliding in' Free improvisation- turn-taking or play. Being heard. Large percussion, drums, cymbals=loud playing **Oral instruments=vocal confidence/conversations** Small percussion, piano. Non-verbal, Musical Self-expression. Musical relationship. Communication. Vocalisation Singing. Disguising initial attempts at vocalising.				
b) Physical	Control and expression in the physical realm lead to control of the voice Relevant for younger children and adults not 11-17 yr olds				
c) Emotional/ social	Therapeutic relationship parallels mother/ infant interaction = emotional/ social communication Social interaction Playing. Developing relationship. Improved confidence/self-esteem				
	TIME IN THERAPY ➔ **(Approach-Communication with staff, inclusion of staff and parents in therapy)** **Rapid progress for younger children**				

4.6 Potential modifications to the theoretical framework

The survey reached respondents working with a broad and varied SM population, therefore any suggested modifications to the framework must reflect this aspect. The framework was based on a single case study with a child with SM in early years education and the further case studies will also be for this age group. Survey data suggests that physical aspects are less relevant for older age groups although this requires further investigation. The final framework for the study will be weighted towards the evidence from the multiple case studies as the research is primarily focussed on these younger age groups. However, survey respondents indicated that the other elements of the framework – musical, social interaction and the therapeutic relationship- are very important in therapy practice with other people with SM. One possible modification suggested by the data is that a 'no-pressure approach' should have greater prominence from the start of the therapy process and be a shared approach for the multi-disciplinary team including the parents or carer.

4.7 Conclusion

The survey mapped characteristics of Music Therapy provision across the UK for people with SM. Findings showed Music Therapists typically providing early intervention treatment with children achieving speech generalised into classroom settings as the main outcome. In contrast, the survey also highlighted work with less studied populations such as adolescents and adults with SM and learning disabilities. This feature may be due to Music Therapists specialist skills in working with clients with learning difficulties. Respondents shared a clear sense of positivity about the use of Music Therapy as an intervention for SM. Questions inquiring about different elements of the framework offered strong confirmation of the essential role of music and sound with the physical element being less prominent with older populations. The important of a 'no-pressure approach' embedded as part of a multi-disciplinary team and a flexible therapeutic process, utilising different elements at different times, were also noted as being invaluable. These findings were noted on the theoretical framework but at this stage revision of the framework was inappropriate as this survey explored Music Therapy across a wider population. Potential modification of the theoretical framework will be explored in more detail in subsequent chapters.

Chapter 5 - Interviews with UK Music Therapists

5.1 Introduction

This chapter builds on survey data evidencing and exploring the practice of Music Therapy for people with SM in the UK by drilling for more detail and depth through interviews with Music Therapists with experience in this field. Focus groups were considered but were impractical due to the geographical spread of available Music Therapists across the UK. In addition, individual interviews allow pursuit of greater depth and more personal perspectives. The main question for this chapter is: How do experienced UK based Music Therapists describe their practice of working with children with Selective Mutism?

Interviews have been used widely in Music Therapy research to gather data in many different clinical areas including bereaved teenagers (McFerran, Roberts & O'Grady 2010), children with oncological diseases (Glawischnig-Goschnik, Kassama & Papst 2016), post-surgery adolescents (Kleber & Adamek 2013), Guided Imagery and Music for patients with depression (Lin, Hsu, Chang, Hsu, Chou & Crawford 2010), and Song writing for mothers who have experienced childhood abuse (Day, Baker & Darlington 2009). In other studies interviews have been used to gain an understanding of the Music Therapists' experience of their practice (Cooper 2010, Nicholson 2015).

5.2 Aims and research questions

This chapter will address the following aims:

> To gain an in-depth, nuanced understanding of other UK Music Therapists' experience of working with people with SM.
>
> To further describe UK Music Therapy practice in this clinical area and then compare the data with the theoretical framework under scrutiny in this study.

These aims will be addressed by asking the following questions:

- What are other UK Music Therapists' experiences of working with people with SM?
- What is their understanding of SM?

- How have they used Music Therapy for this clinical population?
- What are their approaches and techniques?
- What did Music Therapists report as the outcome?
- What did Music Therapists think about the theoretical framework as a description of Music Therapy for people with SM?

5.3 Methods

5.3.1 Population

The population for the interview was the 75 members of the British Association of Music Therapy that responded to the survey on the topic of Music Therapy and Selective Mutism (4.4.1).

5.3.2. Sampling strategy

Purposive sampling was employed to identify suitable interviewees. Survey respondents were asked if they would be willing to be interviewed on this subject. Respondents that replied positively to the interview request were selected on specific criteria based on their survey responses. These criteria are:

- a significant amount of work in this clinical area or
- work in this area which they regarded as successful (in order to explore Music Therapy techniques that support positive outcomes)

5.3.3 Data collection

Six interviews took place between October 2014 and April 2016. They were face to face apart from one interview which was held by Skype owing to the interviewee's distant location. Interviews were arranged at a location convenient for the interviewee and ranged from 70-110 minutes.

The interviews had an abductive structure to enable new data to critique the theoretical framework. First, interviews used an inductive approach allowing for rich, in-depth description (Kvale 1996, Ritchie & Lewis 2003) but with similar topics covered with each interviewee. Secondly, they began to explore which elements of Music Therapy are considered useful for clients with Selective Mutism. Finally, an artefact (Kara, 2015) -the theoretical framework (Appendix 1.1)- was presented to

each interviewee late in the interview as the deductive component, inviting interviewees to respond to each element of the framework in terms of their own experiences of conducting Music Therapy with people with Selective Mutism.

The questions explored three main areas:

1. The therapist's background and experience
2. Full and detailed case narratives, including approach, techniques and outcomes
3. Elements from the theoretical framework and direct comment on the theoretical framework itself

For the full list of questions please see Appendix 5.1.

Questions were used as a guide rather than followed prescriptively, whilst still ensuring specific topics are covered. The initial questions were designed to elicit essential background data including information about the clients' clinical profile and referral route to Music Therapy provision. Questions regarding clinical cases were more improvised and discursive but aimed to develop exploration of different presentations, techniques and outcomes. Later questions about the theoretical framework were more focussed in style.

5.3.4 Interview analysis method

The interviews are analysed using template analysis as described in section 3.3.3. In summary the interviews are transcribed, coded and then the codes categorised to generate themes. The themes are then placed on the theoretical framework to note how they fit or challenge the framework.

5.3.4 Interviewee characteristics

Information about interviewees' Music Therapy experience and specific SM experience is summarised in table 5.1 below. This information helps contextualise interviewees' understandings of this clinical area. It also indicates specific clinical populations with very different presentations and experiences.

Table 5.1 Interviewee background information

No. of years' experience	Type of experience	No. of SM clients	Type of SM clients
35	Psychiatric hospitals. Mainstream education	2	SM & English as an additional language
5	Special Primary School	1	SM & Cerebral Palsy
30	Education (all) & mental health -adults	14 or 15	SM & Severe difficulties 'Trauma'*
34	Pre-school and primary age	8 or 9	Younger children with mild learning difficulties or Autism and SM. Older children- SM alone
18	Mainstream primary	9	Early years with EAL & 'Trauma'
8	Mainstream and specialist provision	4	SM & Autism SM alone

*The interviewee described cases of mutism linked to trauma under the umbrella of SM.

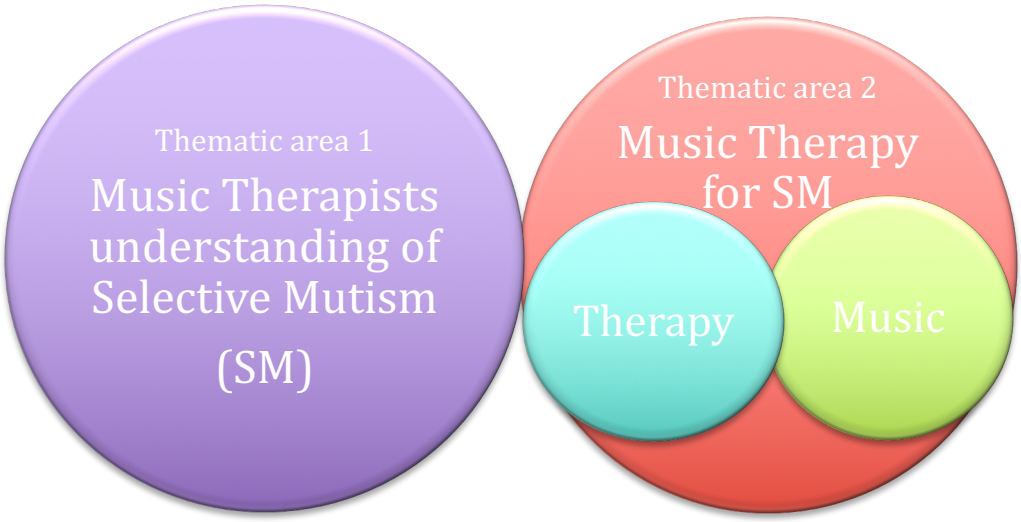
5.3.5 Ethical considerations

Potential risks of the interviews are low, however interviewees are likely to have concerns about how the information about themselves and their clients will be used and stored. The purpose of the whole research project and the interviews within this was outlined in a participant information sheet (Appendix 5.2). Details about signed consent and withdrawal of consent were provided. The sheet explained that the data would be securely stored, analysed and reported anonymously (Appendix 5.3). The interviews were anonymised and given a unique I.D. number. Digital recordings of the interviews will be destroyed once the study has been completed. Ethical approval for this study was given on 8th November 2013 by the Music and Performing Arts Departmental Research Ethics Panel at Anglia Ruskin University (Appendix 6.5).

5.4 Results

Themes were grouped into two main thematic areas (Figure 5.1), each with a number of sub-themes as shown in Figure 5.2 and Figure 5.3 below.

Figure 5.1 Main thematic areas and themes within thematic area 2



5.4.1 Thematic area 1. Interviewees' relationship to the conceptualisation of Selective Mutism

Many of the codes from the interviews linked to the conceptualisation of Selective Mutism and our relationship to this clinical area and body of knowledge as Music Therapists. Themes highlighted seven particular topics (see figure 5.2 below).

Figure 5.2 Topics within thematic area 1

5.4.1.1 Lexicon of SM

Interviewees used a range of language to describe their clients with SM. Three interviewees focussed on describing their perception of their clients' problem rather than naming it as SM. For example, one interviewee simply called it "not-talking" which was the way it may have been described at that point and place in time.

> "if they had just not-talking there wouldn't have been so much in place" (Interview 4).

Another interviewee said:

> "a very shy quiet child" (Interview 1) rather than "a child with Selective Mutism".

Five interviewees used outmoded language or interpretations to describe their client's Selective Mutism, similar to findings from the case study literature (Section 2.5.4). Phrases such as: "she just wouldn't speak" or "just choosing not to move or

anything" (Interview 4) indicated a possible lack of understanding that anxiety is the primary cause of the mutism. A range of other phrases also indicated out of date conceptualisations: "he just zipped his mouth shut when he went to school"; "there was something very provocative about what he was doing" (Interview 3) ; "there's a real stubbornness to them"; "very strong willed just to be able to sustain that without breaking down" (Interview 6); "he refused to go to PE" (Interview 1).

Two interviewees indicated more awareness of current conceptualisations of SM by correcting or questioning their understanding: "he would refuse to speak, sorry that's totally wrong, he didn't speak" (Interview 5); "this desire for control and that's been a big part of the work and again that's linked to the anxiety isn't it?" (Interview 6).

One interviewee showed a solid understanding of SM when describing her client's presentation:

> "she was starting to speak quite well at home but at school not and so the diagnosis came from then." (Interview 2)

Later in the interview the same interviewee gave a clear, textbook definition of Selective Mutism:

> "So where a child is comfortable talking in one environment- often at home- but has difficulties speaking in other environments where they have the ability to speak for often emotional reasons or they're anxious about talking in that second environment and where it inhibits their learning or development and where it's an ongoing problem" (Interview 2)

Another interviewee who used some outmoded language also described personal experience of SM:

> "my memory of having that lump in your throat and that absolute terror that meant that there was no chance of you even opening your mouth let alone being able to say anything" (Interview 6)

5.4.1.2 Identification of 'Selective Mutism'

The theme of evolving language, understanding and identification of SM as a specific condition was very apparent in many of the interviews, particularly in relation to the term 'Selective Mutism' itself. This is described in comments such as:

> "we didn't call it Selective Mutism, its only recently that that's come up"; "in those early years I probably came across some who weren't diagnosed as such because then they didn't have a diagnosis of Autism let alone SM" (Interview 4)

> "there seemed to be the 2 terms at the time, Selective Mutism and Elective, and trying to understand what those differences meant and forming my own ideas of what they meant and then Elective became archaic and it became Selective.." (Interview 5)

Some interviewees' comments highlight the common misconception and confusion in distinguishing between Traumatic Mutism and Selective Mutism. Five interviewees refer to trauma or a traumatic past for their clients and without having further detail of the case histories the cases remain somewhat ambiguous diagnostically. One interviewee said:

> "but it's very much linked to trauma… so a traumatic event happened for a child and they were SM for about 6 months and then they spoke again so I don't know whether that was shock and what category that comes under? Well they spoke to their parents but they didn't speak at school." (Interview 5)

Another interviewee describes cases of traumatic mutism without defining this as different from SM.

> "There's quite a few children that would fall under the trauma category quite firmly" (Interview 3)

One interviewee described the possible risk of missing SM if children have additional comorbid conditions such as developmental delay:

> "he wasn't referred for SM he was referred because he had development delay across the board and he wasn't speaking and he used to stand in the middle of the nursery, just limp, just stand there, just completely shut down." (Interview 6)

Issues around who diagnoses SM were also mentioned:

> "I'm not entirely sure that she has been diagnosed with SM, an educational Psychologist and a play therapist that had worked with her before refers to

her as having SM so I don't know whether a formal test has been done but her history largely fits with that." (Interview 2)

5.4.1.3 Knowledge gaps

The lack of training and information on SM was something that interviewees commented on:

> "I don't remember it being something that we learnt about particularly and I remember going and doing research myself and finding there was nothing." (Interview 5)

> "when I first started working with [name] I had no idea what I was doing really, I hadn't come across Selective Mutism in my training, yeah I had absolutely no idea what to do at all" (Interview 6)

Interviewee 5 expanded on the regret they felt at the way they supported a client with SM early in their career:

> "I feel I raised his anxiety by leaving so much silence in his sessions […] I just feel I was exacerbating it.[…] that was one of those things that I look back on and think I could have changed how I handled that. [...] I didn't agree with the way I'd worked, I think there is something about being trained to meet whatever is brought to the room." (Interview 5)

The cause of SM was considered by another interviewee:

> "I don't think we ever got to the bottom of what was going on, but [...] he started speaking in the therapy sessions and started speaking round the school" (Interview 3)

Accessing good supervision as a way of increasing expertise and understanding about SM, was articulated by one interviewee:

> "having a supervisor who knows a little bit about what you're doing is kind of helpful." (Interview 6)

The role of speech and language therapy input was unclear for some interviewees. One interviewee referred to a client only receiving "sporadic speech and language therapy […] SLT sort of once every 3 months and as a sort of consultation" (Interview 4). Another interviewee stated:

> "I don't know if the SLT has the tools to work with this, I actually don't know […] but 8 years ago it was still 'I think we can change their behaviour', so no specialist interventions but yeah some tailored strategies to get a child to speak". (Interview 5)

5.4.1.4 Intuitive understanding of SM

Despite some specific knowledge gaps interviewees also demonstrated a high degree of intuitive understanding and insight into some areas of SM through both clinical experience and general levels of expertise as therapists. One interviewee, who used outmoded language in other parts of the interview, described insight into how SM can become 'entrenched':

> "I sort of see it as 9 year olds, early teenagers, and then I see the pre-schoolers, I see them as two separate groups really. The pre-school ones are the ones that get better, or they have in my practice, you know it's not enough children to generalise but you know, that seems to have been what happened and maybe that's because I had access to them at three or three and a half or two and a half, whereas I didn't see the others until a bit later, or it might have been more entrenched, I don't know…" (Interview 4)

Another experienced therapist noticed this happening too:

> "I think the first child was more straightforward. She was in year 1 and the other child was in year 3 and so had gone a lot further down the line with the SM" (Interview 1)

The impact of learning English as an additional language (EAL) was described by another experienced therapist:

> "well there's all the different theories about the mother being overprotective but my feeling at the time would be, I did have a sense of trauma but I wasn't sure about that either, my feeling was that having EAL and being shy and unconfident in the first place it could've been that, being self-conscious about whether he was getting the language right or not would be a factor and with his mum being quite unwilling to reveal herself" (Interview 1)

And one interviewee noted an important factor for some children with SM and their families:

"They were socially isolated." (Interview 6)

The impact of the communicative dynamic with the mother was also described:

> "she was very sweet and kind to him in the sessions but very overbearing, and sort of answering for him." (Interview 5)

Many interviewees also talked about the importance of generalising speech into the classroom after a child with SM has begun speaking in the therapy room.

> "he started speaking in the therapy sessions and started speaking round the school, it just transferred straight over." (Interview 3)

> "Yes, so it [generalisation] was in stages and slightly behind what was happening in the Music Room." (Interview 6)

One interviewee showed awareness of the impact of the wider political environment and also the classroom dynamics for children with SM:

> "the funding's not there. It's tricky, sometimes it is just a money decision." (Interview 6)

> "those are the children that also get missed, and so you can take a child back to a classroom and nobody's noticed that they've come back." (Interview 6)

5.4.1.5 Emotional awareness

A particular strength of Music Therapy is our expertise in emotional awareness and processing. Elements of this expertise were evident in the interviews particularly in relation to the subject of anxiety. Different aspects were considered, such as its origins, intensity and its effect on others. Interviewee 5 described some of these elements:

> "possibly this anxiety is coming from their mothers who are anxious too." (Interview 5)

> "… how horrific it must be for a child with that kind of anxiety to carry on, like just any way of supporting them I find very important." (Interview 5)

Interviewee 6 described her understanding of the roots of the anxiety:

> "It was like the dynamic of the home environment was so incompatibly different with the dynamic of the outside world that they just don't know

what to do once they get outside the home and it causes such anxiety that something had to shut down and sometimes it's the voice". (Interview 6)

Another interviewee described the link to a parent:

"she [mum] was very shy, husband was very outgoing, quite loud and overbearing and it just struck me how like his mum he was" (Interview 1)

Anxiety was also described as being manifested in the team around the child:

"I think there is something about the anxiety that there is around these children 'cause they're not speaking and we've got to get them to speak, it's like working with a child who's been abused and they say 'oh we've got to get disclosure', people get very understandably caught up in a lot of anxiety," (Interview 3)

Interviewees also discussed the emotional effect of having SM:

"There is a lot that is rumbling around inside her without having any self-expression" (Interview 1)

And the importance of ultimately being able to use words to explore difficult feelings:

"she started to initiate a conversation around deeper topics" (Interview 2)

Interviewees also described how powerful emotions were sometimes a useful trigger for speech:

"when she felt slightly cross or frustrated that was something that pushed her into verbalising" (Interview 6)

5.4.1.6 Complex SM

Interviewees described many examples of working with children with SM and other comorbid conditions. Two interviewees mentioned children with cerebral palsy and SM:

"that's another group of children so, very physically disabled but very able intellectually, [...] that group of children is often selectively mute because they don't talk outside the home and I hadn't talked about it until this very instant about the fact that there could be a connection"- (Interview 4)

Other interviewees discussed learning difficulties and SM or Autism and SM:

> "Some were in schools for children with severe learning difficulties who could speak and were doing that quite well but just weren't doing that at school and were talking at home." (Interview 3)

> "Then [name], had Autism […] She could speak. She used to speak in the playground but not in school." (Interview 6)

A few interviewees described complex emotional issues and SM:

> "it really was very, very complex […] he wouldn't reveal himself to anybody he didn't know and so she [mum] was his kind of model rather than the dad who was very outgoing and this bad relationship with the brother and the cousins from Pakistan and this intense feeling of shame" (Interview 1)

One interviewee highlighted a particularly entrenched and complex form of SM alongside severe mental health issues:

> "they can't walk any more so they come into the unit in a wheelchair and sometimes they carry on regressing and they go into a foetal ball and become young again……they maybe would be classed as Elective Mutism because they would go on talking at home but would stop talking outside" (Interview 4)

5.4.1.7 Teamwork

The role of team members, -including parents, teachers, teaching assistants and other health professionals-, and teamwork in the Music Therapy intervention was another theme that emerged strongly from the data. As seen in 5.4.1.2 teamwork may be important in the diagnosis as well as the treatment of SM and relates to the overarching theme of our relationship as Music Therapists to current conceptualisations of SM. Interviewees described the different perspectives of teachers on Music Therapy for children with SM:

> 'he had a good teacher, she was very clued in, and she was into drama herself, and she said "look he needs to communicate somehow with us, it's very hard, I don't know what it is […] if he's having a conversation with somebody somewhere that's a start"' (Interview 3)

And how this can vary with different teachers:

> "[Name]'s teacher didn't really get why I was taking her out of class, […] thought that she would probably just get better if she was normalised and kept with the other children. […] in the previous year group it was her teacher that pushed and pushed for her to be referred to me […], and thought that Music Therapy would really help this child" (Interview 6)

Thoughtful team referral processes were especially apparent for one interviewee:

> "one of reasons she got referred to me was [name] was speaking in full sentences with the play therapist and at home but […] not really speaking all that much expressively in the context at school." (Interview 2)

Positive examples of teamwork were mentioned by four interviewees:

> "she [educational psychologist] put forward an intervention that she was hoping someone at school could use with [name] and we talked about whether there was a way I could build that into MT" (Interview 2)

> "Yes, it was very much in parallel, and we [SLT and MT] sat there and we talked about it. […] we think actually we've got to be really consistent" (Interview 6)

The involvement of parents as an active part of the team was mentioned by two interviewees. One interviewee discussed how initial meetings with parents improved the therapy process:

> "I hadn't really started to build up good communication with parents yet, so now, if I am referred a child I bring in parents to the consent meeting I explain to them, we have a chat" (Interview 6)

Another interviewee described a generally poor clinical environment with lower levels of communication and understanding from the teacher and disappointment with the onward referral process:

> "I did have some contact with the teacher, but not a great deal. I think she [the child] was beginning to use language in class, as far as I know."

> "one teacher […] would pretty much make him say Good morning."

> "he should be referred to CAMHS as he does need therapy […] it really did upset me 'cause I did ask for assurances that it would continue" (Interview 1)

Interviewees also mention the positive or negative role of the wider school team. One interviewee mentions the invaluable role of a teaching assistant (TA):

> "she would speak in her reading group to a TA that she had a particular rapport with in little group work" (Interview 2)

And later the supportive team approach:

> "Very supportive and I think that's really important actually and so I don't think I could have worked this way in a school without such a supportive Head". (Interview 2)

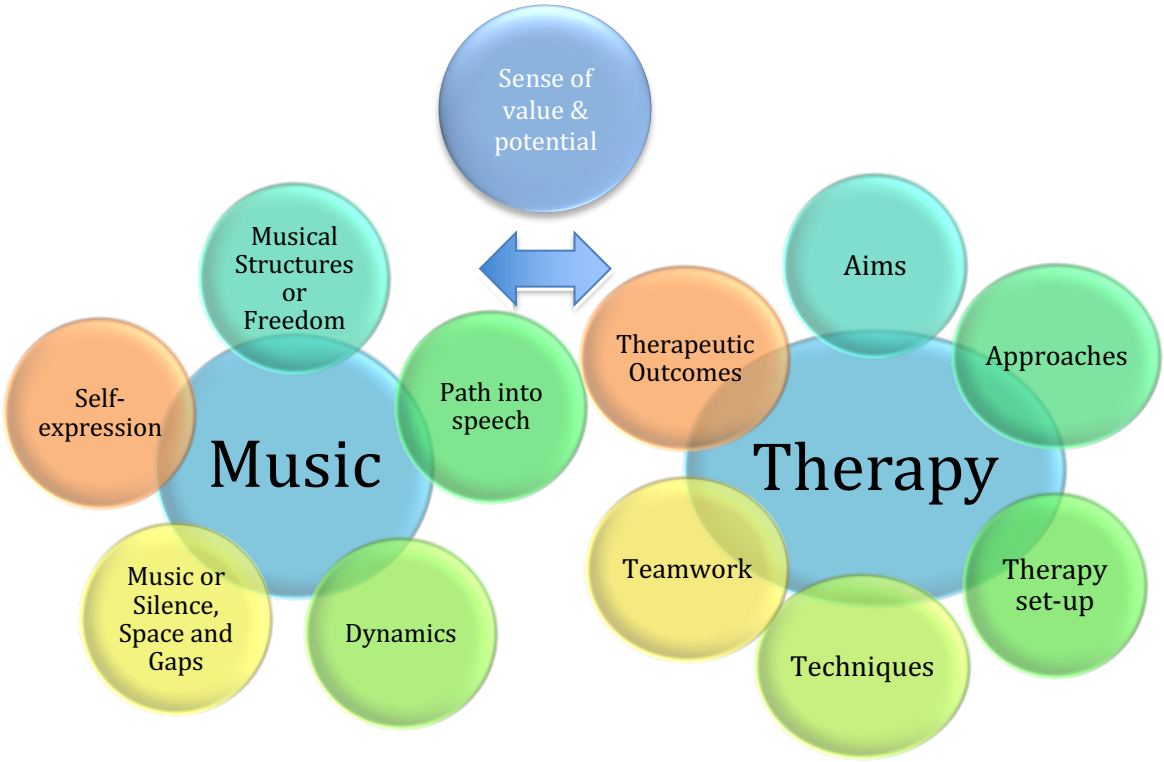
Another interviewee describes the lack of human resources in the school to support SLT intervention:

> "SL[T] gave the school the guidelines from the book that we know about SM. School didn't allow enough resources to carry out that particular intervention with her" (Interview 6)

5.4.2 Thematic area 2. Music Therapy and SM

Within this second thematic area the categories seemed to divide naturally into two key themes: those elements that are more linked to the *music* of Music Therapy and those that are more linked to aspects of *therapy* and *therapeutic thinking*. Despite the apparent simplicity of having these two large themes these elements are not separate and distinct but overlapping or closely connected. Some codes also relate to a number of different themes.

Figure 5.3 Thematic area 2. Music Therapy and SM



5.4.2.1 Sense of value and potential

By way of introduction to the 2nd thematic area I will describe an integrative sub-theme that frames the responses given by many of the interviewees; that of the sense of value and potential of Music Therapy for people with SM. In five of the interviews there was a tangible sense of excitement and positivity about working in this area. These phrases exemplify a feeling of the potency of Music Therapy for people with SM.

> "we're the ones who can do this work" (Interview 3)
>
> "I do think that music is an incredibly powerful tool with this client group" (Interview 5)

Similarly enthusiastic comments described children's progress:

> "A lot of them came to me aged three, three and half and they weren't talking at all and they left talking fluently and it's always terribly exciting when they start talking" (Interview 4)

> "I feel really excited for [name] that she is making this progress." (Interview 2)

> "he really caught up and was flying by the time he left school which was great." (Interview 6)

> "I think it was quite extraordinary just the timing for that family and the impact that that intervention had made and everything around it." (Interview 3)

5.4.3 Musical elements

5.4.3.1 Self-expression

Interviewees shared a range of clinical examples and views on the key issue of musical self-expression. One interviewee gave a concise general overview of this issue:

> "It's all the developmental stuff but also the very sophisticated musical stuff" (Interview 3)

Interviewees gave examples of energetic self-expression:

> "playing the recorder with great wailing and shrieking sounds" (Interview 1)
> "there'd be a lot of playful improvisation and also the opportunity to be dramatic, opportunities for loud playing, for pushing things" (Interview 4)

Other interviewees considered less intense aspects:

> "music seems to be such an opener for [name] and as an aside she seems like quite a musical child and it's just something that she loves doing." (Interview 3)

5.4.3.2 Music or Silence, Space and Gaps

There was a lot of discussion about how we as therapists use the musical space in the room. One interviewee described the essence of their musical approach as:

> "music to capture or connect with or put underneath what they are doing" (Interview 3)

Decision making and thinking about the role of music or silence with a person with SM was a key issue. As mentioned in the first thematic area, interviewee 5 discussed

regrets about early experiences in this clinical area but later shared musical approaches that worked better.

> "I would just form music around her presentation and the atmosphere in the room…a lot of guitar based [sc music] and just gentle things and then some space" (Interview 5)

Another interviewee describes moving from one approach to another as the therapy progressed.

> "I tried actually leaving silence at the start of the sessions, which didn't feel possible in the initial sessions but we've got to a stage where we can try that and the feelings around that [...] the first time I did that there was quite a wait and then [name] said 'the chimes' and we've got to a point where now I don't speak at the start of the sessions and [name] will say, 'let's sing Hello' or 'I think we should do this' and she has actually started to boss me around which is fantastic." (Interview 2)

5.4.3.3 Dynamics

Dynamics and volume are another key musical element that seemed particularly interesting for this client group:

> "her musical voice was also quite quiet, the volume increased over the course of the sessions and she chose to start playing on the drums and in the individual sessions, the volume of her voice, I've been quite taken aback, it's been quite loud, it's almost like there's a lot to come out" (Interview 2)

Volume formed an interesting part of a discussion on the role of interactive, musical dialogue for people with SM.

> "a lot of musical relatedness and sort of some very interesting dialogues which changed in the feeling from very loud to almost inaudible, there was this musical relatedness which could be broken off" (Interview 1)

Volume was also relevant in regard to a client's use of singing:

> "after a few weeks I noticed [name] looking like she really wanted to speak or sing and after a few weeks she started to sing in quite a big voice, she sang 'hello' back" (Interview 2)

5.4.3.4 Path into speech

Many of these different elements overlap, combine and contribute to a therapeutic journey into speech that was described clearly and movingly by many of the interviewees. The musical link to the voice through singing and song was a key feature of many of the therapy narratives. One interviewee described quite a novel approach:

> "I sing-talk and so we make up songs in sessions but when I go to meet [name] in class I'll use a singy voice and I will initiate a conversation and that seems to really work for [name] so even though she doesn't sing back she talks back and more and more she's been responding to me in class." (Interview 2)

The use of kazoos (a small inexpensive plastic instrument that you sing through) as a bridge from music to speech and also for fun was mentioned by a few interviewees:

> "the patterns of turn-taking and speech that can happen with kazoos, and also the change in the contour of the sound and imitation and pitch." (Interview 6)

> "he started making sounds with the kazoos in July […] then came back in September and started talking". (Interview 6)

Interviewees described other paths into speech:

> "the child becomes more free physically as well, […], then sounds and vocal sounds, and then words seem to come and then we can be excited about it together." (Interview 4)

> "she put this CD on and would listen to this over and over again […] and she started to smile and sing along and over weeks started to really engage with me and then we would need the CD less and she would talk and she would speak" (Interview 5)

Sometimes the path into speech is swift. This quicker process seemed to be helped by the use of louder sounds:

> "I think he just shouted, he famously shouted, when he was playing something really loud, yes he did, he shouted "no", very firmly, "no" and you know what we do with a "no" and so we had a "no" song, all of that and took

it in to the music and I remember singing "-his name- says "no" and then he said "yes"" (Interview 3)

5.4.3.5 Musical Structures or Freedom

The rationale for employing either an element of structure or musical improvisation in the sessions was explored by many of the interviewees.

> "I'd try to balance that with much freer things, so being very aware of structure versus freedom in the improvisations or structure within the music, being quite predictable" (Interview 4)

> "He couldn't cope with free play." (Interview 5)

> "there's a kind of balance between the child's own ideas, bringing one's own material, letting the child direct, and be directed" (Interview 4)

This idea of balance in the interaction between client and therapist appeared to be an important concept for the therapeutic relationship. One experienced interviewee said:

> "these children liked to be the people who are holding it and being in control so I played around with changing it at times, so that I took control, […] and of course the give and take and the turn-taking, […] you have to work hard to keep it creative and not get into stuck patterns." (Interview 4)

Examples of musical structures and their function were discussed. Some of these concepts also overlap with the second main theme of therapeutic thinking.

> "So very much a structured game or structured activity, repeated, to find that safety. Even things like our greeting and ending songs, so powerful for the child coming in and knowing what is going to happen." (Interview 5)

Songs were a common musical device used by many of the interviewees:

> "she liked the songs we were singing, you could almost see it bursting out of her and she wanted to sing along, she never spoke at all but she did sing." (Interview 5)

One interviewee describes an innovative shouting out game for children with cerebral palsy and SM:

> ""stretch up tall like a house, curl up small like a mouse" and then we'd all fall asleep and then she'd have to kind of shout to wake us up, so that was a

> playful way of her having control, so it's giving these children with very little physical control over their movements a means of controlling the physical environment using their voice." (Interview 4)

The idea of call and response was used in various formats:

> "we had musical call and response, we had vocal call and response around the Hello song…singing Hello in different ways and experimenting with different voices and singing different rhythms or using different rhythms on the piano." (Interview 4)

And questions and answers, often naming specific items, became useful to assist with verbal expression:

> "she named instruments that she would like to play when she was asked and then participated in Hello and Goodbye and finger puppets and she narrated what was going to happen next and so I would say 'what's going to happen next? Where are they going to go?' and she would reply." (Interview 1)

5.4.4 Therapy and therapeutic thinking

5.4.4.1 Aims

Interviewees were asked directly what their therapeutic aims and objectives were. Many interviewees were initially keen to point out that they were not specifically aiming for speech:

> "let's see where we go. I'm not going to guarantee that this child is going to come out of here talking, we can have a good go." (Interview 6)

> "we're not here to try to get you to talk" (Interview 3)

Aims seemed to be more generally around offering a way of relating, connecting and communicating:

> "To make contact I think was a big one, to find a meeting place where I had somehow reached the child and somehow opened up and reached me, even if it's just a teeny thread… they're not really connected to anyone or anything so can I connect even it's for a little half hour session in a week." (Interview 5)

Providing a sense of safety in order to help facilitate the therapeutic relationship was embedded in some interviewee's aims:

> "emotional expression is always a big goal for those children, and to be able to be spontaneous and creative and to form a relationship that is built on trust and it doesn't have to be verbal because that can be the stepping stone for a verbal relationship. I think the safety of the space is crucial. If you've got interruptions with a child with SM you're never going anywhere." (Interview 6)

Many interviewees mentioned confidence and self-esteem as an important therapeutic aim that could lead to speech:

> "to build [name's] self confidence and self-esteem and really those are the two main aims that I have at the back of my mind that that will contribute to her vocal confidence" (Interview 2)

5.4.4.2 Approaches

Interviewees described a range of approaches. A "pressure off" approach –widely described within SM literature- was often apparent in some of these descriptions:

> "the main philosophy I have is not to push the speech at all, to just be completely ordinary and playful." (Interview 4)

> "never reacting if they did make a little sound, don't react, just be normal [...] You need to say something very subtle and calm don't whoop." (Interview 5)

Some interviewees described the importance of play in their approach:

> "That she could be playful, she could decide what would happen next." (Interview 1)

> "It's this idea of playing, of being free in play and just humour, these two with whom it worked so well, just laughing together, and also with the CP [cerebral palsy] children just having a chance to be silly and relax into being a child," (Interview 4)

Interviewees also described the importance of feelings and a psychodynamic approach in sessions:

> "a very psychodynamic way of thinking is for me with this client group so important because it's really enhanced my work being able to think what did I feel? and what was I feeling from them? and being able to break that down." (Interview 5)

> "Talking, talking about her feelings will seemingly come from nowhere and she'll suddenly say…talking about her family, last week talking about death, […] she has quite a lot of anxiety about her own death." (Interview 2)

Some interviewees either deliberately or intuitively used behavioural approaches to assist the therapeutic path into speech. One interviewee described her initial response to a behavioural approach:

> "after about 4 months the SENCO was giving him stickers as rewards for good speech and I wasn't doing anything like that because I thought it was bypassing the problem and not dealing with it." (Interview 5)

The interviewee then described how she instinctively and successfully tried a behavioural approach:

> "I whispered to him one day, if you can say Hello first then you can pick out of the sack first, and he said Hello, that was it, from that week on he sang Hello and Goodbye during the songs, and once you've broken that ice it gets a little bit easier and now he's singing along with the songs, and then after about 3 weeks I felt that it was about the right time to say "good singing" and acknowledge, it's all very gentle but yes we got there and I did go to the tactics of reward and, yes I thought there was an irony in the fact that I'd done that as I'd been against it however many years ago." (Interview 5)

Awareness of the impact of behavioural patterns was also apparent when interpreting family dynamics:

> "his mum would do it for him and cuddle up to him and reply for him and give all his answers". (Interview 5)

> "[Grandma] became the focus, and just to encourage her to give him space and say that's OK if he's not ready to answer we've got to give him that time." (Interview 5)

Some therapists were inadvertently using behavioural techniques through the therapeutic set-up they had chosen. One therapist chose to work with parents in the therapy room that could be viewed as fitting the behavioural 'sliding in' technique.

> "When the children arrived they wouldn't be talking but there might be a kind of code between them and the child might do something and the parent would be like "he wants or she wants" and I wouldn't have a clue. And gradually as they became more verbal then they would speak to their parents in the session" (Interview 4)

One interviewee described a carefully planned intervention blending conventional Music Therapy with behavioural techniques:

> "the Educational psychologist from [borough] who had been involved as well, we spoke on the phone and she put forward an intervention that she was hoping someone at school could use with [name]. She suggested a staged approach with [name] working with someone she trusts in an enjoyable activity, -it's actually quite a behavioural approach" (Interview 2)

The interviewee goes on to describe how speaking is generalised into the classroom setting:

> "we might go into the reading corner in the classroom space and on those occasions she will slowly start to speak sentences" (Interview 2)

Generalisation of speech will be described again more fully below under 'outcomes'. The interviewee also makes suggestions about how aspects of this intervention could be further modified and improved from a behavioural perspective:

> "it might be a nice idea to take musical activities such as that at some point out of the classroom [location of the music therapy] to try with her class group". (Interview 2)

Many of the therapists demonstrated an open, responsive approach to therapy:

> "Always we were trying to work out what was going on for them, how to be with them, whether to leave them in their own space, whether to facilitate them, but because of the nature of the group the way that I run it, there is this free time mixed in with the structure and so it meant that you were covering it, all the different options throughout anyway" (Interview 5)

The importance of a child-led stance was mentioned throughout the interviews:

> "I wouldn't necessarily structure things but if it was necessary I might in some shape or form, I wouldn't go in with a thought that I'm going to do this, that or the other, it's much more to respond to what they are bringing into the room, would be my way of working." (Interview 3)

> "looking for any clues as to what sparks them, what makes them feel more comfortable, what makes them feel more interested, is it no music at all or making a teddy bear bounce up and down,". (Interview 5)

The importance of employing "relentless positivity" was a striking comment made by interviewee 3 when discussing therapeutic approaches.

5.4.4.3 Therapy set-up

Interviewees provided a range of different therapy set-ups to create a suitable space for the children. For some, group work with parents seemed appropriate but required different techniques from individual therapy:

> "they were assessed one to one and had the parent consultation and felt that there was high need […] we noticed that they played near each other and they wouldn't speak but they would find each other in the nursery and so it made sense to put them in a group together […] I did that mother infant interaction and modelling that to the mum" (Interview 5).

Another child was more comfortable in a group setting than individual therapy:

> "I put him in a group with two others […] and he was so much more comfortable and slowly found ways of vocalising through the music because the music was there a bit more rather than the instruments just sitting in front of us." (Interview 5)

One interviewee described adding puppets as additional members for an individual client:

> "I think that I did decide to bring them in as she found it difficult one to one and that it was quite intense and that she became a little bit stiff and so I felt that there could be an intermediary." (Interview 1)

Another interviewee described how group work didn't work for her client:

> "we tried a small group with [name] and two of her class mates, that wasn't at all successful."

One interviewee described the difference in attendance patterns between younger children and adolescents:

> "they [adolescents] came as outpatients, […] and so it was very difficult getting regularity whereas […] with these pre-schoolers they were very committed families […] And of course I'm always working with the parents as well." (Interview 4)

Interviewees generally stated that therapy was provided once a week with one notable exception:

> "we have 2 sessions each week and the first of those sessions is very much the way I would work with other children, […] and then we have a second session on the following day where […] we can watch video together of a previous session, we have a MT scrapbook where we write ideas down, […] we invite a friend in or an adult to look at those things together". (Interview 2)

Length of sessions was generally said to be around 30-60 minutes but with some flexibility for younger clients:

> "when they start it's 10 minutes and then maybe it's 15 and then maybe it's a bit longer and then gradually they've done 30 minutes." (Interview 6)

In regard to the duration of therapy two interviewees described similar amounts of input for clients in schools:

> "I would say that on average it was about an academic year, from September to July, once a week, that sort of thing." (Interview 4)

Some interviewees mentioned the breaks in therapy as being either positive or negative:

> "every time there was a break or a holiday he came back, and it was like he had planned that he was going to do something different and he'd come back and try something slightly out of his comfort zone." (Interview 6)

> "last week was the first week back and I did notice that she seemed a little anxious and quieter than she'd been for a few weeks leading up." (Interview 2)

Endings were also described as potentially helpful in encouraging speech:

> "in the last session of the group the little girl who sang said something on cue [...] and so the other little girl did as well, and once they'd both shouted this thing" (Interview 5)

5.4.4.4 Techniques

Interviewees described a wide range of therapeutic techniques to engage their clients. One interviewee described a standard and very useful Music Therapy technique:

> "But then musically picking up on the slightest change […] it can be something like the child just moving the foot, [....]and it's just suddenly tapped in time to the music and you follow it and the child realises that you are following it and that's an amazing ice breaker, I think it's one of the first things we learned in our training is mirroring anything that they bring to the room, with the child that is SM that's often so important as they are often mute in their whole physicality." (Interview 5)

Interviewees also described how their flexible approach allowed for more novel techniques to be used such as playing CDs and discussing the music (5.4.3.4). One interviewee described a range of interesting tools:

> "Making a music therapy scrap book […] Videoing sessions, and watching those back together, […] I usually ask [name] 'then when we meet tomorrow would you like to choose someone to bring and where would you like to meet and could we watch some video together?'" (Interview 2)

Sharing nice instruments or objects in the sessions was an important tool for one interviewee:

> "the real breakthrough was when I brought in this instrument [gets out lovely Indonesian metallophone] and the other thing that really helped was taking in small stuffed toys- a small teddy- and finger puppets as well. It took the focus off her. And using the puppets she would start to say things." (Interview 3)

Another interviewee incorporated art materials and natural provocation into her therapy sessions:

> "she quite often used to draw a playground. She'd draw a slide and swings and if I wasn't guessing everything that she'd drawn properly she used to get so exasperated that she would then start to try and tell me." (Interview 6)

Humour and laughter were discussed as an important resource in the therapy sessions:

> "I think humour was something that was incredibly important in working with her and [name]" (Interview 6)

> "And her facial expression was quite flat but then she began to laugh and we compared the ears on the puppy and the bear and our own ears- really getting into that play and on that occasion she sang Goodbye." (Interview 1)

Interviewee 3 used kazoos in a light-hearted, fun way with a whole class (described above). Interviewee 4 described how play, humour and silliness were integral to their approach (described above).

The music in music therapy is a cross-cutting theme which appears across this thematic area as it can also be viewed as a therapeutic tool. One interviewee clearly described the role of music as the main resource in the therapeutic relationship.

> "Having the time and resources of the music to build that non-verbal link and communication through music to build a relationship not based on words so they can express themselves non-verbally but so you can build a relationship non-verbally which can then very much facilitate that verbal [interaction]". (Interview 5)

5.4.4.5 Teamwork

The role of teamwork was an important theme that emerged in the interviews. Assisting with transitions was described by one interviewee:

> "what I'll often do when I start is get a teaching assistant who really knows them from the nursery to come with them to the room, and if they need that person to stay then fine we'll just wean it off gradually but if they don't then for that assistant to just acknowledge where the child is and then I'll take

them back to that teaching assistant so that child knows that there's one person that they know saw them go and saw them come back." (Interview 6)

General support for the therapy alongside a good classroom environment was also highlighted as important for positive outcomes:

> "I talked to his teacher about what was happening and she was a very interested and supportive of Music Therapy person so very easy to work with in that way but I think to be honest they had it right in that class room anyway, it was a safe communicative space where the children could be heard." (Interview 6)

Other interviewees described a different perspective on Music Therapy intervention from within their teams:

> "Well the two nine-year olds and the teenager who was about 13 I think, they'd had endless amounts of treatment already and I think it was like 'oh well let's try music therapy'" (Interview 4)

> "for some of them there would have been a sense of urgency about the referral and a sense of concern and worry, and 'we're losing them', it's getting worse, somebody's got to do something, and sometimes as the Music Therapist you'd be the last bus stop, "we've tried speech and language therapy and it's not worked, we've tried…whatever" and you don't know if this is going to work but we'll give it a go." (Interview 3)

The role of speech and language therapy (SLT) was mentioned by a few interviewees. One described sharing some ideas for SLT to incorporate in their intervention:

> "she's willing to give 'sing-talking' a go and she's running her own group with the class but she's naturally integrating some of these ideas with the class." (Interview 2)

Another interviewee described the lack of awareness of the value of speech and language therapy for a child with SM:

> "See none of the children have had SLT sought for them, amazing though it is they haven't been put forward for SLT." (Interview 5)

5.4.4.6 Therapeutic Outcomes

The therapeutic result or outcome of the Music Therapy intervention was inevitably an important topic that was discussed by interviewees. The speed, depth of improvement and sustainability of the progress towards communication or speech were all factors reported on in the interviews. Some described rapid, positive results:

> "he thawed very quickly, it was probably within 2 or 3 sessions, he just loved making a lot of noise, interestingly he didn't disclose anything that he was bottling up or anything like that it was just more to do with his confidence." (Interview 3)

> "the change was amazing in [name]. She was quite anxious, nervous in the first session and by the fourth session she was singing with me. To do this at school felt really exciting and that music could be a real way in […] speaking spontaneously in sentences in the session, um, in quite a loud confident voice, even intonation-wise, the way that we sing Hello together the way that she varies the pitch and rhythm in her voice has now become musically more confident." (Interview 2)

> "she only had one session but she talked in the session and that was the first time she had talked to anybody outside the family." (Interview 3)

Other positive outcomes took a little longer:

> "It was five terms work by the time we had finished, he was speaking in a normal voice by the December, but I discharged him in the March." (Interview 6)

> "they stick in the mind because they were long pieces of work." (Interview 5)

One interviewee questioned the sustainability of the positive results for her client:

> "Like [name] and the Grandmother. Well I suppose it's successful in that he could answer questions in the classroom and so on, which is something, which is a huge thing, but I wonder if he could have done that anyway with age just growing up through the school and feeling or was that part of having the MT support I don't know but it felt that I had never really cracked that one, that was really hard to let go of that one because I just felt that patterns had been set to fuel and support his SM and I almost felt that without the MT

> he would regress back and he would never speak at home barely at all because he would always be rescued." (Interview 5)

The interviewee was careful not to overstate the extent of the results:

> "when we ended he had reached the point where he could say Hello in the hello song and goodbye in the goodbye song and make a choice with one word." (Interview 5)

The timing of the intervention also seemed crucial:

> "the younger age group they've all got better. The older ones, the 9 year olds and the 12 year olds didn't" (Interview 4)

One interviewee discussed a client who regressed due to complex factors:

> "And really from the time I started working with her when her music was quite expressive, communicative, by the time she left in year 6 it felt empty, so it was very very difficult for her" (Interview 6)

The generalisation of speech to other settings was acknowledged by different interviewees:

> "She would answer questions, she wasn't particularly forthcoming, but she would speak in her reading group to a teaching assistant that she had a particular rapport with in little group work." (Interview 5)

> "he started speaking in the therapy sessions and started speaking round the school it just transferred straight over." (Interview 3)

> "he was already in small groups for some stuff anyway that quite naturally provided a place for it." (Interview 6)

One interviewee shared how her client confidently reassured another child:

> "[name] went over to her and said "don't worry, it's ok, it's good to talk about things" it was just amazing." (Interview 2)

5.5 Interviewees' responses to the framework

Late in the interview the theoretical framework was presented to the interviewees as an artefact to think about and discuss. Immediate responses to the framework were generally positive:

> "yes and with the 1st one [process] we went through that- and the anxiety- that was definitely what happened at the beginning and as she expressed more there was that build-up of trust." (Interview 1)
>
> "I feel that ties in a lot with how sessions have been with [name]" (Interview 2)
>
> "Well the first thing I'd say is that it seems to fit very neatly with what I've been saying." (Interview 3)

However, one interviewee immediately suggests potential modifications and additions to the framework:

> "I'm wondering where this story telling element might fit in […] it's got its emotional links but it's not primarily emotional either, is it symbolic? Maybe there's a symbolic line that could be in there too." (Interview 6)

Other interviewees also made comments regarding the structure and content of the framework:

> "these two I'd possibly change a little bit, it might be 'offering a potential space and a safe structure', [pause] and somehow that is alternating with being child-led and there's perhaps another one which is holding the anxiety, 'holding' the feeling" (Interview 4)

Some comments reflected on the different elements of the framework:

> "It's the old NR[4] thing, it's about a way of thinking about the whole child in the room, musically, so you listen to their vocalising, it could be singing words, it could be grunting anything, you think about the frequency of that, where is it in the tonality is it not, where its placed, is it on the beat off the beat, (Interview 3)

And also on 'sliding in' to speech:

> "that sliding in is I think what the music does, it slides in, because it's a body art, you fill in from the body, you do it from your body so that sort of fits, and yes parallels spoken conversations," (Interview 3)

[4] Nordoff and Robbins - Music Therapist pioneers

> "we've talked about the mother-infant interaction, and the voice is such a powerful thing there, that sometimes having the instruments to go through before we get to the voice, it's a progression, it's less personal somehow, through tapping on the table, through drums, through things that don't sound like the voice, to kazoos and things that do start to sound like the voice."(Interview 6)

And some interviewees expanded on ideas from the framework by giving further clinical examples:

> "I don't think I've mentioned [physical] that much but the motivation to move over and play the piano, with isolated finger movements, and that's very much where we started, at the piano and now we've gone on to the emotional /social emotional as the relationship has developed." (Interview 2)

> "so the way she's used her voice, goes along with this [framework] it's just two words about the instruments singing Hello and then suddenly wanting to talk about quite deep life topics……. And I think that's a really important line the no pressure approach" (Interview 2)

> "He was quite rigid physically. It was only when we rolled the rainstick back and forth that he began to loosen up and he conducted me one time with the rainstick and he was going from side to side but otherwise he was quite rigid" (Interview 1)

> "Maybe there is a creative kind of extra bit here that is actually still Music Therapy, 'cause if I think about the work I did with [name] and the art materials and guessing, the guessing and the timing of the guessing is musical. And the ebb and flow of that game is musical." (Interview 6)

5.6 Discussion

The discussion will begin with a summary of points from thematic area one and two, followed by discussion of the themes in relation to the theoretical framework.

5.6.1 Thoughts on Thematic area 1 - Music Therapists' understanding of SM

Within the general population and across a range of professions we are developing our understanding of SM. However, this understanding is less established and embedded than for other conditions such as Autism. The interviewees' experience

and relationship to the clinical area of Selective Mutism covered a broad spectrum. Some relatively inexperienced interviewees demonstrated good awareness and up to date understanding of SM whereas some experienced therapists propounded outmoded perceptions of SM. There were also cases in between with interviewees combining common misconceptions with intuitive understanding. This reflects the situation across many professions and in the general population as a whole. Despite descriptions of resourceful, responsive and successful therapy interventions there was often an underlying sense of a lack of proper grounding in SM in both historical work and in relation to more recent practice. Most interviewees either expressed ideas or used language about SM that is now considered inaccurate or outmoded, or they indicated that as a profession we need more training and support in this area.

Despite this inconsistent knowledge base, an intuitive, insightful understanding of SM was developed by many interviewees through a close therapeutic relationship with their clients.

Interviewees appeared to demonstrate how skills inherent in Music Therapy practice are effective when applied to clients with SM. Emotional awareness; psychodynamic thinking; close observation skills; and sophisticated knowledge of human interaction are invaluable resources in treating people with SM. Music therapists also gave detailed descriptions of therapy for comorbid conditions such as people with cerebral palsy and SM or Autism and SM which could be of particular value to the SM community. Another interviewee noticed how parents were unwittingly perpetuating their child's lack of speech through their own compensatory behaviour. This common dynamic is recognised as a 'maintaining factor' for SM in the Selective Mutism Resource Manual (Johnson and Wintgens 2016). Other interviewees understood the importance of generalising speech out of the therapy room into other environments which is a key component of a behavioural approach to SM.

Teamwork is a crucial 'integrative theme' that connects our relationship with the body of knowledge about SM to all our thinking about Music Therapy for people with SM. Connecting with others in a team around a child, or recruiting expertise into a team is one way of enhancing the knowledge base for a therapeutic intervention and also enables information sharing which is so key to any therapy but is especially pertinent when working with people with SM. The way a team communicates and functions can either assist or inhibit progress quite dramatically.

This was mentioned by many interviewees, examples of which are: a successful collaboration with an educational psychologist; a negative, undermining relationship with a head teacher. Employing a knowledgeable supervisor was a practical suggestion by one interviewee.

In regard to the following thematic area members of the team intrinsic to successful therapy included parents, classmates, teachers and teaching assistants who helped with transitions.

5.6.2 Thoughts on Thematic area 2. Music Therapy and SM

Fundamental to all our communication is the need for self-expression. For people with SM music can provide an invaluable channel for expressing, connecting and communicating. Interviewees demonstrated sophisticated thoughtful approaches that focussed on nurturing this opportunity for their clients in numerous ways. For the more experienced interviewees a confident, relaxed, open approach was apparent and most interviewees stated that a client-led approach was fundamental to their practice.

Much of the detail of the cases described by the interviewees emphasised and reiterated the elements of the theoretical framework, highlighting perhaps the obvious potential that Music Therapy has for 'sliding in' to speech for people with SM. The opportunity to communicate and be heard through non-verbal means thus leading to musical dialogue, the role of dynamics, structure or improvisation, the use of the voice through oral instruments and singing, was a common thread in the therapy narratives. A sense of ebb and flow in the interaction also seemed helpful.

Innovative techniques were also shared, such as multiple family group work and twice weekly sessions blending traditional music therapy with a behavioural approach. The use of 'sing-talk' and specifically invented songs to encourage the use of voice were other notably novel techniques.

There was an overarching sense of excitement and enthusiasm for helping children suffering with SM that was matched by positive outcomes. However, a slight wariness or perhaps lack of confidence prevailed as regards explicitly stating a therapeutic aim of supporting speech acquisition. It is true that initial therapeutic endeavour should be around developing rapport and connecting with clients, however, people with SM need to receive effective interventions for their fundamental problem. Lack of swift action often results in SM becoming entrenched

and intractable, potentially with additional mental health issues and so Music Therapists could perhaps be more assertive about their role in effective early intervention. Conversely, there is perhaps another role for work with older children and adults that has an initial focus on anxiety reduction and supporting other mental health issues, but these clients are not the focus of this study.

As with the review of practice literature, there are often familiar therapy processes or paths into speech across many of the case descriptions but also little therapeutic anomalies that add depth to the research.

5.6.3 Results in relation to the theoretical framework

The theoretical framework under scrutiny in this study evolved from a single case study with a young boy of nursery age and any critique takes into consideration that it is essentially an Early Years Framework. Data from the whole of the interviews is now explored in relation to the theoretical framework.

5.6.3.1 Revision of the Theoretical Framework

Themes and sub-themes from both thematic areas were arranged on the Theoretical Framework (see Figure 5.4 below). The themes from thematic area 1 did not fit neatly on the current framework and so in order to place them logically it was necessary to locate and create an appropriate space. Since our knowledge and understanding of SM is something that we bring to each Music Therapy session and also something that we should aim to develop and update, I felt that this aspect should comprise a column of its own to encapsulate the data. I also felt that this should come prior to the therapy process thus implying a suitable degree of preparation in order to work in this clinical area.

Another modification was to add ‘teamwork’ as an additional layer running through the therapeutic process. The themes of ‘therapy set-up’ and ‘approaches’ to therapy, with important sub-themes, were placed within stage 1 of the therapeutic process. This section was substantial and proceeds directly on from thematic area 1 in column 1 – Music Therapists understanding of SM.

Other themes and sub-themes enriched and illuminated the theoretical framework. However, data relating to the physical component of the framework was less prevalent and so, dependent on the outcomes of the case studies, this could perhaps

be modified to some extent. Overall, this array of data describing clinical experience adds greatly to our knowledge base as Music Therapists working in this clinical area.

Figure 5.4 Themes and subthemes from the interviews placed on the theoretical framework

Education and training in SM and how to treat it. Suitable supervision and teamwork, knowledge of the potential special value of MT, including skills with Complex SM, emotional awareness, awareness of quiet children, sophisticated interaction	**Therapeutic process** **Parallel layers of communi-cation**	1.Offering a potential space **Therapy set-up** Where? When? Frequency/duration Group or individual? With parents? **Approach-** pressure off Behavioural? Open, free & responsive. Child-led and flexible Aims	2. Manifesting anxiety – having it contained and processed Noticing family/team dynamics	3. Gradual build-up of **trust** and contact through listening and accepting – **Tools-** non-verbal relationship Puppets Nice instruments Mirroring MT scrapbook Creativity Listening to CDs Watching videos of therapy Art materials	4. Gradual development of shared, meaningful communication and play Exploring feelings Symbolic play Ebb and flow Interaction Humour and laughing	5. Need to end therapy – healthy, confident separation Breaks Outcomes Generalisation
	a) Musical	**Music or gaps/silence** **Path into speech** **Dynamics** **Structure or Freedom** "Smoke-screen" Interaction **Singing and songs** Call and response. Questions and answer**.** Kazoos Mirroring speech Containment				
	b) Physical	Singing and songs- link to the voice Freedom of movement Drama **Path into speech**				
	c) Emotional/ social	**Intuitive response** **Self-expression** **Turn-taking** Humour and laughing Connecting **Communicating** **Confidence and Self-esteem** **Impact of having SM** (sophisticated) non-verbal Interaction				
		TEAMWORK- including teachers/parents/whole school/other professionals-SLT-/supervisors *NB- Bold is used to give emphasis to certain features*				

5.7 Conclusion

Data from the interviews formed two main thematic areas:

- Music Therapists' understanding of Selective Mutism,
- Music Therapy practice for children with SM.

This latter thematic area consisted of themes linked to the music of Music Therapy and also themes connected to the therapy or therapeutic thinking. Overall, the interview data broadly support the theoretical framework and imply that Music Therapists have a range of therapeutic skills that have particular value and application for clients with Selective Mutism. However, the data also indicate that the impact of Music Therapy might be greatly enhanced by a better basic understanding and more thorough knowledge of Selective Mutism. Suggested modifications to the theoretical framework from this data set reflect this conclusion. The data greatly enrich our understanding of the multiple ways in which thoughtful therapy may be provided.

Chapter 6 - Case Study Methods and Settings

6.1 Introduction

This chapter outlines the background to the multiple case studies including:

- Case study theory and design
- The multiple case study method (and analysis)
- The setting for the case studies including data from 6 key informant interviews from the borough in which the case studies take place.

Having investigated other Music Therapists' clinical practice with clients with SM through case study literature and a survey and interviews of Music Therapists, undertaking further case studies provides the opportunity for an in-depth examination of how and why Music Therapy might help children with SM and a comparison of these data with the original theoretical framework. Explanatory multiple case studies (Yin 2009) allow for theory to be developed and key elements of an intervention, that appear to have significant potential for a particular clinical need, to be thoroughly explored and analysed as to their relevance and utility.

6.2 Music Therapy Multiple case studies

Music therapists have used multiple case studies to explore a variety of clinical issues. For example, Lagesen (2014) presented a conference paper on mixed-method multiple case study research exploring the impact of collaborative Music Therapy on the care of adults with Huntingdon's disease. A qualitative-quantitative study of multiple cases of Music Therapy for 3-5 year old children with language disorders was presented by Covre and Zanini (2016) at the European Music Therapy conference in Vienna. Another example is a multiple case analysis of a Music Therapy programme for adolescent refugees from North Korea (Choi 2010).

Two articles are of particular relevance for this study: one (Rolvsjord 2015) for the analysis techniques used and another (Thompson & McFerran 2015) for the similarity of subject matter. Rolvsjord (2015) uses semi-structured interviews to investigate how clients with mental health issues make Music Therapy work for them. Seven case studies of collaborative Music Therapy processes are explored through open-coding and thematically analysing 'meaning units'. Themes and

narratives from the interviews are triangulated with other data, such as the video recordings and clinical notes to provide nuanced, thick descriptions of the cases. The findings are presented as a table of themes, such as 'initiatives' and 'engagement across contexts', and subordinate themes such as 'joking and teasing', and 'caring for the therapist'.

Thompson and McFerran (2015) investigate communication and interaction in four case studies of Music Therapy with young people who have profound intellectual and developmental disabilities. They highlight the selection of case study as a method of investigation as being appropriate when the phenomenon was difficult to separate from the context, citing Yin (2009) and Flyvberg (2011) as influencing this decision. Thompson and McFerran use quantitative methods to compare the frequency of communicative behaviours in their clients during Music Therapy as opposed to playing with a favourite toy. A similar quantitative method of analysis could have been used for the present study, however, the research question here focusses on the essential nature of what is happening in the therapy sessions, whereas Thompson and McFerran (2015) were measuring the impact or increase in communication, which was more relevant for young people with profound intellectual and developmental disabilities.

My approach to the process of case study research is grounded in the key principles described by the influential case study researcher Yin (2009), Psychotherapy research (McLeod 2010) and the established tradition of Music Therapy case studies and research (Bruscia, 1991; Hadley, 2003; Aldridge, 2005; Meadows, 2010). Using the phenomena of the cases to enrich, evaluate and extend a theoretical framework (Yin 2009) each case is analysed using 'Template analysis' (King 2012; Brooks et al. 2015). Template analysis was employed across the data sets in preceding chapters by using an initial template – in this case the theoretical framework (Figure 1.1) - as a tool through which to scrutinise and compare data.

The multiple case studies will address the primary research question:

> Does a theoretical framework, developed in single-case study research, explain the process of Music Therapy across a number of cases of children with SM?

In addition, secondary research questions, as detailed in Chapter 1 (1.6), will also be considered:

> What are the main ingredients of Music Therapy that appear useful for children with SM?
>
> How do the therapy narratives from the multiple case studies enrich or challenge the theoretical framework?

The following additional questions are used to guide the multiple case study approach:

i) What is the chain of evidence that demonstrates the key elements and narrative in each case?

ii) Are those elements the same or similar across different cases?

iii) Do these elements fit on the theoretical framework?

iv) How do they fit on the framework? Is one aspect more important than another?

v) Do the elements combine or overlap?

vi) Are any other factors, missing from the framework, important for the success or failure of the therapy?

vii) How long was the therapy process in each case?

6.3 Case Study Theory and Design

I now introduce some theories of case study research and how they have influenced this project.

6.3.1 R.K. Yin

Yin defines a case study as:

> '…an empirical enquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (2009 p18)

Yin is a key writer and researcher in the field of case study research and his books provide substantial grounding for investigations using the case study method. In his book *'Case Study Research-Design and Methods'* (2009), Yin provides a

comprehensive approach to planning and undertaking case study research. Yin states that when commencing a research project, the design should be 'a logical plan for getting from here to there'. An initial consideration should be whether case study is an appropriate method for a specific research question. Yin suggests that:

> "In general, case studies are the preferred method when (a) "how" or "why" questions are being posed, (b) the investigator has little control over events, and (c) the focus is on a contemporary phenomenon within a real-life context." (2009 p2)

Five components of research design that Yin suggests are particularly important for case studies are:

1. a study's questions;
2. it's propositions, if any;
3. its unit(s) of analysis;
4. the logic linking the data to the propositions; and
5. the criteria for interpreting the findings

For this study, my proposition is that Music Therapy appears to help young children with Selective Mutism and so my units of analysis are cases of Music Therapy with children with SM.

Yin highlights the key role of theory development in case study research and the way that theory may be tested and subsequently modified through the outcomes of the case study. He also suggests that this aspect may be achieved through the use of prior research to provide a 'rich theoretical framework' (2009 p 36).

Yin (2009 p143) describes the explanation building process of case study work in a number of stages:

1. Making an initial theoretical statement
2. Comparing the findings of an initial case against such a theory
3. Revising the theory
4. Comparing the details of the case against the revision
5. Comparing the revision of the facts of a 2nd, 3rd, 4th case

6. Repeating this process as many times as it is needed.

According to Yin, the quality of research designs can be judged by four key tests.

- *Construct validity:* identifying correct operational measures for the concepts being studied
- *Internal validity* (for explanatory or causal studies only and not for descriptive or exploratory): seeking to establish a causal relationship, whereby certain conditions are believed to lead to other conditions, as distinguished from spurious relationships
- *External validity*: defining the domain to which a study's findings can be generalized
- *Reliability*: demonstrating that the operations of a study –such as the data collection procedures- can be repeated, with the same results

Tactics for ensuring that case studies pass these four tests are suggested by Yin. For this study several tactics are especially pertinent such as establishing the chain of evidence in showing the 'path into speech' (construct validity). As these case studies are 'explanation building' I need to clearly identify the data that shows how Music Therapy is helping a child with Selective Mutism rather than any factors external to the therapy (internal validity). If successful, the theory can be generalized through replications in similar cases (external validity). We also need to provide a clear enough protocol so that the operations of the case could be repeated with the same findings and conclusions (reliability).

Yin discusses the importance of the 'chain of evidence' (2009 p122-124) in increasing reliability in case study research and how this logical sequence should be checked both forwards and backwards. This evidence is compared to forensic evidence in a court case whereby the jury need to be convinced by the argument and evidence that leads to specific conclusion. In this way a case study report or, in this case, the PhD thesis and each case within it, needs to have a logical, convincing chain of evidence. Anyone reading it should be able to see how the conclusions were reached.

6.3.2 J. McLeod

In his book "Case Study Research- In Counselling and Psychotherapy" (2010) McLeod describes the historical role and impact of case study research from Freud's renowned early case reports to the present day. McLeod maintains that case study remains a central strand of the knowledge base for counselling and psychotherapy and that it is 'highly influential during the formative phase of new treatment approaches'. In particular he states that:

> 'The publication of case reports leads to further research, with larger samples, and to the provision of training programmes for practitioners who are convinced by the case evidence and want to learn how to use the new methods' (2010 p2)

The role of case studies in advancing theoretical understanding is also described in detail. Once developed, theory may be tested and revised through the analysis of case studies. The importance of contextualising case studies is emphasized. McLeod suggests four key reasons for why case studies are vital in developing a knowledge base:

1. Narrative knowing
2. Complexity
3. Knowledge in context
4. Practical expertise in action

Narrative knowing is the human story about a sequence of events that allows us to organize, interpret and make sense of experiences in a way that reflects human purpose and intentionality.

Complexity Qualitative case studies allow us to gather together, describe and analyse evidence from complex, sophisticated therapy processes.

Knowledge in context In therapy research there are often questions about the therapeutic impact of events and experiences that were outside of the therapy approach that was delivered. For this reason and for a more comprehensive understanding of the case and it's 'fuzzy boundaries' it is essential to gather rich data on the therapeutic context.

Describing and analysing practical expertise in action McLeod explains how the active part of a therapeutic relationship is being researched in therapy case studies and that this is qualitatively different from most of the examples given by Yin which are often a study of a specific 'thing' such as a factory or a town (McLeod 2010).

The importance of a 'pragmatic evidence base' (Fishman 1999) in developing the knowledge base for therapy that works in practice is outlined in detail in chapter six of McLeod's book (2010). The importance of a pragmatic approach was noted in one of the aims of my MA study (Jones 2012) as: to develop knowledge and theory about the way that Music Therapy can provide a pragmatic, holistic and flexible intervention for foundation stage children with SM and EAL.

The key methodological role of pragmatism for this study was described in chapter 4 of this thesis and resonates with the Pragmatist notion that knowledge can give us the capacity to take appropriate actions within a specific context. For example, Selective Mutism is a specific clinical issue that may be greatly helped by the appropriate use of Music Therapy as an intervention. McLeod states that:

> "The vision here is of a knowledge base that specifies how to get things done, in relation to dealing with social problems and human suffering." (2010 p94)

McLeod goes on to describe how reporting requirements can introduce a high-degree of rigour into case study methods. The *Pragmatic Case Studies in Psychotherapy* journal uses a specific template for case study reports that includes appendices of supporting case study data, two critical commentaries on the report and subsequent rejoinder to be added by the author.

Detail on theory-building case studies is discussed in depth in McLeod (2010) chapter nine. A method is suggested that resembles both Yin's explanation building case study method and the method for the present study:

1. Develop a theoretical starting point
2. Selection of a case
3. Construction of a rich case record
4. Immersion in the case
5. Applying theory to the case

6. Identifying gaps in the theory: applying the case to the theory
7. Refining the theory
8. Testing the revised version of the theory against further cases

At stage 4 of the process key 'passages' in the therapeutic process are highlighted for closer examination. McLeod describes the latter stages of this case study method as abduction whereby the theory is revised to fit the observations from the case. This is similar to the template analysis process used in this study. Stage 8 implies a multi-case approach to theory building whereby each new case offers new theoretical insight and understanding.

6.3.3 Aldridge and Aldridge

G. Aldridge (in D. Aldridge 2005) outlines a case study method for music therapy - Therapeutic Narrative Analysis- that preserves the narrative of the case and employs the use of therapeutic 'episodes' in the analysis (2005). G. Aldridge refers to the social science concept of 'punctuation' (Bateson 1972) in describing the way we refer to meaningful patterns of behaviour in our lives. Aldridge describes an episode as an event, incident or sequence of events that form part of the narrative and are the basic units for the research methodology. The phases of Therapeutic Narrative Analysis are:

1. *Identify the narrative* Gather the material together that will form the narrative- a case study or series of case studies
2. *Define the ecology of ideas and settings* Explicate the theoretical ideas present in the literature or from your own standpoint.
3. *Identify the episodes and generate categories* Identify the episodes that are crucial for analysis. Generate a set of constructs from that episodic material and identify categories for analysis.
4. *Submit the episodes to analysis* Analyse the episodes according to their contents using the guiding framework of the constructs.
5. *Explicate the research narrative* Synthesise interpretations based on therapeutic traces to form a therapeutic narrative.

Once video or audio extracts are selected, the conversion of these musico-therapeutic events into the 'lexical realm' should be in the practitioner's own words. Aldridge states:

> 'It was essential for me to use a natural language description as I was struggling to make explicit what I felt to be an understanding within me. Being pushed into using specific words can also push us into a premature categorization that is not 'new' (…) I knew there was another set of personal understandings ready to emerge' (2005 pp 43-45)

Aldridge explains how at the end of the process the researcher then places the findings into a new theoretical construct or within an established landscape of thought. The role of the supervisor in checking the patterns that emerge is highlighted as helpful for establishing validity and self-reflection.

6.3.4 Multiple case study design

Yin (2009) contrasts the purpose of single case studies, which test 'critical', 'extreme', 'typical' or 'revelatory' cases with multiple case studies which test the replication logic of an initial finding. If two or more cases are shown to support the same theory then replication may be claimed. This method has some similarities with the process of template analysis used to analyse data throughout this thesis (3.3.3).

Yin (2009) considers that the evidence from multiple cases can provide a more compelling and robust argument akin to undertaking multiple experiments (2009 p53). However, the time and energy resources required for a multiple case design may challenge an individual researcher.

Yin's logic for exactly replicating or changing case study conditions is useful for this research when considering referrals of children with either English as an additional language (EAL) or English as a first language (7.1).

In the present study multiple case studies are investigating complex human relationships creating more opportunities to add further depth, richness and understanding to our theoretical framework.

6.3.5 'Meaningful moments' in therapy and therapy research

In *Case Study Designs in Music Therapy* (2005) D. Aldridge discusses the phenomena of 'individual development and significant incidents in the patient-

therapist relationship'. A range of terminology has emerged to define these phenomena such as 'episodes' (Aldridge 2005), 'passages' (McLeod 2010 p169), 'pivotal moments' (Gavrielidou & Odell-Miller 2016) or 'meaningful moments' (Aigen 1990, Amir 1996). For the purposes of this discussion and for my research analysis I will use 'meaningful moments' as an umbrella term for this concept.

Meaningful moments have been investigated in two key ways in Music Therapy research. Firstly, the essence of the meaningful moments has been explored (Gavrielidou & Odell-Miller 2016, Amir 1996). Amir describes meaningful moments as being when clients experience powerful 'life-changing' insight (1992 p92). 'Pivotal moment' (Gavrielidou & Odell-Miller 2016) is an alternate term employed in Music Therapy research within Adult Mental Health, meaning:

> "a turning point, a moment of pivoting, or change, where something is seen from a different perspective or point of view and seem to be significant and nodal for the person involved". (Gavrielidou and Odell-Miller 2016 p. 50)

Other terms that denote the same or similar concepts are 'significant moments' and 'change moments'. This concept of significant, nodal moments of change is subtly different from the broader concept that I will use for data collection in my case studies.

Secondly, meaningful moments have been used as a tool in the analysis of case studies or as the 'evidence' in the case (Aigen 1990, Jones 2012, Aldridge 2005, McLeod 2010). In his case study research Aigen uses meaningful moments by:

> "allowing those moments and events that were most meaningful to emerge from the extensive set of session notes and treatment summaries". (Aigen 1990 p. 58)

6.3.6 Use of meaningful moments in this study

In this study meaningful moments blend these two concepts and are selected because either:

a. they represent and encapsulate a particular episode in the therapy or
b. they are a nodal moment of significant change, for example, a sudden leap forward into vocalisation or speech.

Once chosen they provide the chain of evidence for the case studies (Yin 2009) and illustrate the key thematic material of the study.

When working with children with SM meaningful moments are experienced as part of a journey or pathway towards speech. Analysis (6.4.8) will focus on identifying the therapy narrative from a process of immersion (1), analytical data reduction and distillation of the case study data (2) and then choosing the meaningful moments (3).

Miles and Huberman (1994) describe data reduction as selecting, focusing, simplifying, abstracting and transforming data in such a way that conclusions can be drawn and verified. Data displays such as mind maps and diagrams can also assist in this process. Miles and Huberman also highlight that the analysis process begins at the data collection stage and so a research diary was used to capture emergent thoughts at each stage of the research process. They also stress that the aim of data analysis is to move beyond initial impressions and create a close fit between theory and data (Miles and Huberman 1994).

6.3.7 Meaningful moments and context

When considering the use of meaningful moments as a research method McLeod's reminder about context is helpful.

> "Research that attempts to analyse what is happening at the level of the single session, or an event within the session, is in danger of either failing to take into account important contextual factors, or of not being able to access sufficient instances of the phenomenon being examined." (McLeod 2010 p. 3)

Context is an essential component of this study at each stage of the research design. Awareness of the wider situation for people with SM is the essential background for the study. Broad contextual data has been captured by exploring historical Music Therapy practice for SM with the survey and interviews exploring increasing detail of practice in the UK. At the most focussed point of the study meaningful moments or snapshots of therapy are closely examined to demonstrate the causal link between components of the therapy and improvements in communication, vocalisation and communication. However, the background context to the Music therapy interventions was also highlighted in the survey and interviews of Music Therapists. This included both the therapist's knowledge of SM and the school environment and

teamwork around the child. Therefore, at this most focussed point of data collection the interplay between therapeutic events and any environmental factors will be attended to and described.

In addition, this study uses an expanded definition of meaningful moments which allows for the possibility that meaningful therapeutic events might occur outside the physical location of the therapy room. These are referred to as 'Contextual meaningful moments'.

6.4 Case Study Protocol

This protocol describes a multiple case study of school-based Music Therapy for children with SM.

6.4.1 Eligibility

The eligibility criteria were as follows:

Inclusion criteria

The population for the study was foundation stage school children with Selective Mutism in an inner London borough.

Exclusion criteria

Children were excluded if they were not in a nursery or reception class (aged 3-5) at the start of treatment or if their presentation was complex, for example, a child with additional learning difficulties, a disability or emotional or behavioural difficulties. Formal diagnosis of SM by an SLT was not required for referral to the study as many children go undiagnosed, however recognition of SM is straightforward for any professional with training in this area or through the use of the Selective Mutism resource manual (Johnson and Wintgens 2001).

6.4.2 Sampling strategy

Sampling was 'purposive'; young children of nursery or reception class age were sought as early intervention is known to be effective and recommended as best practice for children with SM (Johnson and Wintgens 2001).

6.4.3 Recruitment strategy

Recruitment to the study was via the Special Educational Needs Coordinator (SENCO) network in the borough. SENCOs are located in each school and are

responsible for organising appropriate interventions or in-class support for children with additional learning needs or disabilities. An initial presentation about Selective Mutism was given at a borough-wide SENCO network meeting to raise awareness of the condition and the research study within the borough. The presentation outlined the definition of SM including the more complex task of identifying children with SM and English as an additional language (EAL) which is essential in an inner-city borough. The importance of early intervention and the potential impact of not identifying and treating SM was also outlined alongside the general 'no-pressure' approach and the usual treatment options such as SLT and CAMHS referrals. A summary of the research project, description of the potential impact of Music Therapy and how to make referrals to the project was then presented. SENCOs were asked to consider if any children that they were currently working with met the criteria for SM and to then refer them to this research project. Once a child was referred an initial discussion with SENCOs was used to check that the referrals met the criteria for SM. This was followed by a school-based meeting with the SENCO and the child's class teacher including a naturalistic observation of the child within the classroom setting by myself –the therapist- to ascertain their presentation. If a child still met all the criteria for SM a parent was then invited for an interview.

6.4.4 Parental interviews

Parental interviews followed the outline given in the Selective Mutism Resource Manual. -Appendix 6.1- This included using a 'talking map' to identify the location of speech and no speech (Johnson and Wintgens 2001). If necessary, translators were used to support and translate this interview.

The Spence pre-school anxiety scale -parent report- (Spence & Rapee 1999) -Appendix 6.2- was administered during the parent interview in order to:

1. identify and screen out children whose higher levels of anxiety required an onward referral to Child and Adolescent Mental Health Services
2. get further baseline data to describe the children in each case.

6.4.5 Pilot study

A pilot case was set up to test the methods and procedures prior to the main case studies taking place. All the procedures –parental interview, Spence anxiety test, consent process, assessment and therapy process as described below- remained

unchanged for the subsequent case studies and so the pilot case is being retained as part of the main study.

6.4.6 The Music Therapy Sessions

After the parental interview two assessment sessions were offered to determine whether it was felt that the child might respond positively to Music Therapy. Parents were informed of the outcome of the assessment sessions and all the children initially assessed received ongoing individual Music Therapy sessions as part of the study.

As part of the intervention staff and parents were given information about SM with an emphasis on the general philosophy of reducing pressure on children to speak whilst offering plenty of opportunities for self-expression (Johnson and Wintgens 2001). This approach was reinforced in weekly handover discussions with staff to discuss children's progress within therapy and in the classroom.

Weekly individual sessions of Music Therapy were provided in the most appropriate space within the school setting of each child. Sessions took place in term-time only with breaks for school holidays. A naturalistic timescale was employed with no pre-determined number of sessions. The broad approach was that children would receive Music Therapy until such time as it was deemed successful or until it was felt that the child had gained as much as was useful or appropriate from the intervention. For children with SM this meant in practice until confident speech had emerged and was then generalised across settings into the classroom or it was felt that they were not going to speak or benefit further from therapy. The length of the session was guided by the needs of the child but was usually around 30 minutes.

The Music Therapy sessions embraced a warm, playful approach which was also needs-led, flexible and responsive to the child. Each session had a familiar structure with a Hello and Goodbye song and improvised music or musical play in between. A number of Music Therapy techniques were employed such as containing, reflecting, attuning, offering a musical structure, following the child's initiative or lead, amongst others.

A range of appealing instruments were brought to the sessions by the Music Therapist with some resources being added in response to children's needs. For example, a didgeridoo, a small toy karaoke machine with interesting voice effects, echo microphones, and a talking parrot were purchased in an attempt to encourage

specific therapeutic goals. These resources were then available to subsequent children. The impact of being both the researcher and the therapist for this study is noted here as although the clinical techniques were broadly the same some for all the cases, some deepening of clinical understanding and widening of resources may naturally have improved the therapy received by later clients.

6.4.7 Ethical considerations

When working with vulnerable children it is vital to consider the ethical implications of the research activities. Young children do not have capacity to consent to participate in research therefore consent was requested from parents and assent to therapy was sought from the children. Whilst Music Therapy is generally thought of as a low risk intervention, the therapy and research processes, including use of video data, need to be explained to parents to gain informed consent. The purpose and potential benefits and risks of participating in the research project were outlined in a participant information sheet (Appendix 6.3). Details about signed consent and withdrawal of consent were provided.

The assent process for therapy was also described to parents explaining that their child would be gently encouraged but never forced to attend a session and that it would be made clear that it was their child's decision whether or not to attend. The participant information sheet explained that the data would be securely stored, analysed and reported anonymously (Appendix 6.3). The participant information sheet and consent form (Appendix 6.4) were presented prior to the parental interviews when they were further discussed and it was explained that they could withdraw their child from the study at any point. Parents were given copies of the consent forms that they had signed. Interpreters were provided for any parents who required language support. Ethical approval for this study was given on 8th November 2013 by the Music and Performing Arts Departmental Research Ethics Panel at Anglia Ruskin University (Appendix 6.5). In later case studies some peers were added to the therapy sessions. Agreement was given by the Panel to use a modified participant information sheet (Appendix 6.6) with parents of additional children. Consent forms (Appendix 6.4) for supporting therapy roles were signed by parents of the additional children.

6.4.8 Case Study Analysis Method

The modified version of template analysis (King 2012, Brooks et al. 2015) used for analysing the case studies is now described below.

1. Immersion in data of 1st case:
    1.1. Reading clinical notes, research diary, watching videos-transcribing key sections. Inductive, holistic engagement with case.
    1.2. Open-coding of clinical notes using highlighter. Further comments boxes used to write down any additional thoughts or analysis.
    1.3. Plotting codes onto a mind map and clustering codes together to create categories.
    1.4. Noting the themes that interpret and connect the categories.
    1.5. Producing a thematic map.
2. Analytical Data reduction and distillation through
    2.1. writing summaries and creating data displays of the therapeutic narrative. For long and/or complex cases further condensing may assist in highlighting the key factors in the process.
3. Choosing the evidence of the case. Selecting the moments or episodes of the case that highlight and evidence the case narrative.
    3.1. Transcribing the evidence in detail
    3.2. Data mining Further insight or sub-themes from this analysis may be included in the mind-maps or thematic maps
4. Template analysis. Placing the themes and sub-themes on and around the TF.
    4.1. Noting how themes link to and do or do not fit on the TF.
    4.2. Identifying potential modifications to the TF.
5. Detailed narrative description/analysis of whole case using meaningful moments (MMs).
6. Therapy narrative and choice of meaningful moments checked by research supervisor.

7. Whole process repeated with each case study.
8. Themes across all cases combined, analysed and described as a whole (Ch 8).
9. Description of themes and subthemes compared to theoretical framework with further reshaping and revising of the framework to make sense of all the data.

6.5 Case Study Setting

The six case studies take place within a large inner-city borough. The borough is densely populated with an ethnically diverse community and high levels of recent migration, poverty and deprivation. In order to establish the care pathway for children with SM in the borough, data from six key informant interviews - professionals working in the borough with children with SM- are described and compared with international care pathway research (Keen, Fonseca & Wintgens 2008). Describing the local professional context to this research enables us to begin considering the potential place of Music Therapy in a local care pathway for SM.

The six interviews were undertaken with three Speech and Language therapists (SLTs), an Educational Psychologist and two Child and Adolescent Mental Health Service (CAMHS) practitioners from tier 2 (community and primary care) and tier 3 (clinic setting). The predominance of SLTs was deliberate and was due to the researcher's prior understanding that this is the profession most likely to assess and treat children with SM. The SLTs had different areas of expertise that were useful in answering questions on specific aspects of the care pathway.

The interviews were semi-structured with a range of questions –see Appendix 6.7- to elicit similar information from each interviewee. The aim of the questions was to discover:

- Background information about each interviewee- professional role, years in position, ideas about SM
- An outline of any experience with children with SM
- Their understanding of the current care pathway for children with SM in the borough
- Their perspective on other provision for SM in the borough

- Their views on the use of Music Therapy for children with SM in the borough.

6.5.1 Ethical considerations

Potential risks for the interviews are low, however interviewees are likely to have concerns about how the information about themselves and their clients will be used and stored. The purpose of the whole research project and the interviews within this was outlined in a participant information sheet (Appendix 6.8). Details about signed consent and withdrawal of consent were provided. The sheet explained that the data would be securely stored, analysed and reported anonymously (Appendix 5.3).

6.5.2 Analysis

The interviews were analysed deductively using the interview schedule as a tool for reporting on specific topics focusing on how clinicians describe their experience and thoughts on the local care pathway and the potential place of Music Therapy within that. The purpose of the interviews was a descriptive summary of the local provision rather than drilling for depth or breadth of information. A summary of the main responses to questions about care pathways, including the place of Music Therapy on the care pathway, are seen in table 6.1 below.

Table 6.1 Summary of detail from interviews

Profession	**View on local Care Pathway**	**View on Music Therapy's place in the pathway**
Senior SLT*	SLT should be 1st point of contact 'MJ' ** approach	Music Therapy could be provided if no Key Worker is available in school to undertake the usual 'MJ' intervention
Highly specialist SLT	SLT 1st for assessment- then 'MJ' 'no-pressure' approach in classroom. Highlighted difficulties of 'Remote working' in NHS i.e. handing over to a teaching assistant.	Already incorporated musical instruments into sessions. Would consider the use of MT if it is available.
Specialist SLT	SLT 1st. 'MJ' approach but highlighted importance of MDT –multi-disciplinary team- approach	MT could be provided after SLT assessment and alongside MJ approach
Educational Psychologist	SLT supervised by SM specialist, then referred to EP for more complex cases, or CAMHS for complex needs using systemic environmental approach	Liked the idea of MT if working closely with family and school
Early years Tier 2 CAMHS practitioner OT background	Referred from SLT to CAMHS. Psychoeducation for parents and school. Play therapy or CBT for child.	Ambiguous response. Highlights difficulties due to long waiting lists and lack of clear pathway.

CAMHS Psychotherapist CBT + heavy psychodynamic aspect	SLT 1st for straightforward cases-manualised school based approach. Any trauma related cases referred straight to CAMHS	"why not? Go for it" Suggested MT is good for children with SM and ASD and more generally using music as a stepping stone Importance of accessibility of MT service

*Speech and Language Therapist

**'Maggie Johnson' approach from her training in conjunction with Selective Mutism Resource Manual.

The main themes emerging from the care pathway interviews are described below.

6.5.2.1 Care pathway economics

The cost of service provision is a factor affecting and influencing care pathways for many children requiring support including those with SM. All key informant interviewees described how their services were funded, whether they were free or purchased by schools. Interviewees described different levels of provision available to different schools.

A minimal, consultation-only level of SLT service was provided free to all schools with more substantial provision needing to be bought in. CAMHS services were free but had a long waiting list of around 8 months and a higher threshold of need for admission. Educational psychology had no free level of service and was purchased on demand by schools. Music Therapy could either: be bought in by schools; be paid for as part of a child's statemented provision for Special Educational Needs; be provided free as part of an externally funded project.

6.5.2.2 Referral and Assessment of SM

SLTs described how for children under 5 referrals to SLT would come via a health visitor, GP, parent or paediatrician at a developmental assessment. Children over 5 years old could be referred to SLT by their class teacher, Special Educational Needs Coordinator (SENCO) or parent.

All interviewees indicated that SLT should be involved initially in assessment and intervention with more straightforward cases. SLT assessment of SM involved creating a speaking map and checking receptive and expressive language skills. One SLT interviewee suggested that another professional, other than SLT, could do this if

they had the required SM training. These suggestions strongly align with the care pathway research (Keen, Fonseca and Wintgens 2008).

All interviewees said that a full and thorough assessment and diagnosis was the main priority at this stage. Educational Psychology should be used to identify further factors and for treating social difficulties but not for more complex cases such as emotional trauma. These should go to the Child and Adolescent Mental Health Service (CAMHS).

One SLT suggested that they would adopt a multi-disciplinary team (MDT) approach and take advice from CAMHS at an early stage. This was due in part to the physical location of their department next to the CAMHS team. Another SLT interview emphasised that they would refer on to CAMHS if a child wasn't showing quick enough progress and would look for a professional with expertise in SM.

6.5.2.3 Intervention and treatment

Speech and language therapy. Speech and language therapists referred mainly to the 'MJ' approach citing the SM training given across the UK by Maggie Johnson, the Selective Mutism Resource Manual (Johnson and Wintgens 2001) and the Selective Mutism Information and Research Association -SMIRA- as key resources offered to schools and parents and professionals. Interventions started with a general school-based approach handing over ideas to a key worker or classroom assistant. One SLT also discussed the use of musical instruments to facilitate turn taking as part of an intensive interaction-type treatment (Nind and Hewett 2012) and also encouraged the use of other vocal sounds. Another SLT stated that the success of the intervention depended on the experience and expertise of the professional, the key worker and the school itself.

Educational Psychology. The educational psychologist interviewee described an intervention that was based on observation, consultation, reviewing and working closely with the parents in thinking about the child. The main conceptualisation was that SM is an anxiety disorder and that developing a coherent hypothesis is key in planning ways of reducing the anxiety. Teamwork was highlighted as important including considering the class teacher's anxiety levels and also setting realistic targets. Cross-borough working with specialist supervision was suggested as a

possible means of resource-sharing as experience is fairly limited due to low numbers of referrals generally.

CAMHS practitioners. The tier 2 and tier 3 CAMHS practitioners both described the use of Cognitive Behavioural Therapy (CBT) as an aspect of their approach. One therapist described psychoeducation for parents and school as being important and that their technique borrowed from play therapy. The other interviewee employed a strong psychodynamic component and also used play and drawing to develop the therapeutic relationship.

6.5.2.4 Comparison of local care pathway with international care pathway research

Responses to care pathway questions are compared below to the principles established from international consensus-based research (Keen, Fonseca and Wintgens 2008).

1. ***Diagnosis of SM by trained professionals.***
   One SLT interviewee acknowledged that although it is often SLT that recognise and diagnose SM this could undertaken by any professional that has received SM training.
2. ***First point of contact***

   All interviewees stated that SLT should be the first point of contact for children with SM. The Senior SLT described confusion in schools about who to refer children to but that SLT should be the initial referral for a thorough assessment. She also stated that other services could take this role if they had a similar training.
3. ***Access to resources***

   The importance of having access to appropriate resources and support such as SMIRA (The Selective Mutism Information and Resource Association) was acknowledged by many of the interviewees.
4. ***Assessment and intervention for coexisting problems***

   Onward referrals to CAMHS for complex cases was clarified by many of the interviewees particularly the SLTs and CAMHS practitioners.
5. ***Early intervention to avoid complex intractable cases.***

   Early intervention was not specifically mentioned by any interviewees except

once when considering waiting list lengths as a factor in deciding referral routes.

6. ***Intervention based where mutism occurs, i.e mainly at school or occasionally at home***

   Interviewees all practised in accordance with this principle but with some discussion regarding CAMHS clinic-based services that may support children with complex presentations if a school-based approach is unsuccessful.

7. ***Close involvement of parents in intervention delivery***

   A team-based approach that included parents was apparent in five out of six interviews.

8. ***Monitoring improvement through increased social functioning***

   This principle was clear in all of the interviews.

9. ***Frequent early stage monitoring of improvement***

   Precise levels of monitoring were not specifically mentioned by the interviewees. However, some therapists saw clients for weekly sessions and SLTs followed the MJ approach, handing a staged programme to teaching assistants or key workers, which implied frequent monitoring.

10. ***If no substantial progress is achieved onward referrals to specialist multimodal teams should be made.***

    Most of the interviewees described this pathway to specialist services.

11. ***Use of SSRIs to support treatment through multimodal programmes.***

    The use of SSRIs was not mentioned by any of the interviewees.

Despite there being a good fit between clinical practice and the recommended principles of care pathway research (Keen, Fonseca and Wintgens 2008) it was apparent that there was no clearly stated care pathway for children with SM in the borough.

6.6 Conclusion

This chapter has outlined the principles and theories of case study research that inform the design and method for the multiple case studies. Interviews of six key informants provide background information and outline ideas about care pathways

for SM within the borough. Results from the case studies and analysis are presented in the next two chapters.

Chapter 7 - Multiple case studies: results

7.1 Introduction

All the case studies except for the pilot study took place in locations that were new to the therapist. There were 6 case studies in total (Table 7.1). The first five cases were children with SM and English as an additional language (EAL). This was not deliberate but the location of the study in an inner-city borough meant that this pattern of referrals was perhaps likely. Although having EAL can be a contributing factor amongst the causes of SM (Toppelberg 2005) I did not believe that Music Therapy was only helpful to those with SM and EAL and therefore for the final case I deliberately sought out a child with SM and English as their first language.
In this chapter I present the evidence of the 'path into speech' for each case, which constitutes stages 3 and 4 of the analysis process (6.4.8). This is to give a sense of the sequence of events within the case studies prior to the presentation of thematic and subsequent template analysis in chapter 8.

Table 7.1 Summary of background information for the 6 case studies

Name	**Age** Years. Months	**School year at start**	**School year at end**	**Gender**	**Ethnicity**	**EAL**	**Language(s) spoken at home**	**Start date**	**End date**	**No. of sessions**	**Spence Anxiety test level**
Daniel[5]	4.4	Nursery	Nursery	Male	Ivorian (Côte d'Ivoire)	Y	English & French	21/1/14	24/6/14	19 weeks	Elevated
Pilar	5.2	Reception	Year 1	Female	Ecuadorian	Y	Spanish	14/1/15	13/7/16	49 weeks	Elevated
Tasha	4	Nursery	Reception	Female	Congolese	Y	Lingala & English	6/2/15	15/7/16	48 weeks	Elevated
Maria	3.10	Nursery	Reception	Female	Ecuadorian	Y	Spanish & Waorani	11/5/15	7/12/15	21 weeks	Elevated
Rabiyah	4.10	Reception	Reception	Female	Somali	Y	Somali	7/12/15	13/5/16	16 weeks	Normal
Mark	4.5	Nursery	Reception	Male	British	N	English	11/5/16	12/12/16	16 weeks	Normal

[5] Pilot case- included in study as no significant changes were made to the design after this case

7.2 Results

The cases are set out in the order in which they occurred since the overall timeline –a total of nearly three years- may have implications for the analysis of the cases. Each case contains:

I. A brief summary of the child's background history as provided in the parental interview prior to assessment.

II. A table with an overview of the Path into Speech (PinS). This relates to stage 2.1 in the analysis method (6.4.8). The tables have slightly varying amounts of detail, depending on both the length and character of the therapy processes.

III. A diagram giving an overview of the phases of each case.

IV. Transcriptions of meaningful moments that have been selected to represent the key events and evidence of each case are available in Appendices 7.1-7.6. These represent stages 3 and 5 of the analysis process (6.4.6). The cases are anonymised and children have been given different names. Some additional brief detail is given in the Appendices to provide a sense of the whole case narrative. The meaningful moments themselves are referred to as 'MM1', 'MM2' etc.

NB It should be emphasised that the meaningful moments are the key evidence of this study and these appendices should be read in conjunction with the case descriptions in this chapter and will be referred to heavily in chapter 8.

V. A diagram of the meaningful moments placed on a theoretical framework to show the main features and thematic content on a therapy timeline. This represents stage 4 of the data analysis process (6.4.8).

VI. A brief analysis addressing the key connections between therapy content, process, and progress towards speech.

Table 7.2 Summary of paths into speech

Name	No of sessions	Summary of PinS
Daniel	19	Atypical- speech in nursery not in therapy
Pilar	49	Painstakingly slow creep into speech- although improvements outside of session
Tasha	48	Long complex process due to additional factors and lack of support
Maria	21	Intense, rapid progress, speech bursting through
Rabiyah	16	Quick path into speech- Mention teacher's comment about whispering in class after S9.
Mark	16	Quick path into speech- sliding speech developed with friends into the session and using this to boost confident speech generally

7.3 Daniel

7.3.1 Daniel – background

Daniel was referred to me at the nursery school in which I was currently working as he had not spoken at all in that setting. In the parental interview Daniel's mother stated that Daniel had an older brother who was a late speaker and a younger sister who had cerebral palsy. Daniel was described as speaking normally at home but had no speech at all outside the home. The family were living in temporary accommodation which Daniel was finding stressful. Also, two years prior to referral Daniel had witnessed an incident of domestic violence towards Daniel's mother from his father. Daniel's mother was very unhappy in her marriage and later stated that she wished to separate from Daniel's father.

7.3.2 Daniel – Path into Speech

Table 7.3 Summary of PinS - Daniel

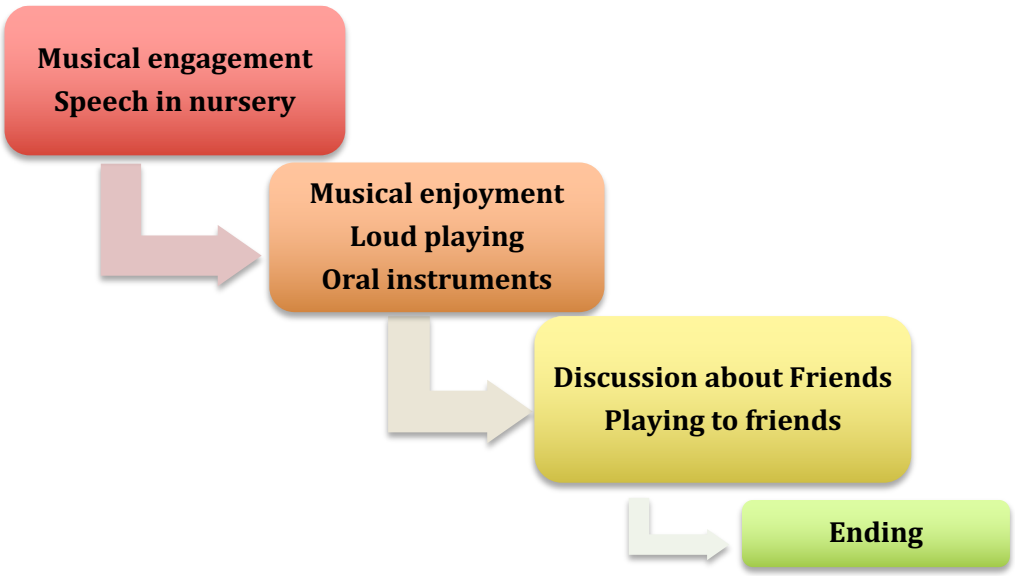
Session	Therapy	Speech progress
1*	Copying me. Also likes 'same time playing'	Speech reported in nursery with 2 adults shortly after this session.
2	Quite loud playing. Plays cymbal with his hand. 'Mouthing'	Speech increased in nursery after this session. Counting in front of keyworker.
3	Happy to attend. Loud cymbal.	
4*	Loud cymbal crashes and loud drum.	Witnessed Daniel speaking to his friend prior to this session
5	Skipped to session. V musical and interactive. Beaters in the air.	Responding with one-word answers to key worker.
6	Smiling and skipping to session. Relaxed, free play.	Another report of speech, this time at lunchtime.
7	Really loud cymbal playing. Delighted discovery of recorder.	Responding to closed questions from other staff
8*	Loud cymbal playing. Intense overblown recorder.	Talking across all nursery settings.
9	Clackerpillar. V engaged drumming.	
10*	Spoke in session. Said that he was "fine". "I have 2 friends."	
11**	Wants to bring a friend. Plays recorder.	
12	Vocalising whilst playing swanee whistle.	
13	Moving and dancing to guitar	
14*	Observed playing and chatting to friends. Pulls the blind up, takes cymbal to window, performs loudly to friends outside	Speaking freely to friends and more reluctantly with single word responses to adults.

15	Lots of 'mouthing'. Smiles whilst playing recorder. Points it out of the window. We go into the garden. Says "Snail"	
16	Sings into kazoo.	
17	Discuss ending. Unable to play kazoo. Mouthing and throwing his beater.	
18	Enthusiastic loud playing. Takes a drum near the window. Playful approach.	

*Denotes a session from which a meaningful moment was transcribed. **Denotes a contextual meaningful moment.

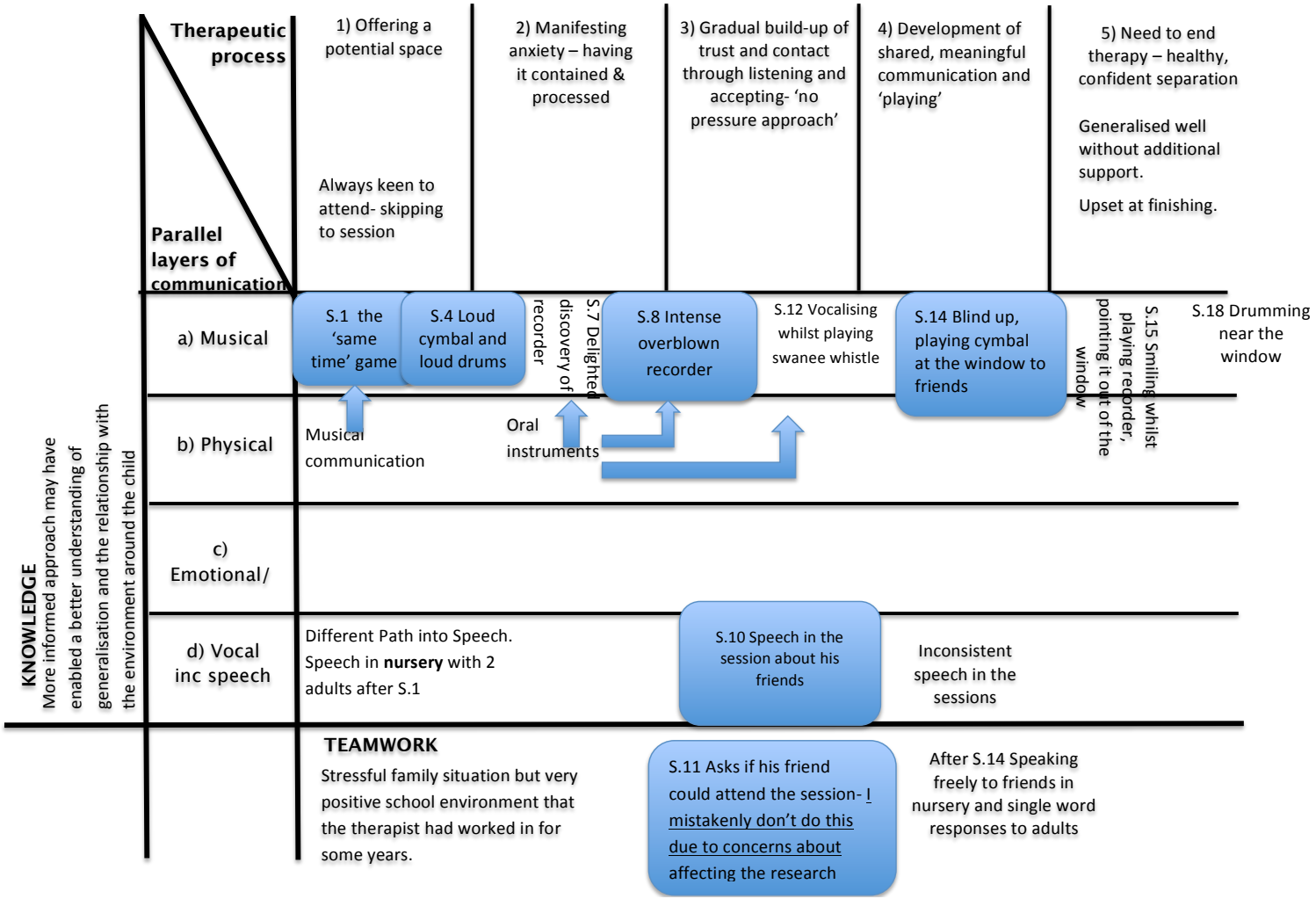
Daniel's therapy seemed to fall into the phases shown in Figure 7.1, with very positive engagement in the musical aspects of therapy, especially loud playing and oral instruments, with a later focus on the importance of social relationships.

Figure 7.1 Phases of Daniel's therapy process



Transcriptions of the meaningful moments for Daniel and further detail of the case narrative are given in Appendix 7.1.

Figure 7.2 Daniel's Path into Speech on the theoretical framework



7.3.3 Daniel – an atypical path

Daniel's journey into speech was different in comparison to the subsequent cases which may have been partly linked to my relationship with the nursery. This was a setting that I had worked in for many years prior to starting the case study and with whom I had an established positive working relationship.

Daniel engaged very positively in his first Music Therapy session, appreciating and enjoying the opportunity for musical interaction. It was reported to me that Daniel had begun speaking to two adults in nursery in the week following his first Music Therapy session. Daniel enjoyed playing the cymbals and other instruments loudly and expressively and this appeared to support significant growth in verbal confidence as he began speaking more to friends in the nursery. This positive energy was also seen in his skipping to the sessions. His delighted discovery of the recorder in session 8 perhaps indicated a sense of how this instrument could help him use his 'voice'.

Speech in Music Therapy appeared in session 10, emerged sporadically and fleetingly in further sessions and then disappeared again. Communication between myself and nursery staff was excellent due to the long-standing relationship and consequently their understanding of how to support a child with Selective Mutism was at a high level compared to other schools. In best-case scenarios, once a child's speech begins to be established in the school setting, with good support they should be able to increase and build confident speech with all people across that setting. This is because they are in that school setting every day and should have plenty of opportunities to build on their progress. In this way, speech development within school could overtake the gains made in short, weekly therapy sessions.

I believe that to some extent this is what happened with Daniel although in addition, perhaps due to the positive nature of the relationship, he may have felt some pressure to also talk in the sessions as he was already talking in the nursery and this situational pressure then made speech more difficult to achieve. However, the important goal of speech in the nursery was achieved.

7.4 Pilar

7.4.1 Pilar – background

In the parental interview, conducted with the assistance of a translator, Pilar's mother explained that Pilar had an older sister, aged 11. Her main concern was Pilar's lack of speech at school and slight delay in her spoken language skills compared to her older sister, although these had not been assessed. Pilar had been referred for speech and language therapy and the therapist had recommended a pressure-off approach, avoiding teasing or bullying amongst her peers and to:

> 'have fun and develop confidence with non-speech sounds e.g. use musical instruments for fun and to allow the child to communicate through the instrument; have a 'conversation' between two instruments; make a 'band' and march round the room, taking turns to be the leaders'. (*Speech and Language Therapy team at Pilar's school)*

7.4.2 Pilar – Path into Speech

Pilar's therapy felt slow, frustrating and exhausting. In session 7, I developed the sensation of having a 'lump in my throat' that persisted until I had completed all the case studies (see Chapter 8). As the process unfolded with Pilar, new challenges and complexities emerged that hindered progress but our mutual sense of commitment deepened within the therapeutic relationship and ultimately shone through. This commitment was supported by Pilar's mother who was thoughtful and attentive throughout the therapy process.

Table 7.4 Summary of PinS – Pilar

Session	Therapy	Speech progress
1 * * *	Frozen presentation. Warmed up through throwing the shaky eggs. Noisy ending	
2	Violent egg throwing	
3	Big noisy finish- perhaps doesn't want to finish	
4	Loud squeaky recorder. Cymbal crashes	
5	'Other room' game starts	1st vocalisation "Ah"

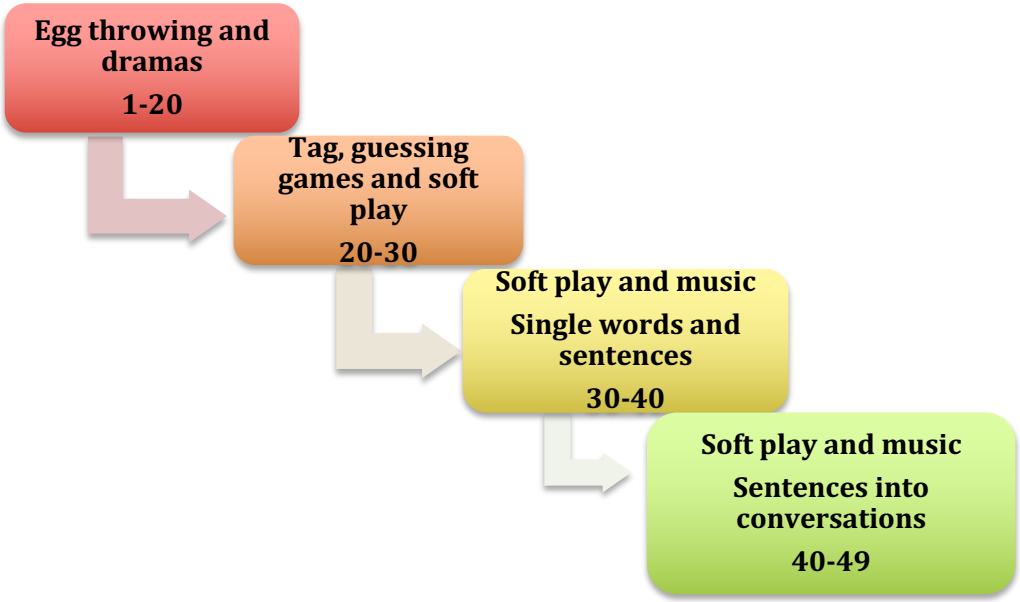
	Kazoo to take home	
6	Loud cymbal. Aggressive egg throwing.	Plays Kazoo. Possible vocal sounds & a giggle
7	Lump in my throat.	Speech increased with friends
8	P- Pretending to use Magic	
9	Wets herself	Audible laughter
10	Dramatic play	
11 *	Puppet play	Oral instruments close to vocal conversation
12	Difficult meeting with SENCo and class teacher prior to session.	
13		Mouthing words. Audible giggling
14 *	Really positive session- Playing connect 4. Celebratory tinsel throwing.	Audible giggling + laughing + speech like vocalisations
15	Wants me to go to her house.	Loud expressive laughing 'take'*
16	Drama- slightly 'off the boil'	
17		Laughing giggling raspberries "bop"
18		"Shh" and "Ding dong"
19	Feels a bit lost	
20	Stuckness SENCo says therapy can't continue.	Says "Ding dong"
	Summer holidays - Pilar's mother upset about the discontinuation	
21	Therapy allowed to continue in Art room after school	
22	Games and longer session. *I learn from current teacher about cause of SM –being shaken by a nursery school teacher-*	Loud laughing
23	Laughter + 'hide & seek'.	Has read to teacher.

24 *		Lots of laughing and vocalising “ay ow” (hello) “yeah” lots of “uh oh”
25	Working in the soft play room for some of the session	Says “me”
26		I witness her talking loudly to friends
27	Didgeridoo warm-ups	Verbal sounds close to speech
28		Word-like sounds
29	Makes a card for her teacher	
30		Laughing and vocalising in the soft play room
31	**New Year- in soft play room**	Vocal responses to questions. Conversation with sounds.
32 *	Class teacher leaving	“Yes, yay, flash, uh, oooh, yep”
33	Boisterous	“no” ‘Monster’ noises
34		“Uh huhs” and kazoo games “hmm, anything”
35	Warm up racing	“yeah”
36 *	musical improvisation, games	Lots of “no”s
37	Therapist’s feeling of tiredness and exhaustion. Longer session helping to get speech going.	Vocalisations
38 *		“Sleep” colours and counting Quiet sentences
39		Safe words and phrases then gradually adding more and more in. Longer sentences “Do your homework”
40		“
41		
42		Reading from the book. Long sentence chatting* The most that she has ever done.
43	Harmonica WTs cup phones	Really good talking- almost normal

	Negative class teacher	
44		Lots of long sentences
45	Wrong colours game as a 'warm-up'	Long sentences- conversations
46		Talks from the beginning of the session. Lots of chatting
47		"
48	Physical activity to 'warm up'	Louder chatting
49	"	Says "Badger is dead!"

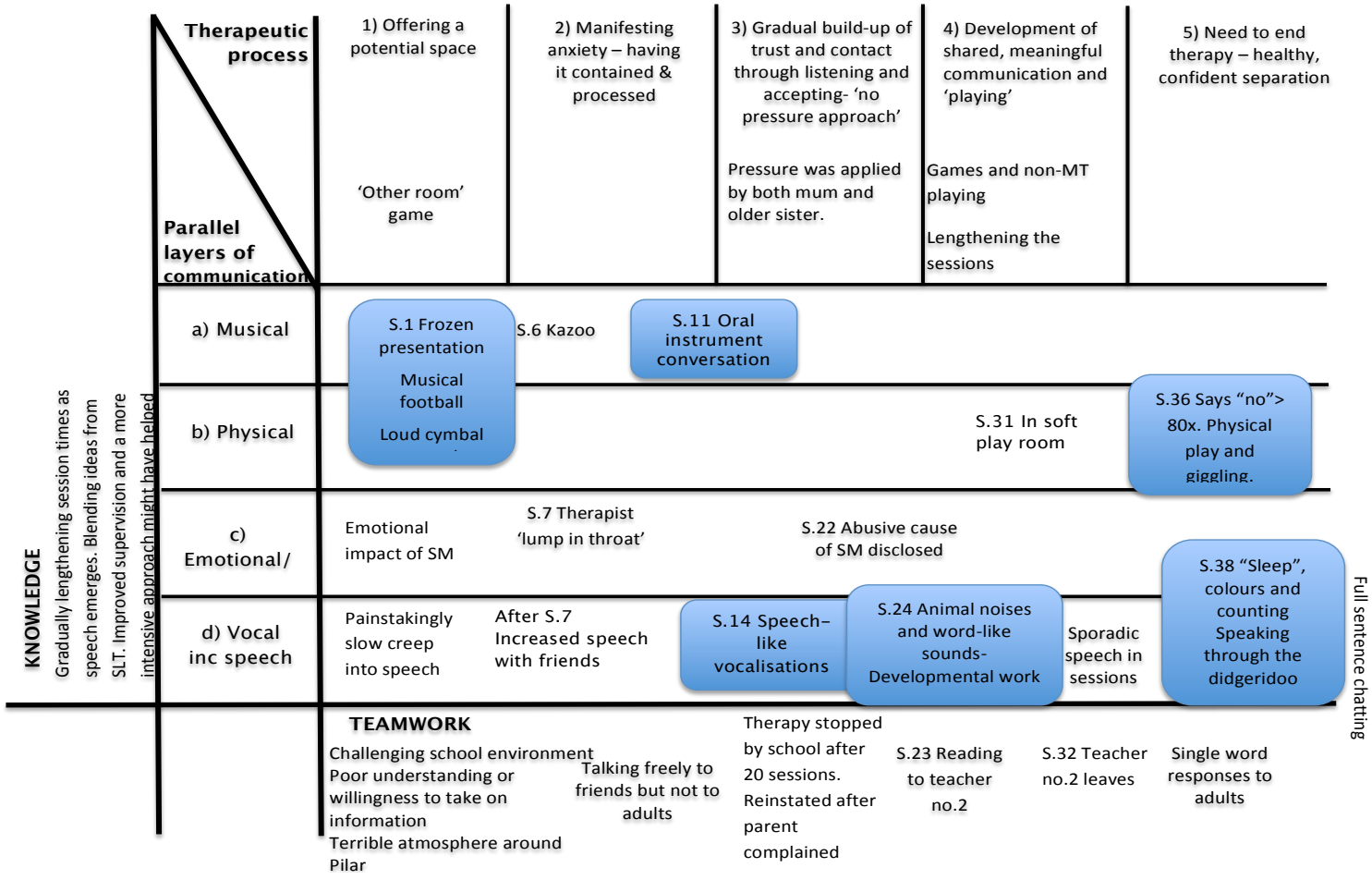
As Pilar's therapy process was quite lengthy it is helpful to summarize the process further (Figure 7.3) into the 'phases' that seemed to occur naturally.

Figure 7.3 Phases of Pilar's therapy process



Transcriptions of the meaningful moments and further detail of the case narrative for Pilar are given in Appendix 7.2.

Figure 7.4 Pilar's Path into Speech on the theoretical framework



7.4.3 Pilar – a long path

Pilar's path into speech was long and challenging but this has provided an opportunity for a closer examination of the complexities of her case. Pilar had good initial engagement in therapy with promising early vocalisations and laughter, however a variety of factors impeded her progress producing a comparatively slow and complex path into speech. This included a break in sessions at a critical time in the summer term between sessions 17 and 18 which seemed to induce a feeling of stuckness in the therapy. Within school Pilar made positive gains in speaking to friends but this was not generalised to adults perhaps due to an abusive experience with a previous nursery teacher (referred to above). This experience along with unfortunate breaks in therapy may have impacted the development of a trusting therapeutic relationship and contributed to the slow pace of change.
It is also worth noting that Pilar was the oldest child in the study. Early intervention is highly recommended for SM (Johnson and Wintgens 2001) and if left untreated it can become increasingly intractable, however it is unclear at what age this begins to significantly impact the effectiveness of therapy provision. In comparison, Rabiyah was only 4 months younger than Pilar and had a swift path into speech. Although age may have influenced Pilar's progress this impact was probably minimal when compared to other factors such as the challenges within the school (8.9).

One of the main issues in therapy was that although Pilar might make small gains in a session, the following week we would revert back to a similar place to the previous week. Eventually the same gains might be repeated and developed but frequently they disappeared again for a few weeks, perhaps due to other challenges. Although the phenomenon of 'warming up' in a session was common to all of the children, Pilar's pattern of incremental change was the slowest. However as seen in Table X, there was gradual solid progress that culminated in confident speech.

Although Pilar's slow pace of progress was unfortunate, it does provide an opportunity to examine her path into speech in detail as the rate of change affords this process greater clarity. Ideas for improving future therapy provision can also be explored. Table X (PinS) shows the 'speech progress' in the right hand column. Table 7.5 is a summary of that process for ease of reference.

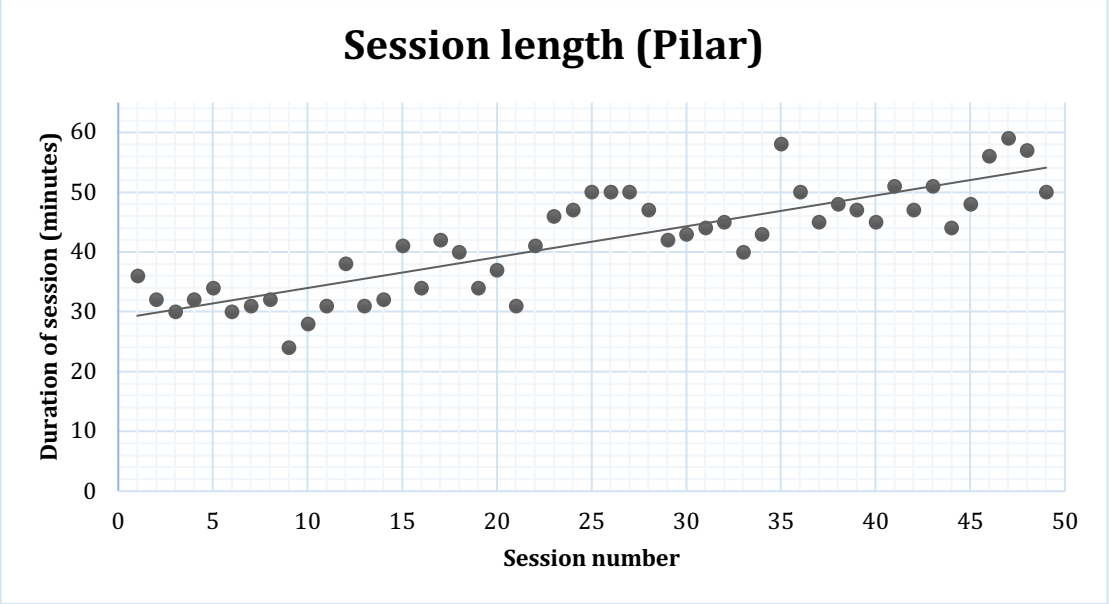
Table 7.5 Pilar's speech process

Session	Speech event
5	'Ah'
14 (MM5)	Audible giggling, laughing and speech-like vocalisations
18	"Shh" "Ding dong"
24 (MM6)	Animal sounds "Ay oh" (Hello) "Yeah" "uh oh"
32 (MM7) Slow	"Yes" "Yay" "Flash" "uh" "oooh" "yep"
36 (MM8)	Lots of "no" s
38 (MM9) Fast	"Sleep", names, colours, counts, quiet sentences
39	Safe words + phrases. Gradually adding more
40	Same as 39
41	Same as 40
42	Long sentence chatting
46	Speech throughout session. Lots of chatting

Table 7.5 shows key features of the oral/verbal path into speech with corresponding Meaningful moments indicated. After the 1st vocalisation in session 5 I sent a kazoo home for Pilar to 'practice on' which resulted in her playing it in session 6 followed by possible vocal sounds and a giggle. This perhaps impacted her vocal confidence and her class teacher then reported increased speech with her friends. These developments were gradually augmented over sessions 8-17 with louder giggling and speech-like vocalisations such as "uh oh" (MM5 Appendix 7.2). In sessions 17-34 Pilar increased the range of her single word-like sounds that crept close to speech. Perhaps the most interesting examples were her saying "ay ow" for 'Hello', "uh hu" with an upward inflection for 'yes', and "uh uh" with downward inflection for 'no'. There also started to be occasional "yes"s and "no"s. The sessions were full of laughter around Session 24 with this almost seeming to be in place of speech. This

laughter was often linked to physical games such as 'hide and seek' and chasing around the room which seemed to build energy and courage.

Figure 7.5 Session lengths – Pilar



Around session 24 there also began to be a distinct pattern of increased vocalisations towards the end of each session that became especially pronounced as Pilar started to speak in therapy. In response to this pattern and Pilar's general inclination to stay in the room, (as noted above in the theme 'Session frequency and length'), I began to further lengthen the sessions with the aim of optimising the impact of this therapeutically productive time. Figure 7.5 is a graph of session lengths showing a general increase from around 30 minutes at the beginning of therapy to 40 minutes at session 22. The session length then increased to approach 60 minutes towards the end of therapy, representing a significant increase over the second half of the process when rapid progress was being made.[6]

Progress was very gradual until session 36 when there was a sudden acceleration in Pilar's rate of verbal output. From session 31 therapy sessions had moved to the soft play room at Pilar's request where she was able to extend her previous physical games such as chasing around the room into a variety of boisterous activities. This perhaps helped to build the intensity to burst into speech in session 36 when Pilar

[6] Session 9 was shorter as this was when Pilar urinated in the session and we finished early. Session 21 was shorter than sessions either side as this was the first session after the summer holidays, we were in a new room and I was keen to meet Pilar's mother afterwards. Sessions jumped in length around Session 25 as time was split between two rooms due to Pilar requesting to visit the soft play room. Session 35 was longer because Pilar's older sister was late picking her up.

used the word “no” more than 80 times interspersed with “yes” approximately 10 times. This felt like a huge breakthrough. Session 37 was relatively quiet with some “no”s but not in the same quantity. The next breakthrough was in Session 38 when Pilar instructed me to “sleep!” several times before speaking in fuller sentences through the didgeridoo (8.4.2.2). She then used a piece of a cardboard box as a pretend telephone and spoke into it in long sentences. The ‘wrong colour’ game also began in this session whereby I would incorrectly name the colour of a ball and Pilar would correct me.

From session 43-45 there was also a sense of ‘warming up’ the voice during each session using the ‘wrong colours’ game and initial conversations where only single word responses were needed from Pilar. Louder, more confident speech began to appear earlier in each subsequent session. However, there was sometimes a need to just play and not always focus on specific speech activities. From session 46 Pilar spoke confidently throughout the sessions becoming relaxed and assured about her speech. The conversations that then occurred brought a new dimension to the therapy as Pilar shared aspects of her life.

7.5 Tasha

7.5.1 Tasha – background

The interview with Tasha’s mother was also conducted with the aid of a translator. Tasha was one of four siblings with one older and two younger sisters. They lived in overcrowded temporary accommodation that was some considerable distance from their school. Tasha was born prematurely at 7 months, spending some time in hospital, but had normal development after this. Tasha’s mother explained that Tasha knew English very well and tended to reply in English even when spoken to in Lingala. However, she explained that Tasha’s speech stopped when she stepped outside of her flat. Due to the nature of the family situation the interview took place in a large play room at a children’s centre attached to the school and Tasha played a ukulele in the room, sneaking sideways glances at me. Towards the end of the interview she also spoke to her mother in front of me.

7.5.2 Tasha – Path into Speech

Like Pilar’s therapy narrative in the previous section, Tasha’s therapy process was also lengthy and complex in nature. At the end of the transcriptions of meaningful

moments I give a little more detail about the introduction of classmates into the sessions and also the transdisciplinary work that was so important for this case (see Appendix 7.3)

Table 7.6 Summary of PinS – Tasha

Session	Therapy	Speech progress
1*	Initially frozen, but with musical engagement and self-expression	Small nods
2	Loud chinese cymbals in Goodbye song	
3		Class teacher reports laughter in class Eye contact and smiles in session
4	Very keen to attend	Smiles and humour
5	Free and expressive music	Good facial interaction/smiles and eye contact
6	Slow to warm up after Easter	
7	Playing everything/playing loudly	Plays kazoo (sliding in from home)
8		Kazoo conversation
9		'ooh' into mic
10	Amazing improvisation on sensory wall equipment	
11	Beautiful singing into the new microphone for most of the session- very moving	Report that Tasha has spoken to a teaching assistant and there was a 'big celebration'
12*	More microphone singing	
13*	Loud xylophone & cymbal	"no" x 3 + other vocalisations
14		"cold" "how are you?" "I want to go toilet" "crocodile wants to make some food"
15*		"mouse is cooking" Lots of speech at the end of the session.

16*	Extended session. Free improvisation. *Punky twinkle twinkle. Separation anxiety. Doesn't want to go back to class.	Lots of speech.
Summer holidays 17	*(Tricky reconnection with no speech, gaps in therapy, homelessness, potential child protection issues)*	Says "Hello" early in the session
18		"Heads"
19		Vocalising and singing using the mic
20		Singing but not speaking
21	Draws a picture. Possible Child protection issues flagged to outreach worker.	Laughing and vocalising
22*	Bubble tube colour speech	*After 4 months of not really speaking/progressing* Names lots of colours
23*		Says "fine" straight away. Lots of chatting about family. Naming colours & matching with scarves
24		Reading a penguin book- "I am small" at the end of each phrase Favourite food discussion. Teaching assistant (TA) comes in and joins in. Chatting with TA outside in corridor.
25	Plays the didgeridoo	Struggling to get support to generalise speech
26		Confident talking Slow generalisation- no support yet. I discuss with outreach worker.

27	Talks to TA in the session but the TA is called back to class.	Talked in corridor on way to session Talked outside the front of the school and back down the corridor
28		Talks to TA in corridor
29*		Says "I want some friends. I want some friends to play with me here!" I then plan to introduce children into the session
30		Tyreese unable to attend as no consent gained as yet
31	Tyreese starts, the whirling ball of energy Tasha- slightly showing off Ty turning off lights- helps with speech- imaginary mouse and screaming	Ty-"She just talked!" "Are you my friend?" Ta- naming animals & says "poo" &"wee" Ty- "Do you like me?" Ta "Yes"
32	Bonding. Sweet conversations about their hair	"I'm going to buy you a.."
33		Tasha- "who likes snow, spiderman etc etc" Too intense for Tyresse who wants to leave.
34	Tasha wants another friend to attend, Tyreese is jealous	Aware of the desperate need for some help with generalisation.
35	Mary added. Tasha gives everyone pretend ice creams	
36**	*1st contact with James -SLT- interrupting the session about a meeting. Further emails ensue and James begins a sliding in programme immediately!!(See Appendix 7.3)*	Tasha- bit shy with speech at the beginning

37	James- intensive work	Post-therapy meeting with J and SLT. T's English is in normal range. Seeing T 2x per week. TA or CT Rene will see T 3x PW! Sudden dramatic switch to intensive work. T has also spoken to CT Naomi now. J organised education session for whole staff team!
38	Child protection concerns and traumatic abuse investigation for children. Tasha still wants a session. Lots of nice playing together.	T- "I live in Africa" Random talking about identity T "Who wants to look at the sky? Who wants to look at the shape of the clouds?"
39	T wants other people to attend- v insistent.	James has reached optimum group size to allow Tasha to talk. Tasha reports to James that her father is shouting at her to talk.
40	Emotional work in Music Therapy.	Speech Therapy now really taking place within James's sessions. Psychoeducation has happened in school. Talking to class teacher.
41	Superhero music/drama. Group bonding- special ending	
42.		Explained to CT that J is now the 'sliding in' therapy and is ahead of me on this.
43.	Fighting a monster together.	
44.	Musical statues.	Easier transition for T into class but no speech there as yet
45.	No Tasha in this group.	
46	Dancing and relaxation	

47**	With me - further emotional work and positive group bonding. Then a meeting with Tasha's parents.	With James-successful sliding in to next class teacher and speaking in front of the whole class.
48	Positive, celebratory final session	Tasha says that she is "very, very shy"

* Denotes a session from which a meaningful moment was transcribed. **Denotes a contextual meaningful moment.

Transcriptions of the meaningful moments and further detail of the case narrative for Tasha are given in Appendix 7.3

Figure 7.6 Phases of Tasha's therapy process

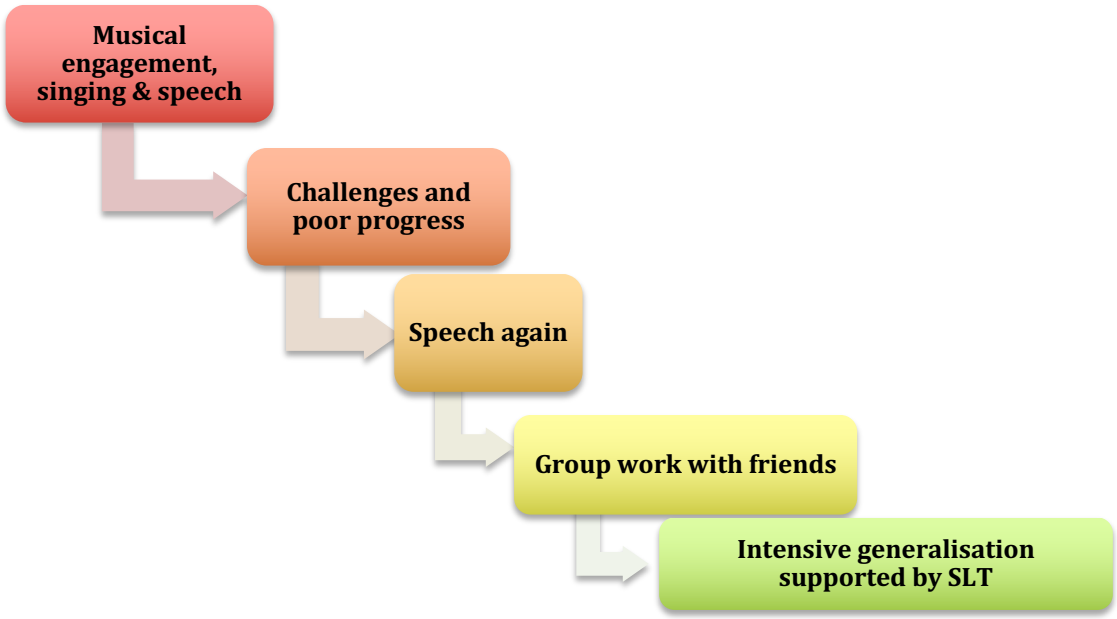
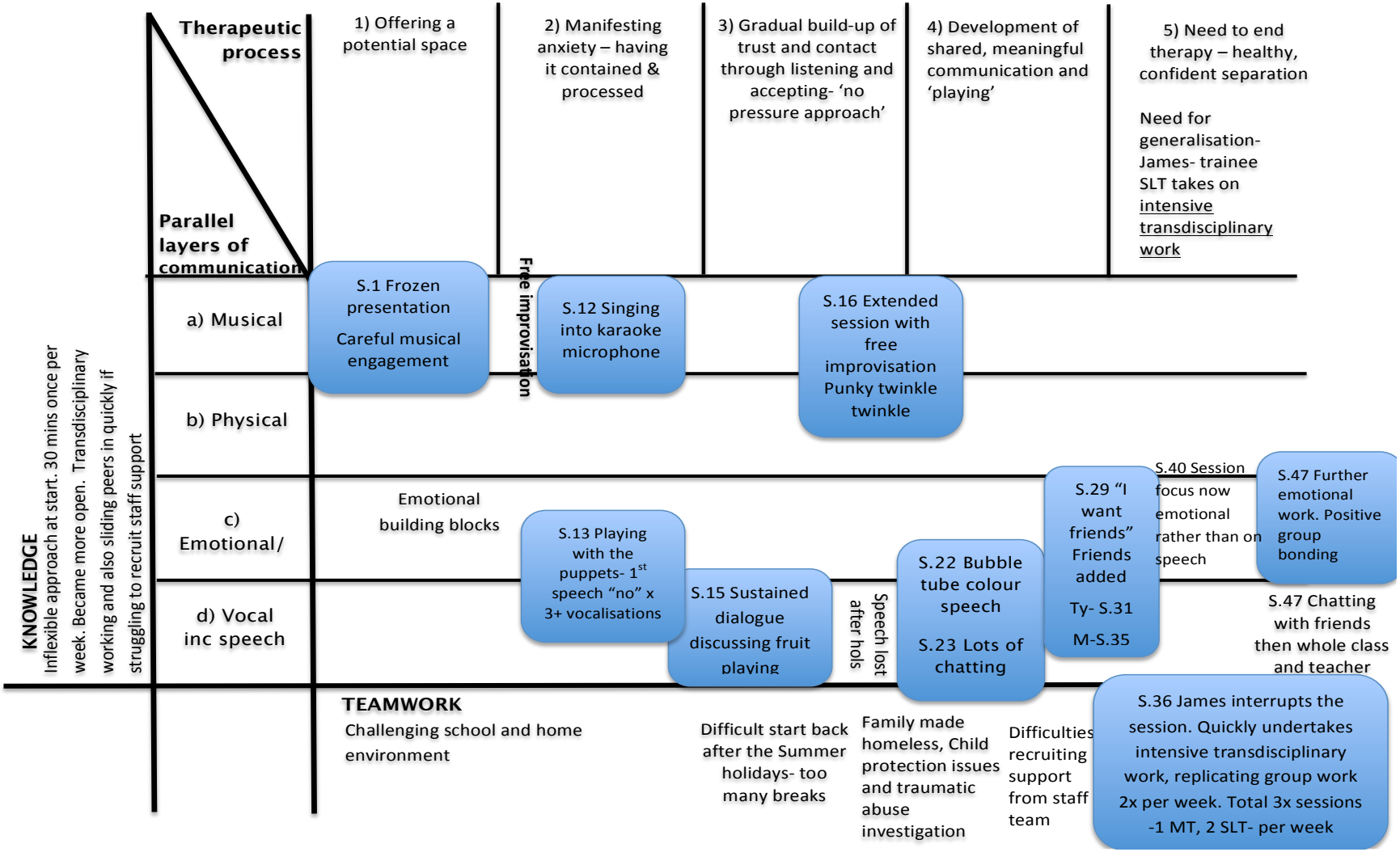


Figure 7.7 Tasha's path into speech on the theoretical framework



7.5.3 Tasha – Essential transdisciplinary generalisation

Although Tasha had a similar number of sessions to Pilar, Tasha had a fairly straightforward path into speech within the Music Therapy sessions themselves. There was a slightly tentative but then very positive engagement with musical interaction that built up to the point of using play and then speech in session 13. However, along the way Tasha had some significant emotional issues and environmental factors that impeded her progress. These issues are explored extensively in the thematic area 'Emotional' and also in 'Generalisation' in chapter 8.

One other factor that was important in Tasha's path into speech was a sense of building intensity and playful activity which was true of both Session 13 (Appendix 7.3 MM3 Table X) and session 22 (Appendix 7.3 MM6 Table X). This was also true for Pilar (see above) and Maria (below) who both used physical activities to build up the intensity in the sessions.

As James became an intrinsic part of Tasha's Path into speech the therapy roles split quite clearly with James taking on most of the speech work allowing me to move into a more psychotherapeutic role, addressing issues around peer relationships and difference. The role of transdisciplinary work in Tasha's case is explored in detail in chapter 8.

7.6 Maria

7.6.1 Maria - background

The parental interview with Maria's father took place with the support of the Special Educational Needs Coordinator as an informal interpreter. Father presented a picture of Maria as being quite anxious, explaining that she was nervous and afraid of many things such as dogs, thunderstorms, loud sounds, some cartoons and monsters. He said that Maria found it difficult to speak when meeting new family members for the first time and that her mother had similar issues with SM at the same ages. In addition, Father suggested that he was also quite a shy man but that their country of origin –Paraguay- was culturally similar to Brazil which is loud and festive. Church was an important social aspect of their lives and Maria did have some minimal speech in this setting. After an observation of Maria in nursery I noticed that Maria spoke to Father in the playground within clear view of staff and friends. Within the

nursery setting I felt that Maria was perhaps being treated quite unpleasantly by her classmates but had no means to defend herself and communicate about this. She appeared quite subdued in this setting.

7.6.2 Maria - Path into Speech

Maria presented with a high degree of anxiety as seen through her frozen physical presentation, flat affect and rapid playing of different instruments. As the therapy progressed it felt as though the anxiety was rapidly transformed within the therapeutic relationship into a useful, positive energy. Maria was able to express herself and play in a setting where her feelings had previously been suppressed due to her SM.

Along the therapeutic journey there was a gradual build up and intensification of helpful therapeutic tools, such as laughter and dancing, always taking the lead from Maria, that resulted in increased vocalisation. Maria found a number of different ways to express herself and the intensity of this expression often appeared to match both her anxiety and the urgent need for a communicative outlet.

Table 7.7 Summary of PinS - Maria

Session	Therapy	Speech progress
1*	Appears anxious. Plays lots of instruments in rapid succession.	
2*	Cymbal crashes. Doesn't want to finish.	
3		Humour and laughter
4*	Dancing with scarves	Loud laughing
5*	Bubble song	Laughing/shouting/exclaiming
6*	Fighting puppets	Roaring/vocalising into the mic
7	Dancing	Giggles/screams, Speech-single words
8	Slide building	Expressive full sentences
9*		Lots of speech and generalisation into nursery
10	**After Summer holidays** Lots of chatting in session	Talking to new class teacher when I pick her up!

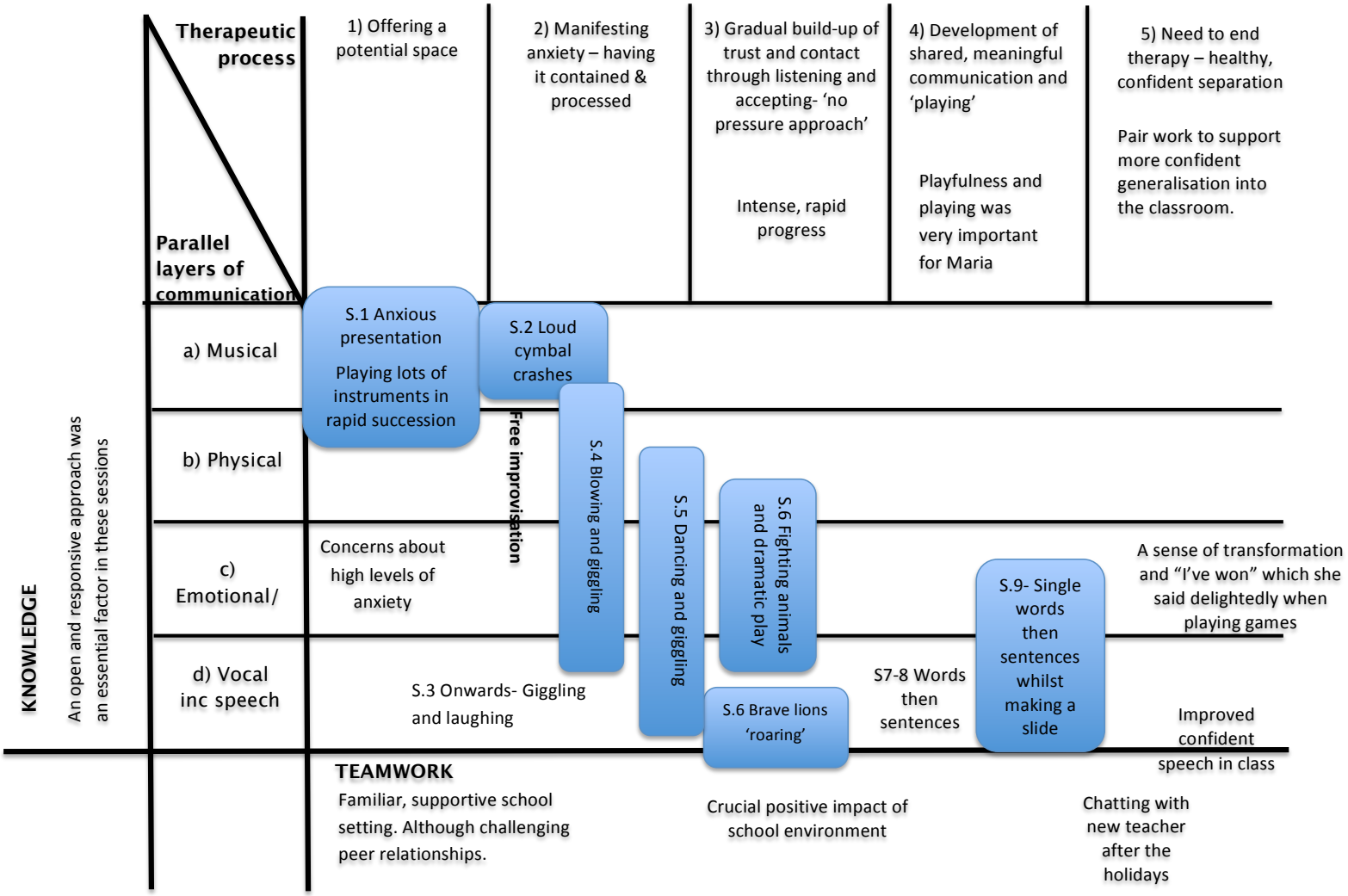
11	Chatting and playing	
12	"	
13	Chatting, playing, teaching	
14		Less confident in class. Thinking about adding a friend into the session.
15		Chatting about which friend
16-21	*Friend added. N.B. For these sessions only consent for therapy rather than for the research was gained and so only a general overview is given of this stage.*	*More confident in class.*

***** Denotes a session from which a meaningful moment was transcribed.

Figure 7.8 Phases of Maria's therapy process

Transcriptions of the meaningful moments and further detail of the case narrative for Maria are given in Appendix 7.4

Figure 7.9 Maria's path into speech on the theoretical framework



7.6.3 Maria – a short and positive path

Maria was assessed as being very anxious but I decided to continue seeing her as she showed signs of engaging well in Music Therapy. Her path into speech was surprisingly rapid and transformative with Maria appearing to utilise her anxious energy through physical movement and laughter to move into speech. Many other factors in her journey were fairly similar to the other cases such as loud cymbal playing and playing oral instruments but her excited dancing and creation of a slide made out of slippery cushions and scarves was a more individual feature. The supportive nature of the environment around Maria, both at home and at school, played an important role in generalising her speech from the therapy room into her class room. There was a nerve-wracking break at the end of the summer term when Maria had just started to speak in therapy. I was very concerned that the long Summer holidays might undo Maria's progress. However, this situation was overcome by the preparation and response of the reception class teacher with the creation of a positive, supportive environment for Maria. The importance of having a flexible approach was crucial as Maria later initiated playing board games to create opportunities for speech and developing longer conversations and greater speech confidence after the summer holidays. The sensitivity of the class teacher also partly prompted the further pair work as she wanted Maria's speech in class to become more confident.

7.7 Rabiyah

7.7.1 Rabiyah – background

In the parental interview Rabiyah's father explained that she had 3 older sisters and one younger brother in the nursery school a year below her. Rabiyah's father then shared a video of Rabiyah talking normally at home. He said that they are a normal Somali family and that he speaks to them in Somali but they now answer him in English. Rabiyah's father described a normal development path for Rabiyah but with some speech delay as she didn't start speaking until she was 3 years old. The family lived in a very sociable Somali community, spending time in each other's houses. Rabiyah's father described how Somali culture is not typically quiet as they shout to each other from house to house. Rabiyah's class teacher confirmed that Rabiyah

doesn't talk to her friends in the playground or anyone else in school. Despite this she says that Rabiyah does otherwise seem very happy.

7.7.2 Rabiyah - Path into Speech

Rabiyah moved rapidly into speech and was a more straightforward case in comparison to longer cases. However, once speech emerged there was also a challenging change in dynamic that was important to consider in thinking about the broader context of working with children with SM (see below).

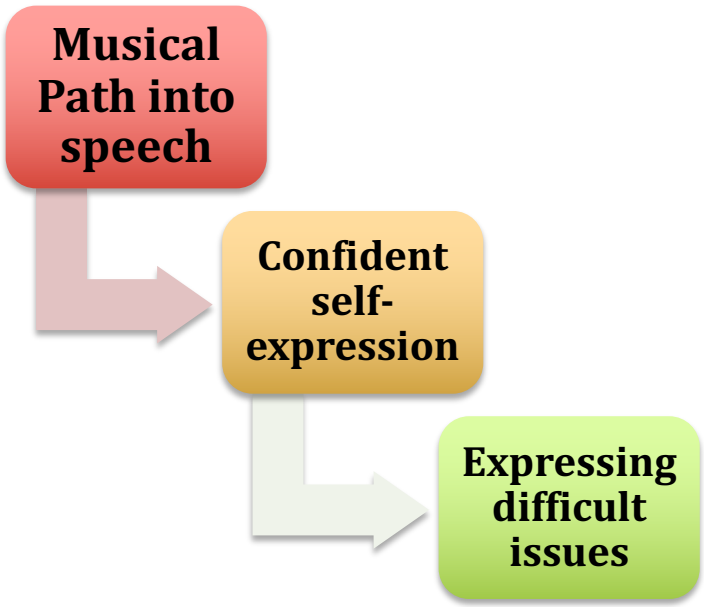
Table 7.8 Summary of PinS - Rabiyah

Session	Date.	Main features of session	Speech Progress
1*	7/12/15	Positive session. Likes oral instruments, the same time game and smashing the cymbal	Quiet chuckles.
2	14/12/15	Fire alarm (short session). Plays mouth organ. Awareness of mouth. Kazoo going home.	Laughed out loud in class after session 1.
3*	11/1/16	Dance like. Loud bash on cymbal. Kazoo singing. Doesn't want to leave.	Tentative naming of animals in session.
4	21/01/16	Singing into karaoke mic. Mini-process into speech.	Naming colours of puppets.
5	25/1/16	Very confident 'Wheels on the bus'- Mummys-"shush". Daddies- "stop that noise!" seemed quite symbolic.	'Old Macdonald' naming animals. Extended ending as lots of naming colours.
6	8/2/16	Didgeridoo talking.	
7*	22/2/16	Improvising long notes. Louder and more confident. "It's stuck"	Confident didgeridoo conversation
8	26/2/16	Loud and shouty into the didgeridoo.	Lots of talking/questions.
9*	4/3/16	Heartfelt singing. Mic in mouth. Lots of language. Animal pooing on me.	Talking to friends and Teaching Assistants (TAs) outside. Class

			teacher (CT) reports whispering in class.
10	11/3/16	Cheeky. Pushing boundaries.	Conversation with R reported by another CT.
	17/3/16		CT reports speech all day in classroom.
11	18/3/16	Talking normally. Possibly feels powerful. Takes headscarf off.	
12*	15/04/16	Lots of chat about everything. Wants to be my teacher. Shift in power dynamics.	
13	22/4/16	Talking. Risk taking. Bossy, cheeky.	Using a loud voice to CT and friends.
14*	29/4/16	Shouting in from outside. "I hate you, I'm joking"	
15*	6/5/16	"I'm going to beat you up you dumb girl!" Sharing abusive/bullying feelings	
16	13/5/16	Showing nice smelling herbs. Playing with soap and water.	
17	20/5/16	More music. Doesn't like Goodbye.	Normal speech in class.
18*	27/5/16	Upset at finishing. Wants to stay forever. Long discussion.	

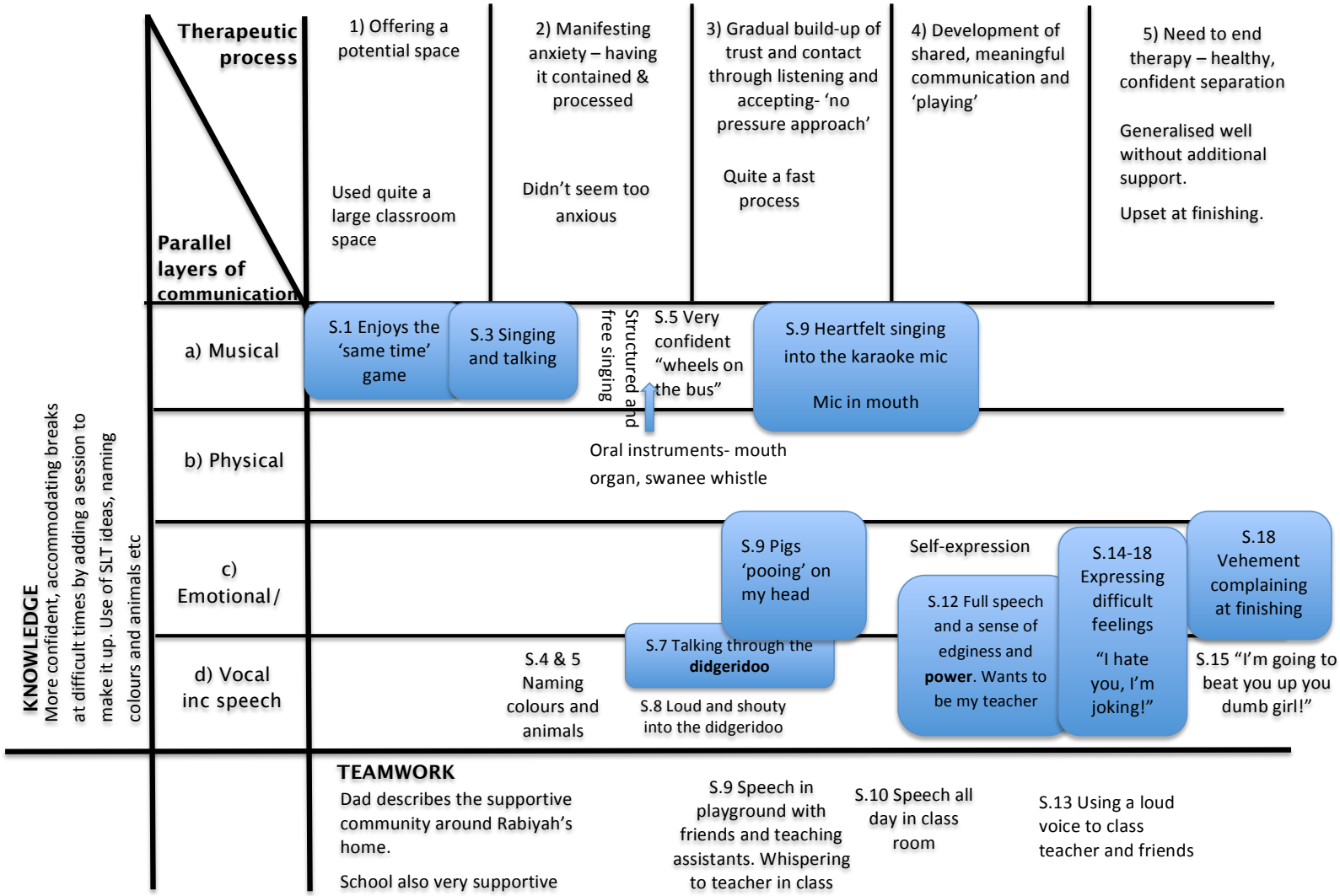
* Denotes a session from which a meaningful moment was transcribed.

Figure 7.10 Phases of Rabiyah's therapy process



Transcriptions of the meaningful moments and further detail of the case narrative for Rabiyah are given in Appendix 7.5

Figure 7.11 Rabiyah's path into speech on the theoretical framework



7.7.3 Rabiyah - fast speech, then exploring other issues

Although Rabiyah's path into speech was fast compared to Pilar and Tasha some of the features of the sessions were very similar just more condensed. Like Maria, Pilar and Tasha, Rabiyah also appeared to be quite anxious at the beginning of her therapy but quickly relaxed and 'warmed up' within the first session. Rabiyah responded to the opportunity for musical communication by playing energetically, loudly and then laughing in her first session.

Rabiyah continued to engage well in the second session, focussing on oral instruments but being unable to make a sound into the kazoo. I sent the kazoo home and in session 3 she was then able to play it. In session 3 she quickly moved on to singing into the echo mic and then the karaoke mic which she put inside her mouth.

Later in session 3 Rabiyah was able to name some of the finger puppets, always replying into a microphone. For a few weeks, Rabiyah always used a microphone of some sort to speak through until session 7 when she spoke independently, repeatedly exclaiming "It's stuck" in reference to a ball that she pretended was stuck in the didgeridoo. From then on Rabiyah really established confident speech in the sessions which generalised quickly and naturally into the class room and other settings across her school. The therapy then took a different path and seemed to create a space to explore some emotional issues that were perhaps connected to having SM.

7.8 Mark

7.8.1 Mark – background

Mark was born prematurely at 34 weeks' gestation and spent two and a half weeks in hospital. Mark's mother reported that she hadn't experienced any attachment issues and that his subsequent development was normal except for his SM. Mark had four older and two younger siblings and a baby nephew living in his family home. One older brother had some issues with anxiety and Mark's father was described as being quiet. Mark's mother described Mark's extreme separation anxiety upon starting Nursery in the spring term and so had taken him out and started again in the autumn term. Mark still took a long time to settle despite the additional time at home. The nursery teacher later stated that he had been one of the most challenging children to settle, crying for a month and then once again for another month after restarting in the Autumn.

Mark initially spoke to his nursery teacher but after a week off school due to illness could no longer speak in that setting. Mark's mother described a speech pattern typical for a child with SM -speech at home but not at school- explaining that he occasionally didn't speak at home when he was unhappy. Mark couldn't speak to his uncle at his Grandma's house but could when they went to stay in their caravan. Mark enjoyed socializing with a good friend at nursery whose family were close neighbours.

Towards the end of the interview the class teacher exclaimed "we've got less than 10 weeks to get this sorted". I explained that this could be experienced as pressure.

In a later discussion with the class teacher we arrange that the best place for the therapy to be located was in the staff office/kitchen. It was the only space in the nursery area that could be a separate private space, which would be essential for a child with SM. It was small and rather dirty but I decide that this was the best possible location and Mark seemed very happy to go in it, perhaps because it was usually a space that was out of bounds to children.

7.8.2 Mark - Path into Speech

Table 7.9 Summary of PinS - Mark

Session	Therapy	Speech progress
1*	Quite anxious. Explores walkie talkies and mouth organ.	Mouth movements. Sense of being close to speech. Little vocal sound. Spoke to Pauline at end of day.
2*	Oral instruments	"mm, mm" vocal sounds
3	Star wars theme appears.	Vocal sounds into walkie talkie. Issues with nursery teacher's understanding of SM.
4*	Star wars drama. Loud cymbals.	Vocalising mouthing. Vocal conversation with kazoos. 24.30
5	Vocal instruments. Seems to want longer session.	Woofs and sings into mic. Grunts at 'pirate pete'.
6	I seem under pressure. Lots of oral instruments.	Vocalises and mouth movements
7	Fighting and gun noises	Says 'no'

8*	**After Summer break.** Comes in for a 'look' with Jacob	Audible speech with friends outside and in the classroom. Whispers "ghostbusters"
9*	Superhero play	Mark 1st speech 6.48. 20.00 onwards is just speech. In class, a few words to CT
10	Pretend play and speech	Talking the whole session Jacob- "stop talking!" to Mark.
11	Continual chat and play	Talking to TA lots
12	**2 week break.** Bit shy, need a warm-up. Taking my instruments away.	Mark talking to CT, another TA and children. Can't stop talking in session. Jacob talking to everyone.
13	Mark can't stop chatting. Musical support for the drama.	CT concerned about Mark's hesitancy still.
14	Taking away my music powers. Using music as well.	Chatting to each other about the game.
15	Chatting, dramatic play and music.	Mark has a successful birthday party - shy at first then talking to everyone.
16*	Amazing session. Vivid imaginary play.	V. Positive feedback from parents. Discussion of issues around attending SLT groups outside of school for SM.
17*	Mark- "I'm trying to talk young man". Jacob- physical, throwing things around. Very positive ending.	M & J discuss plans for generalization of their play into the classroom and taking the ending chart into class and presents home to unwrap.

***** Denotes a session from which a meaningful moment was transcribed.

Transcriptions of the meaningful moments and further detail of the case narrative for Mark are given in Appendix 7.6.

Figure 7.12 Phases of Mark's therapy process

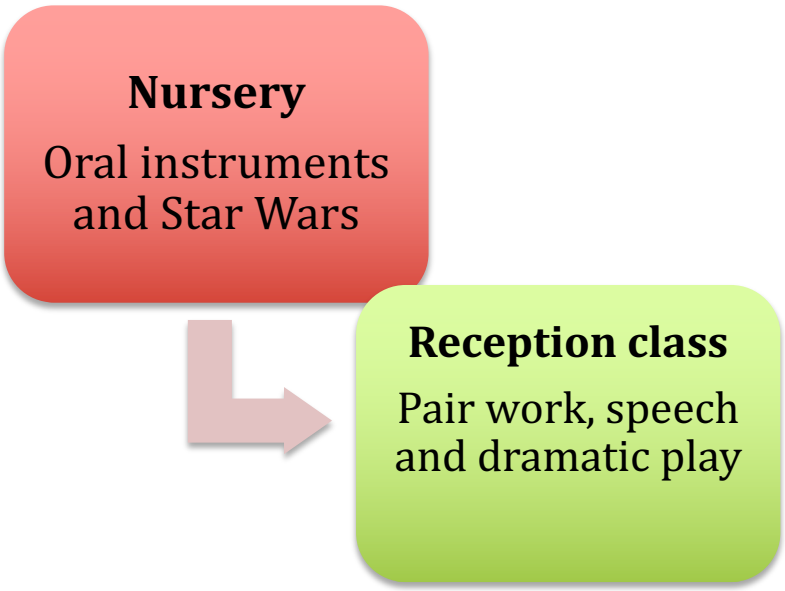
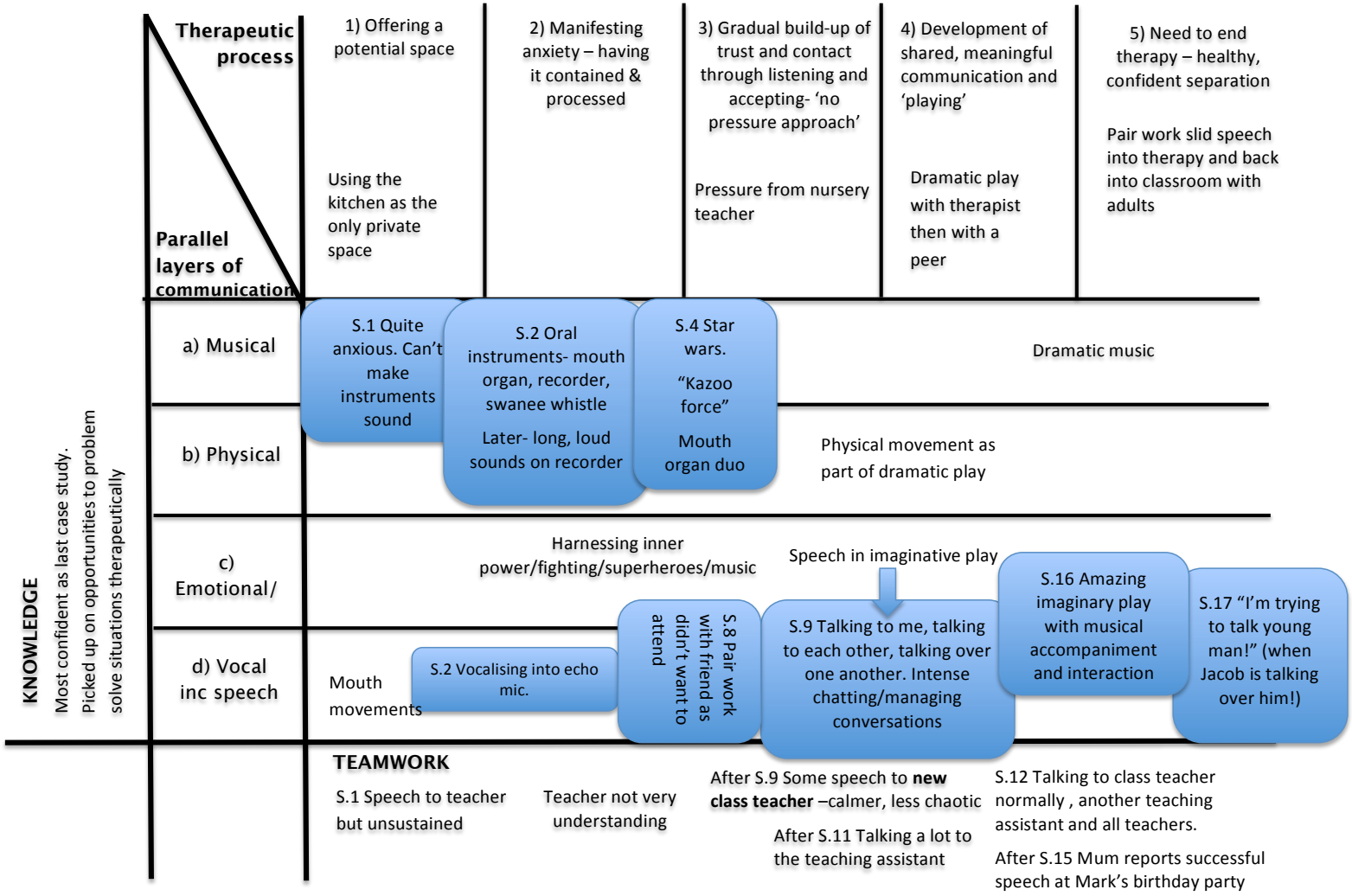


Figure 7.13 Mark's path into speech on the theoretical framework



7.8.3 Mark- embracing peer work

Mark was described by his class teacher as being one of the most challenging children to settle that she had ever worked with which perhaps indicated something about both Mark and the nursery teacher. When I started work with Mark we only had time for 7 sessions before the summer holidays. There was a certain amount of pressure from the nursery teacher and also pressure on myself as the therapist/researcher for the therapy to be successful, however, this self-inflicted pressure was an underlying presence in all the case studies.

In the first 7 sessions Mark engaged very well and presented a similar pattern to many of the other children in the studies but with some individual features. Mark made little "hm hm" vocal sounds from session one, which felt as though he was very close to speech. After his first therapy session he did speak to his nursery teacher after school, however this wasn't sustained perhaps due to the teacher's quite overbearing communication style.

Oral instruments had a very important role in Mark's path into speech. He took a keen interest in, but was unable to play them in the first session. In the second session he played lots of oral instruments, then later vocalised into the echo mic, then at the end played the recorder very loudly pointing it up in the air. In session four we developed vocal conversations using 'kazoo force' and playing 'Star Wars' battles and this style session continued until the summer holidays.

Mark was speaking with friends but not school staff after the holidays and so I decided to 'slide' speech in to the Music Therapy sessions by inviting his close friend to join us. This worked well and dramatic, imaginative play involving plenty of speech emerged in the sessions whilst I monitored Mark's speech progress outside the sessions. The new class team were more responsive to advice and generalisation happened quite quickly in this setting, alongside solid progress in other social settings such as his 5th birthday party.

7.9 Conclusion

The evidence from the Paths into Speech for the 6 case studies has been described through tables, diagrams of therapeutic phases and appendices of transcribed meaningful moments giving detail of the key ingredients of Music Therapy that are helpful for children with Selective Mutism. The therapy process was significantly

longer in 2 of the cases which is a concern when children have SM due to the risk of entrenchment. Pilar's lengthy case was examined in more depth in this chapter highlighting potential improvements to Music Therapy practice that were learned from this case. Issues emerging in Tasha's case are described thematically in chapter 8 as are all pertinent themes from across the Multiple Case studies. Themes from the cases are presented on individual theoretical frameworks and in diagrams prior to synthesising on a revised theoretical framework. Practice implications from the cases are outlined in chapter 9.

Chapter 8 - Multiple Case Studies: Analysis and discussion

8.1 Introduction

In this chapter I discuss the themes that were elicited from coding the clinical notes from each case study. In Appendix 8.1 themes that were generated from individual mind maps of codes are presented as diagrams for each separate case study. Appendix 8.2 is a diagram that shows how a final set of themes (Table 8.1) evolved from the individual themes. Similar themes were grouped together in the same area of the diagram and formed 'thematic areas'. In this chapter themes are illustrated by referring to clinical notes from the sessions, as well as meaningful moments in the appendices and examples from the Paths into speech (PinS). Examples from the case studies are used to illustrate the most interesting or common features of the themes rather than providing an exhaustive list of examples. Quoted session notes are given a code referring to the name and session number such as 'NotesDS1' for clinical notes from Daniel's first session. (For Maria and Mark, Maria is Ma and Mark Mk).

I first present a table of the themes from all the case studies organised into overarching thematic areas and themes. The column on the left -Thematic areas- represents similar themes that have been grouped together (Appendix 8.2). The column on the right is a list of all the themes collated from all the individual case studies (Appendix 8.1). Many of the themes are closely connected, such as 'Vocal/Oral' and 'Music of Music Therapy', therefore some themes may be discussed within different thematic areas as these are 'cross-cutting themes'.

Table 8.1 Thematic areas and themes

Thematic areas	**Themes**
8.2 Therapist's knowledge, skills and approach including therapy set-up.	• Session frequency and length • Openness and responsiveness • Incorporation of Speech and language therapy ideas • Equipment • Session space • Mistakes made/lessons learned

8.3 The Music of Music Therapy	• Always keen to attend
	• Musical engagement
	• Musical Self-expression
	  o Loud and very loud playing
	  o Dramatic music
	  o Instrumental improvisation
	  o Sung improvisation
	• Musical conversations, communication, relationship

8.4 Vocal/Oral	• Oral/Vocal features for each child
	• Features and uses of oral instruments and 'props'.
	  o Specific role of kazoos-Link to voice
	  o "I have something special!" Didgeridoo playing
	  o Other oral instruments
	• Oral-musical conversations

	• Singing • Vocal equipment and props • Other vocal expression • Humour and Laughter
8.5 Physical	• Frozen physical presentation • Physical action • Mouthing and mouth related behaviour • Lump in throat- 'Globus sensation'
8.6 Dramatic play/ imaginative play	• Imaginative play in the case studies

8.7 Emotional	• The therapeutic relationship
	• Anxious presentation
	• Immediate positive emotional impact
	• Building confidence
	• Increased happiness
	• Emotional issues related to SM
	  o Friendships
	  o Late disclosure of abusive cause of SM
	  o Sharing repressed feelings
	  o Symbolism
	• Non-SM related issues
	  o Potential abuse, attachment issues
	• Emotional improvements

8.8 Generalisation	• Creating a supportive environment

	• Introducing friends into sessions • Transdisciplinary working
8.9 The environment around the child	• Challenging school environment- Pilar • Complex school and home environment- Tasha • Chaotic to calm environment- Mark • The therapists' engagement with the environment around the child
8.10 Power	• SM as disempowering • Speech as empowering • Exploration and use of power

8.2 Therapist's knowledge, skills and approach including therapy set-up

8.2.1 Session frequency and length

The set-up for each of the multiple case studies was a weekly, 30-minute, individual session of Music Therapy at a regular time slot within an established space. This set-up reflected previous experience of providing therapy for young children in early years settings where children's concentration and focus is limited and 30 minutes can feel relatively long. Although this is a 'naturalistic' study I felt that these parameters needed to be defined to provide some consistency in the research.

Although some protest at sessions ending is common in therapy provision the frequency and length of the Music Therapy sessions became an issue and a theme in most of the case studies.

In some of the cases the children were able to clearly articulate how they felt about the session frequency and length. This was especially clear for Rabiyah who after a discussion about the Easter break in session 11 said that she wanted me to: "come every day, even in the holidays and on Saturday". In session 18 Rabiyah said that she didn't like the sessions because I didn't let her come and I didn't let her stay

there, which appeared to be a roundabout complaint regarding the frequency and length of sessions.

In session 25 Tasha clearly pointed to the inadequacy of the session frequency by saying "I want to do it every day". Tasha often seemed upset at the end of sessions and said that she felt "sad because it has finished" at the end of session 29. Maria appeared to indicate that she wanted to stay longer by playing more at the end of the sessions. In my session 2 notes I wrote:

> "I am reluctant to stop but it is time to finish. Maria is quite busy playing lots of different things ending with a big cymbal crash." *NotesMa2*

Playing lots at the end of the session was also a feature of Pilar's therapy. About the end of session 1 I wrote:

> "I sing a quick Goodbye song and Pilar continues to play lots of different instruments very enthusiastically" *NotesP1*

With Pilar, Maria and Tasha it became obvious that it was both necessary and important to extend the session time particularly once vocalisation and then speech occurred. This was because there seemed to be a pattern of gradually increasing vocalisations or speech within each session but a sense of starting over again each week. Extending the session time was one simple way of improving the trajectory of progress. As a result, I changed my approach to session times to offer a more flexible, needs-led approach.

With the second case study -Pilar- there was a slow and exhausting creep towards speech that is clear in the 'Overview of the path into speech' (Table 7.4). The vocalisations and speech that emerge towards the end of each session appear to increase with the gradually extended sessions which are around 30 minutes at the start of therapy to 50 minutes in the last few sessions (Figure 7.5). There is a sense that this was a more instinctive response from me as a therapist rather than a deliberate decision at this stage in the study, although in session 24 when she is making a lot of vocalisations I note: "she obviously doesn't want to leave and she hides in the tent".

In Tasha's case notes, lengthening the sessions becomes more conscious and I explain how I am struggling to extend her session, which needs to finish by lunchtime, and so I have to arrange to collect her early. In the 'Overview of the path

into speech' (Table 7.6) I state we manage an extended session in session 16 and Tasha begins to talk after some loud singing (MM5 Appendix 7.3), at around the 30 minute mark. The session then continues with lots of speech until around 55 minutes at which point Tasha says "I don't want to go back (to class)!". There is a break in Tasha's speech progress due to a range of issues but when it re-emerges in session 22 I write in my session notes:

> "… she only starts talking later on and it would be good to stay and continue it and become more confident if this happens…A full hour might be really helpful!!" *NotesT22*

A few weeks later in session 25 Tasha talks about therapy saying: "I want to do it every day".

I write a very similar assessment of the situation after session 7 in Maria's therapy:

> "I really feel the need to extend the session as Maria wants to stay longer and I think that if she stayed longer she would end up talking perhaps. I can't really go in more than once a week? I don't think, but I could make it longer. It's like the intensity builds up and up until she is doing lots of vocalising and bits of speech and she is just so close to bursting forth" *NotesMa7*

In session 8 Maria talks around the 30 minute mark and I extend the session to 50 minutes until she is talking confidently in full sentences. It is interesting that I question whether I can go in more than once a week with Maria as this is an aspect that I become slightly more flexible about in the case study with Rabiyah. This change was perhaps in response to Pilar and Tasha's lengthy therapy process which I considered may have been partly due to breaks at critical points in the therapy just before the long summer holiday in Pilar's case and just after in Tasha's. Some of the breaks were due to unfortunate timing and seasonal sickness but could have been ameliorated to some extent with better planning, preparation and transdisciplinary work (8.3.3). After session 6 with Rabiyah I write:

> "We then had half term and so I decide to see Rabiyah on the Monday and the Friday of the following week so that we didn't have a big break at a time when she is making so much progress." *NotesR6*

The nursery teacher also suggests that it would be beneficial to see Mark more than once a week. Session frequency will be explored further in the section on transdisciplinary work as this is an important theme in its own right.

8.2.2 Openness and responsiveness

Embracing an open, responsive stance to therapy provision was another important theme arising from the case studies. This meant being open to engaging in activities that could be viewed as outside of a Music Therapist's remit. For example, most of the children initiated or engaged in playful 'non- musical activities' at some point in their therapy process (see table 8.2) and it felt important to whole-heartedly engage with all means of self-expression especially as play was an aspect of their learning that may have been hugely impacted by the SM.

Table 8.2 Playful activities

Name*	**Type of play**
Daniel	N/A
Pilar	Playing 'connect 4', dramatic play, physical play such as 'chase' and using the ball pool, building with cushions
Tasha	Puppets & Dramatic play.
Maria	Blowing bubbles, dancing with scarves, making 'slides', fighting puppets
Rabiyah	Dramatic play
Mark	'Star Wars' and other superhero type games

*Cases presented in the chronological order in which they were conducted.

All these playful activities (Table 8.2) were thought about from a Music Therapy perspective in relation to elements such as: timing; self-expression; cross-modal attunement; vocalising; humour; and some activities felt crucial in supporting the leap forward into vocalisations or speech. For Pilar playing 'Connect 4' resulted in 'giggling, laughing and speech-like vocalisations' (Table 7.4).

For Tasha, vocalisation was initially achieved through singing but then her first words occur as part of a game with puppets when there is much excitement and laughter (MM3 Appendix 7.3). Maria's activities are combined with music but once again lead to increased excitement and laughter, exclamations and speech (Table 7.7).

Mark used vocal sounds into a kazoo as the 'force' in a 'Star Wars' battle (MM5 Appendix 7.6). He then begins to speak in Session 8 (MM7 Appendix 7.6) saying 'Ghostbusters' to initiate a specific drama with his friend. Dramatic or imaginative play will be explored further in a separate theme later in the chapter.

Taking the lead from the child and being directed by their needs is often key to therapeutic progress. Once Tasha had started speaking she articulated her need for friends stating 'I want friends' in Session 29 (MM8 Appendix 7.3). We gradually

formulated a plan and developed small group work with peers identified by Tasha (Table 7.6).

For some children it was important to be open to just talking for much of the session once speech was established in the therapy room and to forget about music if necessary. This was particularly true of Maria who mainly wanted to chat and play games after the summer holidays, which felt very important in developing her confident speech (Table 7.7). Allowing ourselves as music therapists to take on a slightly different role links directly with the next section.

8.2.3 Incorporation of Speech and language therapy ideas

Awareness and understanding of SM should always be at an optimum level in order to increase the impact of therapy provision. In the case studies this meant that I attempted to employ current understandings, including any relevant resources or tools, wherever appropriate in and around the sessions.

One example of putting this knowledge into practice was when supporting first speech in the sessions. After singing songs in the sessions Rabiyah was able to name animal finger puppets as part of singing 'Old Macdonald' (Table 7.8). From reading the Selective Mutism Resource Manual (Johnson and Wintgens 2001) I understood that naming familiar objects was less anxiety provoking for a child with SM than spontaneous, unplanned speech and so this was something that I incorporated in to the sessions when I felt that a child was moving closer to speech. Naming colours in a bubble tube also helped Tasha re-establish speech in the sessions (Table 7.6).

Pilar's long therapy process often felt a bit stuck and so I was continually searching for new ideas to help move her into speech. I therefore borrowed a guessing game from the Selective Mutism Resource Manual (Johnson and Wintgens 2001) which I describe in MM6 (Appendix 7.2). For Maria, blowing bubbles from a pot that she found in the therapy room seemed helpful (Table 7.7) and this is a technique used by Speech and Language Therapists to encourage Oro-motor skills (SMIRA website 2017).

8.2.4 Equipment

Over the duration of 3 years I gradually increased the equipment that I used, each time with a specific purpose in mind. Some equipment ideas were again borrowed from Speech and language therapy practice, others were musical.

A small toy karaoke machine was introduced with Tasha as I felt that the previously purchased echo microphones didn't provide much amplification and that children would perhaps be more encouraged with this toy. This was very successful with Tasha first in session 11 (Table 7.6) then as shown in MM2 (Appendix 7.3).

'Pirate Pete- the repeating parrot' was a fluffy toy parrot, recommended by the Selective Mutism and Research Association (SMIRA), which repeats back any sounds or words that are said to it. I introduced the parrot with Tasha in session 35 once we had moved into group work. I was struggling to get any support with the generalisation of speech back into the classroom and thought that this might provide a helpful transitional speech object. Unfortunately it wasn't helpful in that way due to the lack of engagement from staff (8.9) but it did play a role as an amusing group member at times.

Walkie Talkies were introduced later on in Pilar's therapy sessions (Table 7.4) simply as a tool to encourage more vocalisation and talking. However, they were a little complicated to use and so Pilar only engaged with them for a limited period of time. One boy in Tasha's group sessions enjoyed using the Walkie Talkies and Mark used the bleeping sounds incorporated into the devices as a way of communicating in session 1.

A didgeridoo was introduced into session 25 with Tasha (Table 7.6) as she was so musical and it felt appropriate to try new instruments. She found it amusing and was able to manage a good sound on it as well as talking through it. The didgeridoo was pivotal in Rabiyah's therapy process as she named colours on it, spoke spontaneously about a ball going down it and then had a conversation through it (MM3 Appendix 7.5). For further exploration of the role of the didgeridoo see "I have something special!" in the 'Oral/Vocal' thematic area (8.4).

8.2.5 Session space

The session space was another important factor in the therapy set up. Pilar was initially in a room that connected to a side room through an open door space with no physical door between them. Playing in the side room and communicating through the wall or door space became a feature of her sessions. At a later stage in the therapy Pilar initiated going into the soft play room in her school and ultimately this became the therapy space. Having a degree of flexibility and working in the best

available space for any particular child was key. For Mark this meant working in a kitchen area in his otherwise open plan nursery setting to provide a crucial sense of privacy. With Tasha it was important later to utilise corridor and outside spaces to facilitate generalisation of speech.

8.2.6 Mistakes made/lessons learned

These are mainly noted in the pilot study. With Daniel I should have picked up on his suggestion to bring a friend into the session (Table 7.3). Although he was speaking in nursery, facilitating his initiative might have aided his speech within the session. With Daniel, and throughout the whole case study phase, it would have been helpful to have had a clinical supervisor experienced in working with SM to help think about some of the issues more effectively.

The therapy with Daniel could have arguably been viewed as finished once he was talking in nursery. There was no specific requirement for him to talk to me and in some ways this could potentially have undermined the therapy. This additional and unnecessary pressure to speak was perhaps seen in Daniel's ability to speak early in sessions and then his later return to silence; his ability to play the kazoo and then being unable to play. It perhaps would have been far more productive to focus my attention on the aspect of the therapy that was helping him develop confident speech outside the sessions, namely the music. The desire for him to speak in sessions was more about my issues and inexperience as a therapist/researcher than his needs. Greater vigilance and awareness of opportunities to progress therapy, especially those initiated by the client, would have helped Daniel move forward more satisfactorily in Music Therapy.

Pilar's therapy was extremely lengthy and tiring and, as with Daniel, I feel that having an experienced SM supervisor might have been beneficial. Providing longer sessions, perhaps more than once a week could have shortened and eased the therapy process. Stronger collaborations with other professionals and additional staff training might also have helped.

Another learning point with Tasha was in regard to generalisation. Given the under-resourced school environment I could have focussed on bringing children into her sessions rather than recruiting a conversational partner from the staff team. I could

also have searched more widely within the school environment in order to enlist the help that materialised later (8.8).

8.3 The Music of Music Therapy

This theme outlines the powerful, multi-faceted and rich resource of the musical elements within Music Therapy for children with SM. The positive appeal and value of using sounds and music is revealed in numerous ways. The themes have been arranged to give a sense of how the children responded to musical elements over the course of their therapy. Vocal and oral aspects of Music Therapy are described in the subsequent thematic area due to their key role in the therapeutic narratives despite much overlap between the two thematic areas.

8.3.1 Always keen to attend

All the children in the study were keen to attend their Music Therapy sessions, perhaps because the therapeutic relationship was being offered through the accessible medium of music. In his clinical notes I write that Daniel was 'keen to attend' session one, 'happy to attend' from session 3 and that he 'skipped' to Music Therapy from session 5. As described in the first thematic area (8.2.1) Tasha and Rabiyah later verbalised their positive feelings about attending the sessions. Both Maria and Pilar were keen and smiley at the beginning of their sessions. Mark was happy to be ushered into his first session before it is properly set up and helps to choose and arrange instruments. Once in the therapy space, enthusiasm for the Music of Music Therapy was also shown in a number of other ways.

8.3.2 Musical engagement

Anxiety balanced with natural curiosity or sometimes enthusiasm is a feature in most of the early musical engagement. Pilar, Tasha and Maria express their anxiety through different forms of musical engagement in their initial sessions. Pilar had a dramatic transformation. Presenting as anxious and 'frozen' at the start, she found it difficult to produce a sound on any of the instruments (MM1 Appendix 7.2). However, after an improvised game of 'Musical football' (MM2 Appendix 7.2) Pilar became very musically engaged culminating with a noisy ending to the session that included multiple cymbal crashes (MM3 Appendix 7.2).

For Tasha, musical engagement was hugely important throughout her whole therapy process. Although anxious and frozen at the start of her sessions, Tasha immediately engaged with a gentle, focussed style (MM1 Table 7.6). Maria's initial musical engagement also showed her anxiety, -as seen in MM1 (Appendix 7.4)-, through the rapid exploration of many different instruments.

Mark appeared less anxious than the other children and explored instruments by helping to set up in the first session. He later also used the Walkie Talkies as instruments. Daniel and Rabiyah engaged enthusiastically from the start with musical elements such as the 'same-time' game -playing at the same time as the client- (Table 7.3; Table 7.8) and also playing loudly and interactively.

8.3.3 Musical Self-expression

Engaging in musical self-expression is a powerful tool for children with Selective Mutism. This section is broken down into the different features that were important for the children.

8.3.3.1 Loud and very loud playing

Self-expression was evident most dramatically in the loud playing of the children in this study who otherwise spent most of their school time in silence. They often played loudly early in their therapy process and for everyone except Mark the cymbals were the most popular instrument.

Daniel's louder playing begins in session 2 on the cymbal (Table 7.3), continues in sessions 3 and 4 (MM2 Appendix 7.1) and is thereafter a prominent feature of his Music Therapy. In session 14 (MM6 Appendix 7.1) he gives a loud 'performance' to his friends who are spectating just outside of the window.

As noted in the previous sub-theme -musical engagement- Pilar finishes her first session with many loud cymbal crashes (MM3 Appendix 7.2). This is an ongoing feature of Pilar's early therapy sessions with loud recorder playing appearing in session 4 (Table 7.4).

Tasha plays the Chinese cymbals noisily in the Goodbye song of session 2 (Table 7.6). Loud playing, alongside other features, also precedes Tasha's first speech, occurring in Session 13 (MM3 Table 7.6). Loudness and singing combine in session 16 with a punky rendition of 'Twinkle Twinkle little star' (MM5 Appendix 7.3).

Maria engages in loud cymbal playing in session 2 (MM2 Appendix 7.3) and then just prior to her first speech occurring she does some loud 'roaring' (MM6 Appendix 7.3). Rabiyah also engages in loud cymbal smashing at the end of her first session (Table 7.8). For Mark, very loud playing of oral instruments is a more prominent feature of his sessions as seen in Session 2 (MM4 Appendix 7.4) with loud cymbal playing only briefly explored in session 4 (Table 7.9).

8.3.3.2 Dramatic music

For Mark, the music also took on a different role, that of accompanying his dramatic play. This was particularly important once he was working as a pair with his friend Jacob and I took on a more supportive but also dramatic musical role. Alongside this, music also became manifest as an element within the drama. In session 4 kazoo battles were used to represent the 'force' in Star Wars battles with myself (MM5 Appendix 7.4). 'Music power' later became a dramatic element which was taken away from me through the stealing of instruments which were then used by Mark and Jacob (Session 14 Table 7.9).

8.3.3.3 Instrumental improvisation

The importance of an open approach to Music Therapy provision for children with SM has been outlined in the first theme. This could perhaps be described as somewhat 'improvisatory' in nature as we respond creatively to the needs and ideas of individual children. In this section the specific use of musical improvisation as a means of self-expression is explored as it is a key resource in the Music Therapy toolkit that was utilised in these cases. Qualified Music Therapists usually view the whole presentation and interpersonal communication of a person as inherently 'musical' (1.4.3). Rather than addressing this broader notion of musical improvisation in this section I am focussing specifically on the more concrete manifestation of musical improvisation whereby children are playing instruments, or using objects as musical instruments, or 'musical play'. Children with SM may at times prefer a more structured approach to musical engagement because of their high anxiety, although the children in this study also found this freer form of musical communication useful to varying degrees.

Tasha showed a natural affinity and inclination towards creative musical improvisation which formed the key feature of most of her individual sessions (Table

7.6) although she found this musical freedom challenging at the start. After session 2 I write:

> "She chooses the ukulele. She looks quite closely at my guitar and tries to copy me. I play 'Twinkle twinkle' as I know that last time she played along to the rhythm of the tune."

In this session I tried to ease her anxiety by offering a reassuring musical structure. Tasha appeared to find the Goodbye song supportive at the end of Session 2 and she played 'quite loud and rhythmically' on the Chinese cymbals.

After Tasha's anxious start and tentative first few sessions (MM1 Appendix 7.3) I describe her playing in Session 5 as being 'free and expressive'. At this point in the sessions she communicated her enjoyment of improvisation through eye contact, smiles and clear focus as well as the music itself. Tasha's brilliant capacity to improvise was demonstrated most uniquely in session 10 (Table 7.6)) when we improvised together using the sensory wall equipment which included fake grass, metal chains and other textured surfaces.

Rabiyah responded enthusiastically and straightforwardly to the medium of improvisation from the start of her first session. This is reflected in my clinical notes which include many sentences such as: 'Rabiyah carries on playing the shaky egg. She plays with more energy and I copy her and she really likes this'. It is also seen in the 'same-time' game of MM1 (Appendix 7.5) which demonstrates her enjoyment of musical communication and connection.

Daniel also responded positively -if a little unconfidently at first- to musical improvisation. In session 2 I write that he 'Really explores volume on the chimes ppp - f (as quiet as possible to loud). Very aware of my responses.' Improvisation continued to be the dominant medium of communication for the duration of the therapy as illustrated in Session 4 (MM2 Appendix 7.1) and Session 14 (MM6 Appendix 7.1) on the cymbal and drums.

Pilar, Maria and Mark also used musical improvisation in their sessions, albeit slightly less prominently than the others. After a musical start Pilar returned to musical improvisation towards the end of her lengthy therapy process and I wrote in my notes: 'I then play the train whistle. She again plays the didgeridoo and then we have a lovely improvisation with the swanee whistles and drums' (Session 36).

Maria also used musical improvisation (MM1; MM2; MM3 Appendix 7.4) but later in the sessions it is blended with other expressive forms such as dancing and puppet play. Mark's improvisation was often focussed on oral instruments (MM2 Appendix 7.4) which will be covered in the theme 'Vocal/Oral' (8.4).

8.3.3.4 Sung improvisation.

Two children used singing to express themselves using free improvisation. Tasha sang movingly and expressively through a karaoke microphone for much of session 11 (Table 7.6) and continued this in session 12 (MM2 Appendix 7.3). Rabiyah sang in a similar way through the karaoke microphone in session 9 (MM4 Appendix 7.5). Further exploration of singing will be under the Vocal/ Oral theme (8.4.4).

8.3.4 Musical conversations/ communication/ relationship

Interactive musical communication using features, such as turn-taking, following the child's lead and 'same time' playing, often felt like we were having a distinct musical conversation or dialogue. Children who have been silent in school have a need to be 'heard' and listened to and so where possible it is important to follow their musical lead to demonstrate that their communication is valued and the focus of this developing musical relationship.

In his 4th session Daniel led a long improvisation on the drums which I followed through mirroring the changing beat and intensity of his music (MM2 Appendix 7.1). However, just before the end I brought the tempo down and picked up my guitar to give a musical indication, prior to mentioning verbally, that it was nearly time to finish. Daniel acknowledged this shift and mirrored me by picking up a ukulele and gently following the mood of my guitar playing. The musical dialogue was inter-personal or 'bi-directional' both through the musical mirroring and turn-taking and through the focus on Daniel as the 'client' whilst acknowledging the 'containing' role of the therapist as another person in the room. In this way it also felt part of a developing musical therapeutic relationship.

For Tasha, her musical dialogues built up in a more hesitant style but seemed full of meaning. Her anxiety in the first few sessions was such that I frequently commented in my clinical notes how I felt that musically she was 'copying' or following my lead. However, this started to change in session 5 (around 20 minutes in) when I modelled a more free, experimental style on the xylophone, which Tasha then

followed on the hanging chimes. Our turn-taking on the cymbal, in which she was initially following or 'replying' to me, reversed with her daring to take the lead. Session 5 established a strong sense of musical communication, conversation and a clear idea of a musical relationship.

8.4 Oral/ Vocal

The oral and vocal components of the case studies could have been discussed as part of the previous thematic area -Music- however, as these components provide a vital connection to the voice for children with SM this aspect requires detailed examination and space. Because there is an obvious and clear benefit of the oral and vocal aspects of Music Therapy for this client group it is important to drill deeply into all aspects of this data set to highlight the depth and breadth of its application. Although important to have a clear overarching aim to elicit words and support speech, it is crucial to investigate how these multiple expressive oral and vocal resources of Music Therapy become stepping stones on a path into speech for children with SM.

This thematic area is named 'Oral/ Vocal', however it is important to precisely define each label and the essential connections or musical overlap between them as this maps out part of the special value of Music Therapy for children with SM:

> *Oral*- referring to anything related to the mouth such as: an Oral instrument- like a recorder or swanee whistle; Oral movements e.g. mouth movements.
>
> *Vocal*- referring to anything related to using the voice. E.g. singing, humming, playing the kazoo, laughing, shrieking, vocal sounds or speech.
>
> *Verbal*- anything relating to words.

8.4.1 Oral/ Vocal features for each child.

Table 8.3 highlights how the children in the case studies were able to make vital progress and move from Oral to Vocal to Verbal.

Table 8.3 Oral/ Vocal elements

Name	**Summary of Role of Oral/ Vocal elements**
Daniel	Delighted discovery of recorder. Lots of recorder/ swanee whistle generally and vocalising through it as well as blowing.
Pilar	Loud recorder. Kazoo. Oral instrument conversations. Giggling, laughing, speech sounds. Slow creep towards speech.
Tasha	Early use of kazoo. Long expressive sung improvisations. Singing, laughing, vocalising prior to speech.
Maria	Blowing train whistle leads to giggling. Blowing bubbles. Loud laughing, roaring. Panting, exclaiming. Shrieking & screaming.
Rabiyah	Oral instruments in 1st session. Mouth organ. Kazoo goes home. Kazoo singing. Singing into mics. Use of songs prior to speech. Use of didgeridoo as a tool for speech.
Mark	Picks up but can't play mouth organ, recorder, kazoo and echo mic in 1st session. Plays mouth organ, recorder and swanee whistle then vocalises into echo mic in Session 2. Loud kazoo battle in Session 4.

8.4.2 Features and uses of oral instruments and 'props'.

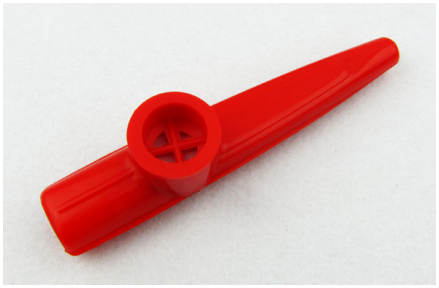
Table 8.4 lists the various oral instruments, equipment and props that were available in the sessions. How they were used is then described below.

Table 8.4 Oral instruments, equipment and props

Oral instruments	Oral equipment/props
Recorder Swanee whistle	Toy Karoake mic Echo mic

Kazoo	Talking parrot
Mouth organs	Walkie Talkies
Didgeridoo	Bubbles
Train whistle	Cup telephone
Ocarina	An old mobile phone

8.4.2.1 Specific role of kazoos - link to voice



Kazoos are an inexpensive pocket-sized instrument (costing less than £1) which make an interesting buzzing sound, similar to the traditional paper and comb. They are of particular interest in Music Therapy for children with Selective Mutism as they require the use of voice to make a sound rather than blowing. This is very different to other oral instruments such as the recorder that just require air to be blown through them to make a sound. Children with SM can find kazoos challenging to play at first either because:

1. they experience confusion about how to play them, as many children and adults do, or;
2. they realise that vocal sounds are required and they are not at that stage in their journey into speech where they feel able to use their voice into them.

However, the requirement for voice in kazoos means that, if used sensitively, they can be a powerful resource for children with SM. One strategy that I employed with children experiencing initial difficulties in playing a kazoo was to give them one to take home and 'practise' on. In part, this mirrors some of the 'sliding-in' activities for SM whereby a person or parent moves from being a conversational partner at home to a conversational partner at school. In this version the kazoo becomes a 'vocal object' or 'conversational object'. The logical extension of this strategy is

then to slide the 'conversational object' into the classroom. This was attempted with some of the children and also with other props such as echo mics and the talking parrot. Table 8.5 gives a summary of each child's use of the kazoo in therapy.

Table 8.5 Kazoo usage

Name	Use of kazoo (Kz=kazoo) (S=session)	Assessment of Kz use Link to PinS (Path into Speech)
Daniel	S6- unsuccessful attempt to play Kz. *(S10- vocalising and blowing into the recorder)* S11- further unsuccessful attempt with Kz S14- lovely singing through the Kz. S15- another unsuccessful attempt to play Kz.	Mirrors on-off pattern of speech in MT.
Pilar	S5 Kz home after unsuccessful attempt to play S6 Plays Kz. Relaxed vocal response from therapist. P plays kazoo 'really close to my face' S8 Noisy Kz in Goodbye song S15 Sings into Kz. Speaks one word S22 Kz + vocal noises	Possibly helpful in 'warming up' the voice for speech with friends.
Tasha	S5 Kz home after unsuccessful attempt to play S7 brief successful attempt. S8-Kz conversation. S13- Kzs taken in to classroom	Kazoo conversations. Integral to PinS on 2 occasions.

	S15- Kzs used in 'call & response' conversation More sustained speech a few minutes later. (MM4 Appendix 7.3) S22- Kz used as a spy glass for looking into an imaginary world- different sliding in to speech	
Maria	S5 & S6 unsuccessful attempts to play kazoos. No attempt to extend this activity as vocalising in other ways.	Not so important
Rabiyah	S2 Kz home after unsuccessful attempt to play S3 Successful attempt. Sequence of events into speech. (MM2 Appendix 7.5)	V. helpful
Mark	S4 unsuccessful then successful use of Kz. V loud Kz part of drama. (MM5 Appendix 7.6)	V. helpful.

8.4.2.2 "I have something special!" - Didgeridoo playing

The Didgeridoo is a long tubular wind instrument from Northern Australia. It is played in a similar way to other large wind or brass instruments by slowly blowing a 'raspberry', with gently vibrating lips. Singing through the didgeridoo is also used to add another layer of sounds to the main note.

Although an entirely different instrument, the didgeridoo can play a similar role to the kazoo due to the potential for using vocal sounds. It is an appealing instrument used for generally encouraging oral confidence as it requires big breaths to play. It can also be used to speak through with a similar effect to the 'cup telephone' i.e. one person speaks through one end whilst the other person listens and so on.

The didgeridoo was introduced into the case studies with Pilar in session 26. The aim was to support more potential for oral variation and creativity at a point when Pilar was starting to produce a range of vocal and word-like sounds (Table 7.5). She responded positively by laughing, vocalising and making 'raspberries' through it. Pilar continued to vocalise into it in subsequent sessions but then in session 38 she used it to speak through. This was notable as it seemed to be a time when she was attempting to push herself into speech in the sessions and was also initiating using other oral props such as an imaginary telephone.

Table 8.6 Didgeridoo usage

Name	**Didgeridoo (Ddg) usage**	**Assessment of role**
Daniel	N/A	N/A
Pilar	S26- laughing, different sounds & raspberries through Ddg S27- Vocal sounds through Ddg S31-Points at Ddg but doesn't play S36- Vocalises down Ddg S38- Talks through Ddg S42- Talks a lot through Ddg	Generally helpful in 'warming up' the voice to speak.
Tasha	S25- Plays Ddg after several attempts S26- Plays the Ddg	Enjoys the Ddg but not intrinsic to PinS

	S31- Shares with Ty "I have something special"	
Maria	N/A	N/A
Rabiyah	S6- plays and talks through Ddg S7- puts a beater in the Ddg Names the colours on the Ddg when asked. Puts a beater down the Ddg. "It's stuck!" 1st spontaneous words. S8- 'yes'/ 'no' conversation through Ddg + "It's stuck" game again. Chatting through the Ddg S10- Blows raspberries down the Ddg S12- " S13- Uses Ddg to hit drum. Throws gently in air. S14- 'ner ner ne ner ner' through Ddg. Rolls Ddg on Gato drum then tosses away. S15- stands on Ddg.	Important feature in PinS. 1st spontaneous speech "It's stuck". Symbolic of SM Then slightly abusive Ddg use.
Mark	N/A	N/A

The didgeridoo was introduced to Tasha's sessions after she had started speaking and so although she enjoyed playing it, the impact on her path into speech was not as important as for other children. However, as she says, she did view it as a "special" instrument.

Rabiyah benefitted hugely from playing with the didgeridoo throughout her sessions. Although Rabiyah had previously used single-word answers to name animals and colours, the didgeridoo provided the imaginative 'space' for her first spontaneous speech when she pretended that a ball –which she had hidden in her hand- was stuck in the didgeridoo and so she said "It's stuck". This game was repeated many times

along with the phrase “It’s stuck!”. The didgeridoo was also used as a tubular ‘telephone’ for verbal conversations and was intrinsic to Rabiyah’s path into speech.

8.4.2.3 Other oral instruments

Daniel appeared to be delighted when he first played the recorder in session 7 and showed this by smiling at the same time as playing. In session 8 Daniel used loud, intense overblowing on the recorder to produce quite an expressive, mournful sound. Later, in session 12 Daniel vocalised at the same time as blowing into the recorder and also the swanee whistle.

Pilar also enjoyed playing the recorder in session 4. In my notes I write that there was a feeling of humour in our turn-taking and that Pilar’s playing becomes increasing loud and squeaky. Rabiyah also played the recorder loudly in her first session. Maria often played the train whistle and in session 4 (MM3 Appendix 7.4) it was blended with other musical elements and instruments as part of a lovely interaction that led to humour and giggling. Mark’s preference for oral and vocal instruments was particularly striking. MM1-MM6 (Appendix 7.6) all track this progress from initial anxious picking up and putting down of oral and vocal instruments through to loud forceful playing of kazoos in session 4.

8.4.3 Oral-musical conversations

Within these case studies many features emerged that strongly mirrored developmental stages of interaction and communication. This aspect of the work seemed particularly relevant as the overall aim of the therapy was to increase all communication and achieve confident speech, which is a key focus of early infant development. As most of the therapy processes could be interpreted from this perspective, in this section I describe a few particularly notable examples.

Musical conversations are one example of interaction that frequently occurred in some form throughout the case studies. Some have been explored above (8.3.4) but here I look at examples using Oral instruments that step even closer to and sometimes directly precede speech. A good example of this is with Tasha in Session 8. I describe our ‘conversation’ in my notes:

> ‘I respond to her (kazoo) sounds with my kazoo and she quickly becomes more confident and louder and expressive -slidey glissandi sounds- almost like speech. We copy each other and have quite a long silly conversation.’

The next stage in Tasha's PinS was singing through a microphone, with words then appearing in session 13.

In session 11 Pilar and I had a long musical conversation with Pilar playing the swanee whistle in an adjacent room which I reflected and responded to vocally (MM4 Appendix 7.2). The dynamics of the musical conversation developed from me being a more active partner leading with drums and voice, to later taking a step back, leaving some gaps and following Pilar's lead. In session 13 she moved on to mouthing words and an audible giggle (Table 7.4) and then in session 14 laughed and made speech-like vocalisations (MM5 Appendix 7.2).

As Pilar's therapy sessions took place over such an extended period of time it seemed as though she was almost following language development milestones in her slow development of speech within the sessions: giggling; word-sounds; single words; repeated words; quiet sentences; longer sentences; conversations.

In session 6 Maria engages in a brief expressive exchange as a 'roaring' lion (MM6 Appendix 7.4) and then an extended oral/vocal interaction in session 7 that was as close to a conversation as it is possible to be without using words. However, a few single words such as "Hello" and "yes" and "no" then emerge at this point somewhat mirroring early patterns of language development. Tasha's first word in session 13 is "no" which also seems to follow this pattern.

8.4.4 Singing

The role of singing in Music Therapy for children with SM is explored in this section. Table 8.7 presents an overview of the use of singing for each child.

Table 8.7 Overview of singing

Name	**Free singing**	**Structured singing**	**Assessment of role**
Daniel	Through swanee whistle, kazoo and recorder	n/a	Quite important
Pilar	Brief moments of singing through the kazoo	n/a	Not so important

Tasha	Kazoo singing S7 Mic singing S11 & S12	Punky 'Twinkle twinkle' S16 Teaches me an African song S26	**Very important**
Maria	Briefly into Mic S7	Nursery rhymes and singing Hello in pair work	Not so important
Rabiyah	Lots of singing. S3 in Kazoo, echo mic, karaoke mic. S4 Karaoke mic, also to dolls. S9 Heartfelt improvisation	S5 V. Confident 'Wheels on the bus'. 'Old Macdonald' etc Teaches me the 'rocket song'	**Very important**
Mark	S5 V briefly sings into echo mic	n/a	Not important

The use and role of singing varied widely across the case studies. For Tasha and Rabiyah it was hugely important both for self-expression using free improvisation and as part of their individual paths into speech. Tasha appeared to 'warm-up' her voice through improvised singing in Sessions 11 & 12 (Table 7.6, MM2 Appendix 7.3), prior to using words in Session 13 (MM3 Appendix 7.3). Tasha also sang a loud punky version of 'Twinkle Twinkle' in Session 16 (MM5 Appendix 7.3) which felt like a celebration of her vocal confidence.

Rabiyah moved swiftly from free improvisation to known songs which provided the opportunity for speech through naming animals and colours in Sessions 3 & 4. Both Tasha and Rabiyah also taught me a song that they knew which seemed to feel empowering for them. With Tasha this was an African song that was completely unknown to me and difficult to learn - 'Si ma ma ka'- and with Rabiyah it was the 'Rocket song' which was more familiar to me.

For Pilar, Maria and Mark it felt as though other aspects of Music Therapy were more important in their path into speech than singing- such as vocalising, laughing

and imaginative play. With Daniel, there were brief moments of singing into other instruments but singing never became very important in his process.

Singing, like speech, is a very personal form of self-expression that requires voice. Singing may therefore feel anxiety provoking for a child with SM and so is something that they either can or can't access. Overall, only Rabiyah and Tasha fully utilised singing in their Path into Speech. Maria sang once she was able to speak confidently in the sessions.

8.4.5 Vocal equipment and props

Many items could be considered and used as vocal equipment. However, in this section I start by looking at how the children used various forms of microphones in the sessions and then discuss other equipment and props.

The echo mic is an inexpensive plastic toy microphone that can cover the mouth providing a small echo sound with little amplification.

Stock photo

To provide some equipment with amplification I also bought a small toy karaoke machine as a practical way of providing a microphone that had a small portable amplifier. As well as a small range of song options it also had a 'harmony setting' which added a layer of harmony on top of the sung note.

This karaoke microphone and harmony setting was first used by Tasha in Session 11 and it sounded beautiful. Perhaps due to the quality of the sound, she sang movingly for the whole session and continued in a similar vein in Session 12 with speech following in session 13. In this instance, this appealing toy karaoke machine seemed instrumental in building vocal confidence and then speech.

In session 3 Rabiyah moved from the kazoo to the echo mic to the karaoke machine mic. Later in the session she named animals for 'Old Macdonald had a farm' into the karaoke mic (Table 7.8). Rabiyah used the echo mic to speak through prior to just using her voice on its own and then through the didgeridoo in session 6. In some ways it felt that the microphones provided a bit of support or 'cover' for her initial use of voice before unsupported speech could appear. Spontaneous speech happened in session 7 (MM3 Appendix 7.5). From session 8 Rabiyah was asking me questions and it felt as if there was a shift in the power dynamics.

Maria used the echo mics to 'roar' into before roaring independently in Session 6. In session 7 she then said "hello" into the karaoke mic. As well as being useful for eliciting and supporting speech the microphones were explored again in a more celebratory way by Maria once she was speaking confidently.

Mark made some vocal sounds into the echo mic in Session 2 which seemed part of a general interest in oral and vocal instruments. In session 5 and 6 he also 'woofed' into the echo mic.

Pilar made vocal sounds into the echo mic in Session 34, although this was not generally an important feature in her sessions. However she did use the old mobile telephone in Session 38 as a prop to extend her single words into slightly longer sentences.

A range of other oral props were available in the Music Therapy sessions such as a homemade cup telephone, some 'walkie talkies' and 'Pirate Pete the talking parrot'. The Walkie Talkies were used by Pilar in Session 39 as a playful means to increase confident speech once it had occurred in the sessions. Pilar also enjoyed using the cup telephone in Session 47 once she had started talking.

However, Maria found her own prop in the form of a pot for blowing bubbles in a cupboard in the room. Bubble blowing is a common Speech and Language therapy activity for encouraging oral skills. Maria enjoyed blowing bubbles and we also made up a bubble song and dance to accompany this (MM4 Appendix 7.4).

One hope with the oral props was that they could also be used as a transitional conversational object to help generalise speech back into the classroom. This however relied on the support of staff and because this was often lacking it was mainly unsuccessful (8.9).

8.4.6 Other Vocal expression

Vocal or Oral sounds in some form were integral to the therapy process for all children in this study. In this section I examine the other expressive vocal sounds that some children made on their path into speech, excluding singing, laughing or speech which are covered separately in other sections.

Table 8.8 Other vocal expression

Name	**Examples of vocal sounds** **S = session**	**1st speech**
Daniel	n/a	
Pilar	**S5** "ah", **S14** "ah" "uh oh" "raah" loud exclaiming "eee" "aha", **S17** "Bop", **S18** "shhh" "ding dong" **S24** "ay ow" "uh oh" & laughing, panting & vocalising 'aah' with her running	(v gradual) **S24** "yeah" **S25** "me" **S32** "yes, yay, flash, yep" **S36** "no" x lots **S39** "do your homework" **S46** chats throughout session
Tasha	**S13** Blows into the mic also "hmm" "yer" and squeaks and coughs **S15** Clicking noises with her mouth prior to speaking later in session **S21** Coughing and 'tired' vocal sounds	**S13** "no" @29.40 mins into session **S22** Names colours as part of game
Maria	**S6** Roaring like a lion. **S7** Lots of exclaiming "aah" "uuh" "aooh" "uh uh" "uh oh" screams, and many other vocal sounds **S8** "aaahohoh" "aah" "hnn" "ha" "he" "unn" "uuhhnn" "huh" "oohp" shrieks	**S7** "Hello" "No" & "Yes" **S8** "no" many times. Later expressive full sentences

Rabiyah	n/a (uses singing prior to speaking)	**S3**
Mark	**S1** "hm" & coughs **S2** "hm hm" "mmmm" (MM3) **S3** "oh" "Hm hm hmmmmm" + heavy breathing sounds (MM4) **S7** Gun sounds **S8** "Tsch, tsch" "khooo" –play fighting noises-	**S8** Whispers "Ghostbusters"

Table 8.8 shows how many children increased their vocalisations just prior to speech. However, for some this was also combined with other elements such as singing, and also humour and laughter (8.4.7).

8.4.7 Humour and Laughter

This is an important cross-cutting theme that combines emotional, physical, vocal and communicative components which played a pivotal role in the emergence of vocalisation and speech for some children in the study. Humour and laughter was noted both within therapy sessions and reported by staff in the classroom environment as signifying progress. This section explores the key link to the voice for children with SM.

Despite Pilar's lengthy, complex therapy process, playing the kazoo and possibly vocalising was concurrent with giggling as early as session 7. After this session Pilar's class teacher noted that her speech with friends in the classroom had increased. From session 9 onwards audible laughter became an important feature of Pilar's sessions. This was often closely connected with attempts at vocalisation, as noted in session 13 -mouthing words and giggling; session 14 (MM5 Appendix 7.2) –laughing and speech-like vocalisations; session 15 –loud laughing then a single word 'take'. This pattern continued and was prominent in session 24 where I noted that the laughter seemed to be "in lieu of speaking" and later that "she does a kind of laugh for 'yes'". In session 24 Pilar also used many other vocal sounds as transcribed in MM6 (Appendix 7.2). MM8, in session 36, shows the emergence of words after almost continual giggling and laughing (Appendix 7.2).

Giggling and laughing were also a prominent feature of Maria's sessions but were closely connected, almost enmeshed with other elements such as musical attunement, oral instruments, attempts at speech and physical self-expression. A paragraph from my session notes describes this close connection through a sequence of events in session 4:

> "(Maria) Then moves on to the large ocean drum and hits it and I sing "we are we are drumming" but then attune really directly to her hitting. She really likes this and puts her hand in front of her mouth and begins laughing. She also seems to mouth something and I really wonder if she is trying to speak or has actually said something really quietly. She then grabs a recorder which really feels like it is linked to trying to speak and wanting to try an oral instrument. I vocalise and grab a recorder. She points to the scarfs and I get them over and make up a scarf song which she joins in dancing to. Really smiley."

A little later in session 4 (MM3 Appendix 7.4) Maria again seemed aware of the significance of giggling as a use of voice, perhaps also of her own path into speech, as she self-consciously put her hand in front of her mouth when she giggled. In session 5 the laughing became 'shouting and exclaiming'.

The significance of laughing was also noted by some of the children's class teachers. Tasha's teacher reported that she noticed her smiling and laughing in class after 3 sessions. Rabiyah also chuckled quietly in her first session and her class teacher then reported that she was laughing out loud in class after this first session.

Humour and laughter were deliberately employed in the transdiscipinary work with Tasha. James used humorous games such as encouraging Tasha to shout out cheeky words walking in the corridor. Tasha also made a plasticine 'poo' when working with James in the corridor which caused much loud laughter and encouraged Tasha to involve new group members in her session (NotesTS45).

8.5 Physical

8.5.1 Frozen physical presentation

Children with SM often present with a 'frozen' presentation both in therapy and in school. Physical activities that require movement (e.g. P.E) can be challenging for a

child with SM. Both Tasha (MM1 Appendix 7.3) and Pilar (MM1 Appendix 7.2) initially presented with quite a frozen presentation. Tasha sat in the same place for the whole of the first session only moving her body minimally to play the instruments. In my session notes I describe her as looking fairly 'petrified'. Pilar was similar at first but after an invented game of 'musical football' (MM2 Appendix 7.2) she became much more physically active within this first session.

Pilar and Mark experienced initial difficulties playing instruments and producing sounds, which seemed part physical and part emotional, mirroring the issue of SM. Pilar found it impossible to press the button on the hand bells quickly enough to make a sound (MM1 Appendix 7.2) but by the end of the 1st session was able to play the cymbal (MM3 Appendix 7.2). In his 1st session Mark picked up many instruments to explore them but couldn't play them, eventually 'playing' the ringer sound on the 'Walkie Talkie' as a means of communicating (MM1 Appendix 7.6). Later in the first session he does manage to play lots of oral instruments (MM2 Appendix 7.6).

8.5.2 Physical action

Conversely, strong physical gestures and movements were later an important feature of the therapy process for Pilar, Maria and to a lesser degree Mark.

After her frozen start Pilar appeared to find some release in throwing shaky eggs across the therapy room. This felt quite violent at times (NotesPS3). Later in her therapy process Pilar initiated moving her sessions into the 'soft-play' room which provided many resources for boisterous physical play. Pilar had previously enjoyed playing chase in another therapy room and continued it here along with various other games in the ball-pool including much ball throwing.

Later in the soft play setting it seemed clear that Pilar employed physical self-expression to help build up the intensity in the session in order to vocalise and speak. There was also a sense of 'warming-up' her voice through the many vocal sounds that accompanied her physical activities. In my notes for session 24 I write that she 'vocalises with all her running' and that 'She is very vocal but doesn't quite burst into speech'. Imaginative physical games are a huge component of Pilar's therapy as words start to emerge in Session 32 (MM7 Appendix 7.2).

For Maria, physical components were also a key part of her therapy process. In session 4 Maria used the scarves as props for dancing and late in the session did some star jumps -these feature again later in her therapy process. Bubble blowing emerged as a feature in session 5 and this was subsequently developed into the 'bubble dance' accompanied by a 'bubble song' (MM4 Appendix 7.4).

In session 7 Maria continued with over-exuberant dancing which I then describe as 'crazy' and which resulted in a few almost deliberate falls. In addition, Maria made a 'slide' from cushions and scarves that was accompanied by expressive vocalisations and eventually a few words: "yes"; "yeah"; and "no". It is interesting to note that a common behavioural technique for Selective Mutism is called 'Sliding in' (Johnson & Wintgens 2001) and Maria's actions seemed to physically symbolise this process. Another example of dancing and slide-building from session 9 is described in MM7 (Appendix 7.4). In session 7 Maria also engaged in a 'tug of war' with me using a scarf.

In session 8, after some more dancing, Maria stood on the gato drum, jumped off and then engaged in hopping around the room just prior to engaging in full expressive speech, however towards the end of the session physical self-expression continued to be important as she slid around the floor on the scarves saying that she was skiing, and jumping off the gato drum. In my session notes I wrote that I felt that she was engaging in some 'risk-taking' and perhaps mirroring the risk of leaping or 'sliding' into speech.

This process into speech was repeated again in Session 9 with: dancing; jumping off the gato drum and then in addition: showing me her muscles, running on the spot and then doing gymnastics. After making a 'slide' again she began to talk and then asked "can you do star jumps?" She then stated "It's exercising! And running!"

Physical movement was also an important part of the sessions for Mark although this was more integral to his dramatic play and so will be discussed in the section below 'Dramatic play/imaginative play'.

8.5.3 Mouthing and mouth related behaviour

Mouthing could have been discussed in the Oral/ Vocal thematic area but has been described here as it seems to represent a very specific physical aspect of the path into speech. Mouthing is a small but highly significant physical movement that many of

the children did, sometimes just before they spoke. Often these silent mouth movements look as though the child is just about to speak and probably serve the purpose of 'warming-up' the mouth muscles with the intention of speech (Johnson and Wintgens 2001). Table 8.9 shows the sessions in which mouthing occurred and the sessions when speech occurred.

Table 8.9 Mouthing in session

Name	**Mouthing occurrence**	**Speech occurrence**
Daniel	**S1** Touches mouth and mouths a bit 'like he is thinking about saying something' (NotesDS1) **S2** Mouthing **S3** Mouthing **S5** Lots of mouthing **S15** Lots of mouthing **S17** Lots of mouthing	After **S1** with 2 nursery staff After **S2** increased speech in nursery **S4** Speaks in the session *Inconsistent speech in sessions but consistent increase in speech outside of sessions*
Pilar	**S1** Class teacher asks her to mouth my name- which she does **S13** Mouthing words as she writes	**S14** Speech-like vocalisations **S18** "Ding-dong" **S24** "Yeah"
Tasha	**S18** Some mouthing (this was in the break in speech)	**S13** 1st speech **S22** Speech regained
Maria	**S3** Mouthing with attempts at whispering but v anxious **S4** Mouths and looks close to speech then plays recorder **S5** Lots of mouth movements, very close to speech	**S7** 1st speech

Rabiyah	**S1** Sure that she mouths as if to sing at the beginning of the session but difficult to ascertain on the video **S2** Pursing lips and awareness of mouth	**S3** Speech in session
Mark	**S1** Lots of mouthing as if close to speech **S4** Mouthing and vocalising **S6** Lots of mouth movements, pursing his lips but also noticeable relaxing of his mouth **S7** Mouth more relaxed, expressive and more mouthing	After **S1** with nursery teacher **S8** Whispers in session. **S9** Lots of speech

8.5.4 Lump in throat - 'Globus sensation'

Physical components were an important ingredient in the therapy for many of the children. It was also something that was relevant to myself as the therapist/researcher. In the middle of Pilar's relatively lengthy therapy process I began to experience the sensation of having a 'lump' in my throat. At times it was quite painful but had no medical cause. After consideration in clinical supervision it seemed that one explanation could be that this was a physical manifestation of SM that I had embodied as the therapist. Children with SM also often report a strong physical sensation of feeling 'choked' when trying to speak. An internet search revealed that this phenomenon is called 'Globus Sensation' and is commonly linked to our emotional wellbeing (<https://www.qvh.nhs.uk/wp-content/uploads/2016/08/Globus-Rvw-August-19.pdf>). It was fascinating that this disappeared once the case studies were completed.

8.6 Dramatic play/imaginative play

8.6.1. Imaginative play in the case studies

Imaginative or dramatic play was an important means of expression for some of the children in the study. Play is a key aspect of children's development that may be hindered by the lack of speech in the school environment. Imaginative play between children often employs rich descriptive language to evoke a scenario or imaginative landscape. This creative realm provides another type of space to inhabit, explore and perhaps take on another personality or role (Kenny 2006). With an open approach to therapy, many types of play can be embraced as part of the therapeutic narrative.

Pilar initiated a lot of imaginative play early in her therapy narrative with long sequences involving puppets, scarves and 'magic' perhaps symbolically representing the transformation required to achieve speech (NotesPS7). Later however, physical movement became a more vital element in her path into speech.

Although musical improvisation was the dominant medium in Tasha's therapy, an element of imaginative play was helpful in her path into speech. In session 13, after 20 minutes of musical improvisation Tasha showed some curiosity about the puppets in the room. The novelty and humour involved in the subsequent joint play seemed to provide the final crucial ingredient for eliciting first speech in the sessions (MM3 Appendix 7.3). An element of pretend play continued to be important for supporting speech over the next 2 sessions (MM4 Appendix 7.3). After a disruption in the course of her therapy, imaginative play once again provided a key ingredient in engaging Tasha into speech. This was in Session 22 (MM6 Appendix 7.3) when we used the kazoos as 'spy glasses' to provide a view into an imaginary space and then named the colours in the bubble tube which I called the 'sea'. Further imaginative play was important in the group work phase of therapy where the children chose to be different superheroes and fought monsters together.

For Maria, dramatic play through the use of puppets appeared to give her permission to explore different feelings. In session 4 her cow puppet attacked my hippo and when I asked if they were friends she shook her head. The fighting puppets continued in session 6 (MM5 Appendix 7.4). I kept an open mind about the precise meaning of this play but thought that it could have been about difficult peer relationships, feelings of frustration or developing a sense of her own power.

Maria also responded well to a light-hearted approach to play. In session 3 she passed me a wooden spoon guiro and when I proceeded to pretend to eat the shaky eggs with it she laughed and joined in.

Imaginative and dramatic play was absolutely key to engaging Mark in a successful therapeutic journey. Mark was fascinated with the torches on the Walkie Talkies and in session 3 I suggested that they might be 'light sabres' (the main weapon in the film 'Star Wars'). This was immediately appealing although I became concerned in this session that he was no longer using as much voice. This theme was expanded in Session 4 when Mark eventually managed to play the kazoo by engaging him in another 'Star Wars' style kazoo battle. This is described in MM5 Appendix 7.6.

'Star Wars' provided some continuity in the 'taster' session (Table 7.9)) with a friend after the Summer holiday (MM7 Appendix 7.6) during which Mark whispered his first word "ghostbusters" to change the direction of the drama. In MM8 (Appendix 7.6) I describe how Mark appeared to use dramatic play to find and demonstrate the inner strength to move into speech. Once they were talking in the session Mark and Jacob then discussed the drama (MM9 Appendix 7.6). From this point onwards dramatic, imaginative play took centre stage in the therapy sessions, mostly involving continuous, intense dialogue about superheroes and super powers. Later in the sessions they became a little more relaxed and music was included in their play as both instrumental sounds and as the dramatic concept of 'music power' (MM10, 12, 13 Appendix 7.6). This concept seemed to capture symbolically their potent blend of music and drama. In these late sessions I also stepped back and provided a dramatic musical accompaniment (MM14 Appendix 7.6). This provided me with a place to observe, in awe, their total immersion in an imaginary world and to reflect on the power of play. Towards the end of session 16, Mark said to Jacob "We are in that world right now!" (NotesMaS16).

In their final session the boys made plans for moving their play back into the classroom which felt like the perfect ending to their therapeutic journey, taking control of their lives and shifting their confident speech into the place where it needed to be.

8.7 Emotional

For many of the children the emotional impact of having SM seemed heavy but once their SM had improved or gone then this impact was lifted. This heavy burden was partly experienced by myself as the therapist through the dynamics of the therapeutic relationship and perhaps also symbolically through 'globus sensation', a feeling of having a lump in my throat (see 'Physical'). Working with six different individuals the emotional components of the therapy were wide-ranging across the cases. In this section I discuss the various issues that emerged, some of which were relevant to all the children and some to only one or two. For all the children there was an overriding, urgent sense of their need for effective therapy and then, once successful, a palpable feeling of relief and happiness.

8.7.1 The therapeutic relationship

The therapeutic relationship emerged as an overarching theme in the analysis as it seemed to be of huge relevance for these children with SM. All of the children in the study presented as either anxious, 'frozen' or significantly affected in other ways by their communicative isolation at nursery or school as manifest in absent, impoverished or challenging peer relationships. Being offered a form of therapy where the therapist relates to you through a medium that you can access means that the isolation associated with SM can start to be broken. This therapeutic relationship can then become the vehicle for positive growth and change, assisting both the communication and emotional issues simultaneously. In this way, the therapeutic relationship was also the safe space or container through which key issues were experienced and explored.

Maria was highly anxious and isolated in her classroom environment, but through an open and responsive therapeutic relationship she had a means of communicating and relating. Maria was fascinated by my interest and attention to her actions and sounds, particularly when the musical communication was very clear, such as in 'same time' drumming or very close playing. This close playing can be seen in MM3 (Appendix 7.4) when I reflect her sounds quite directly, evoking humour through this exchange and later by accidently playing at exactly the same time as her.

Offering freedom of expression through a light-hearted and playful approach enabled Maria to express herself in any way that she felt was useful such as bubble-blowing, physical movement and laughter (MM4 Appendix 7.4).

8.7.2 Anxious Presentation

SM is an anxiety disorder and therefore many of the children in the study presented with initial anxiety. Four of the children had elevated scores on the pre-school anxiety scale (Spence and Rapee 1999). Aspects of this theme have been discussed under 'physical' (8.5) due to the anxious 'frozen' presentation of some children such as Tasha and Pilar, and the initial inability to make sounds, e.g. Pilar and Mark.

There was a feeling of intensity about the therapy for Maria who seemed very anxious but energised herself quickly into speech though laughing**,** dancing, physical movement and literally sliding into speech by exclaiming, shouting, then bursting into speech and suddenly becoming talkative. Thus, a question emerges from this case study about the nature and role of anxiety. Can anxiety states enable therapeutic vitality and energy, particularly in children, if they are supported with the means and space to express themselves? Brooks (2014) suggests that transforming anxiety into excitement is possible in adults and for Maria this also seemed to be the case.

Tasha also seemed terribly anxious as seen in her initial frozen presentation in Music Therapy and in her demeanour when travelling to and from sessions. She often had a flat, anxious expression, almost a scowl, and vehemently protested against going back to her classroom after sessions. Once Tasha began to speak in the sessions, she started to describe her feelings saying that she felt "horrible" (Session 20) and "scared" (Session 21). In session 30 Tasha again seemed to try to describe the feeling of having SM saying "I am tired to ask the teacher". In the final moments of the last session Tasha described how she was "shy, very shy" and didn't like other people looking at her.

8.7.3 Immediate positive emotional impact

In 'The Music of Music Therapy' (8.3) I describe how the children were all keen to attend their sessions. This enthusiasm for Music Therapy then produced an immediate positive emotional impact. Rabiyah's class teacher noticed her laughing out loud in class after session 1 and Tasha's class teacher reported the same result after 3 sessions. The impact on confidence and speech is described below.

8.7.4 Building confidence

Many of the children appeared to increase in confidence within the sessions through a build-up of trust in the therapeutic relationship and in itself this is positive but not especially remarkable in the context of a safe Music Therapy space. However, the feedback from the teachers on how the children changed in the classroom appeared to be a clear indication of the impact of therapy in relation to increased communicative confidence.

Daniel, in particular, showed clear enjoyment in attending his music therapy sessions and I felt that his engagement in musical improvisation and the musical relationship provided some emotional 'building blocks' that resulted in increased confidence. Outside of sessions Daniel was reported to have spoken to two members of staff after his first session of Music Therapy and this increased each week until he was communicating with everyone. Similarly, Mark was also reported to have spoken to his nursery teacher after one session of Music Therapy, although this speech wasn't immediately sustained.

Pilar seemed much more confident by the end of her first session of Music Therapy and her class teacher reported that her speech had increased with her friends after 7 sessions (Table 7.4). After some particularly expressive and moving singing in Session 11 Tasha was then reported to have spoken to a teaching assistant in her classroom (Table 7.6).

8.7.5 Increased happiness

Humour and laughter is a previously described cross-cutting theme which overlaps with the theme of increased happiness as humour and laughter is usually associated with improved mood (Mora-Ripoll 2010). Whilst this improvement was clear within the sessions for many of the children, (8.4.7), indications of increased happiness through smiling and laughing were also noted by class teachers for Tasha and Rabiyah.

8.7.6 Emotional Issues related to SM

8.7.6.1 Friendships

For both Maria and Tasha having SM seemed to have a detrimental effect on their peer relationships and friendships. When I observed Maria in her nursery

environment she appeared very anxious and isolated and seemed to get picked on by some of the other children. Being unable to speak up about this may have had a negative impact on her wellbeing.

Tasha was also desperate for friends and she communicated this once she was able to speak in the sessions. In session 29 she said, "I want to have friends. I want some friends to play with me here". Then later in the sessions she reiterated that she didn't have any friends. Once we introduced some friends into the session Tasha was sometimes a little over keen which was challenging for one child. However, as the weeks went on these relationship issues seemed to diminish and resolve.

8.7.6.2 Late disclosure of historical abuse that caused SM

Half way through the therapy with Pilar, her class teacher mentioned that the possible cause of Pilar's SM was being shaken by a teacher in a previous nursery school. Pilar's mother had shared this information with the class teacher. This felt quite shocking and perhaps explained the slow progress of the therapy and some of the challenges of Pilar's relationships with teachers. Early in the sessions, Pilar also frequently threw shaky eggs hard towards me (NotesPS3), and I wondered if this was expressing some anger or frustration about what had happened to her.

8.7.6.3 Sharing repressed feelings

Rabiyah had a swift path into speech but then there was a change in mood with different feelings being expressed in the sessions (Figure 7.10). A sense of edginess emerged in the music, -the cymbal was hit with a chime bar and didgeridoo (Session 6)- and in session 9 Rabiyah stated that a toy wooden animal was "pooing on your head" and everywhere in the room (MM5 Appendix 7.5). This felt quite symbolic as Rabiyah started to bring some more challenging feelings into each session (MM6 Appendix 7.5).

Rabiyah had already expressed, non-verbally, a sense of annoyance about the length of the sessions through: loud cymbal playing right at the end of the session (session 1); playing all the instruments in rapid succession (session 3); attacking me with the badger puppet (session 5). However, with voice and self-expression perhaps came a sense of power and an ability to share a range of issues that may have previously been repressed. "No" (Session 11) and negative expressions such as "I don't like it" and "nothing" (Session 15) were frequently stated. Boundaries were tested, such as

standing on the didgeridoo and saying that she was going to write on the cymbal (session 17), and power dynamics were explored through playing at being a teacher and wanting me to be the silent, quiet child (session 12). Stronger statements such as "I'm going to beat you up, you dumb girl" (Session 15 MM7 Appendix 7.5) seemed to suggest that Rabiyah may have experienced some bullying or unpleasant behaviour from other children.

Ambivalence towards myself as the therapist was expressed from session 11 onwards when Rabiyah repeated statements such as "I hate you, I'm joking" (MM7 Appendix 7.5). Alongside this Rabiyah also said that she wanted me to come in to school "every day, even in the holidays and even on Saturday".

Rabiyah's increasing ability to assert herself and express challenging feelings seemed to be symbolised and condensed in her response to the Goodbye song. In session 12 when I suggested that it was time for the Goodbye song she said "no". In session 13 she just wanted to leave without the Goodbye song. Later in the therapy process, as we approached the last few sessions, Rabiyah expressed negative feelings about ending. In the penultimate session (17) Rabiyah said that she didn't like it in the Goodbye song. In the final session (18) when I said that it was time to sing Goodbye she said, "No, I hate it".

8.7.6.4 Symbolism

There were examples of symbolic play or symbolism occurring in the case studies and although some of these were perhaps coincidental to the type of play it is interesting to record them as they may relate to other therapists' experiences in this field.

Puppets fighting were a feature of sessions for both Maria and Tasha. For Tasha this happened just as she was beginning to speak in the sessions (MM3 Appendix 7.3). Acting out Star Wars battles (MM5 Appendix 7.6) was a feature for Mark who used kazoos as the 'force' which seemed very symbolic. Superheroes emerged as a later theme when Jacob joined the sessions.

Superheroes were also a popular theme in the group work with Tasha. Mainly it felt as though this was perhaps about taking risks in self-expression and experiencing a sense of power, both important tools in overcoming SM. Also, in Tasha's group phase, one of the members tried to understand SM and explained how she previously

didn't want to eat a tangerine but now she can. This felt like a good, albeit naïve, analogy for the sense of overcoming anxiety about something.

It seemed both ironic and symbolic that when Rabiyah spoke for the first time in Session 7 it was to repeat the phrase "It's stuck" many times as she became verbally unstuck. Also, prior to exploring some difficult issues in the session Rabiyah pretended to put 'pig poo' on my head (MM5 Appendix 7.5). Later when she said to me "You dumb girl" (MM7 Appendix 7.5) I wondered whether she had experienced being called this due to her SM.

Maria's slide-building possibly symbolising 'sliding-in' to speech is mentioned above (8.5.3). Early in Pilar's therapy sessions she pretended to use 'magic' and I wondered if she felt that these powers would be helpful to make her SM disappear. The 'globus sensation' (8.5.1) experienced in my throat during the case studies was perhaps the most potent symbolism in the sessions.

8.7.7 Non-SM related issues

8.7.7.1 Potential abuse, attachment issues

Some of the children had emotional issues that emerged during the therapy and some had issues concurrent with therapy. Tasha was perhaps the most complex case. In her referral her outreach worker had suggested that she felt that Tasha had some attachment issues perhaps exacerbated as she came from a very large family. In therapy Tasha gradually became quite attached to me, finding it challenging to separate at the end of sessions to return to the classroom and expressed that she wanted to see me at other times in the week. This appeared to parallel the relationship with her mother whom she would frequently exclaim that she wanted to see. This may have been in part normal for her young age -just 4 years old at the start of therapy- and also perhaps due to the isolation of having SM and wanting to return to an environment where she could speak confidently.

Tasha was living in overcrowded, temporary accommodation and after the school summer holiday was again made homeless. The outreach worker had additional safeguarding concerns that the children were perhaps being left alone at night so that the mother could work. Towards the end of therapy there was also a traumatic investigation of a sexual abuse allegation made by another sibling. In combination, these factors highlighted the importance of Tasha being able to express herself freely

and me being receptive to working with a range of feelings in the therapy room. This made the process more challenging and complex for us both.

8.7.8 Emotional improvements

Overall each child seemed to benefit emotionally from attending Music Therapy sessions. Table 8.10 is a summary of the perceived improvements.

Table 8.10 Summary of emotional improvements

Name	**Emotional improvements**
Daniel	Happier and more confident
Pilar	Positive due to speaking
Tasha	Improved peer relationships and confidence
Maria	Seemed transformed by the therapy, like a different child. When she said "I've won", it seemed symbolic of her successful therapy process.
Rabiyah	Positive expression of a range of issues
Mark	Harnessing his inner power

8.8 Generalisation

Once speech had occurred in Music Therapy various 'sliding in' techniques were considered and employed to generalise speech according to the needs of each child's situation. In the analysis, generalisation became an important theme with implications and recommendations for practice, initially for myself as the therapist-researcher but ultimately for other Music Therapists working in this area. This theme

was formed of an accumulation of therapeutic experiences and events including mistakes made, opportunities missed or taken and general practice that worked well.

The table of generalisation techniques provides a summary of generalisation techniques used and the outcome for each child.

Table 8.11 Generalisation techniques

Name	**Generalisation technique**	**Staff approach and understanding of SM**	**Speed of Generalisation Outcome**
Daniel	1. Creation of 'pressure-off', enabling & aware nursery environment. 2. Missed opportunity for introducing friend into session.	Excellent – therapist had long-standing relationship with the school	Rapid generalisation Speech in nursery but not in sessions.
Pilar	1. Attempt to create 'pressure-off' enabling home & school environment. Multiple challenges with implementation.	Very poor on the whole although one excellent but short-term member of staff	Inconsistent speech in school environment dependent on relationship with staff
Tasha	1.'Pressure-off environment' in school. 2. Attempt to 'slide' school staff in to session- not enough resources. 3. Successful sliding of 2 peers into session. 4. Successful transdisciplinary team work to assist generalisation using: group duplication; physical sliding	Poor but dramatic change to excellent towards the end.	Slow generalisation Speech across all locations with staff and pupils

	close to classroom; sliding into classroom and generalisation to all staff members including a new class teacher.		
Maria	1. 'Pressure-off environment'. 2. Speech sliding in to nursery classroom. 3. Speech sliding in to reception class with prepared environment. 4. Peer introduced to sessions to support increased speech confidence with peers.	Excellent-therapist had prior relationship with the school	Confident speech across all settings.
Rabiyah	1. 'Pressure-off environment' created in class room. Fast, natural generalisation.	Excellent – Class teacher had previously studied SM	Confident speech across all settings.
Mark	1. Attempt to create 'pressure-off environment' in nursery. 2. Creation of 'pressure-off' enabling environment in reception. 3. Friend brought into therapy. 4. Successful psycho-education with parents, implementation of strategies to extend speech.	Poor then excellent with change of class teacher.	Confident speech across all settings.

8.8.1 Creating a supportive environment

As described in chapter 6 (6.4.6), significant measures were taken in all schools to inform and educate staff about supporting a child with Selective Mutism. This engagement was sustained for the duration of therapy and carefully reiterated with any change of staff. Table 8.11 summarises the techniques used, the approach and

understanding at each school and generalisation outcomes in each case. In schools where staff had a good understanding and approach to SM children had a faster generalisation process.

Similarly, dramatic positive or negative changes tended to occur when children moved class or where there were other changes in personnel, further emphasizing the importance of having an understanding and supportive approach to SM. This was particularly pertinent for Pilar who had an understanding teacher for one autumn term but an otherwise negative experience with teachers before and after this. Tasha and Mark experienced positive changes in school staff which had a beneficial impact on their SM. In addition, Daniel and Maria's schools -where I had an on-going or prior relationship with staff- appeared to absorb information and implement environmental improvements more successfully.

Schools where staff had some prior understanding of SM also seemed to have improved generalisation such as with Rabiyah and latterly Tasha. Rabiyah's case is a good example of the generalisation process happening quite 'naturally' in this supportive environment. These were the stages:

1. After the 1st session the class teacher (CT) reported that Rabiyah was laughing out loud in class.
2. After session 5 the CT reported that Rabiyah was talking to her friends and spoke to herself – CT- in the classroom.
3. After session 8 she was talking to teaching assistants in the playground.
4. Before session 9 I observed Rabiyah talking to children and TAs in the playground.
5. After session 9 another teacher reported that she had a conversation with Rabiyah and that whatever I am doing, it is working.
6. After session 12 the CT reported that Rabiyah had used a loud voice with her and also to her friends.
7. After session 17 Rabiyah's CT reported normal speech in class, full sentences and normal speech to friends.
8. Following this, other teachers enthusiastically report to me that they have had a conversation with Rabiyah.

8.8.2 Introducing friends into sessions

Daniel requested to have a friend in his therapy sessions (MM5 Appendix 7.1) and in retrospect I felt that not complying with this was a huge mistake and personal learning point. My rationale at the time was that because this was a research project I was unable to bring a friend into the session as this would have changed the project and created complex consent issues (6.4.7). Another indication that sliding across this nursery/therapy boundary would have been helpful was Daniel pulling up the blinds on the door, positioning the cymbal near this door and performing loudly to his friends outside (MM6 Appendix 7.1). Also, the fact that Daniel had developed speech with his friends at nursery would have felt like the most meaningful progress, opening up the world of play and socialisation, and so attending Music Therapy on his own may have felt less important or relevant. At times, I did note a sense of boredom in his sessions. From this therapeutic narrative, it seems that pair work could have made a positive impact and since this is a 'naturalistic' study I could have adapted the therapy to suit the needs of the child.

Pilar might also have benefitted from peer work as she was talking to other children in her classroom but not adults (Table 7.4). Sliding a friend into the therapy sessions might have brought speech in too and then ultimately enabled the speech to 'slide out' to adults outside of the therapy sessions.

With Tasha, there was a lack of staff support available due to budget restrictions within the school and engaging staff to assist in the generalisation process was challenging. Eventually, Tasha led the way forward and movingly asked to have friends in the sessions (MM8 Appendix 7.3). Upon reflection, it would have been prudent to proceed more swiftly on to this method of generalisation rather than continuing to attempt to recruit help from staff (NotesTS27). Ultimately however, once we had created a small, successfully conversing group the next stage of generalisation needed to be considered. Throughout the case study I monitored any developments and speech outside of therapy but unfortunately Tasha's improvements in group therapy didn't carry over into her classroom. The final stage of generalisation will be discussed in the next section.

Maria and Mark engaged in pair work after they had achieved a degree of speech within their school environment, with a view to consolidating and further generalising their speech. Maria was already speaking to everyone in her classroom

environment although the supportive class teacher believed that pair work was important for her to gain more confidence and volume (NotesMS15). This final phase of work achieved these outcomes. As part of this phase Maria enjoyed playing various board games often shouting "I've won" in amazed celebration which also felt quite symbolic of her successful speech process (Figure 7.9).

Mark had begun speaking to friends out of earshot of adults and initially refused to attend Music Therapy after the summer holidays (Figure 7.13). Understanding that his speech with friends was crucially important to him I made a snap decision to invite his best friend Jacob for a 'taster' session (Table 7.9). Jacob had previously had SM and remained fairly quiet in school so was a perfect candidate for pair therapy. Pair therapy enabled Mark to quickly speak to me in the sessions and then generalise his speech to specific adults and eventually everyone in his class room. It was interesting that once both boys had begun speaking confidently in the sessions Mark in particular found it hard to stop. There was an almost continual verbal outpouring and part of my role seemed to be supporting them to manage and contain this (MM9 Appendix 7.6).

At this stage, Mark's mother was also in frequent contact to discuss ideas for supporting the generalisation process. She planned an ambitious birthday party for Mark and reported his huge gains in his being gradually able to play and talk confidently to his full class group within his home environment.

8.8.3 Transdisciplinary working

With Tasha the process of generalisation required immense patience and perseverance. However, there was a point in the group phase of the process when we became stuck and were unable to progress without engagement from the school (Table 7.6). Whilst persisting to attempt to recruit support from classroom staff solid help emerged in an unexpected way. In session 36 (Figure 7.7) there was an interruption from an unknown member of staff knocking urgently on the door stating that Tasha was needed for a full team review meeting. I negotiated adequate time to round off the session satisfactorily as the meeting seemed important.

After the session I exchanged emails with the member of staff, 'James' (MM9 Appendix 7.3), a volunteer and trainee Speech and Language Therapist (SLT) based at the school. I explained about SM, shared the 'Planning & Managing a Small Steps

Programme' (Johnson and Wintgens 2015) and suggested the possibility of him starting a similar group session in the same space but carefully 'sliding' into the room. James subsequently reported that he had managed this successfully, describing Tasha as 'relaxed and talkative' in his session.

We arranged to meet after Session 37 to discuss a plan for Tasha with the main SLT. James suggested that he could initially run a group twice a week but then planned to slide in another class teacher who would eventually run another group three times a week. The main SLT also felt that an education session on SM for the whole school was important. From one chance meeting Tasha was moving from frustrating once-weekly sessions to intensive transdisciplinary work which felt like a much needed and timely plan.

In order to move towards speech in the classroom I suggested that James might do some group work in the corridor. This again was successful and James found that using plasticine evoked discussions of 'poo' and general toilet humour which gave Tasha the confidence to invite new children to the group. A few weeks later Tasha's next classroom teacher was introduced to the group and speech established with her. The following week Tasha participated in a 'meet the teacher' session in her next classroom and spoke to her new teacher in front of her whole class (MM10 Appendix 7.3).

8.9 The environment around the child

Another aspect of the case studies that became apparent whilst they were in process and later throughout the analysis was the impact of the environment around each child. Each case study took place in a different school setting and this, alongside the child's background and home life, provided a vastly different context for the therapy work. Whilst I, as therapist-researcher, provided a somewhat constant factor in the study, all other environmental factors were different and so this narrative around each child became an important consideration. The 'table of generalisation techniques' (Table 8.11) reflects the schools' approaches to SM and the dramatic effect on the therapy for each child. This section provides more discussion of the challenges and positive aspects within the school and family environment but with a particular focus on Tasha (Table 7.6) and Pilar (Table 7.4).

8.9.1 Challenging school environment - Pilar

Pilar's therapy took place within a challenging school environment that felt unsupportive and actively undermining at times (Figure 7.4). Her first teacher was overbearing and suspicious about Music Therapy. This lack of trust was also manifest by other staff members such as the Special Educational Needs Coordinator (SENCo) and the head teacher which culminated in meetings with very challenging dynamics. Music therapy was moved, stopped, then reinstated after Pilar's mother complained. Pilar's therapy took place over the course of 18 months when she had four different class teachers. All except one of the teachers found it hard to absorb information about SM despite ongoing regular communication to discuss resources and progress.

The one teacher that was fully engaged and formed a positive relationship with Pilar, -including eliciting speech with her-, then left after the Christmas break which was a huge loss for Pilar. This same teacher made the discovery, as disclosed by Pilar's mother, of the likely cause of the SM which was being shaken by a nursery teacher at an earlier private nursery. This was subsequently reported as a child protection issue but may have partially explained some of the challenging relationships with class teachers. This early incident may also have impacted the Music Therapy itself and been the cause of the mild undercurrent of animosity towards me at the beginning of the process.

Alongside this there was a sense that the family were also putting pressure on Pilar to speak to me. I sourced information leaflets about SM in Spanish for Pilar's mother which explained the 'pressure-off' approach but she still often asked Pilar to speak to me at the end of the sessions. Occasionally Pilar's older sister picked her up from the sessions and was demonstrably cross with Pilar for not speaking to me and found it difficult to understand why she couldn't.

8.9.2 Complex school and home environment - Tasha

Tasha also had a complex school and home environment (Figure 7.7). Although her nursery teacher was experienced and supportive, her reception class teacher seemed to struggle continually with a lack of resources and teaching assistants for her class. It was therefore difficult to recruit much support for Tasha's therapy and generalisation process.

Tasha also had multiple challenges within her home life such as poverty and being made homeless. Around session 38 in her therapy process there was also an investigation into a disclosure of abuse that was quite traumatic for the whole family. In addition to this, the parents also separated at this point and at the same time Tasha reported that her father was shouting at her to talk.

8.9.3 Chaotic to calm environment - Mark

Mark's nursery environment was quite chaotic with sessions taking place in a kitchen area and being frequently disrupted by the nursery teacher despite persistent reminders that this wasn't helpful. The nursery teacher also didn't seem to understand SM saying that it was 'sickening' that Mark spoke to his friend outside school. She also applied pressure to the therapy by saying that she had to have him speaking by the end of term. Mark's situation completely changed in his reception class as the teacher was much more understanding and organised (Figure 7.13).

8.9.4 The therapists' engagement with the environment around the child

Within each school positive and negative experiences of team working, including the relationship with parents or carers, appeared to have a crucial impact on the progress of the therapy with implications for future Music Therapy provision.

In all settings I began the case studies by having a session with the current class teacher to explain about SM, to signpost towards any further reading or resources and to explain what to expect from the study. I also interviewed the child's parent or carer and offered similar information. Regular contact was then continued throughout the course of the case study with education sessions given to any new class teachers and further resources suggested as required.

Differences in response to the information between the schools highlighted the importance of having a range of strategies for increasing awareness and understanding of SM. For example, the pilot study, which took place in my regular work setting, went well as I had a long-standing relationship with that school. Maria, Rabiyah and Mark's schools were able to engage positively with the information and also had successful results.

8.10 Power

8.10.1 SM as disempowering

After coding and analysing the data from the case studies 'power' felt like an over-arching theme relating to and linking many of the other themes that emerged. Selective Mutism as an anxiety disorder feels like a very disempowering condition which restricts the use of our most expressive communication tool, the voice, in places where it is much needed.

SM also compounds situations where the use of speech would help to resolve an issue. This was felt particularly keenly with Tasha who needed to share something important about her home life at a time when she couldn't speak (Table 7.6). We used drawing materials but this was much more challenging to understand than simply having a conversation. Being able to speak at this point would have been empowering as she would have been able to explain what was happening at home. In her nursery setting Maria also seemed disempowered by her SM as she was unable to stand up for herself within her peer group. It also seemed to restrict her play which is very disempowering within a nursery setting.

8.10.2 Speech as empowering

The power of speech in imaginative play was highlighted by Mark and Jacob whose imaginative play mainly involved speech. For Rabiyah I felt that with speech and confidence came a shift in power dynamics with Rabiyah wanting to pretend to be my teacher (Table 7.8 MM6). Her later verbally abusive expressions (Table 7.8 MM7) gave the impression that she had perhaps been on the receiving end of some bullying behaviour and was now able to express and explore this.

8.10.3 Exploration and use of power

Ultimately for Pilar, we understood that her SM was caused by an abuse of power from an early nursery teacher (Table 7.4 Session 22).

In the case studies children explored the notion of power symbolically through 'superheroes', 'music power' and play fighting. In the group stage of Tasha's therapy the whole group fought a 'monster' together (Table 7.6 Session 43). When James, the trainee SLT, supported the work with Tasha it felt as though we had been rescued by a powerful 'superhero'. Within each school staff had a powerful influence

on the course of the therapy such as in Pilar's case where they tried to end the therapy.

I also felt that on an emotional level the children were harnessing their inner power and energy. For Pilar and Maria this was expressed as physical energy and for Mark this was through dramatic play.

My relative position of power as a therapist was palpable when making decisions about the length, frequency and when to end sessions. Some of these decisions were questioned by Tasha and Rabiyah once their voice had emerged in therapy, underscoring the importance of speech as a personal resource. Both Tasha and Rabiyah also taught me a song that they knew which seemed empowering for them.

That many of the children also moved quickly towards louder, powerful instruments was often one of the main features of the Music Therapy process. In my session notes for Tasha I write:

'And then she plays the cymbal which is a bit noisy. I get the feeling that she wants to use lots of energy and power in the session' *NotesTS7*

8.11 Conclusion - The revised theoretical framework

In chapter 5, after the interviews were analysed and themes placed on the original framework a pre-therapy section was added expanding the framework to include the importance of knowledge of SM and how to approach the therapy before starting work. The pre-therapy section also stated the potential special value of Music Therapy for this client group such as awareness of and skills for working with complex SM, emotional understanding, general awareness of quiet children and the provision of a sophisticated form of interaction. Teamwork was also added including teachers, parents, the whole school, other professionals such as speech and language therapists and supervisors (Figure 5.4).

Figure 8.1 Revised framework for work with foundation stage children with SM

1.APPROACH Thorough assessment tools Open/flexible approach blending SLT techniques Knowledge of where to access further resources and supervision. Creating and preparing a team (inc. parents & staff) to provide a positive, calm, no-pressure approach around the child. Ground work for Transdisciplinary work if needed.	**Therapeutic process** **Inter-connected Music Therapy ingredients**	**TIME IN THERAPY ➔ (Rapid or slow progress)** **2**. Offering a potential space (see no.1) with appropriate equipment **'no pressure approach' throughout** **3**. Manifesting anxiety –need a playful, light touch *Anxiety released/transformed through approach and ongoing relationship*	**4.***<u>*Therapeutic relationship*</u> *developed through child-led, (or sometimes therapist-led if the child is anxious), (playful) musical communication, being listened to and 'heard' including other media where important or appropriate to the child.* **Sessions lengthened or increased according to needs of the child.* **Breaks prepared for including providing additional sessions to sustain progress.*	**5.** <u>Generalisation</u> of speech supported through: a) planned team work b) peer group work c) transdisciplinary work using 'sliding-in' principles	**6**. Need for a positive ending.
	a) **M**usical b) **O**ral/**V**ocal	Musical self-expression, communication & conversations (parallels spoken conversations) 'sliding in' & empowering through music. Structured or improvised music? Being heard, being loud, using oral instruments or microphones, encouraging all vocalisations-laughter **(E)**, singing, shouting, word-sounds, words, short-phrases, long sentences, conversations. Leaving the music behind.			
	c) **P**hysical d) **I**maginative play	Self-expression in the physical realm leads to release of anxiety, positive risk-taking. Dancing Accessing the realm of dramatic, imaginative play- *links to **E & V** &* **M**			
	e) **E**motional/ social	The transformation of anxiety & isolation through accessing healthy social interaction. Role of humour and laughter in releasing and transforming anxiety. Harnessing inner power. Developing self-confidence. Peer friendships. Addressing SM & non-SM related emotional issues. Emotional issues in school context. Symbolism. Therapeutic relationship parallels parent/ infant interaction = emotional/ social communication- Stern			
	f) **C**ontext	a) Crucial impact of context –school & parents response to information b) Continual monitoring and checking in with parents/teachers/teaching staff as part of therapy process- providing resources c) 'Real life' context- Environment around the child- additional challenges/issues in school and home-life			

After analysis of the multiple case studies, themes from the individual Paths into Speech (Figures 7.2; 7.4; 7.7; 7.9; 7.1; 7.13; Appendix 8.3) were combined and placed onto the revised framework structure from chapter 5 (Appendix 5.4). This theoretical framework was further revised with the result above (Figure 8.2). Looking across all the children's Paths into Speech it is clear that a) the music of music therapy and b) oral/vocal elements played a crucial, if not dominant role in all the therapy processes. After this, children often broaden their scope of play to incorporate other elements -c) and d)- to assist them on their journey. Imaginative or dramatic play -d)- was added as this was a frequently occurring theme across the case studies. Aspects 1-6 are features of the therapeutic process that are common to all of the cases. I have called the context f) as this is an ongoing element that should be attended to as part of the therapy and may greatly affect its course. The pre-therapy section was further expanded and renamed 'Approach'. The 'team work' component has been renamed 'Context' and again expanded to include a broader range of influences on the therapy process. 'Manifesting anxiety' has been moved from second section of the therapy process into the first as it is something that primarily manifests at the start of therapy. The word 'Gradual' has been removed from the description of the process as this is misleading as for some children the process is relatively fast. The detailed implications of the revised framework will be discussed in chapter 9 in relation to the findings from the preceding chapter.

Chapter 9 – Music Therapy and Selective Mutism: Synthesis, implications and conclusion

9.1 Introduction

This study grew out of the need to develop further understanding and knowledge about how Music Therapy appears to help children with SM. It used a theoretical framework for this phenomenon taken from my MA case study and tested it across multiple data sets. These data investigated the broad context of Music Therapy provision for clients with SM, historically and in the UK. After these contextual stages, the main phase of the research focussed on an in-depth examination of the theoretical framework using multiple case studies of Music Therapy for foundation stage children with SM.

In this final chapter I use template analysis (section 3.3) to synthesise the data from the literature review, survey, interviews and the multiple case studies. I then use the final version of the template or theoretical framework to answer my main research question:

> Does a theoretical framework, developed in single-case study research, explain the process of Music Therapy across a number of cases of children with SM?

In summary, I show how the research confirms and deeply enriches the content of the main elements of the original theoretical framework, indicating that Music Therapy has powerful ingredients for helping young children with Selective Mutism. However, the study also highlights important modifications that develop and strengthen the framework, providing a pragmatic template from which to develop and guide future practice and research in this area.

I begin the chapter by explaining the process of data synthesis across the data sets and the subsequent adaptation of the theoretical framework. I then describe the findings from the synthesis of the study data that informed each element of the adapted framework. The implications for Music Therapy practice are considered within each element of the framework. The theoretical and policy implications of the findings are then set out in detail. These are followed by the strengths and limitations

of the various aspects of study. Implications for further research are explored followed by final reflections and concluding statements.

9.1.1 Paths into Speech

When describing the final iteration of the framework it is important to begin with a key observation that all the children in the case studies began to speak in therapy and school during the course of their Music Therapy treatment. Whilst multiple case studies are not a randomised control trial, and therefore do not indicate statistical effectiveness, it is important to note this pattern and that subsequent analysis of the therapy is based on a 'Path into Speech' rather than a process with a different outcome. This evidence corroborates the initial 'proposition' (6.3.1) that Music Therapy appears to help children with SM. This 'Path into Speech' is further reinforced by the literature review (2.5.3), national survey (Qu 12) and interviews of Music Therapists that all suggest Music Therapy is a useful intervention for SM (5.6.2). The first five of the six case studies were children learning English as an additional language. The last case study of a child who spoke English as his first language appears to suggest no obvious difference in any features of the Path into Speech. However, further investigation of possible differences is required (9.8.1).

9.1.2 Process of synthesis

At the end of each chapter presenting new data, potential implications for the theoretical framework were considered. This included where data might fit and whether any revisions might be necessary to incorporate developing themes. The final framework (figure 9.1) is a synthesis of all the data sets but with revision of the theoretical framework weighted mainly towards the multiple case studies from foundation stage children with Selective Mutism (3.3.3).

9.1.3 Adaptation of the original framework

Figure 1.1 shows the original theoretical framework from my MA single case study research followed by a summarised description of the original framework. An overview of the stages of a number of structural adaptations to the original framework is now described. The final iteration of the revised theoretical framework will be outlined in detail in section 9.2.

Music Therapy and Selective Mutism literature (Chapter 2)

After reviewing the 17 Music Therapy case studies the themes from this literature review were placed on the original theoretical framework. Many Music Therapists cited in the review stated outmoded conceptualisations of SM but in spite of this seemed to provide beneficial therapy for their clients. A pre-therapy column was introduced to incorporate this theme of Music Therapists' understanding of and relationship to the subject of Selective Mutism (2.5.4). Other themes such as loud playing (2.5.5) and the role of oral instruments (2.5.6) confirmed aspects of the framework and were placed within the original structure (Figure 2.1).

Survey data (Chapter 4)

After the survey, which explored Music Therapy for people of all ages and types of SM, specific elements of the framework were recognised as significant for all people with SM. These aspects were musical and social interaction and the therapeutic relationship. Physical elements appeared to be less important for older children and adults. Overall, respondents agreed that Music Therapy had a positive effect and reported increased speech across all settings for children aged 2-7 years old. A further modification from the survey data was to include a grounded 'no-pressure approach' which should be shared by the team supporting the child, including the parents or carers. in the column preceding the start of therapy.

Interview data (Chapter 5)

The interview data demonstrated that Music Therapists are excited and enthusiastic about the potential role of Music Therapy for children with SM. They described how Music Therapists have a range of therapeutic skills that have particular value and application for clients with SM but that these would be enhanced by a more thorough knowledge of SM. The pre-therapy column on the framework was therefore saturated with further themes from the interview data including:

- Education of Music Therapists about SM and how to treat it
- Suitable supervision of Music Therapists and teamwork around the child
- Knowledge of the potential special value of Music Therapy including skills with complex SM, emotional awareness, awareness of quiet children

The revised theoretical framework from this data set included a new layer beneath the main framework which was labelled ‘teamwork’ to encompass the main professionals and people involved in supporting a child with SM, stressing the role of parents or carers in this team approach.

Multiple Case Study Data (Chapters 7 and 8)

The data from the multiple case studies saturated the theoretical framework with rich detailed information. The new column, developed from the previous data sets and preceding the start of the therapy process, contained an extensive set of themes linked to approaching and preparing for Music Therapy with a child with SM. Below the main framework another row was added to contain ideas about the role and impact of the context around the Music Therapy sessions. The stages of therapy across the top of the framework were also adapted to reflect changes from across the data sets and this will be discussed in depth in the following section.

The synthesis of the data was a linear process that happened in stages across the data sets gradually building to the final framework in this chapter. Therefore, the theoretical framework at the end of the case studies (Figure 8.2) and the synthesised framework below (Figure 9.1) are subtly different due to further time spent considering all data sets and final important inclusions. Both frameworks are presented saturated with key information from the data sets to illustrate the link between the data and the framework. However, the final framework could be simplified into the main structural components -similar to the original framework (Figure 1.1)- for ease of explanation and readability in transmitting the concepts to other clinicians and multi-disciplinary school teams. Detailed explanation of the components would be provided after the simplified diagram of the framework.

Figure 9.1 Final revised theoretical framework

<table>
<tr>
<td rowspan="4">1. APPROACH (Pre-therapy)
a) Understanding SM (Education and training)

b) Open/flexible approach blending SLT techniques inc. assessment tools

c) Creating & pre-paring a team (inc. parents & staff) to provide apositive, calm, no-pressure approach around the child.

d) Ground work for Transdisciplinary work if needed.

e) Knowledge of where to access further resources and supervision.</td>
<td>Therapeutic process

Inter-connected elements of Music Therapy</td>
<td>TIME IN THERAPY ➔ WITH CLIENT (Rapid or slow progress)

2. Offering a potential space (see no.1) with appropriate equipment ‘no pressure approach’ throughout
3. Manifesting anxiety –need a playful, light touch
Anxiety released/transformed through approach and ongoing relationship</td>
<td>4.*<u>Therapeutic relationship</u> developed through child-led, (or sometimes therapist-led if the child is anxious), (playful) musical communication, being listened to and ‘heard’ including other media where important or appropriate to the child.
*Sessions lengthened or increased according to needs of the child.
*Breaks prepared for including providing additional sessions to sustain progress.
*Micro-processes of ‘warming-up’ the voice (B.)</td>
<td>5. <u>Generalisation</u> of speech through:
a) supportive environment around the child (see 1)

b) planned team work

c) peer group work

d) transdisciplinary work- group duplication- sliding-in other staff</td>
<td rowspan="4">6. Need for a positive ending.</td>
</tr>
<tr>
<td>A) Musical
B) Oral/Vocal</td>
<td colspan="3" rowspan="3">Musical self-expression, communication & conversations (parallels spoken conversations) ‘sliding in’ & empowering through music. Structured or improvised music? Being heard, being loud.
Using oral instruments or microphones, encouraging all vocalisations-laughter (E), warming-up the voice (4) singing, shouting, word-sounds, words, short-phrases, long sentences, conversations. Leaving the music behind.
Self-expression in the physical realm leads to release of anxiety, positive risk-taking. Dancing
Accessing the realm of dramatic, imaginative play- links to A, B & E
The transformation of anxiety & isolation through accessing healthy social interaction.
Role of humour and laughter in releasing and transforming anxiety.
Harnessing inner power. Developing self-confidence. Peer friendships.
Addressing SM & non-SM related emotional issues. Emotional issues in school context. Symbolism.
Therapeutic relationship parallels parent/ infant interaction = emotional/ social communication- Stern/Trevarthen</td>
</tr>
<tr>
<td>C) Physical
D) Dramatic & Imaginative play</td>
</tr>
<tr>
<td>E) Emotional/ social</td>
</tr>
<tr>
<td>F) Context</td>
<td colspan="3">a) Interactive <u>relationship</u> between ‘therapy’ and environment-gains in one supporting gains in the other.
b) Crucial impact of context –school & parents’ response to information
c) Continual monitoring and checking in with parents/teachers/teaching staff as part of therapy process- providing further resources
d) ‘Real life’ context- Environment around the child- additional challenges/issues in school and home-life</td>
</tr>
</table>

9.2 Explanation of the synthesised framework

In this section I discuss each component of the framework, which illustrates findings through synthesised data from the literature review, survey, interviews and case studies. For each component I also consider implications for Music Therapy practice with children with Selective Mutism. In the discussion that follows, the numbered stages and lettered elements of the framework correspond to the lettered and numbered components in Figure 9.1 above.

9.2.1 Stages of Music Therapy for children with SM

Stage 1. Approach

1a Understanding Selective Mutism

The study consistently indicates the importance of music therapists' having a good understanding of SM before working with children with SM. The literature review revealed a history of misunderstanding of SM within the Music Therapy profession (2.5.4) that paralleled changing historical perceptions (1.2.1), although the experience described in the therapy process often transcended these stated misunderstandings. Respondents to the survey cited a 'no-pressure' approach as being important, demonstrating knowledge of Johnson and Wintgens' (2001, 2018) comprehensive manualised approach. In the interviews Music Therapists' mixed understandings of SM became a substantial thematic area (5.4.1) with 7 different themes (5.4.1.1-5.4.1.7). In the multiple case studies, my own gaps in clinical knowledge regarding possible treatment options were highlighted (8.2) and clinical learning from the case studies evolved further throughout this process.

Implications for practice

A general lack of understanding and awareness of SM continues to exist within the general population. In addition, parents of children with SM show on-going concerns about education and health care services for children with SM, as seen in the SMIRA Facebook pages at: <https://www.facebook.com/groups/SMIRASelectiveMutism>

Therefore, as Music Therapists we must engage with, and take an active role in, educating both ourselves and our multi-disciplinary colleagues about SM, in order to develop and plan effective practice.

One key example of how Music Therapists' collective knowledge gaps may impact clinical treatment is in relation to trauma and traumatic mutism and the important difference between this condition and SM (5.4.1.2). The difference is clearly defined below:

> "Children with reactive (traumatic) mutism communicate normally before the precipitating event and become withdrawn across all environments afterwards. In contrast, children who have SM only find it difficult to communicate in specific situations. The vast majority have experienced nothing out of the ordinary and, as a group, they are no more (and no less) likely to have been abused than any other child". (Johnson & Wintgens 2016 p. 13)

The legacy of the assumption that all mutism is the result of trauma or abuse has misinformed some Music Therapists' conception of SM. Education and training about SM is required to iron out any misconceptions in preparation for providing therapy. This should be underpinned by a strong knowledge and understanding of the main techniques used by other professionals, in particular Speech and Language Therapists who have developed a comprehensive manualised approach (1.3.3) that includes the development of local and national care pathways for SM (Keen, Fonseca and Wintgens 2008). The methods and techniques used by different therapies may vary greatly but the main principles and environmental approach around each child should be the same or similar. This should include the 'pressure-off' approach (Johnson and Wintgens 2001) and a clear understanding of the generalisation of speech which should play an integral role in any therapy intervention for SM (1.3.3).

Education and training in SM can take a variety of forms for example:

- access to information and resources such as the Selective Mutism Resource Manual (Johnson & Wintgens 2001, 2016);
- training in SM from Maggie Johnson (2001, 2016) or other recommended providers;
- advice and information from the Selective Mutism Information and Research Association (SMIRA) via their comprehensive website and social media pages for parents, professionals and young people with SM.

The requirement for improved understanding of SM should be communicated to the Music Therapy profession as the present study shows that our particular skills and resources place us in a unique position of great potential to help children with SM. This position seems apparent across the literature review, survey, interview and case study data regardless of training backgrounds. As a profession we are making a small positive impact in this field. With additional training, knowledge and resource sharing we could develop and strengthen our role, being better team players and stronger advocates for our position in supporting children with SM (9.5).

1b Open/flexible approach

The survey (Qs 7 and 8) and interviews described a broad range of useful approaches (5.4.4.2) alongside the importance of team work. They also highlighted the special value that Music Therapy and Music Therapists offers such as:

- musical improvisation as a sophisticated/comprehensive medium for interaction and self-expression.
- being aware of the quieter children;
- being aware of and able to work with children with complex needs and SM;
- having skills in working with children's emotions.
- being able to offer a playful approach which feels appropriate for early years.

<u>Implications for practice</u>

The data indicates that Music Therapists are in a strong position to offer useful therapy for SM but that they should take an open, flexible approach. With a solid conceptualisation of SM through education and training (9.5.2) our Music Therapy practice can follow whichever expressive medium is suggested by each child and be tailored to their individual needs. At times, it might be important to abandon the medium of music for a while in order to follow the lead or needs of the child, whilst being relaxed and comfortable with this (8.2.2). Music Therapy should always be a means to an end. We need to view ourselves as Music Therapists providing therapy rather than restricting ourselves with too rigid a definition of Music Therapy.

As part of this broad approach it is necessary to have a good working knowledge of current SLT methods and techniques, and blending them with Music Therapy

techniques as required for effective treatment (1.3.3; 5.4.4.2; 8.2.3). This is essential for a comprehensive assessment in addition to using a 'talking map', interviewing a parent [7,8], supportive work such as creating a 'no-pressure approach' environment around the child, generalisation work and for additional ideas if a child isn't progressing as expected. As part of this, sharing relevant portions of the information and resources described above is useful to support teachers' and parents' understanding of SM. This blending of SLT and behavioural components into Music Therapy practice could be described as a 'multimodal' approach (Oon 2010).

My original template described a psychodynamic approach as this formed a key aspect of my Music Therapy training. Through this study, particularly the Music Therapy case study literature (2.5.4.3), I now believe that Music Therapists should be wary of adopting an overly analytical stance as SM is not generally associated with a specific prior cause and has a multifactorial etiology (1.2.3). The high anxiety associated with SM is often largely alleviated once a young child begins to speak. (This may be different for older children, adolescents and adults). One interviewee felt that her practice had been 'wrong' when she responded to a silence with silence and inadvertently increased the client's level of anxiety (5.4.1.3). Extra sensitivity and care must be employed when using a psychodynamic approach to Music Therapy in responding to an SM client's silence. This is perhaps comparable to a social situation with someone that is socially anxious when a friendly supportive response might be to talk a little more rather than leaving long anxious silences. Reflecting anxiety and awkwardness with silence can exacerbate rather than support anxiety and so reaching out with warmth and sensitivity it is possible to offer a supportive bridge or context for communication. This is however a fine-tuned balancing act and sometimes it is crucial to leave small gaps or space to fill but not long anxious silences (5.4.3.2). Conversely, I have found that it can also be helpful to appear inattentive and absorbed in your own playing, creating an unfettered space for the child to explore their own music in parallel play and perhaps develop the confidence to attract the therapist's attention. This dynamic could be a result of having too much attention and focus associated with not speaking at other times

[7] Parents with EAL may require an interpreter.

[8] Although SM doesn't typically have a 'cause', the therapist should ask if there was anything that happened as occasionally there is a specific event that may need addressing.

which could feel like ‘pressure’ in the therapy room. Generally, a light-hearted approach seems most helpful when a child has SM (Cline and Baldwin 2004 p.6; 5.4.4.2; 8.2.2.1).

1c Creating and preparing a team around the child

The study demonstrates that within a school environment it is important to create a team around the child with SM to support and deliver a clear and consistent approach (5.4.1.7; 8.8.1; 8.8.3). This follows the SLT advice and should include parents or carers and staff relevant to the child (Johnson and Wintgens 2001; 2016).

Implications for practice

Developing a team can include mapping out who might be appropriate team members for generalisation of speech (1.3.3.4) and transdisciplinary work if necessary. Ideally it is best to offer a whole school training or presentation to develop awareness and understanding of how to support a child with SM. Guidelines on what to include are described in the Selective Mutism Resource Manual (Johnson & Wintgens 2001, 2016). An aware, supportive school and home environment increases the likelihood of therapy provision being successful and SM being recognised in other children.

1d Knowledge of further resources

General awareness and understanding of SM remains inadequate and so working in this field can be challenging at times (7.4.2). Knowledge of further resources may help address these challenges.

Implications for practice

When undertaking the multiple case studies, sourcing a clinical supervisor experienced in SM would have helped support specific SM related issues. My advice to Music Therapists working in this area would be to seek out an SM-experienced supervisor either from within the Music Therapy profession or a related profession, such as SLT or Psychology. There are also excellent resources online to support professionals working in this field such as SMIRA’s closed Facebook group for professionals, <https://www.facebook.com/groups/752150244881629/> who offer experienced professional perspectives on a range of SM related topics, documents about treatment issues and signposting to other resources.

Stage 2. Offering a potential space

This aspect is the second stage in the process after the approach or 'pre-therapy' (Stages 1a-1d above) (see Figure 9.1). This potential therapy space for children with SM should be created after adequate education and training. The therapy should also be located in the place where the SM occurs which in many cases will be a child's school.

Implications for practice

The therapy set-up should include awareness of the issues around location, session frequency and length with options for flexibility (2.5.2; 8.2.1). There needs to be the possibility of increasing these parameters if important for extending and intensifying improvements in confident speech (Figure 7.5; Stage 4).

Location. The multiple case studies in this investigation all took place in the schools that the children were attending. Selective Mutism is sometimes called 'situational mutism' (SMIRA website 2019) because children with SM are mute only in particular situations or locations. For this reason, it is absolutely essential that any therapy provision should focus on the place where the SM occurs (Johnson and Wintgens 2001; 2016; Keen, Fonseca and Wintgens 2008). For most children with SM who are attending school this means that Music Therapy needs to be located in the school environment. Within schools a place needs to be found that is relatively quiet, as free as possible from any potential disturbances and somewhere that the child is as relaxed and comfortable as possible.

Session Length. The length of the therapy sessions should follow the lead and needs of the child, perhaps around 30 minutes for early years, and increase -or decrease- accordingly. It is of paramount importance that the therapist follows the lead of the child and initial sessions may be shorter if a child has a poor attention span or focus.

However, if a child appears to want a longer session or seems to be making more progress towards the end of the session, the research suggests extending the session, perhaps up to 50 minutes (Figure 7.5; Stage 4) would be a good bench mark, as this could speed up the progress of the therapy. It is important that children with SM access effective early intervention as they are not fully accessing their education and the condition is stressful with risks of becoming entrenched (1.3.1).

Frequency. The multiple case studies show that once weekly therapy can be challenging when there is an urgent need for self -expression for children with SM, who would like to be speaking every day (2.5.2; 8.2.1). In a publication on 'sliding-in' techniques Johnson and Wintgens (2015) suggest that a 'shaping' programme should take place at least three times a week for a minimum of a term without a break otherwise it feels like starting over again each week for the child. The ChildMind institute in the U.S also offer both individual and group intensive work for children with SM to overcome practical issues such as having to travel long distances to access specialist intervention.

Music Therapy provides a similar role to 'shaping' whereby speech is elicited with someone other than the parent in the school setting. As this study focussed on weekly therapy, which seemed adequate in most cases but not necessarily ideal, I would recommend a flexible approach to frequency and consider increasing this if possible if the rate of improvement is slow, such as in the case of Pilar (8.2.1).

Stage 3. Manifesting anxiety

Manifesting anxiety appeared on the original template timeline after the section 'offering a potential space'. On this revised template it is brought forward to share the same position as 'offering a potential space'. This is because anxiety is usually manifested in the initial sessions but often quickly dissipates or transforms into positive expressive energy (8.7.2). The associated frozen physical appearance also appears to rapidly thaw with the interpersonal contact in the therapeutic relationship (8.3.2). This perspective on anxiety has changed from the description on the original framework which was more Psychodynamic and suggested that the anxiety needed containing and processing (Figure 1.1).

<u>Implications for practice</u>

Listening and containing (1.4.4) remain important tools, however employing light-hearted playfulness (2.5.5.5; 8.2.2.1) and humour (2.5.5.4; 8.4.7) may offer a gentler way of connecting with an anxious child. There is less need to consider the origins of the anxiety as it is predominantly associated with the requirement for speech (1.2) and through working in the 'here and now' much of the anxiety will pass when a child begins to express themselves and then speak. For this reason, very high levels

of anxiety in a child with SM should not be viewed as a barrier to their successful treatment (7.6.2).

Factors external to the therapy room may increase a child's anxiety and we need to be alert to this happening and undermining the therapy; for example, teachers unwittingly applying pressure on a child to speak (7.8.1).

In respect to musical communication children with SM are sometimes too anxious to take the lead and find free improvisation anxiety provoking. Clear musical structures, such as well-known nursery rhymes with opportunities to name things, may be invaluable resources in the sessions and provide a sense of safety and containment (Table 7.8). This is comparable to the Johnson and Wintgens 'stages of confident speech' (2001) whereby more directive musical communication has a low communication load -less anxiety provoking- and free improvisation has a high communication load -anxiety provoking- and is similar to an improvised conversation. However, using music is different from speech and some children are able to improvise easily without appearing too anxious (Table 7.6).

Stage 4. Therapeutic relationship

This central section replaces the 'Gradual build-up of trust and contact through listening and accepting - 'no pressure' approach' (no.3) and the 'Gradual development of shared meaningful communication and 'playing'' (no.4) on the original template.

Implications for practice

It was important to remove the word 'gradual' as this gives the impression that a slower process is acceptable. However, this is not appropriate for early intervention in a child with SM because:

a) there is often a sense of urgency in the need for self-expression;

b) it is important to support a child into speech as quickly as possible to prevent entrenchment (1.3.1);

c) the Path into Speech in Music Therapy may be quite fast (Table 7.1; Table 7.8).

Again, the focus has shifted from a more analytical Psychodynamic approach into working in the 'here and now' through an active, playful relationship (8.2.2.1),

developing musical or other communication as suggested in no.4 on the original template (Figure 1.1).

There is an interesting parallel between how Autism Spectrum Disorder (ASD) was misinterpreted by some in the 1950s as being 'caused' by a lack of maternal warmth (Kanner 1943, Bettelheim 1967) and the search for a 'cause' for SM. Our understanding of ASD is now far more evolved, we no longer look for a familial 'cause' and instead apply psychodynamic awareness to think about relationships in the here and now. A similar approach should be employed for SM.

Alongside this, as noted in 'Offering a potential space' (Stage 2), sessions may be lengthened or increased in frequency according to the needs of the child. This may become particularly relevant if:

- a child is making slow progress and increasing the session length or frequency might improve the impact of therapy
- a child starts vocalising or talking towards the end of a session and is keen to extend this activity in order to thoroughly establish their speech.
- a child is taking the normal duration of the session to 'warm-up' into speech and this is happening each week. At this point, the research suggests that it is imperative to increase the length or frequency of sessions as a more intensive approach at this critical time may resolve the SM and prevent it becoming entrenched.

Within the therapeutic relationship it is important to follow the lead of the child into whichever medium is useful to them. It may be important to abandon the music of Music Therapy for a while whilst remaining in role as a Music Therapist and remembering to bring the music back in when it is necessary or helpful as an accompaniment to another activity (8.2.2.1).

WARNING- MIND THE GAP- watch out for breaks and holidays (8.2.1).

If therapy sessions are once a week, breaks can be a considerable issue for children with SM and any gains made may disappear. Some breaks may be unavoidable due to sickness but other breaks should be carefully planned and perhaps compensated for, depending on where the child is at in their Path into Speech. Within the school system the regular breaks for holidays can create setbacks for some children with SM

(7.4.3). If possible, one suggestion might be to offer an extra session just before or after a one-week break to give more sense of continuity. If longer breaks occur at crucial times in the process then it may be helpful to offer additional sessions over the school holiday period.

Stage 5. Generalisation

Generalisation, a critical phase, has been added to the new theoretical framework prior to 'ending therapy'. Generalisation was mentioned briefly in the description of the original theoretical framework (1.5.2 stage 5) but has now been given much greater emphasis. It emerged in the interviews (5.4.4.6) and became an important theme in the multiple case studies (8.8). As Johnson and Wintgens (2001, 2016) state, it is a crucial phase in the development of confident speech in school for children with SM. Once speech has been established in the Music Therapy sessions it is essential that this is then generalised out to the classroom and wider school settings.

Implications for practice

All the techniques suggested below are based on Johnson and Wintgens (2001, 2015, 2016) established methods and should be adapted through familiarity with the concepts of 'sliding in' and generalisation. Generalisation is supported through:

a) creating a supportive environment around the child (Johnson and Wintgens 2001)

This should be established from the outset of therapy as described in the 'approach' to therapy and refreshed with each change of staff or classroom environment (6.4.6). If a warm, friendly and supportive environment is in place then generalisation often happens easily with little additional 'sliding in' required.

b) planned team work

When speech happens in the sessions but does not appear to generalise fairly swiftly into the classroom environment then some additional techniques may be needed to assist this process (8.8). As a first stage, the therapist should attempt to slide speech into the classroom herself through being the conversational partner along the route back into the classroom and then arranging to spend time with the child in the classroom either with or without other children present.

Alternatively, a member of staff who has most rapport with the child should slowly slide-in to the sessions and quietly observe then engage in conversations with the child. This should be done according to the sliding-in techniques outlined by Johnson and Wintgens (2001, 2015, 2016). This speech can then be moved physically closer to the classroom, perhaps first in an empty classroom or smaller adjoining room that is less anxiety provoking and more comfortable for the child. It may also be that a child is more comfortable initiating speech with a classroom assistant in the playground before establishing speech with their teacher. Providing adequate training, resources and support should mean that staff are aware of different possibilities and opportunities. These techniques depend on staff availability and if a school is unable to release a member of staff then the next stage may be a more appropriate course of action.

c) peer group work (8.8.2)

When staff are unavailable or if peer group work seems to be indicated, or perhaps requested by the child, then other children can be gradually added to the sessions at a pace that suits the child. The child should be asked who they would like to join them in the sessions and permission gained from parents or carers for the new child to provide a supporting role. Often this will be mean that speech is then generalised with the peer or peers into the classroom. Sometimes this will need to be fairly structured, perhaps undertaking activities with the peer or peers at a time when other children are not around. Peer work can also be undertaken to consolidate any progress into speech in sessions and in the classroom with the aim of developing greater confidence in the classroom environment.

d) transdisciplinary work (8.8.3)

If therapy is progressing slowly or has stalled and the therapist is not able to increase the frequency of the sessions then transdisciplinary work may be hugely beneficial for the child (Appendix 7.3 MM9 MM10). This can also be helpful for supporting generalisation of speech into the classroom as ideally the team member identified to take on the work should be based within the child's school. One definition of transdisciplinary working is taken from Twyford and Watson (2008):

> 'Transdisciplinary level: this includes practice with other professionals across traditional therapeutic boundaries and, while it requires commitment, team

> members practising in this way 'support each other in practice: physically, emotionally and intellectually…sharing a common search for meaning in the experience of client care' (Twyford and Watson 2008 p.5).

A particularly relevant aspect of transdisciplinary practice for Music Therapists working with SM may include 'role release' which is when one team member 'up-skills' a colleague to provide the same or similar role to them using high levels of consultation and collaboration (King et al. 2009). Role releasing is effective when you:

- have the right person at the right time for the right reasons
- still have access to the expert
- have up- skilled each other, saving costs and time
- are working to a common goal or shared meaning
- are multi-skilling- teaching each other skills for example occupational therapy teaching the SLT, or parents
- have the family at the centre of the practice when working with children

An example of transdisciplinary work was shared by an interviewee describing her collaboration with an educational psychologist (5.4.1.7). Transdisciplinary work can only be successful if appropriate staff members are available to take on this work under specific conditions and with shared goals.

> 'When collaborative work comes from client need, has a clear focus and purpose, provides sense of achievement and is undertaken with an awareness of the roles of all collaborators, then the process has significant potential'. (Twyford and Watson 2008 p. 34)

Asking a colleague to provide a session that has similar components to a Music Therapy session but incorporates useful aspects of another therapy can be hugely beneficial for a child with SM. With one of the case studies (Tasha) this also freed up my sessions to focus on some invaluable emotional processing work.

Stage 6. Ending

The aim of achieving a positive ending is similar to the original framework however the emphasis is no longer on reworking separation anxiety.

Implications for practice

Having a child who is confidently speaking and whose speech has been generalised back into the classroom environment is crucial before therapy is ended. If therapy has not been successful then further plans, such as intervention from another professional, should be initiated within the multi-disciplinary team (1.3.9). After a successful ending the child should be monitored at regular intervals to ensure progress is sustained and any further advice given as required.

9.2.2 Elements of Music Therapy for children with SM

The main elements of Music Therapy that are helpful for children with SM will now be outlined. Although they have been separated into six distinct elements, as will be discussed further, this is a somewhat artificial distinction since these elements frequently overlap and combine in various activities led by the children.

Element A. Musical

Each phase of the research consistently demonstrates that musical communication is a powerful resource and therapeutic tool for young children with SM (Figure 4.19). However, the description of musical elements on the original framework was just a starting point. This study adds greater depth and detail about this rich resource for children with SM.

The role of music to provide a way of connecting and relating is articulated by Mahns (2003; Figure 2.1):

> 'The ability of Music Therapy to include non-verbal expression seems to offer alternative healing prospects to those that are mute' (p. 60)

The urgency of the need to communicate and the accessible, appealing nature of music as a means of self-expression was demonstrated both in children's enthusiasm to attend sessions (8.3.1) and in the resultant loud playing which is a theme across the literature (2.5.5.1), survey (Figure 4.17), interviews (5.4.4.3) and case studies (8.3.3.1). This musical feature seems to symbolise the issue for children with SM encapsulating the dramatic contrast between the frustrated silence in school and the inner drive and need for self-expression. Expression of this emotional frustration is most poignantly captured in both the silent and loud screams of children in the case study literature (2.5.5.1).

Appreciation of the potential role of loud playing for children with SM was acknowledged in the description of the original theoretical framework (1.5.2) and this aspect was therefore somewhat anticipated and prepared for in the multiple case studies. Provision of louder instruments such as cymbals, large percussion and vocal amplification alongside the usual array of instruments meant that the ability to play loudly was clearly available and supported in the therapy sessions. Many of the children accessed this opportunity for loud self-expression early in their therapy sessions (8.3.3.1) which perhaps dissipated some frustrated communication and ameliorated the need for 'screams' as described in the literature (2.5.5.1). However, a sense of frustrated vocal communication was clearly conveyed through the loud use of oral instruments (Appendix 7.6), roaring (Appendix 7.4) and very loud singing (Appendix 7.3).

Although loud playing is a notable phenomenon of work in this field, the ongoing presence of the musical relationship (8.3.4) as an accessible means through which to communicate is the most important and enduring feature of the therapy. The general, musical components of Music Therapy such as instrumental or sung improvisation (8.3.3.3), and opportunities for musical conversations which parallel spoken conversations, are ideal resources for developing confident self-expression and speech in children with SM. With sung improvisation the musical expression uses the voice and moves very close to speech. The elements of musical conversations, spontaneity and relationship are aspects that closely parallel the functions that the voice would otherwise provide. Further detail of the role of music in the music therapeutic relationships in the multiple case studies are covered in 8.3.

Implications for practice

Many of the essential musical elements of Music Therapy that are helpful for children with SM are already an intrinsic part of Music Therapy provision prepared for through comprehensive Music Therapy training courses. This study shows that Music Therapists should have an element of confidence about the positive role Music Therapy can play in helping children with Selective Mutism. However, therapists should be mindful of the potential role of loud playing and have a wide range of instruments available to support this aspect.

Element B. Oral/Vocal

On the original theoretical framework (Figure 1.1) the oral and vocal elements were included within the musical component. However, as this element is of such relevance to SM they are now a separate, although closely connected, element on the framework. This is to allow space for their depth and detail to be captured and to create an awareness of the role of each of these elements on the Path into Speech.

B1 Role of Oral/Vocal elements on Path into Speech

Engagement with musical instruments is often, but not always, the first element used in the therapy process or Path into Speech, followed later by a gradual use of oral and vocal aspects. In the first 5 case studies, all the children initially engaged musically through playing instruments and then later used oral instruments and vocal elements (Figures 7.2; 7.4; 7.7; 7.9; 7.11). In the last case study, there was an immediate focus on oral instruments (Figure 7.13). In 3 of the cases the use of oral elements or oral instruments seems to directly precede the emergence of speech in the sessions (Figures 7.2; 7.7; 7.9). Table 8.3 provides an overview of each child's use of oral/vocal elements in the multiple case studies.

B2 Oral instruments

The use of oral instruments as a key therapeutic resource is clearly described in much of the Music Therapy case study literature (2.5.6). Oral instruments encourage and empower the voice with particular instruments such as the kazoo, which require voice rather than just breath, providing an especially close connection. The use of different oral instruments is examined in detail in chapter 8 (8.4.2) with a suggestion for the kazoo to be used as a 'sliding in' instrument.

The use of other oral instruments, equipment and props (Table 8.4; 8.4.5) appeared pivotal for some children who found it easier to vocalise first using a microphone than just using their voices. Vocalising in this way also provided the opportunity for musical conversations using turn-taking structures that closely mirrored spoken conversations (8.4.3).

B3 Singing

The use of singing in sessions (8.4.4) was a theme that may have been expected to claim a more prominent place in the study. However, only 5 of the 17 Music Therapy case studies in the literature mention the use of singing (2.5.6) and only 37% of

survey respondents indicate that singing was important for their clients. Singing (8.4.4) did not emerge as being important for all children in the multiple case studies (Table 8.7). However, it played a very important role for 2 children, was quite important for another child but was not important for 3 children. This was perhaps because singing is such a personal form of self-expression that commonly induces anxiety especially on an individual level and so may also be avoided for this reason in children who are anxious about speech.

B4 Humour and laughter

This is an important cross-cutting theme which emerges first in the Music Therapy case study literature (2.5.5.4) demonstrating its power as a resource for both relieving anxiety and eliciting voice in the sessions. In many of these published case studies humour and laughter appears to be actively encouraged in the sessions. It features strongly again in many of the interviews (5.4.4.4) and for one interviewee was integral to their approach. Humour and laughter played a particularly key role in two of my case studies -Pilar and Maria- (8.4.7) with both children appearing to use laughter to connect to the voice and speech (Appendix 7.2 MM5; Table 7.7). Humour and laughter were also helpful in 'sliding' Tasha's speech down the corridor and into her classroom (8.4.7).

Implications for practice

A wide selection of oral instruments such as recorders, kazoos and microphones should be provided in each session. Care should be taken with kazoos as they require voice and may feel anxiety provoking at first. However, due to their low cost they can be sent home for 'practising' on and provide a tool for 'sliding' some vocalisation into the sessions. Any other playful wind instruments should be incorporated if available. This oral/vocal element includes all other vocal sounds (8.4.6) which should be encouraged and given space in the Music Therapy process providing essential, expressive steps on the path into speech. Humour and laughter should be encouraged wherever possible as part of a light-hearted, playful approach as it provides a link into speech for some children.

Many children appear to be 'warming-up' their voice to speak, however, this process should be closely monitored and sessions increased in length or frequency so that the goal of speech is reached (see Stage 2 above). Monitoring of mouthing (8.5.4), vocalisation and verbalisation both inside and outside the therapy room through

careful video observation of sessions and ongoing liaison with school staff is an essential part of the therapy process.

As part of the process of encouraging and eliciting speech, therapists should consider offering structured activities that require specific well-known responses. Familiar nursery rhymes, such as 'Old Macdonald had a farm' which requests the naming of animals and making animal sounds, or any other naming or call and response type song that a child can respond to easily, are very helpful in encouraging speech (Table 7.8). This is because answering closed questions is generally less stressful than improvised, open questions (see also Stage 3 above). If a child finds something that is working for them, repeat it and extend it until that activity and its benefits have been exhausted.

At the end of this oral/vocal process children often need the opportunity to practise their speech and as therapists we need to give this our full attention perhaps abandoning playing music or other traditional 'music therapy' activities in order to simply speak and converse with the child.

Element C. Physical

This element is perhaps less prominent than Music and Oral/Vocal elements but must continue to be included on the framework as physical elements can play a vital role for many children with SM. The Music Therapy case study literature described a range of different physical aspects including: anxious physical presentations in contrast with physical relaxation activities; the physical space in the room; physical strength, energy, confidence and risk-taking and physical self-expression (2.5.5.2). The survey indicated that the physical element of Music Therapy sessions is highly relevant or relevant to 93% of 2-4 year olds with SM (Figure 4.20). The interviews describe fewer physical elements than other data sets (5.6.3.1), however the case studies contain rich data illustrating the vital role of physical activity for some children (8.5). An initial description of the physical manifestation of 'Globus sensation' in me as the therapist/researcher was a curious feature experienced during the multiple case studies (8.5.1). As in the Music Therapy case study literature (2.5.5.2), anxious 'frozen' physical presentations are also highlighted in the multiple case studies along with initial difficulties getting instruments to produce a sound (8.5.2). The transformation of anxiety into physical action, often with an

accompanied sense of risk-taking (Table 7.7), was another important feature of the multiple case studies (8.5.3).

Implications for practice

The main implication is for the therapist to be open to follow the lead of the child which may include self-expression through a more physical means such as dance or exuberant physical games or activities.

Element D. Dramatic play/imaginative play

This element has been added to the framework as a reconfiguration of the previous component of 'playing' that was noted on the original framework as part of the therapeutic process (Figure 1.1 No.4). This theme emerged again in the Music Therapy case study literature mainly in descriptions of deliberate playfulness and play (2.5.5.5) and as a way of intuitively reaching out to particularly anxious children. There was also a description of dramatic, imaginative phases of a therapy process (Sekeles 1996).

Playfulness was indicated as an important feature of the sessions in Q10 of the survey. However, in the interviews, playfulness, dramatic or imaginative play was not a particularly strong feature except in references to the use of puppets which appeared very helpful for children with SM. In 5 out of the 6 case studies dramatic or imaginative play was a feature in the sessions. This was particularly true for Mark for whom dramatic, imaginative play was key to the emergence of speech (Table 7.9).

Implications for practice

Working with younger children, dramatic or imaginative play and general playfulness are accessible, invaluable resources that should be fully utilised in Music Therapy sessions, especially if initiated by the child or if required to engage and make contact with an anxious child. Often, dramatic or imaginative play can become blended with another element of the session. For some children this creates another 'space' or realm for them to inhabit, exploring other personalities and characteristics that allow them to harness inner strength and move forward on their Path into Speech.

Element E. Emotional/Social relationship

The original framework stated that the therapeutic relationship parallels the mother/infant relationship (Figure 1.1 element c). Although there will be aspects of this formative relationship present for children in Music Therapy, I don't believe that a reworking of this relationship is particularly relevant or appropriate for children with SM. However, the foundations of this early social/emotional communication underpin Music Therapy practice and provide an essential role in engaging a child in a positive therapeutic relationship. This section now focuses on the broad topic of emotional issues for clients with SM as the social/communication aspect is primarily a tool that is employed in the 'Musical relationship'.

Awareness of emotional issues in people with SM and how these can be supported through Music Therapy is an important theme across this study. Six of the cases reported in the Music Therapy case study literature described how clients experienced emotional improvements (2.5.3) from attending Music Therapy. In the survey, respondents noted clients' emotional issues (Table 4.2) and indicated the importance of emotional self-expression and supporting emotional well-being for clients with SM (Figure 4.26). The interviews highlighted awareness of the heavy emotional impact of SM and also Music Therapists resources for working with these issues (5.4.1.5). In the multiple case studies this emotional impact was observed in many anxious 'frozen' presentations. There was also a sense of an urgent need for appropriate intervention (8.7) and then a swift positive impact from accessing Music Therapy (8.7.3; Table 7.4).

Being able to access a therapeutic relationship through music offers a child with SM a way of expressing difficult feelings and then transforming them through harnessing their inner strength and resources (Table 7.9). Children with SM are frequently anxious but through a light-touch approach can start to feel comfortable and relate to the therapist (Figure 7.9). This relationship can help support the myriad of issues that accompany SM such as the feeling of isolation, the loss of confidence and the desperate need for self-expression and communication (Appendix 7.3 MM8). In

some cases the therapeutic relationship may also uncover other issues such as abuse as a cause of SM[9] or bullying due to SM (Table 7.8).

The therapeutic relationship can also develop the emotional building blocks of increased confidence and happiness, extending this impact further through peer group work (Table 7.6; Table 7.7). There is often the opportunity for humour and laughter (cross-cutting theme) which can transform anxiety into a positive interaction (Table 7.7)

Implications for practice

The emotional element of SM should be carefully attended to as, whilst moving a child into speech will alleviate much of the anxiety, we also need address the potential emotional impact of having SM and any other issues pertinent to the child which may not have been expressed due to having SM. This has implications for the Music Therapy profession both in raising awareness of the particular emotional components of SM and also of our potentially invaluable role as Music Therapists to support these issues.

Element F. Context

This study demonstrates the significance of an informed 'approach'; the important role of generalisation of speech; and highlights the fundamental role of team work and context in a successful therapy intervention for a child with SM. The relevance of context was a constant factor in the study that ultimately became absorbed into the final iteration of the theoretical framework.

The Music Therapy case study literature focuses primarily on the content of therapy sessions and only briefly mentions context when describing the home environment of clients; for example, Mahns (2003). Context and teamwork are not specifically emphasised in the survey which is perhaps partly due to this not being highlighted by me as the researcher in the design of the survey. However, teamwork emerges as an important theme in thematic areas 1 and 2 of the interviews (Figure 5.2; Figure 5.3). Team awareness of SM (5.4.1.7); the impact of a positive or negative environment

[9] NB Children with SM are no more likely than any other children to have experienced abuse however, as with all children under our care we should be mindful of the possibility of abuse.

around the child; parental involvement and positive or negative team work are all described (5.4.4.5).

During the multiple case studies, the context around the Music Therapy sessions took on much greater prominence. This was perhaps because the cases were located within contrasting school environments which emphasised the differences between them. Over the course of this study the theme of teamwork and context shifted from being something that was passively noticed, observed and gently worked with to something that became an active, essential component in the therapy. This is noticeable in the description of 'generalisation' above (Stage 5) which includes detailed implications for practice. This is because however good our therapy practice is within the sessions we need to be able to work very actively with any school team environment for the benefits of the therapy to have real value.

This new component was added and labelled 'teamwork' after the interview data were analysed, then labelled 'Context' after analysis of the multiple case studies. Although all therapy work has a 'context' it is particularly crucial in work with children with SM and in some cases improving the 'context' or environment around a child is all that is needed to support a child into speech (Johnson and Wintgens 2001). The impact of challenging and chaotic school or home environments on children's therapy progress is described in chapter 8 (8.9.1; 8.9.2; 8.9.3).

Implications for practice

Music Therapists should arrive in each school environment equipped with information and resources about SM and be ready to spend some time preparing the ground for the therapy sessions themselves. This may include giving presentations to staff teams and arranging meetings with the team around the child, including the parents or carers. It may also be prudent to consider who may be useful partners in the generalisation process and to gain a level of commitment to this from the school. In some schools it may be possible to plan and share ideas for transdisciplinary working.

9.3 Selective Mutism, Music Therapy and Power

> "People become ill not only because of physical processes, but also because they become disempowered by ignorance and lack of social understanding" Ruud (2010 p11)

9.3.1 Building energy and inner power

Reflecting on the analysis of the study as a whole, power emerged as an overarching theme linking the data on a macro (societal), meso (school) and micro (sessional) level (8.10). SM is a disempowering condition (8.10.1) that greatly impacts children's engagement in school life and their ability to share important information. Alongside this, the lack of understanding and resources for SM is further disempowering. However, the shift when children are supported and able to speak in school is powerful to witness (8.10.2).

Within the case studies, one theme focussed on how some of the children built up the energy and intensity in the sessions just before speaking (8.10.2). This seemed true of Tasha, Pilar, Maria and Mark. For most children there was a strong physical component to this but it was often combined with an additional emotional or playful intensity. With Mark, it was literally 'the force'. This seems to connect directly with Stern's theory of dynamic form (2010) with movement and vitality also seeming helpful in energising the voice. There was a tangible sense that the Music Therapy space enabled and activated children's innate drive towards repair and recovery and provided a "power boost" towards speech. Initial anxiety or nervous energy was converted into physical action then transformed into voice (8.10.3).

The transformative and empowering elements of Music Therapy for children with SM are numerous. They offer a much-needed opportunity for self-expression and a vital link to the voice through oral instruments such as the recorder and the kazoo. Musical instruments such as cymbals and microphones are empowering resources that amplify and exaggerate any attempts at self-expression. Listening and responding to this in a musical therapeutic relationship can help a child feel more powerful and confident providing some emotional 'building blocks'.

In addition, children with SM are often drawn towards instruments that are 'powerful', such as the cymbals or larger percussion, and frequently play these extremely loudly (2.5.5.1; 8.3.3.1). This bold playing firmly dispels the often quoted myth that children with SM are choosing not to speak or 'withholding' their voice. This has made me consider whether initial loud playing might be a specific phenomenon for children with SM. It could be an expression and transformation of anxious energy that is perhaps due to the build- up of frustration caused by a lack of communicative output at school (Bunt 1994).

However, the empowering nature of the intervention needs to be further utilised and we must empower our Music Therapy community to be able to do this. This should in part involve an exponential increase in resource sharing as 'knowledge is power' (5.4.1.3). The empowering experience of Music Therapy was also noticed through some children's strong reactions when sessions were coming to an end. Many children found this quite challenging and as a therapist I felt aware of my power to offer something and then take it away (8.7.6.3).

9.4 Implications for theory

The methodological approach to this study was most closely aligned to 'pragmatism' (Badley 2003). The revised theoretical framework does not present a fixed theory of how to use Music Therapy with children with SM, rather it is a collection of potential resources, a 'toolkit' built from practice, that will hopefully be of some use to other Music Therapy practitioners and most importantly, children with SM, in the future. Despite employing a 'theoretical framework' I have deliberately resisted over-theorising as this study was inspired by the experience and practice of a phenomenon that appears to 'work'. The original theoretical framework was in itself a 'tool' or vehicle for capturing and viewing ideas from practice. The revised theoretical framework perhaps provides another tool for further development. These ideas link most directly to Stige's concept of the 'practice turn' in Music Therapy whereby theory evolves from practice rather than the reverse (Stige 2015). However, some theories are particularly relevant in relation to this study of children with SM.

9.4.1 Theoretical aspects of Music Therapy in relation to SM

9.4.1.1 Communication theory

The musical/social interaction aspect of the original theoretical framework acknowledged the contribution of communication theorists Stern (1985) and Trevarthen (1974). The revised framework remains heavily indebted to these foundational theories regarding the musical nature of human communication and its central role for Music Therapy (1.4.3; Pavlicevic and Trevarthen 1989, Trevarthen and Malloch 2000). These are particularly important for this study which relies upon Music Therapy's ability to offer a form of communication which is accessible to children with SM (8.4.3). In addition, this form of therapeutic communication appears to provide real assistance with speech anxiety or SM.

9.4.1.2 Behavioural therapy

The influence of other recommended interventions in the field of SM has meant that aspects of good practice can be incorporated into Music Therapy practice. Again, there is a strong argument for interdisciplinary or transdisciplinary practice. One important element described above is attending to the classroom environment (see Stage 5 of the revised framework above).

The revised theoretical framework (Figure 9.1) could be described as multimodal therapy (1.3.8) as it borrows many components from the Selective Mutism Resource Manual (Johnson and Wintgens 2001, 2016). However, some aspects that could be interpreted as 'behavioural' are an intrinsic part of Music therapy. 'Contingency management' or 'shaping' (1.3.2) is when speech is elicited in school with a key worker using positive reinforcement. Music Therapy has powerful resources to fulfil this role by positively reinforcing musical communication and then 'sliding' in to speech (Element B from the framework). Using 'generalisation' (Stage 5 of the framework) to shift speech back into the classroom is another important concept borrowed from behavioural theory (1.3.3) that is absorbed into the theoretical framework (Figure 9.1).

9.5 Policy implications

9.5.1 Music Therapy in SM Care Pathways

The potential position for Music Therapy on local or national care pathways for SM depends on a number of broad philosophical issues alongside more pragmatic factors. One initial motivation for the study was a concern that children in the US were being offered pharmacological treatment for SM (Keen, Fonseca and Wintgens 2008) and that Music Therapy could perhaps provide a viable alternative treatment. Behavioural treatments rather than pharmacology are generally recommended as the first course of treatment in the US (Manassis et al. 2009) with pharmacology sometimes offered for treatment resistant cases, often in combination with ongoing behavioural therapy, to reduce anxiety and increase the likelihood of success. In the UK the protocol is similar with SMIRA advising that pharmacological treatments should never be used in isolation (SMIRA 2013).

The main intervention currently recommended for SM in the UK is Speech and Language Therapy following the Selective Mutism Resource Manual (Johnson &

Wintgens 2001, 2016) which sets out a comprehensive behavioural approach to 'sliding in' speech or eliciting speech through a graded 'shaping' programme (1.3.3). Music Therapy offers a powerful alternative approach using child-led, playful, musical and vocal improvisation techniques to encourage self-expression. We are experts at working with the musical building blocks of communication -timing, turn-taking, phrasing, self-expression, vocalisation, nudging from laughter into speech- rather than needing to immediately focus on words. We are able to follow a child's lead and see the expressive, communicative value of working in a soft play room and jumping in a ball pool (Table 7.4) or having a 'mole hole' (2.5.5.3). However, within the UK there are only around 900 Music Therapists compared with 11,500 speech and language therapists and so access to Music Therapy services would be an issue on care pathways. Collaborative transdisciplinary work (8.8.3) might be a prudent and productive way to pool resources and evolve new ideas. Twyford and Watson (2008) emphasise the well-documented value of SLT and Music Therapy collaboration that is due to the close relationship between musical and spoken language.

Local care pathways for Selective Mutism are emerging in boroughs and counties around the UK. Some, such as Wandsworth and Kent, are well established whilst others are yet to be developed. In consensus-based care pathway research Keen, Fonseca and Wintgens (2008) are not explicit about the type of therapy that should be provided for SM, only that thorough assessments should be made to screen for coexisting conditions and that clinical progress should be made and monitored systematically. An open invitation to other therapists to be involved in supporting children with SM through involvement in local care pathways is made by Johnson, Jemmett and Firth (2015). If Music Therapy becomes recognised as being a potentially useful intervention then it can find an appropriate position as an option on care pathways for SM. It is essential that Music Therapists familiarise themselves with current care pathways for SM in their local area as well as the body of practice-based resources such as the Selective Mutism Resource Manual (Johnson and Wintgens 2001, 2016).

Wherever possible Music Therapy provision should be part of a multi-modal team approach (Keen, Fonseca and Wintgens 2008). In addition, Music Therapists should themselves take responsibility for improving awareness of SM in their staff teams.

Detailed information on what to include in presentations to staff is carefully outlined in the Selective Mutism Resource Manual (Johnson and Wintgens 2001, 2016).

In a recent communication (SLT 'A' 2018 personal communication) a local SLT summarised their understanding of the current care pathway for early years and school aged children with SM in the borough. An assessment along with a case history should be followed by addressing environmental factors including an audit of the child's education setting and training staff. A decision is then made on the best form of intervention. Shaping and sliding-in techniques are used with staff and parents usually leading on the interventions, coached by the SLT. It was suggested that Music Therapy could be incorporated into the activities they do, as one step is often non-verbal communication through other means, for example using musical instruments.

Ideally, sensible local care pathways could be agreed and adhered to for SM. However, the reality of achieving this is in a time of economic uncertainty was underlined in the key informant interviews (Table 6.1). The importance of early intervention and the reality of long waiting lists means that a balanced, pragmatic approach to teamwork and treatment is necessary.

9.5.2 Policy outcomes

The following is a list of policy outcomes for the Music Therapy profession suggested in response to this study:

- Trainee Music Therapists in the UK should have access to training on the subject of Selective Mutism that includes basic awareness and understanding of the condition -see Johnson and Wintgens guidelines on training (2001, 2016)- and fundamental principles of treatment including: awareness raising in the school environment; awareness and confidence in our potentially invaluable role with this client group; teamwork with parents playing a central role; signposting to further resources and training.
- To work in close conjunction with the Clinical Excellence Network for SM to build awareness and ideas about the potential role of Music Therapy on SM care pathways.
- To work closely with other professionals in the field of SM to collaborate on the development of future resources.

- To develop policies on resource sharing across boroughs including access to specialist supervision (8.2.6; 1d).
- To develop a specialist Music Therapy group within the UK to share resources and develop Music Therapy provision for SM.
- To develop and share Music Therapy resources with other team members including parents and teachers
- To work with play/drama/dance other therapies and share some of the successful non-musical activities.
- Provide evidence-based knowledge sharing through publications, professional leaflets and online resources.
- Fund Music Therapists to undertake further research in this area.

9.6 Strengths and Limitations of the study

As noted in chapter 1 this project was undertaken by me as both Music Therapist and researcher (1.5.1). The impact of this has both strengths and limitations and is explored in the reflections section (9.8).

9.6.1 Strengths

The survey and interviews of UK Music Therapists were successful in eliciting data exploring Music Therapy practice in this clinical area and for validating the original theoretical framework (Figure 1.1) but with modifications suggested in regard to understanding SM, the approach to therapy and teamwork (Figure 5.4). The survey and interviews also provided a picture of the context in the UK from which to consider implications for practice and make recommendations relevant to the profession.

The Music Therapy literature on SM, whilst providing valuable insight, was largely comprised of clinical case reports. The present study provides learning and insight from a systematic multiple case study design that might usefully be applied to other Music Therapy research with a range of clinical populations where less is known about how Music Therapy works.

The multiple case studies were a strong approach through which to gain insight into the Music Therapy processes that help children with SM and to explore variations

between different cases (Figures 7.2; 7.4; 7.7; 7.9; 7.11; 7.13). A naturalistic approach (6.4.6) was also a strength in the case studies as this allowed more time for complex cases to achieve positive outcomes and to study Paths into Speech rather than other therapeutic outcomes.

The value of template analysis as an abductive methodological tool for enriching and adapting the theoretical framework was demonstrated in all empirical chapters. This method was also useful for interpreting the results of the Music Therapy literature review. A particular strength of the template analysis approach was that it provided a thorough and systematic way to synthesise analysis and learning from across the data sets to produce the final revised framework (Figure 9.1). This provided insight into areas for potential expansion or development as well as enriching and confirming aspects of the original framework.

Employing a Pragmatic 'toolkit' approach to the research was invaluable in enabling the collection of a broad range of data which explored the usefulness of the theoretical framework for children with SM.

9.6.2 Limitations

The survey attempted to capture information about a very specific clinical area - Selective Mutism- in the broadest possible way. The original theoretical framework is for early years provision, however, 43% of clients seen by survey respondents in the year prior to the survey were from older age groups (Table 4.1). As such, findings from the survey offered only qualified insight into the utility of the framework and adaptation of the framework at this point in the study was cautious as a result.

Some respondents to the survey that had indicated that they had worked with high numbers of people with SM -10 or more people- also indicated that they were unavailable for interview. Although some interviewees were very experienced overall the interviewees did not have the level of experience that I had anticipated after an initial review of the survey data. There were only six interviews with Music Therapists and more interviews would have provided a richer representation of practice in the UK. The interviews also described a wider age range of people which limited the number of modifications that could be made before the case studies.

Practical limitations of the multiple case study research set-up were noted once the study was underway and were an integral part of the clinical learning process. I had an initial assumption that the study would be comparing a structurally similar Music Therapy process in each case. However, I learnt that I would need to allow variation in aspects of the intervention (For example, introducing pair and group work) in order to understand how Music Therapy worked differently under different conditions and how a flexible approach is an invaluable component in the intervention.

Setting up multiple case studies in varied, largely unfamiliar school settings underestimated the impact of context on both the therapy and the research. This impacted team working which was sometimes challenging and not as embedded as it might have been in this study. However, this highlighted the environment around the child as a focus in the analysis which became an important theme.

In the coding method, greater detail about the precise origins of codes (For example, date and time of occurrence in session) should have been retained for ease of analysis when codes were gathered into categories on the mind maps. This is mainly because the multiple case studies were investigating a phenomenon -Music Therapy processes- that occurred over a period of time and this dimension needs to be carefully accounted for in the analysis. Time codes on events in the 'paths into speech' would have helped to analyse the speed taken to 'warm-up' or not into speech over the weeks. Microanalysis of vocalisations and verbal utterances in the sessions would have added statistical detail about the development of communication. New wearable technology described only recently in the field of SM could have helped track the quantity these vocalisations (Xu et al. 2018).

9.7 Implications for research

In the recommendations chapter of 'Tackling Selective Mutism' (2015), Sluckin and Rae Smith suggest establishing the efficacy and cost-effectiveness of Music Therapy for SM as a future project for researchers to consider. One possible direction for further research would to develop a handbook and training for Music Therapists working with SM based on the theoretical framework. After appropriate piloting, the handbook could be formally evaluated in a randomised controlled trial. However, the final theoretical framework is just a 'possible line of action' (Badley 2003) or a

partial knowledge (Bhaskar 1975) that requires constant revision and updating. It would be valuable to explore how different Music Therapists understood and employed the theoretical framework.

On-going work to discover how Music Therapy might be further developed and improved for children with SM could take a Programme Evaluation approach. This form of realist evaluation investigates subjects within their real-life situations and attending to the context is part of the evaluation (Pawson and Tilley 2004). Context has a key influence on a child with SM and therapists should consider their capacity to understand and improve this as part of their therapeutic role. A programme evaluation of Music Therapy for children with SM would not only seek to measure the effectiveness of Music Therapy delivered using the handbook, but would also aim to systematically identify if and how contextual variables in the school setting impacted on outcomes.

The survey showed that Music Therapists work with a wide and diverse population including different ages and presentations of SM. Due to the lack of support or appropriate interventions for people with SM further qualitative case studies could explore the adaptation of the framework for older children and adults, particularly as Music Therapy can help address emotional issues that may ensue if SM has become more entrenched. Music Therapists are also aware of more complex presentations of SM, such as those with SM and Autism Spectrum Disorder, who may also greatly benefit from Music Therapy. Evaluation of the potential of group work may also be an appropriate research question. Access and availability is also an issue that should be built into Music Therapy research.

More generally, there is also a need for comprehensive local and national prevalence studies of SM, including SM and EAL, SM and ASD and other more complex presentations. These should also include the persistence levels of SM as this would help inform future research to test the theoretical framework across different populations.

9.8 Reflections

One underlying assumption of the rationale for the research was that Music Therapy would help each child referred to the project, therefore the multiple case studies would be investigating their process into speech rather than addressing other outcomes. This assumption arose from my prior experience of the powerful impact of music therapy for children with SM. The impact of this was to put considerable pressure on me as the therapist/researcher as I was so keen that the therapy should be successful. As highlighted by Yin, undertaking multiple case work requires enormous resources and since the studies were also naturalistic as a consequence some were long and exhausting. During one case, the physiological and emotional outcome of this pressure was for me to develop a lump in my throat or 'globus sensation' (8.5.1). This did not directly affect the therapy however this probable countertransference response or somatisation highlighted the powerful impact of SM for children with SM.

When I originally began this investigation, I did so to discover more about this topic as a practising Music Therapist rather than to make any claims to expertise in this field. I was acutely aware that other professions such as Speech and Language therapists and educational Psychologists had made considerable progress in establishing distinctive treatment models for children with SM. Music Therapy, although appearing to have so much potential for SM, remained far less developed and in need of clarifying the approach, procedures and resources that may help.

Over the course of the three years the accumulating knowledge and skills of the case studies improved the provision slightly for each subsequent child and meant that the Music Therapy offered did not remain fixed or static across the study. However, as these were naturalistic case studies it wouldn't have been possible or ethical not to change my practice as I became aware of techniques that worked better. This also provided the opportunity to explore the advantages and disadvantages of various applications of Music Therapy which ultimately was an asset for the research.

Arguably, being both therapist and researcher would introduce bias into the project as you might expect, as researcher, to prioritise data or interpretations of themes that you experience as beneficial as the therapist. Conversely, you might miss data that didn't fit the preconceptions that come with knowledge acquired through clinical training. For example, you might attribute improvements in the child to the Music

Therapy when in fact these events may have happened anyway as a result of natural processes. It is possible that another researcher e.g a non-therapist or social scientist analysing the same therapy data might draw different conclusions about how Music Therapy works and the usefulness of the theoretical framework.

However, being the therapist and the researcher provides a way of empowering the research process as the therapist's understandings and awareness of how Music Therapy might work directs insight and sensitivity towards areas of relevance and interest. As the focus of the study is on informing Music Therapy practice there is a methodological validity to undertaking the research as a therapist which resonates with the pragmatist approach to generating knowledge which has utility.

> "The vision here is of a knowledge base that specifies how to get things done, in relation to dealing with social problems and human suffering." (McLeod 2010 p.94)

9.8.1 Selective Mutism and English as an Additional Language

When setting up the case studies I was referred five children with SM and EAL and finally a child with SM and English as their first language. I did not attempt to try to achieve greater balance in the referrals as I believed that whatever the antecedent or causal factors SM remains the same and is essentially speech anxiety.

The outcome of a more recent study was that bilingualism in itself does not explain higher rates of SM but reiterates the role of anxiety in the development of SM (Starke 2018). Anxiety may be the one important factor in the differentiation of bilingual children with a risk of SM and children with a 'typical' silent period in second-language acquisition. This knowledge may assist in assessment of children with SM and potentially speed up the process and success rates of intervention. However, as described in chapter one, (1.2.5) evidence for the existence of a silent period is also disputed (Roberts 2014).

Early Years support for EAL children in the borough in which the case studies took place is based on a 5 stage model of proficiency in English, the first stage of which refers to a possible 'silent period' as part of initial language learning.

The acceptance of a non-verbal or 'silent' period of up to 6 months duration, the potential for overlap with SM and the general EAL policy within the borough was a topic of interest for me throughout the study. One concern of accepting a non-verbal

period is that it seems quite unnatural for young children. In any case, positive measures for children with EAL (1.7.5) should create opportunities to embrace the home language throughout this time of learning and ameliorate feelings of anxiety that may be partly exacerbated by the experience of not being able to communicate. What is clear is that children learning an additional language need to be carefully supported and should show signs of progression towards speech within an appropriate timeframe as these children are at increased risk of developing Selective Mutism.

9.3.2 Raising awareness of SM

One stated aim of the study was to help raise awareness of SM and the potential role of Music Therapy for this population. Across the UK knowledge and awareness of SM is growing but inconsistent. On 6th July 2016, a SMIRA-led Parliamentary reception for Selective Mutism awareness was sponsored by the Member of Parliament, Lucy Powell (Appendix 9.1). Young people with SM provided 'sound bites' of their concerns about access to treatment:

> "Too many professionals say 'If you're not willing to speak then we can't help you.'"
>
> From Adult Mental Health Services - "Sorry, we can't treat you because all our treatments involve talking therapy, and you can't talk."

Parents said:

> "Treatment is a Post Code lottery – there's no help at all where we live."
>
> "I want my daughter to get the best from her education, to be able to raise her hand and ask a question or say she needs help. I want my daughter to be free to ask for help when injured. I need more education for the professionals who misdiagnose and are misinformed on SM."

As well as advocating improved understanding and training for Music Therapists in this clinical area we should actively support any awareness-raising campaigns.

As part of raising awareness of this research topic I presented my study in a range of forums including student research conferences; a SMIRA conference (2013); two BAMT conferences (2016, 2018); a European Music Therapy conference (2016); a BBC News Video (BBC 2017a); a Radio 3 programme - Music Matters (BBC

2017b); and as part of an awareness raising workshop for staff in a local nursery. After submission of the thesis I aim to disseminate finding through further presentations at Music Therapy conferences and SLT conferences and as part of the SM Clinical Excellence Network. I also aim to publish articles using the different data sets including further detail on the multiple case studies that I was unable to share due to restrictions on the word length of this thesis. The findings will also be presented to Course Directors for Music Therapy trainings across the UK with the aim of providing lectures and workshops on this topic and to encourage further research in the field. Funding will be actively sought to develop the research and knowledge-based further.

9.9 Conclusion

This study explored the use of Music Therapy for children with Selective Mutism and asked the main question: Does a theoretical framework, developed in single-case study research, explain the process of Music Therapy across a number of cases of children with SM? Through multiple methods this study demonstrated that Music Therapy is a powerful treatment for young children with Selective Mutism. By employing systematic template analysis across the data sets the original theoretical framework was enriched and developed to create a revised theoretical framework which sets out the essential elements and stages of the therapeutic relationship. The study highlighted the importance of improved knowledge and understanding of Selective Mutism including commonly used behavioural approaches and how this greatly increases the impact of Music Therapy provision. An open, playful approach to treatment is essential. The influence of the environment and team around a child was emphasised. Generalisation of speech into the classroom is a fundamental part of treatment to be undertaken by therapists. Transdisciplinary work should be considered as a way of providing additional support for the generalisation process and for sharing Music Therapy ideas and resources with parents and professionals.

Music Therapy is successful because it offers a flexible, open approach to therapy with the opportunity to communicate in child-led ways through a variety of media. Music Therapists consider ‘music’ from the broadest perspective including all sounds, or the timing of a movement, a breath or silence. Children can engage with a variety of overlapping elements, all with a similar purpose, self-expression and

communication. The study demonstrates the potential for Music Therapy to have an empowering impact for young children with Selective Mutism.

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Appendices

Appendix 1.1 Full explanation of original theoretical framework from MA dissertation

Parallel layers of communication

Musical conversations - parallels spoken conversations - 'sliding in'

When discussing the use of a psychodynamic approach Cline and Baldwin say that 'since the focus of the treatment is on issues other than communication, the children's habits of communication continue' (2004 p.104). He goes on to describe therapeutic interventions which have needed to invent new ways of communicating other than speech. Cline and Baldwin give the example of Yanof (1996) who describes playing using noises as a 'pivotal intervention' in analytical therapy. Music Therapy does not need to invent anything. Music therapists already play using noises.

Musical communication is the unique tool that Music Therapists are trained to utilise within a therapeutic context. Our specialist skills in this area mean that we are attuned to the sensitive and careful development of a musical relationship. We are also aware of the parallels to spoken conversations and the related theory in this field. Music Therapy is therefore able to provide another very important process that helps us to facilitate speech for children with SM and EAL. I have discussed the 'sliding in' technique (Cline and Baldwin 2004; Johnson and Wintgens 2001) and feel that Music Therapy provides an invaluable version of this technique by developing musical conversations and providing the tools to develop a clear path into speech. This path allows the child to 'slide in' to speech through oral instruments, vocalisations and singing. Each child can create their own path to speech and at a speed that respects their emotional needs, but the very fact that music offers them a space in which to make sounds and be heard is the first step down this path. The release of being heard and being 'loud' after an extended period of silence is intrinsic to the success of this process.

For Luis, this process happened quite quickly. That the children often head for the louder instruments is also reflected in the work of Roe (1993). The path for some can be quite short and they quickly move through from oral instruments to vocal sounds

or singing and then words. This process enables the child to revisit the 'babbling' stage (Sylva and Lunt 1982), if necessary, to develop confidence before trying out actual words. Another child will 'slide in' by playing very loud sounds and use the volume to cover initial trials at speaking. Other children will use different barriers such as playing under a table or using words with their back turned. Luis did both playing instruments and mouthing words whilst my back was turned. In all these situations it is possible for a child to gradually move into speech whilst the therapist is apparently focussing on the musical communication, thus taking the pressure off the efforts at speech.

Control and expression in the physical realm lead to control of the voice

This is the physical process that takes place in the room. It is quite common for a child with SM to present as 'frozen' and sometimes to have additional problems engaging with activities such as PE (Physical Education) (Cline 2004). This idea is also developed in the group work of Roe (1993) where children undertake physical activities in pairs in order to develop trust. The importance of controlling the physical therapy space and of using 'dancing' as another means of expression seem key to change in this case. Being able to control instruments in a functional way, rearranging them and switching them on and off seemed particularly important and symbolic. I wondered whether the simple switching on and off of a keyboard connected with Luis switching his voice on and off, or if he felt that he had been switched off. Selective Mutism can feel like physical problem. Children report later that they felt as if there was a physical constriction in their voice and throats. Feeling that he could own these instruments in some way was also important. By piling up the musical instruments and saying "Mine all mine" he was owning the means of communication and the therapy process.

Therapeutic relationship parallels mother/infant relationship = emotional communication

The literature on mother/infant interaction describes the function of early communication as primarily social and emotional (Schaffer 1977; Stern 1985). This literature provides a theoretical foundation for Music Therapy practise. The therapeutic relationship parallels this mother/infant relationship and can be used to revisit and rework issues that arose at key developmental stages. In this case I believe that the original mother/infant relationship was strong and healthy as, despite

his initial high anxiety, trust between Luis and myself developed quickly and the therapy moved along rapidly. This gave Luis an opportunity to reproduce a healthy mother/infant relationship but which provided the means to confidently develop another language. Initially this language was musical and then moved into speech. The focus on emotional communication is also particularly relevant for SM (which is sometimes referred to as speech anxiety) as the therapeutic relationship can 'contain' some of this anxiety.

Emotional processing

This is the whole of the emotional process as manifested by the client in any combination of the different realms of physical, musical and emotional self-expression, as described above.

Offering a potential space

This simply means being able to offer the therapy space that the child is able to access. In most cases the actual therapy room will be in the school and should be emotionally accessible to the child. Distance from the classroom is important too. If the room is too close to the nursery or school classroom then the child may still feel impeded by the pressure experienced in this environment. Too far away and the child may feel anxious due to the lack of familiarity with this setting.

Children with SM can be extremely anxious and so a great deal of sensitivity and care may be needed to enable the child to attend. The development of rapport in the transition to and from the therapy space can be crucial. This time is 'unpressured' in terms of communication and is 'contained' by the functional nature of the journey. Luis and I spent a lot of time exploring frost, snow and puddles on our journeys to and from the music room. Ultimately, the therapist's goal is to offer a potential space to play.

Manifesting anxiety - having it contained and processed

The therapy space also needs to be offered on the same day and at the same time each week. This helps to facilitate the containment necessary for emotional processing.

Once the therapy space is emotionally available the client then manifests their emotional being within this space. It is the therapist's responsibility to listen to this emotional communication and respond accordingly. Musical 'containment' offers an acknowledgement of the anxiety without the therapist being overwhelmed by it. This then allows the child to move on in the therapeutic relationship.

In considering the data from the case study it felt important to explore the nature of this anxiety and think about where it had originated from. The process of separating from the primary social relationship with a parent into the social world of nursery school can be intense without the additional need of learning another language. There is a sense of a double loss here that of the mother and the mother tongue and perhaps also the loss of a sense of self. Is the anxiety of SM an extension of this separation anxiety that has not been processed in the usual way by verbal self-expression and socialization in the nursery setting?

Does the pressure of meeting educational targets create additional anxiety for the teachers of a child with SM? This anxiety would then easily be transferred to the child within the nursery. Luis's nursery teacher certainly wanted him to speak before he went up to his reception class. This has also been my experience in other schools where I have heard Head Teachers saying to children "you have to speak before you go into reception."

Is the anxiety purely connected to the function of communication so that when communication is expected this creates an anxious response? This view is more widely suggested in the SM literature (Cline 2004; Johnson and Wintgens 2001). Toppelberg says that "shy, anxious, and/or inhibited children expected to function in a second, unfamiliar language may be more prone to reacting with mutism". This suggests that the anxious personality is a potential factor in creating SM rather than just integral to the mutism. However, she also suggests that not treating SM can result in 'emergent anxiety disorders' (Toppelberg 2005 p.593). So, having SM can

create future anxiety if it goes untreated. All of these descriptions of anxiety resonate with the presentation of a child with SM.

Cline explores the relationship between SM and anxiety in depth and cites research that argues that anxiety plays a key role in creating SM. He then states 'it is no longer possible to ignore the central role of anxiety in SM' (Cline 2004 p.33). I feel that it is important to acknowledge the role of anxiety both theoretically and therapeutically. But whatever its origins, once it is expressed, contained and understood within the therapeutic relationship it may be possible to move on. This connects directly to my next point.

Gradual build-up of trust and contact through listening and accepting - 'no pressure' approach

'To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being part of that client, he is experiencing unconditional positive regard.' (Rogers cited in Kirschenbaum and Henderson 1990 p.225)

Rogers goes on to describe the importance of accepting the negative, defensive and abnormal feelings as well as the good. He also describes caring for the client as a 'separate' person with *permission* to have his own feelings and experiences. This approach is completely congruent with the 'no pressure' approach as described by Johnson and Wintgens but allows it to be effective at a deeper, emotional level. Rogers goes on to say "This is the type of acceptance which is hypothesized as being necessary if personality change is to occur" (*Kirschenbaum and Henderson 1990* p.225).

Mahns (1999) also embraces the idea that children should have a therapeutic space in which to make progress 'while still not reconciling with the public'. In behavioural approaches to SM much emphasis is given to the progression into normal confident speech, whereas Mahns protects the individual's need for emotional growth first.

With regard to this case study, this acceptance was important for Luis not only to process the anxiety but in order to develop a therapeutic relationship which facilitated further meaningful communication and change.

Gradual development of shared meaningful communication and 'playing'

Once the child has experienced this ‘acceptance’ they can move on to own and increase their participation in the therapeutic relationship. The therapy setting should enable them to express themselves in a variety of different ways. These can be musical, physical, symbolic and verbal.

The shared experience of ‘humour’ always seems to have significance in the therapy and this occurred at a time of intense ‘playing’ and before the separation phase.

Need to end therapy - healthy, confident separation

This process of separation and ending was perhaps important in that it reworked some of the difficult separation as experienced when first attending the nursery. In this separation there is a clear sense of a healthy child who is confidently wanting to go back to class to generalize the verbal communication skills developed within Music Therapy.

If a therapist is working within a school setting generalisation can be supported by the transition from the therapy room back into the classroom. However, if a child finds it difficult to ‘slide’ the speech back into the classroom then choosing a friend to attend a few therapy sessions can help facilitate this process.

Appendix 2.1 Summary of included studies

Reference	**Client characteristics** Gender (M/F): Age (years): Presentation: Selective Mutism (SM); SM & Mental Health (SMMH); SM & Learning Difficulties (SMLD); SM & English as an Additional Language (SMEAL); SM & Physical Disability (SMPD)	**Structure of therapy** Frequency/ length/ duration/ number of sessions: Location; School (SCH); Clinic (CL); Client's Home (CH); Private Practice (PP)	**Therapeutic effect/ change** Generalised speech (GS); Speech in therapy (ST); Emotional improvement (EI)	**Understanding of SM/ historical relevance**	**Main features and approach of the therapy/ What was interesting or good about the therapy?**	**Face validity: Does the paper broadly concur with the Theoretical Framework being examined in this study? If not, why not?**
1. Castellano, J. A., & Wilson, B. L. (1970) The generalization of institute therapy to classroom behavior of an electively mute adolescent. *Journal of Music Therapy, 7(4),* 139-147	M 14 SM 'Overprotective parents' Spoke only to immediate family	2 per week 9 sessions CL	GS Limited speech in sessions generalised to classroom and increased numbers of children	'Elective Mutism' Describes 'rigid' robot-like, perspiring presentation Previous behavioural therapy Lots of pressure to speak The session wouldn't begin until he had spoken	Behavioural approach Physical prodding and demanding a response Physical freeing up Borrowing the behavioural approach of the time	The attempt to work on physical aspects first and then verbal behaviour, although the approach is totally different due to being outmoded and behavioural. However, it did have a positive impact. Not much focus on music.

2. Monti, R. (1985) Music Therapy in a Therapeutic Nursery. *Music Therapy 5(1),* 22-27 (part of article)	M 4 SMBL Had to play quietly at home	15-20 mins or as long as the child needs, could be shorter or longer SCH	GS Smile, interaction and speech in nursery	'Elective Mutism' Describes frozen presentation	'To provide an environment in which D could make noise without fear of retaliation, to provide a medium for the expression of suppressed feelings and curiosity'	Yes. Moves quickly to the louder instruments. Expressing frustration.
3. Johns, U. (1986) From Silence to Speech - A case study of a girl with Selective Mutism. In E. Ruud (ed.) *Music and Health.* Oslo, Norway: Norsk Musikkforlag A/S	F 8 SM	Weekly then after 3 months every morning for 1 month 1 year of intensive work SCH	GS Session 10 giggles 1 month later - laughter Speech after 5 months Generalised into classroom	'Selective Mutist' 'Stiff' anxious presentation Hadn't spoken for 4 years except to mum Insightful understanding Does a generalisation process with the client and other class members	To work on acceptance and awareness Real focus on the physical aspect Then oral instruments and then kazoo Singing in a mic, then opening the window and shouting to her friends 'listen to me'	This is quite uncanny in its similarity. Drumming, dancing with maracas, freeing up the body and then oral instruments, singing through the kazoo and then the microphone.
4. Aigen, K. (1990) Echoes of Silence. *Music Therapy 9(1),* 44-61	F 37 SMMH Catatonic Schizophrenia	Weekly sessions for 2 years CL	EI Some speech on the telephone and improved emotional well being Became more related and less anxious Close therapeutic relationship Positive	'Elective Mutism' Deliberately un-psychoanalytical Describes her presentation - 'Is she really choosing -as the word elective implies- not to talk to me in person, or is this something beyond her conscious control?'	Wanted to 'be with' 'Ariane' Focus on describing the events and feelings of the therapy process rather than interpretation Used writing to express herself Gradually more confident and then loud Client describes abuse - being hit and told to shut her mouth	The patient seems very unwell emotionally and presents very differently to younger children with SM. Some similar features; sunglasses to prevent eye contact. Importance of human relationship/ contact. Music as a bridge - point of contact. Physical aspects.

			transition to the new therapist		Hears the sounds of her laughter and her crying in the session	
5. Davies, A & Mitchell A.R.K. (1990) Music Therapy and Elective Mutism: A case discussion. *Journal of British Music Therapy 4(2),* 10-14	M18 SMLD Pervasive developmental delay and Autistic components	Weekly 35 minute sessions over 9 months CL	EI Describes that 'basic trust' was established and the client was able to take risks in expressing difficult feelings	'Elective Mutism' Outmoded but typical for the time Anxiety misinterpreted as control: 'refusal to speak'; 'determined silence'; 'need to control' SM blamed on deep rift in relationship with parents	Creating a 'barricade of instruments', Playing back to back Constantly rearranging instruments Wanting to play behind a barrier Finding direct musical connections challenging Very energetic or forceful playing	Features are really familiar. But the approach feels outmoded and inappropriate.
6. Seidl, S.A. (1995) Therapeutic aspects of music and its effect upon a child with selective mutism. PhD thesis - University of North Dakota	F 8 SM Complex emotional issues	3 sessions per week then 2 sessions per week 60 minute sessions Total of 33 sessions over 5 months SCH	EI Partial ST Partially successful Positive relationship Laughter, singing and some verbalizations in sessions - 'boom' 'click' Speech in one session then regression	Outdated approach: 'refusal to talk'; 'stubbornness' References historical misconceptions around abuse, trauma, need for control etc.	Taped music Relaxation techniques Quite complex Aims to stimulate verbalization Very directive (Interesting case study method: 'constant comparative method'; 'code clumps')	Physical energy - cartwheels and dancing. Loud drumming. Accidental speech when stuck in coat. Slightly risky behaviour.
7. Sekeles, C. (1996) Alon-from the Jungle to the Kings Palace. D.I.M.T (Developmental integrative Music Therapy) with a child	M 6-8.5 SMPD Complex presentation with physical issues	2 ½ years CL	ST Speaks straight away in therapy First 14 months establishing	DSM 3 definition of 'Elective Mutism'	Good to have the assessment in own home Develops a drama therapy approach	Yes, some of it certainly. The playfulness. The strong drumming, the need for movement. The tent.

suffering from MBD and elective mutism In C. Sekeles (Ed.) *Music: Motion and emotion. The developmental-integrative model in music therapy.* Saint Louis, MO: MMB Music			trust - then regresses due to father leaving	Talks about 'persistent refusal to talk' Suggests causes such as 'oral trauma, early hospitalisation and bilingual conflicts'; 'negative trends and the mutism are generally directed at the parents even though the silence is expressed away from home'	Says 'in the Music Therapy room it's forbidden to speak' Building on physical strength and confidence Creates a 'jungle' then a 'recording studio' then a 'royal palace' Working through anxieties and family issues - more balanced Very psychoanalytical 'Jungle' phase talks about strong aggressive drumming and dancing to 'stimulate spontaneous movement' 'Tent' to hide in	
8. Lutz-Hochreutener, C. (1998) Fragments of a relationship: Music therapy with an electively mutistic girl. *Musiktherapeutische Umschau: Forschung und Praxis der Musiktherapie,19(3),* 185 .	F 6 SM	Not stated	GS Speech in sessions, generalised out into classroom.	'Elective mutism' Thoughtful, open, sensitive approach	Flexible and thoughtful Playing the clown Laughter Therapist modelling 'letting off steam' and playing loudly Physical movement 'silent scream' Game where she tells the client to be quiet who then shouts 'no'	Yes. Animal noises, vocal conversation. Need for a layer of protection with a mic or a tent. Permission to play. Being a clown.
9. Trondalen, G. (2001) Visible through an audible voice. *British Journal of Music Therapy, 15(2)* 61-68	F 14 SMMH Paediatric Psychiatric unit	9 months Weekly? 32 sessions of 1 hour duration CL	GS Whispers and then speaks in final session inside and	'Selective Mutism' Offering an opportunity to relate	'Relating experiences through music' Developmental psychology Laughter	Yes. The process of relating and then moving through oral instruments into speech. References Stern and Trevarthen etc.

			outside on the ward		Body activities for relaxation - rocking/rolling Bird calls Kazoo (coughing) Then whispers G prompts her to sing - "Now you can sing" - towards the end of therapy And also to speak, which she does.	Humour and playfulness seem important.
10. Katz, S. (2002) *Music and football: Music Therapy and Play Therapy in a case of Selective Mutism.* Published in conference proceedings of 10th World Congress of Music Therapy in Oxford 23-28th July 2002. Dialogue and Debate, Music Therapy in the 21st Century: A contemporary force for change	M 8 SMEAL Mother Phillipino Dad USA Living in Jerusalem - Hebrew spoken around him	Weekly 50 minute sessions 1 year 8 months CL	GS Vocalises after 3 months Generalisation after 2 years	Outmoded understanding of SM referenced Describes 'a relaxed approach'	Very difficult home life Frozen presentation Inside of the piano, "pressure off" approach Vocal sounds Scary noises Laughter 'Boo' Whispering Lots of Football - Katz feels a loss of confidence and self-worth (as a client with SM might feel)	Yes. Quick, clear path into speech Slow generalisation. Physical components really important. Playfulness and laughter. Pressure off approach.
11. Mahns, W. (2003) Speaking without talking: Fifty Analytical Music Therapy sessions with a boy with Selective Mutism. In Sarah Hadley (Ed) *Psychodynamic Music Therapy: Case Studies.* Gilsum, NH: Barcelona.	M 8 SMEAL Trauma, abuse, social isolation & poverty	50 sessions over 2 years (weekly?) 40mins each SCH	ST Whispers outside of the session (session 21) and then 'slid' in to the session Talks on telephones	Slightly outmoded conceptualisation of causation However, good general approach: 'infavourable factors…preventing communication'	Describes it as Analytical Music Therapy but uses some behavioural techniques as well also drawing, a microphone and a cave Stresses the importance of working in the school Use of telephones.	Yes. Music as a 'bridge between inner and outer worlds'. Talks about music being a 'transitional object' through which to slide in to speech. Trusting therapeutic relationship.

			(session 24) and then in session with a friend	Understands the impact of mum trying to force him to speak: (threatened beatings) Awful school environment	responding to the 'spontaneous, unplanned and the unforeseen' Really daring and free sometimes Matches and a bonfire Being unafraid of using other media	No pressure to speak. Expressing difficult feelings (cymbal thrown on floor and kicked).
12. Amir, D. (2005) Re–finding the Voice – Music Therapy with a Girl who has Selective Mutism. *Nordic Journal of Music Therapy, 14(1),* 67-78	F 6 SM Stops speaking after her brother is born. Possibly tired due to baby being put in her room.	2 years (weekly) 120 sessions Location unclear	GS Session 40 screams when drumming Humming whilst playing louder instruments Sessions 70-95 singing first then talking later, gradually more free and outside of the home	Good conceptualisation of SM, acknowledging that it's not a choice and the role of anxiety. References recent change from Elective Mutism to SM Music as a bridge between inner and outer worlds	Music Psychotherapy Gentle 'no pressure approach' Reduction of anxiety	Yes, No pressure. Containment of anxiety. Potential play space. Trusting therapeutic relationship. Very clear path into speech. Smaller then louder instruments, oral instruments -kazoo and slide whistle.
13. Whelan, D. (2007) *Holding and Withholding: How can Music Therapy 'give voice' to the silence of trauma?* MA Dissertation - Anglia Ruskin University	F 30s SMLD	First 2 years of ongoing therapy CH	GS Starts laughing and speaking in session 22 after 8 minutes More speech and communication in her residential home.	Unclear if this traumatic mutism or SM Described as SM because only in specific situations Big focus on writing about trauma and links to silence	Psychodynamic approach Importance of containment and the trusting relationship Anxious, stiff presentation Lots of silence Need for physical boundaries	Very much about the abuse. Establishing trust. Creating a potential space.

				Emphasis on psychoanalytic approach		
14. Von Moreau, D. (2008) Nur keine Sorge – es geht auch ohne Worte. Musiktherapie mit mutistichen Kindern In C. Plahl & H. Koch-Temming (Ed.s) Musiktherapie mit Kindern. Bern: Huber.	M 5 SMLD & MH Slight lisp. Issues with gait. Abusive father	Inpatient psychiatric setting 8 weeks 13 hours of individual then 7 hours of group outpatient support	GS	Calls it Elective Mutism or Mutism. ICD-10 clearly defined and well understood Describes misunderstandings as well: antecedent trauma; developmental delay; personality issues; familial factors Describes very thorough assessment	Inpatient team approach Very thorough assessment General, clear behavioural plan for SM + some pharmacology but not during Music Therapy Psychoanalytical Music Therapy with focus on emotional wellbeing, joy of self-expression and healing Very playful -'mole' therapy Self-talk and commentary Deliberate lack of eye contact Using provocation and inactivity in the silence Some directive facilitation	Yes. Self-expression. Relaxed communicative exchange. Oral instruments. 'In play the different levels merge together' to propel the game forward. Kazoos, pan pipes, jews harp. Microphones, made-up sounds, no grammar or rules.
15. Vogel, P. (2009) *The Role of the Music in 2 contrasting Clinical Situations with Children.* MA Dissertation – Anglia Ruskin University	F 7 SM Private sessions in own home	2 years CH	GS More confident Talking in playground Laughing out loud at the keyboard	'Choosing not to speak was Anne's defence'; 'refusing'	Use of humour - deliberately sang a German song incorrectly Use of a puppet -became more silly and playful	Humour. Physical movement.

16. Schulz, D. (2011) Developmentally oriented Orff music therapy with a girl with selective mutism: Analysis of videotapes of the therapeutic process. *Musiktherapeutische Umschau: Forschung und Praxis der Musiktherapie, 32(2),* 128 .	F No specific age given SM	29 sessions Weekly 45 minutes 6 months CL	ST Speech in the sessions (Suggests group MT and other interventions to generalise speech)	Excellent background literature and understanding of SM	Orff Music Therapy according to the Iso-Principle Directive, behavioural therapy approach with music used in Hello and Goodbye Incorporates lots of play therapy/ SLT techniques	Not sure that this is fully utilising the potential of Music Therapy. Almost too far into the SLT/ behavioural aspect. But we could perhaps explore incorporating some of these ideas in the sessions.
17. Ala-Ruona, E. (2014) Invitation to the world of silence, sounds and sharing- the 'hard to reach' patient. In J. De Backer & J. Sutton (Ed.s) *The Music in Music Therapy. Psychodynamic Music Therapy in Europe: Clinical, Theoretical and Research Approaches.* London: Jessica Kingsley.	17 M SMMH?	3 years 1 per week for 12 months 2 per week for 18 months 1 per week for 6 months PP	GS Nods and occasional verbal responses, then discussions about music Improved social skills, confidence, self-esteem Attended college Greater independence More relaxed	Not much discussion of SM but outmoded, poor understanding: 'Tim was not willing to have any reflective discussion' etc.	Psychodynamic and eclectic approach Self-expression Expression of emotions Use of the microphone to sing Key role of musical interest to connect with the patient Discussion of lyrics from songs Enjoyment and empowerment Recording and reflecting on the sessions	Musical interaction as a key component. Use of singing (different to talking) Physical component. Sensitive, trusting relationship.

Appendix 4.1 Music Therapy and Selective Mutism survey

Music Therapy and Selective Mutism survey

Survey information

Survey of UK based Music Therapists

Kate Jones- PhD student Anglia Ruskin University
Email:
Faculty: Arts, Law and Social Sciences
Student no:
HCPC registered Music Therapist: AS01550
1st supervisor: Professor Helen Odell-Miller
2nd supervisor: Professor Amelia Oldfield

This survey is investigating Music Therapists' work with children or adults with Selective Mutism (formerly known as Elective Mutism)

Selective Mutism (SM) is defined as the consistent failure to speak in specific social situations in which there is an expectation for speaking, (e.g., at school), despite speaking in other situations (e.g. home).

If you are a Music Therapist and have worked with any children or adults that you think fit this definition, whether or not they have been formally diagnosed, I would be very grateful if you could fill in this survey. It takes about 10 minutes to fill in depending on how much detail you provide.

All the survey data will be stored, analysed and reported anonymously.

I am also interested in any Music Therapy literature on the subject which may not be picked up through the usual online routes. If you know of anyone that has written an MA or article on the subject please email me directly at the above email address.

Music Therapy and Selective Mutism survey

Background data

1. How many years have you been working as a Music Therapist?

- ◯ Less than a year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11-15 years
- ◯ 16-20 years
- ◯ More than 20 years

2. Over your career as a Music Therapist, approximately how many children and adults with Selective Mutism have you worked with? (Select from the drop-down menu)

	Child	Adolescent	Adult
Selective Mutism (SM)			
SM & English as an additional language			
SM & Learning Disabilities			

Music Therapy and Selective Mutism survey

Numbers and presentation of SM clients

3. Over the last 12 months, how many children or adults with Selective Mutism have you worked with? Please use the drop down menus to indicate the numbers of clients of each age group and presentation. Only include each client in one category on the grid.

	Age 2-4 yrs	Age 5-7 yrs	Age 8-10 yrs	Age 11-13 yrs	Age 14-17 yrs	Age 18+ yrs
Selective Mutism (SM)						
SM & English as an additional language/Bilingual						
SM & Learning difficulties e.g language delay, dyslexia etc						
SM & Learning disabilities e.g Autism, Downs Syndrome etc						
SM & additional Emotional issues						
SM & Physical disabilities						
2 or more of the above						

4. Over the last 12 months, was this work: (Tick all that apply)

- ☐ a) individual therapy
- ☐ b) pair therapy
- ☐ c) group therapy
- ☐ d) a combination (both individual and/or pair and/or group for one person)

Other (please specify)

5. Over the last 12 months, where did the therapy take place? (Tick all that apply)

- ☐ a) school
- ☐ b) clinic
- ☐ c) private practice
- ☐ d) residential setting

Other (please specify)

Music Therapy and Selective Mutism survey

6. Over the last 12 months, how were these clients with SM referred to you? (Tick all that apply)

- [ ] Special Educational Needs Coordinator (SENCO)
- [ ] Other school staff
- [ ] Multidisciplinary team (Within school)
- [ ] Multidisciplinary team (Within NHS)
- [ ] Multidisciplinary team (Wider Children's services)
- [ ] Parent/Carer
- [ ] Other (Please specify)

Other (please specify)

Music Therapy and Selective Mutism survey

Therapeutic approaches and techniques (adapted from Odell-Miller,H. 2006)

7. Which way of working best describes your approach with all the clients with SM that you have seen? (Tick all that apply)

- ☐ Behavioural
- ☐ Developmental
- ☐ Psychoanalytically informed
- ☐ Supportive Psychotherapy
- ☐ Creative Music Therapy
- ☐ Analytical Music Therapy
- ☐ Systemic
- ☐ Interactive
- ☐ Client centred
- ☐ Activity Based
- ☐ Guided Imagery in music
- ☐ Medical
- ☐ Other (Please specify in the box below)

Please describe any other approaches that you have used

8. Which Music Therapy techniques have you used with clients with SM? (Tick all that apply)

- ☐ Singing Composed Songs
- ☐ Free improvisation with minimal talking
- ☐ Free improvisation with talking/interpretation
- ☐ Free improvisation with structures- ie.turn-taking or play
- ☐ Theme-based improvisation
- ☐ Activity based
- ☐ Song writing
- ☐ Musical role play
- ☐ Receptive music using recorded music
- ☐ Imagery in music
- ☐ Music for relaxation
- ☐ Other (please specify in the box below)

Please describe any other techniques you have used.

Music Therapy and Selective Mutism survey

Musical elements

9. Were any of the following instruments, played by clients with SM, important in your work? (Tick all that apply)

- [ ] Cymbals
- [ ] Large percussion (drums etc)
- [ ] Small percussion
- [ ] Recorders
- [ ] Kazoos
- [ ] Other oral instruments
- [ ] Piano
- [ ] Guitar
- [ ] Other (please specify)

Please comment on why they were important

10. Were any of the following features important in your work with clients with SM? (Tick all that apply)

- [ ] Increased volume of music
- [ ] Quiet then louder vocalising
- [ ] Singing
- [ ] Babbling
- [ ] Scat singing (nonsense words)
- [ ] Disguising initial attempts at vocalising (under the table, under the volume of other music, back turned etc)
- [ ] Reducing anxiety
- [ ] Dancing and physical movement
- [ ] Playfulness
- [ ] Musical conversations
- [ ] Being 'heard'
- [ ] Feeling in control/making choices
- [ ] Other

Other (please describe)

Music Therapy and Selective Mutism survey

Relevance of aspects of Music Therapy

11. Please indicate the relevance of the following aspects of Music Therapy intervention for all clients with SM that you have worked with over your career.

	Musical elements	Physical elements (e.g. physical movement, dancing, use of space)	Social interaction (e.g. turn-taking, eye contact)	The therapeutic relationship (e.g. emotional processing)
Age 2-4 yrs				
Age 5-7 yrs				
Age 8-10 yrs				
Age 11-13 yrs				
Age 14-17 yrs				
Age 18+ yrs				

Please feel free to comment on what you thought were the important elements of Music Therapy for this client group (if any)

Music Therapy and Selective Mutism survey

Effect of Music Therapy

12. Please indicate your response to the statement below relating to all those clients with SM that you have worked with. If you have worked with more than one person from each age group please indicate the most typical response for that age group.

(Please also indicate the main therapeutic effect and typical length of therapy for each age group that you have worked with using the drop down menus)

"In my experience Music Therapy has a positive effect on clients with SM"

	Agreement with statement for each age group	Therapeutic effect	Length of therapy
2-4 yrs			
5-7 yrs			
8-10 yrs			
11-13 yrs			
14-17 yrs			
18+			

Please summarise in 1 or 2 sentences the main therapeutic effect of Music Therapy for this client group.

Music Therapy and Selective Mutism survey

13. Would you be happy to be interviewed about your work with clients with SM?

- ◯ Yes
- ◯ No

If you answered Yes please leave your email address in this box (Your details will not be linked in any way to the data you provide in the survey)

Music Therapy and Selective Mutism survey

Thank you

Thank you for filling in this survey. This will provide valuable information about the current role of Music Therapy for people with Selective Mutism.

Appendix 4.2 Invitation email for Music Therapy survey

Dear BAMT member,

Re: Music Therapy and Selective Mutism Survey
Selective Mutism is also sometimes referred to as Elective Mutism and simply means a person who is capable of speech but is unable to speak in specific environments or to certain people. This is an anxiety disorder although people may not present as being obviously anxious because in not speaking they are able to avoid the anxiety associated with speaking. It usually manifests in early childhood when children first go to school and the most common presentation is for a child to speak normally at home but not at school or nursery.

If you have ever worked with a child or adult with Selective Mutism at any point in your career as a Music Therapist I would be very grateful if you could fill out my survey. It will only take about 15 minutes and the information you give me will be vital in mapping our professional experience of Selective Mutism and provide essential background data for the PhD research that I am undertaking at Anglia Ruskin University.
More details about the research will appear when you open the link to the survey:

https://www.surveymonkey.com/s/MusicTherapyandSelectiveMutism1

Many Thanks in advance for your contribution to this project which I hope will increase awareness of Selective Mutism and a potential alternative care pathway for this debilitating disorder.

Appendix 4.3 Content analysis of responses to Q12 of the survey positioned on the Theoretical Framework

Therapeutic process / **Parallel layers of communication**	Offering a potential space **Early intervention 1 (Approach)**	2. Manifesting anxiety – having it contained and processed **Emotional expression/relationship 25**	3. Gradual build-up of **trust** and contact through listening and accepting – **'no pressure approach' 11 (Approach)**	4. Gradual development of shared, meaningful communication and **'playing' 11**	5. Need to end therapy – healthy, confident separation
a) Musical	**Non-verbal/musical self- expression 32**		**Interaction 16**		
b) Physical	**Non-verbal/musical self-expression 3**				
c) Emotional/ social	**Confidence and self-esteem 23**		**Vocalisation 10**	**Verbalisation 20**	
	MDT/Staff/parent communication (Approach) 7				

Appendix 5.1 Music Therapist interview schedule

Interview questions – Music Therapists

Introduction

PhD on Music Therapy for Children with Selective Mutism.
Interested in other Music Therapists experience of working with this client group.
The interviews will be anonymised and given a unique ID number.
Digital recordings of the interviews will be destroyed once the study has been completed.

Background Questions

Please briefly describe your current professional role?

Could you give me a brief summary of your career as a Music Therapist? With particular reference to any specific interests or expertise that you might have?

How many children have you seen with SM?

Which age ranges and types of SM do you treat- just pure SM or complex SM?

Could you describe a case that you remember well?
successful? Where? Group? How long?

What is your general perception/conception of SM?

What approach have you used in treating SM?

Any others?

What were your broad aims and objectives?

What techniques/structures did you use in the sessions?

(Although you have mainly described successful cases have their ever been times when this was not successful?)

You have discussed examples of different cases. Which aspects of MT (if any) are/could be most useful to this client group?

Show the theoretical framework. Use as a prompt but minimal description.

Were there any musical features that seemed particularly significant?

Were any particular instruments important in the sessions?

Did you feel that physical elements were particularly important?

How about social interaction?

Was the emotional relationship important at all?

Was there anything else that was interesting about the sessions? Interesting behaviour?

Referral and Assessment? More practical questions as coming to the end.

How are children with SM referred to you?

How do you assess children with SM?

At what stage in their SM do children access MT? Have they had SM for a few months or a few years? Is there a long waiting list? Have they had any other interventions?

How do you monitor outcomes?

Appendix 5.2 Participant Information Sheet – Music Therapist Interviews

Anglia Ruskin University
Cambridge & Chelmsford

PARTICIPANT INFORMATION SHEET - Music Therapy interviewees

Hello,

I am writing to you as a fellow Music Therapist to ask if you would be happy to be interviewed about your experience of providing Music Therapy treatment for children with Selective Mutism. This interview will help provide essential background information for my PhD research project on Music Therapy for children with Selective Mutism.

Section A: The Research Project

Music Therapy for children with Selective Mutism

This project is researching how and why Music Therapy can help young children with Selective Mutism. The general expectation is that participation in Music Therapy can be helpful and we are enquiring how and why this is the case.
Below is a summary of the research with the area that we need your assistance with in bold.

Phase 1 Contextual investigation
A systematic review of peer reviewed literature of SM interventions using online databases.
Scoping review of all literature describing Music Therapy for children with Selective Mutism, including peer reviewed articles, book chapters, unpublished/non peer reviewed reports of new SM interventions in the UK using the Kings Fund library and online searches.
Description of Lambeth SM care pathway using key informant interviews
Survey and **interviews of UK Music Therapists to investigate their experience of Music Therapy work with children with Selective Mutism and elicit information about clinical approaches that are similar or different to the one suggested by the theoretical framework, which is under scrutiny in this study.**
Cross-sectional survey of Lambeth SENCOs to identify children attending Lambeth schools i) with a formal diagnosis of SM ii) SENCO reported SM. Child socio-demographic data, including EAL will also be collected.

Phase 2 Multiple-case study investigation

4-6 case studies will be conducted to evaluate the theoretical framework and establish the extent to which the results of a single case study (Jones 2012) are replicated in multiple cases of SM with and without EAL. The case studies will be chosen from a similar population to the single case study, including SM and SMEAL, in order to evaluate how the theoretical framework applies to both. This will inform any refinement of the framework and assist in developing guidelines for clinical practice.

The research is being undertaken as part of my PhD at Anglia Ruskin University.

What will happen to the results of the study?
The results of the study will be written up as my thesis and may also be published as a journal article. If the study has very positive results the ideas may be written up as book to give information and advice to other Music Therapists about working with children with Selective Mutism. In all of these cases any names or other identifying features regarding your input will be changed so that no one will be able to identify you.

For further information please contact the researcher Kate Jones-

Section B: Your Participation in the Research Project

Why you have been invited to take part?
You have been invited to participate in an interview as your responses in the survey are interesting and suggest that you have had some experience of working with children with Selective Mutism. We would like to ask you a bit more about this experience and why you think Music Therapy may have been successful or not.

Can I refuse to take part?
You can refuse to take part and this decision will be respected.

Can I withdraw at any time, and how?
You can withdraw at any time in the process. Please let the researcher know of your wish to withdraw.

What will happen if you agree to take part (brief description of procedures/tests)?
We will invite you to participate in a semi-structured interview, up to one hour in length at a mutually convenient and suitable location. Skype may be used if this is preferable.

Will there be any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety?
There are no anticipated risks from the interview process.

Will agreement to participate in this research compromise your legal rights should something go wrong?

There are no anticipated risks from the interview process however, if anything unforeseen should happen, your legal rights will remain the unchanged.

Are there any special precautions you must take before, during or after taking part in the study?
You will be required to sign a consent form prior to the interview.

What will happen to any information/data/samples that are collected from you?
Interviews will be recorded using digital recording equipment for the purpose of accurate information gathering but deleted once the data has been transferred to paper or computer records. Information given in these interviews will be anonymised and key informants will not be referred to by name or any other details that would make them identifiable.

Are there any benefits from taking part?
By agreeing to be interviewed you are supporting a study that aims to raise awareness of Selective Mutism and investigate the use of Music Therapy for these children. You may also find that the chance to speak about your clinical work in this area may develop or consolidate your thinking about this clinical area.

How will your participation in the project be kept confidential?
Please see question 8.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix 5.3 Participant Consent Form – Music Therapist Interviews

PARTICIPANT CONSENT FORM- interviewees

NAME OF PARTICIPANT:

Title of the project: Evaluating a theoretical framework for the use of Music Therapy in the treatment of Selective Mutism in young children: a multiple case study.

Main investigator and contact details:
Kate Jones

Members of the research team: 1st supervisor- Professor Helen Odell-Miller. 2nd supervisor- Professor Amelia Oldfield

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

6. I agree that anonymised data may be used for publications and academic presentations.

Data Protection: I agree to the University[10] processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me.

Name of participant (print)……Signed……..Date……

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

[10] "The University" includes Anglia Ruskin University and its partner colleges

---

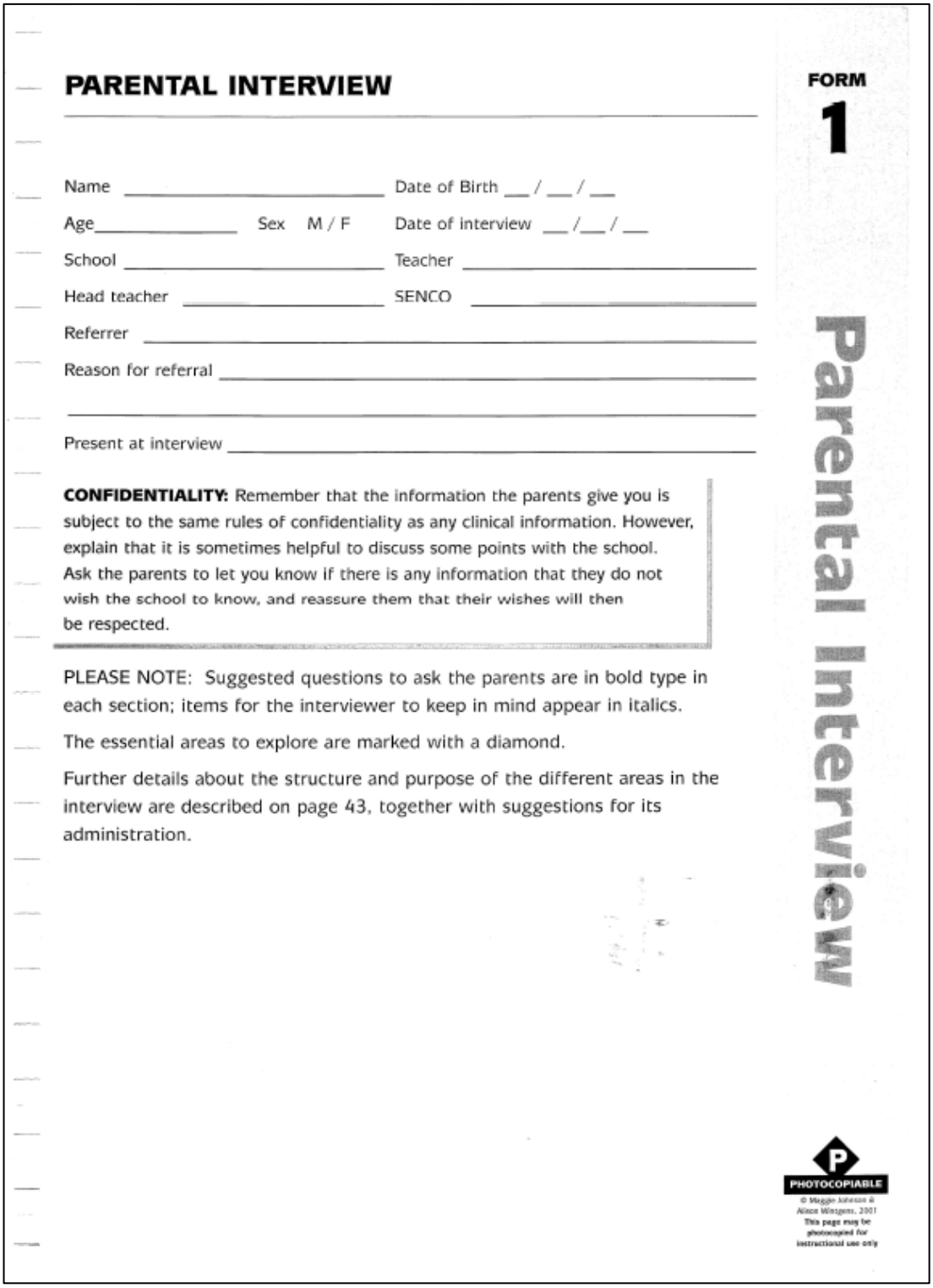
If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

Title of Project: Evaluating a theoretical framework for the use of Music Therapy in the treatment of Selective Mutism in young children: a multiple case study.

I WISH TO WITHDRAW FROM THIS STUDY

Signed: _____ Date: _____

Appendix 6.1 Johnson & Wintgens (2001) Parental Interview



PARENTAL INTERVIEW

FORM 1

Parental Interview

Name _____ Date of Birth ___ / ___ / ___

Age_____ Sex M / F Date of interview ___ /___ / ___

School _____ Teacher _____

Head teacher _____ SENCO _____

Referrer _____

Reason for referral _____

_____

Present at interview _____

CONFIDENTIALITY: Remember that the information the parents give you is subject to the same rules of confidentiality as any clinical information. However, explain that it is sometimes helpful to discuss some points with the school. Ask the parents to let you know if there is any information that they do not wish the school to know, and reassure them that their wishes will then be respected.

PLEASE NOTE: Suggested questions to ask the parents are in bold type in each section; items for the interviewer to keep in mind appear in italics.

The essential areas to explore are marked with a diamond.

Further details about the structure and purpose of the different areas in the interview are described on page 43, together with suggestions for its administration.

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FORM 1 *continued*

Parental Interview

◆ PRESENTING PROBLEMS

Check how long this has been a problem.
Who is worried?
Why are they worried?
What helps or hinders the problem(s)?

What is your main concern about [N]?

Any other concerns?

What questions do you want answered?

What do you want to get out of coming to see us?

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◆ FAMILY

Draw a genogram/family tree.
Ask about ages and occupations.
Ask where people live, and how often they see the family.

Who lives at home at the moment?
Tell me about *your* parents? and siblings?
Which family members are most significant to [N]?

FORM 1 *continued*

Parental Interview

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FORM 1 *continued*

Parental Interview

Has [N] had to cope with the loss of any significant family members?

Ask about pets as well as people.

Is, or has, any of the family been mute, shy or quiet?

Enter on genogram.

Is there any family history of late talking or other speaking problems?

Enter on genogram.

Any history of reading or learning problems?

Enter on genogram.

What languages has [N] been exposed to?

Who speaks what language to whom in the presence of the child?

DEVELOPMENTAL HISTORY

PREGNANCY AND BIRTH

Were there any physical problems?
Get an idea of the significance of the pregnancy and parents' attitude to the baby right from the start.

Did you have any problems getting pregnant?

How did the pregnancy go, and how did you feel about it?

Were there any complications during pregnancy, any worries about your or the baby's health?

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At how many weeks was [N] born?
Tell me about your labour and the birth.
How much did he/she weigh?
Did you or [N] need any medical treatment after the birth?
How long did you both stay in hospital?
Did you feel at all unhappy in the early days or months?

Any postnatal depression that might have affected bonding and attachment?

FEEDING

How did you feed [N]?
Have you had any worries about [N]'s feeding or eating since?
Any worries about [N]'s weight or growth?

Check for any difficulties with chewing or swallowing, faddiness, allergies or special diets.

SLEEPING

How did [N] sleep in the first few months, and how did you cope?
Have you had any problems since that time?
What is [N]'s sleeping and night-time routine like now?

Check for own/shared room, bed-time routine, night waking and nightmares.
Any signs of anxiety in the child?
Any behaviour problems or parenting issues that might need addressing?

Parental Interview

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FORM 1 *continued*

Parental Interview

TOILETING

When was [N] clean and dry?

Has he/she had a period of six months with no 'accidents'?

Does [N] sometimes have accidents now? Wetting or soiling? Day or night?

Could this affect the child's social acceptability?
Does he or she need referral for help with wetting or soiling?

Does [N] have any problem asking to go to, or using, the school toilets?

How much can [N] do for him/herself now?

Can the child manage to be independent with regard to the toilet?

GROSS AND FINE MOTOR DEVELOPMENT

Check ball skills, bike riding.
Look for any signs of general or specific motor problems. Dyspraxia?
Could these account for a lack of independence or social confidence?
Is an occupational therapy referral indicated?

When did [N] sit? And walk?

How well can he/she manage buttons, laces and zips?

How well coordinated would you say [N] is?

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◆ SPEECH, LANGUAGE AND COMMUNICATION – DEVELOPMENT

FORM **1** *continued*

In the first year what sort of a baby was [N]?

Look at early communication, how curious, chatty or sociable he/she was as a baby.

At what age did [N] say his/her first words?

If relevant, what language did he/she first speak?

When did he/she start to join words?

Has he or she always spoken clearly enough?

Have you ever been worried about whether [N] can understand what *you* say?

Signs of verbal comprehension problems?

How did [N]'s talking continue to develop?

Any concerns? Any teasing?

Signs of early self-consciousness?

Has [N] ever seen a speech and language therapist?

If yes, ask for details and outcome.
If no, or a long time ago, is a referral indicated now?

Parental Interview

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FORM 1 *continued*

Parental Interview

Have you ever been worried about [N]'s hearing?

Ask about hearing tests, ENT investigations and procedures.

◆ SPEECH, LANGUAGE AND COMMUNICATION – BILINGUALISM

What languages does [N] speak now? And to whom?

How competent is he/she in each?

And how well does he/she understand the different languages spoken around him/her?

◆ SPEAKING HABITS – DEPENDING ON PERSON AND SETTING

To whom does [N] speak fully and freely, and in what settings?

Does he/she speak a little to some people? Who? When? For what purposes?

How does he/she communicate when he/she does not talk?

Start to gather information to give a baseline picture of the extent of the child's communication. Explore non-verbal communication and conditions under which the child does not talk fully and freely.
What community activities is the child involved in? Sports? Clubs? Church, etc?

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To what extent do you think [N] is aware of the difficulties?
Has he/she made any comments?

How much has the problem been discussed with the child? Does he/she want to be able to speak out?

FORM 1 *continued*

Parental Interview

ATTACHMENT

This section helps with the diagnosis – giving signs of anxiety, selective mutism and/or autistic features.

How did [N] cope with separating and going to nursery and school?

Check early playgroup and school history with regard to how the child separated and settled.

Was this the first time he/she was separated from you?
How many times have you and [N] been apart overnight and for how long?

Check when and how often mother and child have been separated, and how the child reacted. Any illnesses or accidents requiring the child to be in hospital?

How does [N] cope with you leaving now for any time?

How does [N] greet you after he/she has been away from you?

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FORM 1 *continued*

Parental Interview

If [N] is upset does he/she come to you for help and comfort?

◆ TEMPERAMENT

Again, these responses will help with diagnosis and when planning intervention.
Is this consistent with selective mutism? Are there signs of behaviour problems or autism?

How would you describe [N]'s character to me?

How does [N] adapt to new situations? And to new people?

Is [N] easily upset or does he/she get very angry?
What happens? How does he/she show it?
How long does it take him/her to calm down?

Does [N] generally do as he/she is told?

How does the child respond to discipline?

Does [N] have any fears?

Explore past and present fears. Specific incidents? Big dogs, thunderstorms? Any night terrors?

◆ PLAY AND PEER RELATIONSHIPS

What does [N] like playing with?

Who does [N] normally play with?

Were there any problems in the way [N] got on with other children before he/she went to school?

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Does [N] attend any groups, or go to specialactivities after school?

Whether Brownies or Cubs, ballet or kung fu, check the extent to which the child communicates in these settings.
If not attending such activities, have they ever been thought about or tried? Check parents' attitude.

Are there children living nearby of [N]'s age, and would you feel happy about [N] playing with them?

Do parents actively encourage the child to be sociable?

Does [N] have a best friend? And/or a bigger group of friends?

Check who the child confides in and spends time with on a regular basis. After school or at the weekends?
Are the friends at school and/or living locally?

What usually happens when [N] plays with otherchildren?

Is it harmonious? Can the child share? Can the child tolerate losing? Does the child usually lead or follow?

How does [N] get on with other children in class/school? Any teasing or bullying?

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FORM 1 *continued*

Parental Interview

◆ ACADEMIC ABILITIES

How well has [N] done in the past at nursery and school?

How has he/she got on with the teachers?

Did anyone tell you there were any problems?

Do you think [N] is doing as well as he/she should at school now?

If not, are there other reasons apart from the mutism?
Does the child have any additional help with reading, language or for other reasons?

Has [N] missed much school?

If yes, check the reasons. Illness? Anxiety?

How do you get on with the head and class teacher?

SOCIAL HISTORY

Can you tell me a bit about your home?

Get an idea of the nature of the accommodation, garden or playing area and neighbourhood.
Are there stresses and/or restrictions that might impinge on the child's social interaction?

Have you ever, as a family, moved house?

Get an impression of how often, when and where they lived, and the effect on the child.

Is there anything I need to know about your culture?

Check cultural attitudes to silence and mutism.

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Appendix 6.2 Spence & Rapee (1999) Pre-school Anxiety Scale

PRESCHOOL ANXIETY SCALE
(Parent Report)

Your Name: _____ **Date:** _____

Your Child's Name: _____

Below is a list of items that describe children. For each item please circle the response that best describes your child. Please circle the **4** if the item is **very often true**, **3** if the item is **quite often true**, **2** if the item is **sometimes true**, **1** if the item is **seldom true** or if it is **not true at all** circle the **0**. Please answer all the items as well as you can, even if some do not seem to apply to your child.

		Not True at All	Seldom True	Sometimes True	Quite Often True	Very Often True
1	Has difficulty stopping him/herself from worrying	0	1	2	3	4
2	Worries that he/she will do something to look stupid in front of other people	0	1	2	3	4
3	Keeps checking that he/she has done things right (e.g., that he/she closed a door, turned off a tap)	0	1	2	3	4
4	Is tense, restless or irritable due to worrying	0	1	2	3	4
5	Is scared to ask an adult for help (e.g., a preschool or school teacher)	0	1	2	3	4
6	Is reluctant to go to sleep without you or to sleep away from home	0	1	2	3	4
7	Is scared of heights (high places)	0	1	2	3	4
8	Has trouble sleeping due to worrying	0	1	2	3	4
9	Washes his/her hands over and over many times each day	0	1	2	3	4
10	Is afraid of crowded or closed-in places	0	1	2	3	4
11	Is afraid of meeting or talking to unfamiliar people	0	1	2	3	4
12	Worries that something bad will happen to his/her parents	0	1	2	3	4
13	Is scared of thunder storms	0	1	2	3	4
14	Spends a large part of each day worrying about various things	0	1	2	3	4
15	Is afraid of talking in front of the class (preschool group) e.g., show and tell	0	1	2	3	4
16	Worries that something bad might happen to him/her (e.g., getting lost or kidnapped), so he/she won't be able to see you again	0	1	2	3	4
17	Is nervous of going swimming	0	1	2	3	4

		Not True at All	Seldom True	Sometimes True	Quite Often True	Very Often True
18	Has to have things in exactly the right order or position to stop bad things from happening	0	1	2	3	4
19	Worries that he/she will do something embarrassing in front of other people	0	1	2	3	4
20	Is afraid of insects and/or spiders	0	1	2	3	4
21	Has bad or silly thoughts or images that keep coming back over and over	0	1	2	3	4
22	Becomes distressed about your leaving him/her at preschool/school or with a babysitter	0	1	2	3	4
23	Is afraid to go up to group of children and join their activities	0	1	2	3	4
24	Is frightened of dogs	0	1	2	3	4
25	Has nightmares about being apart from you	0	1	2	3	4
26	Is afraid of the dark	0	1	2	3	4
27	Has to keep thinking special thoughts (e.g., numbers or words) to stop bad things from happening	0	1	2	3	4
28	Asks for reassurance when it doesn't seem necessary	0	1	2	3	4
29	**Has your child ever experienced anything really bad or traumatic** (e.g., severe accident, death of a family member/friend, assault, robbery, disaster)	**YES**	**NO**			

Please briefly describe the event that your child experienced.....

_____

_____

_____

_____

_____

If you answered **NO** to **question 29**, please do not answer questions 30-34. **If you answered YES, please DO** answer the following questions.

Do the following statements describe your child's behaviour since the event?

30	Has bad dreams or nightmares about the event	0	1	2	3	4
31	Remembers the event and becomes distressed	0	1	2	3	4
32	Becomes distressed when reminded of the event	0	1	2	3	4
33	Suddenly behaves as if he/she is reliving the bad experience	0	1	2	3	4
34	Shows bodily signs of fear (e.g., sweating, shaking or racing heart) when reminded of the event	0	1	2	3	4

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Appendix 6.3 Participant Information Sheet – Parents/ Cares

PARTICIPANT INFORMATION SHEET- Parent

Hello,

I am writing to you as an experienced Music Therapist working with children with Selective Mutism. I wonder if you would be interested in your child taking part in my PhD research study? If your child takes part then they could receive free Music Therapy sessions. This might help improve their confidence and communication skills.

Full details of the research and what is involved are given below.

Section A: The Research Project

Music Therapy for children with Selective Mutism

This project is researching how and why Music Therapy can help young children with Selective Mutism. We believe that participation in Music Therapy can be helpful and we are enquiring how and why this is the case.

The study will involve participation in individual Music Therapy sessions until such time as the therapist believes your child has received the best results from the treatment. You and your child will be told about the end of therapy and offered the opportunity to discuss the therapy once it has ended.

I am approaching you to invite your child with Selective Mutism to take part in the study. If you consent for them to participate you will be invited to a meeting with me about your child. As part of the research I would like to find out as much relevant information about their history and communication skills as I can before I assess them for treatment. I will need to think about your child's needs and make sure they are suitable for the study. I will also ask you to complete 2 short questionnaires when we meet and again at the end of the Music Therapy treatment.

If I think this is the case your child will then be invited for 2 assessment sessions to see if they might benefit from Music Therapy. If I think that they might benefit they will then be offered ongoing Music Therapy sessions.

It is important that your child is happy to attend the sessions and although they may be supported and encouraged to attend they will never be forced to attend.

The research is being undertaken as part of my PhD at Anglia Ruskin University.

What will happen to the results of the study?

The results of the study will be written up as my thesis and may also be published as a journal article. If the study has very positive results the ideas may be written up as book to give information and advice to other Music Therapists about working with children with Selective Mutism. In all of these cases any names or other identifying features about your child will be changed so that no one will be able to identify them.

For further information please contact the researcher Kate Jones-

Section B: Your Participation in the Research Project

Why you have been invited to take part?

Your child has been invited to take part in the study as they have Selective Mutism and participating in Music Therapy sessions may help them improve their communication skills.

Can I refuse to take part?

You can refuse to consent to your child participating in this study with no adverse affect to their treatment. Similarly, your child can also refuse to take part.

Can we withdraw at any time, and how?

You or your child can decide to withdraw from participation in the study at any time by contacting the researcher and informing them of your decision.

What will happen if you agree to take part (brief description of procedures/tests)?

A meeting with you to get a detailed picture of your child. This will include a short questionnaire about your child's anxiety levels. This is because some children with Selective Mutism suffer from anxiety and we would like to see if Music Therapy can help with this as well.

2 assessment sessions with your child in a therapy room in their school to see if they might benefit from Music Therapy. If they respond well then:

Ongoing weekly individual Music Therapy sessions of approximately 30 minutes duration, continuing until your child has received optimum benefit from the therapy.

You will be asked to fill in another questionnaire about your child's anxiety levels after the Music Therapy treatment.

Are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety?

There are no risks from Music Therapy treatment and your child's safety and wellbeing will be prioritised at all times.

Very occasionally, following an initial meeting or assessment sessions it may be decided that a child is not appropriate for the study. You may feel disappointed if your child is assessed for Music Therapy and then not offered ongoing sessions. If this is the case you will be given a clear reason for the decision and offered other resources and information about Selective Mutism including other treatment options.

Would agreement to participate in this research compromise your legal rights should something go wrong?
There are no anticipated risks from participation in the study but if anything unforeseen happened then your rights would remain the same as in any other situation.

Are there any special precautions you must take before, during or after taking part in the study?
You will be required to sign a consent form agreeing that you are willing for your child to participate in the study and your child will need to agree and show that they are willing to participate in the study.

What will happen to any information/data/samples that are collected from you?
Music Therapy sessions will be recorded to help the therapist make detailed notes about the sessions. These recordings and notes will be kept securely and confidentially and will only be seen by the researcher or the researcher's supervisory team. This also includes any notes from our meeting about your child.

Any subsequent publications about the research will only include anonymised data- your child will not be able to be identified by this information. All names and any identifying features will be changed to ensure anonymity.

What are the benefits from taking part?
We expect that taking part in this study will be a positive experience for your child. They will be offered the opportunity to make music using a range of fun and accessible musical instruments in a way that is specifically tailored to their needs.
There may be significant positive outcomes such as increased confidence, improved communication skills including musical expression, vocalising and speech.

How will your participation in the project be kept confidential?
Please see the answer to question 8.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix 6.4 Participant Consent Form – Parents/ Carers

PARTICIPANT CONSENT FORM- Parents/Carers

NAME OF PARTICIPANT:

Title of the project: Evaluating a theoretical framework for the use of Music Therapy in the treatment of Selective Mutism in young children: a multiple case study.

Main investigator and contact details:
Kate Jones

Members of the research team: 1st supervisor- Professor Helen Odell-Miller. 2nd supervisor- Professor Amelia Oldfield

1. I agree for my child to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my child's role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw my child from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

6. I agree that anonymised data may be used for publications and academic presentations.

Data Protection: I agree to the University[11] processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me

Name of participant (print)……Signed……..Date……

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

[11] "The University" includes Anglia Ruskin University and its partner colleges

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If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

Title of Project: Evaluating a theoretical framework for the use of Music Therapy in the treatment of Selective Mutism in young children: a multiple case study.

I WISH TO WITHDRAW FROM THIS STUDY

Signed: _____ Date: _____

Appendix 6.5 Letter of notification of ethical approval

Anglia Ruskin University

Cambridge Chelmsford Peterborough

Katie Jones

8th November 2013

Dear Katie

Project title: Evaluating a theoretical framework for the use of Music therapy in treatment of Selective Mutism in young children: a multiple case study.

Thank you for submitting your research ethics application to the Departmental Research Ethics Panel (DREP).

I am pleased to inform you that your application has been approved by the Departmental Research Ethics Panel Chair under the terms of Anglia Ruskin University's *Policy and Code of Practice for the Conduct of Research with Human Participants* approval is for a period of three years from DATE.

Please note that this approval is subject to formal ratification by the Faculty Research Ethics Panel.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Policy and Code of Practice for Research with Human Participants and specifically:

The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these changes until you have received approval for them.
The procedure for reporting adverse events and incidents.
The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.
Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the RESC Secretary copies of this documentation.
Any laws of the country where you are carrying the research out (if these conflict with any aspects of the ethical approval given, please notify RESC prior to starting the research).

Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a project risk assessment must have been carried out prior to starting the research).
Notifying the RESC Secretary when your study has ended.

Information about the above can be obtained on our website at:

http://web.anglia.ac.uk/anet/rdcs/ethics/index.phtml

Please also note that your research may be subject to random monitoring by the Panel.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely

Dr Nigel Ward
Chair of MPA Departmental Research Ethics Panel

Appendix 6.6 Participant Information Sheet – Parents/ Carers (friend in therapy/ supporting role)

PARTICIPANT INFORMATION SHEET - Parent/Carer

Friend in therapy/supporting role

Hello,

I am writing to you as a Music Therapist experienced at working with younger children with Selective Mutism. I wonder if you would be interested in your child taking part in my PhD research study? If your child takes part then they could receive free Music Therapy sessions with a friend. This might help improve their confidence, self-esteem and communication skills.

Full details of the research and what is involved are given below.

Section A: The Research Project

Music Therapy for children with Selective Mutism

This project is mainly researching how and why Music Therapy can help young children with Selective Mutism. We believe that participation in Music Therapy can be helpful and we are enquiring how and why this is the case.

The study will involve participation in Music Therapy sessions with X, a friend from the same class who has Selective Mutism. X would like friends to attend Music Therapy sessions with her to help X practice her speech and musical interaction skills with a peer. The Senco and Class teacher feel that this would also benefit the friends and help boost confidence and peer interaction skills.

It is important that your child is happy to attend the sessions and although they may be supported and encouraged to attend they will never be forced to attend.

The research is being undertaken as part of my PhD at Anglia Ruskin University.

What will happen to the results of the study?
The results of the study will be written up as my thesis and may also be published as a journal article. If the study has very positive results the ideas may be written up as book to give information and advice to other Music Therapists about working with children with Selective

Mutism. In all of these cases any names or other identifying features about your child will be changed so that no one will be able to identify them.

For further information please contact the researcher Kate Jones-

Section B: Your Participation in the Research Project

Why you have been invited to take part?
Your child has been invited to take part in the study to support a child with Selective Mutism and participating in Music Therapy sessions may help your child improve their own communication skills.

Can I refuse to take part?
You can refuse to consent to your child participating in this study. Similarly, your child can also refuse to take part.

Can we withdraw at any time, and how?
You or your child can decide to withdraw from participation in the study at any time by contacting the researcher and informing them of your decision.

What will happen if you agree to take part (brief description of procedures/tests)?
2 assessment sessions with your child and their friend in a therapy room in their school to see if they might benefit from Music Therapy. If they respond well then:
Ongoing weekly Music Therapy sessions of approximately 30 minutes duration.

Are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety?
There are no risks from Music Therapy treatment and your child's safety and wellbeing will be prioritised at all times.
Very occasionally, following an initial meeting or assessment sessions it may be decided that a child is not appropriate for the study. You may feel disappointed if your child is assessed for Music Therapy and then not offered ongoing sessions. If this is the case you will be given a clear reason for the decision.

Would agreement to participate in this research compromise your legal rights should something go wrong?
There are no anticipated risks from participation in the study but if anything unforeseen happened then your rights would remain the same as in any other situation.

Are there any special precautions you must take before, during or after taking part in the study?
You will be required to sign a consent form agreeing that you are willing for your child to participate in the study and your child will need to agree and show that they are willing to participate in the study.

What will happen to any information/data/samples that are collected from you?
Music Therapy sessions will be recorded to help the therapist make detailed notes about the sessions. These recordings and notes will be kept securely and confidentially and will only be seen by the researcher or the researcher's supervisory team.
Any subsequent publications about the research will only include anonymised data- your child will not be able to be identified by this information. All names and any identifying features will be changed to ensure anonymity.

What are the benefits from taking part?
We expect that taking part in this study will be a positive experience for your child. They will be offered the opportunity to make music using a range of fun and accessible musical instruments.
There may be significant positive outcomes such as increased confidence and improved communication skills including musical expression.

How will your participation in the project be kept confidential?
Please see the answer to question 8.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix 6.7 Key informant interview schedule

Key informant interview schedule

Key Aims

- Description of Local care pathway for children with Selective Mutism
- Description of referral, assessment and treatment procedures for each service
- Exploration of thoughts about the use of Music Therapy as an intervention and where this could come on the local care pathway for SM

1. What is your job title in Lambeth?
2. What is your general perception/conception of SM?
3. What has been your involvement/role with children with SM?
4. What are the main influences on this thinking?
5. What interventions or approach have you used?
6. Has your approach changed at all?
7. Which age ranges and types of SM do you treat- just pure SM or complex SM?
8. (How do you diagnose SM for children with ASD?) If relevant.
9. Can you describe this?
10. Have they been successful?
11. What would you say are the current care pathways for children with SM in Lambeth?
12. Follow up question?
13. What other interventions/services are you aware of for children with SM?
14. What other interventions/services have you referred children to, if any, and why?

15. Have they been successful? How effective do you think they are?
16. Can you describe this?
17. What are the factors involved in this? (Teamwork?)
18. What are your thoughts about the potential use of Music Therapy for children with SM?

Appendix 6.8 Participant Information Sheet – Key informant

PARTICIPANT INFORMATION SHEET- Key informant

Hello,
I am writing to you as an experienced Music Therapist to ask if you would be happy to be interviewed about your view of the current care pathways for children with Selective Mutism in Lambeth. This interview will help provide essential background information for my PhD research project on Music Therapy for children with Selective Mutism.

Section A: The Research Project

Music Therapy for children with Selective Mutism

This project is researching how and why Music Therapy can help young children with Selective Mutism. The general expectation is that participation in Music Therapy can be helpful and we are enquiring how and why this is the case.
Below is a summary of the research with the area that we need your assistance with in bold.

Phase 1 Contextual investigation
A systematic review of peer reviewed literature of SM interventions using online databases.
Scoping review of all literature describing Music Therapy for children with Selective Mutism, including peer reviewed articles, book chapters, unpublished/non peer reviewed reports of new SM interventions in the UK using the Kings Fund library and online searches.

Description of Lambeth SM care pathway using key informant interviews
Survey and interviews of UK Music Therapists to investigate their experience of Music Therapy work with children with Selective Mutism and elicit information about clinical approaches that are similar or different to the one suggested by the theoretical framework, which is under scrutiny in this study.
Cross-sectional survey of Lambeth SENCOs to identify children attending Lambeth schools i) with a formal diagnosis of SM ii) SENCO reported SM. Child socio-demographic data, including EAL will also be collected.

Phase 2 Multiple-case study investigation

4-6 case studies will be conducted to evaluate the theoretical framework and establish the extent to which the results of a single case study (Jones 2012) are replicated in multiple cases of SM with and without EAL. The case studies will be

chosen from a similar population to the single case study, including SM and SMEAL, in order to evaluate how the theoretical framework applies to both. This will inform any refinement of the framework and assist in developing guidelines for clinical practice.

The research is being undertaken as part of my PhD at Anglia Ruskin University.

What will happen to the results of the study?
The results of the study will be written up as my thesis and may also be published as a journal article. If the study has very positive results the ideas may be written up as book to give information and advice to other Music Therapists about working with children with Selective Mutism. In all of these cases any names or other identifying features regarding your input will be changed so that no one will be able to identify you.

For further information please contact the researcher Kate Jones-

Section B: Your Participation in the Research Project

Why you have been invited to take part?
Music Therapy may have a positive role to play in supporting children with Selective Mutism. What we need to think about is how this might fit into or compliment the current care pathways for children with Selective Mutism in Lambeth. Your experience in this area will help us form a picture of what resources are currently available. We will also ask you about what you think the role of Music Therapy could provide.

Can I refuse to take part?
You can refuse to take part and this decision will be respected.

Can I withdraw at any time, and how?
You can withdraw at any time in the process. Please let the researcher know of your wish to withdraw.

What will happen if you agree to take part (brief description of procedures/tests)?
We will invite you to participate in a semi-structured interview, up to one hour in length at a mutually convenient and suitable location.

Whether there are any risks involved (e.g. side effects from taking part) and if so what will be done to ensure your wellbeing/safety
There will be no risks from the interview process.

Does agreement to participate in this research compromise your legal rights should something go wrong?
There are no anticipated risks from participation in this study however, in the case of anything unforeseen happening, your legal rights remain the same.

Are there any special precautions you must take before, during or after taking part in the study?
You will be required to sign a consent form prior to the interview.

What will happen to any information/data/samples that are collected from you?
Interviews will be recorded using digital recording equipment for the purpose of accurate information gathering but deleted once the data has been transferred to paper or computer records. Information given in these interviews will be anonymised and key informants will not be referred to by name or any other details that would make them identifiable.

Are there any benefits from taking part?
By agreeing to be interviewed you are supporting a study that aims to raise awareness of Selective Mutism and investigate the use of Music Therapy for these children.

How will your participation in the project be kept confidential?
Please seen question 8.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,
TOGETHER WITH A COPY OF YOUR CONSENT FORM

Appendix 7.1 Transcribed meaningful moments on Daniel's Path into Speech

The meaningful moments use some musical terminology to denote dynamics such as pp = pianissimo (very quiet), p = piano (quiet), mp = mezzo piano (fairly quiet), mf = mezzo forte (fairly loud), f = forte (loud), ff = fortissimo (very loud).

Italics denote contextual action prior to or between the selected 'meaningful moments'

MM1. Session one. Copying.

This meaningful moment (see Table A7.1 MM1) is taken from the start of session one. Daniel appeared a little nervous and unsure about what to do but then decided to play the rainstick in the Hello song. He then moved on to explore the instruments that I had just played, adding another instrument when I moved on to another instrument.

Table A7.1 MM1

Time code Minutes. Seconds	**Daniel**	**Kate**
		I have just sung the 'Hello' song and Daniel has been focussed on playing the rainstick.
4.21	Daniel is still playing the rainstick	I take a beater and gently play the cymbal
4.24	Listening and watching attentively	I then play the hanging chimes
4.33	Brief smile	Another tap on the cymbal
4.36		Quick tap on the gathering drum and then I give the beater to Daniel.
4.40	Moves over to the cymbal then	
4.44	Gently plays the cymbal	
4.46		Reach across and tap the cymbal
4.50		Quick pattern on the gathering drum

		Reflective gathering drum
4.52	Starts playing the hanging chimes	Slow, *mp* drum roll.
4.59	Gentle cymbal tap	
5.02	More hanging chimes	
5.07	Another cymbal tap	
		Over to the frame chimes.
5.09	More hanging chimes	Playing frame chimes
5.10	Listening to me	
		Gathering drum
5.18	More cymbal taps	
		Frame chimes
5.25	More hanging chimes	
	Continuing to move back and forth between the two for a while	*Gently moving back and forth and adding in a bit of cymbal and other instruments to gradually develop the improvisation.*
6.26	Daniel adds in the gathering drum	

MM2. Session four. Loud cymbal crashes.

In this session Daniel developed a little more confidence as demonstrated in the volume and intensity of his playing.

Table A7.1 MM2

Time code	Daniel	Kate
	We have had a short break whilst Daniel goes out to the toilet and comes back in again.	
	He sits on the floor and plucks the strings on the ukelele	*Singing reflecting the sound of the ukulele*
15.17		Light tap on the cymbal
15.27	Smiles and stands up and then taps the cymbal with the beater	
15.33		I respond enthusiastically with one hit on the cymbal
15.35	Plays the cymbal again, four times	At the same time as his playing "wooooooooo" descending after he finishes reflecting the diminishing sound of the cymbal
15.39	Sits back down with the ukulele	On guitar: Four strums
15.41		Bluesy singing: "Oooh, Daniel played the cymbal"
15.45	Plays a couple of taps on the drum	
15.48	Starts drumming confidently on	I sit back down next to Daniel
15.50	bongo and gathering drum	
15.55	*The session continues with a loud, free & confident drumming improvisation between both of us.*	I join in by playing a rhythm on the ocean drum

MM3. Session 8. Recorder.

This moment shows the important role of oral instruments in self-expression for Daniel.

Table A7.1 MM3

Time code	Daniel	Kate
14.44	*Playing the ukulele quietly*	*Playing the guitar and vocalising. Minor key*
14.47	Playing the recorder in a short rhythmic pulse	
15.10	Getting longer, like sighs on one note, tailing off at the end	Singing a longer melody linking the recorder pulse together
15.20	Quite intense sounding, like crying	Vocally interweaving with his notes
15.30	Slightly faster again and then adding in ukulele	Continuing to play guitar and sing reflecting his playing
15.37	Ukelele strums without recorder	Guitar and voice
15.42	Back to recorder 'sighs'	"
15.49	Ukelele strums	"
15.58	More recorder 'sighs'	Quite high singing reflecting intense, plaintive nature of the recorder
	The whole recorder improvisation lasts about 4 minutes in total and is very focussed and quite moving.	

MM4. Session 10. Speech in session (brief extract).

At this point in the therapy process Daniel had already been speaking and had increased the parameters of his speech outside of the therapy sessions within the nursery setting. I chose this brief extract as it was the most speech that Daniel used within the sessions and because it has implications in further analysis.

Table A7.1 MM4

Time code	**Daniel**	**Kate**
	Daniel has been outside of the session to go to the toilet. He returns just before the end.	*I decide to ask Daniel a question.*
26.25		"What was the name of that friend out there? I don't think I know him."
26.29	"Andrew"	
26.31		"Andrew? Oh, lovely"
26.34	"I've got two friends"	
26.35		"Have you got two friends? Who's your other friend?"
26.39	"Yussef"	
26.42	"And Andrew"	
26.45		"Aaah. Yussef and Andrew, that's lovely" *I then proceed to sing the Goodbye song.*

MM5. Session 11. Contextual moment.

Prior to session 11 Daniel was painting in the nursery with a friend and asked if the friend could attend the session too. Due the perceived restrictions of the research and the need to gain further consent I said that unfortunately he couldn't bring a friend. This decision and response later became a source of much rumination and debate for myself as therapist and researcher.

MM6. Session 14. Blind up, cymbal performance at window.

We had had a very engaged and connected musical improvisation up to this point, although at the beginning of the session and to some degree throughout the first nine and a half minutes we had been aware of children outside of the therapy space trying to attract Daniel's attention. In this moment Daniel finally gave in to them and embraced their attention.

Table A7.1 MM5

Time code	**Daniel**	**Kate**
	Daniel has gone over to the window and is looking out at his friends and trying to pull up the blind	
9.50	Fiddling with the blind and playing a large tambour next to the window	*Clarifying what he is trying to do with the blind…*"Which way do you want to do it Daniel?"
9.56		"Do you want to look out?"
9.57	Nods	
10.00	Continues drumming in front of the window and also plays the cymbal	I get up and move over to the window and pull up the blind for him

10.12	Playing quite a long improvisation on the drum and cymbal	*Picking up the large gathering drum and joining Daniel to one side of the window so that he is the star of the show but feels supported.* Playing 'quaver quaver crotchet' (short short long) on drum & cymbal in a steady repeated beat just underneath Daniel's dynamic.
10.40	Smiling moves away from the window on his knees and picks up a Penny whistle	Continuing with the beat.
10.44	Plays the Penny Whistle whilst smiling and looking out of the window	Drumming and singing to reflect his whistle playing
10.58	Loud overblown Penny Whistle in a pulse *Daniel continues this performance in front of the window for several minutes but after a while decides to play the cymbal out of sight of his friends, just off to the side.*	

Appendix 7.2 Transcribed meaningful moments on Pilar's Path into Speech

MM1. Session 1.

Pilar appeared happy to attend Music Therapy but presented as quite frozen in the room. After explaining about Music Therapy and singing the Hello song I encouraged her to come over towards the bells and invited her to play them. She simply sat still.

Table A7.2 MM1

Time code	Pilar	Kate
4.45		Playing guitar and singing "which one is she going to play, going to play, going to play, which one is she going to play, going to play today?" (*To the tune of 'Here we go 'round the mulberry bush')*
4.50		"Ooh, can I guess? Is it going to be the red one?"
4.55		
5.00		"Ping!" –Gesturing how to play
5.03		them. "Maybe?"
5.06		Playing guitar gently. "Which is your favourite colour?"
5.09	Pilar points to the pink one.	
5.11		"Ooh that's a nice one! See what it sounds like! Ping, give it a ping!"
5.17	Touches but can't press down the pink one.	
5.18		"You have to press it really hard and quick"
5.20	Tries again.	
		"Hard and quick?"
5.24	Tries again but still not enough	"Harder, quicker?"
5.25	action.	"Oh, does it not work? Let me see"

5.27		I 'test' it for her.
5.29		"Oh, really quick. Press it quickly"
5.31	Tries again but with no sound.	
5.33		I play it again twice.
5.35		"It's quite hard to play isn't it? You played it gently look" (I demonstrate playing it gently)
5.40		"And it didn't work. You have to play…"
5.47	Some tiny head movements	Another ping on the bell Then playing the guitar "Paula's favourite colour is…Would you say that is pink?"
5.56		"It's kinda pinky purple wouldn't
5.58		you say?" "Hm, lovely"
6.03	Points to the bluey purple one.	"Maybe we could try another one now? Which other colours do you like?"
6.05		"That one, that's nice, a kind've bluey purple"
6.07		"Shall we try that one?"
6.11	Presses it down but no sound comes out	
6.13		"Ooh, it's very quiet."
6.18		"Shall I play it?" I ping the purple one.

MM2. Session 1.

Later in the session I devise a game to demonstrate a more playful, relaxed approach using an improvised game of 'musical football'.

Table A7.2 MM2

Time code	Pilar	Kate
		I have set up lots of instruments to hit on the floor when we roll a shaky egg back and forth to each other
17.32	Hits a drum with the shaky egg	Hands in the air "Goal!!"
17.35		I roll the egg back
17.39		"1,2,3"
17.41	Rolls the egg back but it doesn't hit anything	
17.43		I roll it back again.
17.44		"1,2,3,"
17.45	Rolls the egg and hits the drum	
17.46	again.	"Yes, very good!"
17.47		I roll it back
17.48		"1,2,3"
17.49	"	
17.50		"Ping"
17.51		
17.52		I roll it back
17.54	"	
17.56		"Yes, goal!"
17.57		I roll it back
17.58	"	
18.00		"woooo"
18.01		I roll it back

		We continue with this with some theme and variations. Changing the instruments slightly.

MM3 Session 1. Noisy ending

This moment was chosen from the end of the first session to demonstrate just how much Pilar managed to relax and engage over the duration of the session.

Table A7.2 MM3

Time code	Pilar	Kate
32.40	Exploring small percussion quite actively	Hitting an ocean drum and singing, repeatedly "all the fishes in the sea!"
32.47	Plays the cymbal with a wooden shaker	
32.49		I hit it as well.
32.52	Exploring lots of instruments including the cow bell (CB)- each note once	*Singing* "All the fishes in the sea" plus Ocean Drum (OD)
32.55		
32.56		"Oh oh" –in time with CB
33.02		*Sung* "Ooh I like to hear the cow bell" "Ooh I like to hear the cow bell oh oh, ooh I like to hear the cow bell"
33.06	Cymbal crash	
33.07	"	
33.10		Cymbal Crash

33.12	Small percussion in a pulse	Keeping a steady beat with P on small percussion
33.18	Cymbal crash	
33.20		Cymbal Crash
33.22	More small percussion beats	Percussion beat in sync with P
33.27	Cymbal crash	
33.29		Cymbal Crash
33.30	Small percussion beats speeding up	Parallel play. Matching the speeding up.
33.42	5 faster taps on the cymbal with a plastic beater.	I keep playing the small percussion but with increased intensity- some quavers in between the main beat.
33.50	4 faster taps on the cymbal with a sense of an 'up' beat. More lively.	Quick phrases on the hand bells matching the tension in the music
34.04		Tentative cymbal crash Singing "it's raining it's pouring" coming in closer and dancing a bit
34.30	Plays the bells loudly up and down the scale	
34.31		Cymbal crash

34.38 **34.39**	Hits the edge of something making a loud, slightly edgy beat	I crinkle up my face and say "wow that's a loud sound" and play in the same pulse

MM4. Session 11.

In this session Pilar had been using the puppets and scarves in an imaginative game. This moment shows how the use of oral instruments becomes quite similar to having a verbal conversation.

Table A7.2 MM4

Time code	Pilar	Kate
	Dressed up in chiffon dance scarves in the adjacent room.	
23.00		Singing "oooooh Princess P…" and playing a steady, medieval beat on the gato drum.
23.30	Swanee whistle toots	
23.34		"oo, ooooo ooo" mimicking the sound of the swanee whistle. Carrying it on and *continuing on the gato drum as well.*
23.39	Swanee whistle (SW)	Same time vocals 'oo hoo'
23.40	SW	'Wa'
23.41	SW	'Wa'
23.42	SW	'Wo'
23.43	SW	'Wa'
23.44		'Oh ho'
23.45		
23.46		
23.47	SW	'oh ho'

23.48	SW	'hoooooo'
23.49		oooo
23.50		oo
23.51		
23.52		
23.53	SW 'oo hoo'	
23.54	'ooooo'	metallophone attuned to swanee
23.55	'ooo hoo	whistle ting ting
23.56	hooo'	ting
23.57	SW / (ascending)	
23.58		
23.59	SW \ (descending)	'woooo'
24.00	SW /	
24.01	SW \	
24.02	SW Oo hoo	
24.03	Ooo	Sung "ooo hoo
24.04	Oo hoo	hoo"
24.05	Ooo	"oo hoo
24.06	Ooh hoo	hoo"
24.07	Oo	"
24.08	Oo ho	"
24.09	Ooo	"
24.10		"
24.11		"
24.12		"
24.13		"
24.14	*Jumps into the room with the*	"
24.15	*SW in her mouth*	"
24.16		"
24.17	SW /	"
24.18		

24.19	SW \	
24.20		“wooo” /
24.21	SW –	
24.22		“wooo” \
24.23	SW –	
24.24		“wooo”
24.25	SW—	
		“wooo”

MM5. Session 14.

This brief moment was chosen as an example of how positive this session was with Pilar moving from giggling and laughing into these speech-like vocalisations.

Table A7.2 MM4

Time code	**Pilar**	**Kate**
		We have been playing the game ‘connect 4’ which P found in the corner of the room. I am wondering out loud if changing colours would help me win.
15.32-	“uh uh” in a quiet croaky voice *both continuously playing the*	
15.34	*game*	“uh uh” “uh uh uh” “uh uh uh”
15.38		“Oh my gosh, oh my gosh” exclaiming in the game
15.43	Little giggle	
15.50	“uh oh!”	“oh no, oh no, oh my gosh!”
15.52	“uh”	

At the end of the summer term the SENCo telephoned to say that the Music Therapy sessions needed to be terminated as they were too disruptive of the curriculum. Pilar's mother was understandably very upset about this and sessions were rearranged to take place after the end of the school day in the autumn term.

MM6. Session 24.

As part of the therapy I introduced a few more structured games in an attempt to both reduce any anxiety for Pilar and also to experiment with blending Music Therapy and some Speech and language therapy techniques that I felt would fit easily within the parameters of Music Therapy.

In this guessing game a screen had been created from a cloth pegged between two chairs with the same or similar instruments and puppets on either side. Sitting on either side one person made a noise with an instrument or a sound for the animal and the other person guessed what it was by showing the same object above the screen.

Table A7.2 MM6

Time code	Pilar	Kate
12.32		Quick strum on the guitar.
12.35	Looks over the top smiling as she doesn't have something exactly the same.	
12.37		"Do you have something a bit like that?"
12.43	Holds the ukulele up above the screen.	
12.44		"yeah! A ukulele that's nearly the same. Ok your go, you can do whatever you like."
12.51	Just shows me the bear finger puppet over the top of the screen.	
12.53		"Ok, you have to go 'woof, woof"

	Looks for another puppet	
13.00	Quietly- "quack, quack"	
13.05		"Ooh you tricked me then that wasn't the same!" I show the duck puppet above the screen matching her duck puppet.
13.10		"yeaaahh!"
13.13		"that's cute. Is it my go now?"
13.15	Nods	
13.22		"Can you guess what this one is?" "oink oink"
13.26	V. quietly. "Oink oink"	
13.30		"That one…can you guess?"
13.37	Shows the pig puppet above the	
13.38	screen	"Oh hello lovely piggy!"
13.45		"Well done. I thought you might not guess my weird noise. You can choose again if you want."
13.48		"Your turn!"
13.52	Makes a very cute animal noise, perhaps another "oink oink"	
13.54		Exclaiming in a high voice- "Oh what's that!" "It's a really cute one"
14.04		"Is it this one?" Showing the rabbit.
14.13	Shows me the mouse puppet.	

	This game continues and becomes a feature of many of the sessions.	

MM7. Session 32.

This moment was chosen because it shows Pilar's gradual progress towards using words and in this session saying: "yes"; "yay"; "flash"; "uh"; "oooh"; and in this moment, "yeah". This session also happened to coincide with the day that Pilar's much-loved class teacher was leaving to go back to Australia as her visa had run out.

Table A7.2 MM7

Time code	Pilar	Kate
		In this extract there is lots of pretending to be animals and fighting
17.00	Laughing and giggling	"Ooh no, ruff ruff ruff" "I'm going to make some scary noises!"
17.16		"rraaaagh"
17.22	Giggling & play fighting around the hanging 'punchbag' cushion	"ra, ra, ra" Some rhythmic sounds as well. Sounds of musical fighting
17.31	Giggling	Singing in a low scary voice "It's
17.32		raining, it's pouring, the old man is
17.38	Giggling	snoring" whilst playing the rainstick
17.39	"Waa"	and the guitar. Up an octave- "and couldn't get up in the mooorning"
17.42		"wooo"
17.44		"mooorning"
17.47	"Yeah"	

17.48		"Yeah. I'm gonna get her, I'm gonna get her!"

MM8. Session 36.

In this moment Pilar said "no" many times as part of the game that we were playing.

Table A7.2 MM8

Time code	Pilar	Kate
		We are playing a game with the soft cushions where we are both stock-piling cushion ammunition and stealing from each other. So, there is an element of frustration in the drama.
20.30	Giggling almost continuously	*Pretending not to notice in the game that she has taken some of my cushions*- "That's so helpful, such a helpful little girl, always good at building aren't you? Perhaps you are going to be a builder!"
20.40	Laughing	
20.43		"Ok, ooff, who put that there…"
20.45	"Eurgh" slightly dismayed sounding	*taking one of her cushions* "lovely"
20.46	giggling giggling and laughing	
20.50	enthusiastically Quiet/thinking	"And this bit really goes in the middle and this bit?..."
20.54		"goes on there?...oh that looks good"

20.58		"That looks great!"
21.02	Taking a cushion "yeaah!"	"er hm, tum te tum te ta"
		"ooh noo oo, tum te tum te tum"
21.05	"nooo"	Stealing one back "thank you! oh
	Quiet but busy 'building'	thank you!"
21.30		*Lots of busy chat from me for a*
		while.
21.35		"I'll put this bit in the middle and
21.36	Short sharp "no"	that bit there..."
21.38		"yeeass!" "And then this bit 'round
21.39	"No"	here?"
21.40		
21.41	"No"	"Yes, over here, yes!"

MM9. Session 38.

In this session Pilar said "sleep", named colours and counted out loud. She also said some quiet sentences.

Table A7.2 MM9

Time code	Pilar	Kate
		I am in the ball pool and Paula is trying to communicate something to me by writing with her finger on the wall. Almost as part of the dramatic play I am pretending not to understand her.

29.31	"uuurrgh" frustrated vocal down the didgeridoo	
29.34		"Oh my goodness!"
29.36	"Quiet!"	
29.39		"Oh my gosh, do you want me to
29.40		say anything?!" *–into the didge*
29.41	Long, slightly inaudible sentence	
		"Do you want me to stay in here?" –meaning the ball pool
29.50		"I love swimming!"
29.53	*Playing with a telephone*	"Are you on the telephone? Hi Pilar how are you?"
29.56		"Are you all right?
29.57	Another long, quiet more distinct sentence "…not been good"	
30.06		"She's not been good? uh uh!" "really?"
30.13		"Oh no, what do you think I should do?"
30.15	"Get her?"	
30.17		-Mishearing Pilar- "You think I should chase her?"
30.18	Enthusiastically "Chase her!!"	
30.20		"Yeah? Shall I get her? Oooh…
30.25		"Aah ha ha, I'm going to come and get her!"

30.34	"Back into school!" (or something similar)	
30.38		"Oh hu hu no, there's a school in here! It's a swimming pool!"
30.45	"School time" ?	
30.48		"Oh no school, I don't wanna go to school!!" *swimming around*
30.58		"If I go to school, what am I going to learn about? Am I going to learn my colours?" Gesturing at a blue ball and deliberately getting it wrong "Red!" "Pink"
31.07		
31.11	"White!"	
31.12		"What?! Oh yes!"
31.14	"Orange"	
31.16		"Oh, oh yes!" Picking up another ball, "Errrm,
31.20		purple, purple, that's my favourite colour"
31.21	"Green"	
31.24		"That?...is it?"
31.28		"Oh yeah…How 'bout that one is…blue?"
31.30	"Red"	
31.31		"Is it?!"
31.33		"This one is definitely white."
31.37	"Blue"	

31.40		"How come you know your colours and I don't."
31.45		"This is definitely black"
31.47	"Yellow"	
31.50		"Is it? Oh, I didn't know that."
31.54		"This, is Pink!"
32.02	"Black"	
32.03		"No way! It's black?!"
32.10		"Ok. I'm going to get it this time. That is Orange!"
32.14	"Green!"	
32.16		"It's green! I think I definitely need to be at school..."
32.20		"Ok, now we're going to have a counting lesson. We're going to have a counting class."
32.23		"five, three"
32.25	"No...no…One!"	
32.29		"One? One!"
32.35		"One, two,…er five"
32.38	"One, two, three"	
32.39		"One, two, threeee?!"
32.40		"ooh"
32.41		"One, two, three,…seven?"

32.50	Quietly counts up to 10	

From this point on it felt as though we were on the 'home straight', with Pilar improving her speech in each subsequent session until we were having long conversations and I felt that I was getting to know her quite well.

Appendix 7.3 Transcribed meaningful moments on Tasha's Path into Speech

MM1. Session 1. Musical connections.

This first moment shows Tasha's initially frozen presentation.

Table A7.3 MM1

Time code	Tasha	Kate
	Tasha comes into the room and sits down in one spot holding the ukulele having picked it up on her way across the room.	*I explain a bit about Music Therapy and then sing the hello song.*
	Tasha sits completely still except for quick, interested, glances up at me.	*After a while I decide to sing a "we are playing music together" which is to the tune of 'Here we go 'round the mulberry bush'*
3.50		Singing "Can she play the ukulele?" and picking chords on the guitar throughout this moment *mp*
3.56	Plucks a ukulele string	
3.58		Sung "oooh"
3.59		Singing "Tasha played the ukulele, ping, ping, ping"
4.03	Quiet plucking a ukulele string twice	
4.05	It is the 9th of my chord so nice and open-sounding 2 more plucked notes then another note	Singing the same note "la laaa, la laaa" and picking the root chord Vocally picking out the notes that Tasha is playing on the ukelele

	Nice gentle open harmonies between the ukulele and guitar	
4.21		"Tasha played the ukulele" sung with a slight laugh, smiling at T.
4.23	Lots of eye contact and smiles	
4.28		"la laa, la laaaa"
4.36	More gentle picking on the uke	
4.37		Vocally reflecting Tasha's ukulele notes
		Continues in a similar vein with a few harmonic variations for another 3 minutes until Tasha perhaps seems a little stuck and so I sing:
7.48	Careful listening then picking the ukulele in time with the tune. Really concentrating, looks up at the end of the song	"Twinkle twinkle little star etc"
8.18		Spoken "That sounds lovely Tasha"
8.22		"Do you like the ukulele?"
8.24	Tiniest of nods	
8.25		"It's cool isn't it?"
8.30	Playing completely in time with the tune of twinkle twinkle	More "Twinkle twinkle etc"

10.00		With the bat variation and back to twinkle twinkle again finishing at 10.00 *I wonder if Tasha would like to try something else*

MM2. Session 12.

Over the weeks Tasha became musically confident and engaged. Her playing became very free and expressive whereby she was able to sustain a keen focus on improvisation using any instruments and even non-instruments. In session 10 we had a long inventive improvisation on the sensory wall equipment which included ridged and textured forms, metal chains and fake grass. In session 11 Tasha discovered the new karaoke microphone and was absorbed in singing for most of the session. It was the most beautiful and moving session but unfortunately the video player had bounced on and off and so there was nothing on the recording that week.

In session 12 Tasha sang in a similar way (see Table A7.3 MM2 below) but it didn't have quite the same quality as the previous week. However, the essential elements were the same and it is 'evidence' of where Tasha was at in her process towards speech. She had also spoken in her nursery class after session 11 and received a huge 'celebration', something which is usually cautioned against in much of the resources on SM.

Table A7.3 MM2

Time code	**Tasha**	**Kate**
8.07	Completely free improvisation Hitting different instruments.	Free improvisation
8.22 **8.23**	Picks up the microphone and blows and then sings into it. "ooooh"	Sung reflection "ooooh"

8.27	Blows on the microphone	
8.28		"oooooh"
8.29	"oooooh"	
8.30		At a higher pitch and with hands in the air "ooooaaaah"
8.32	"uuuh oooh aaah" dropping a minor 2nd and back up again.	
8.34		"uuh oooo aaah" dropping a minor 3rd and back up again *I make sure that the microphone is switched on for Tasha*
8.43	Vocalises again but using the harmony setting "ooh ooh ooh" up	
8.44	a minor 2nd and back again	Copying T exactly "ooh ooh ooh"
8.46	"ooh ooh" down a min 2nd	
8.48		Copying exactly "ooh ooh" but with a xylophone glissando
8.50		Open guitar strum
8.51		"oo ooooh"
8.52	Higher and even more expressive "Aaaaaah"	
8.54		Copying the higher pitch "aaaaaaah"
8.55	Down a tone "Ooooooohhh"	*Then like a descending melody*
8.57		Down another tone "ooooh"
8.59	Copies the same pitch "ooooh"	

9.00		Lower "oooooh"
9.02	Copies my pitch "oooh"	
9.03		Longer and lower "ooooooh"
9.04	"oooh" *Starting to overlap and singing our own melodies rather than turn-taking*	*A little bit of musical experimenting and vocal exploring*
9.21	High, long, melodic phrase slowly descending.	
9.24	Continuous singing	Answering phrase a little lower in pitch
9.34	Short pause in singing	Just guitar strumming
9.40	Singing a beautiful improvised melody *Continuous improvised singing – quite high pitched until*	Joining in simultaneously *Continuous harmonisation underneath T's melody*
11.15	*Stops singing, puts the microphone down and gets some feedback*	*Stop to explain feedback*

MM3. Session 13. 1st speech.

This brief moment (Table A7.3 MM3) shows the first words spoken in the therapy sessions; three 'no's. This was preceded by quite intense playful activity and giggling which seemed to help with relaxation and vocal warming up to enable spontaneous speech.

Table A7.3 MM3

Time code	Tasha	Kate
29.00	*Lots of giggling at the puppets and the drama.*	*My puppets are trying to hide from T's crocodile puppet by going under a tambour. Quite high pitched, fast narration of the drama.*
29.38		"Under here under here!"
29.40	Loudly "no!"	
29.42		Exclaiming loudly "Aaaah" "Oh under here again"
29.46	Laughing and giggling "No!!"	
29.47		"Yes" Exclaiming loudly and laughing
29.50	"Noooo!"	
29.51		"Ohhh!"

In the following week, session 14, Tasha said three sentences interspersed amongst other therapy activities: "I want to go toilet" (after 17 minutes 38 seconds); "Crocodile wants to make some food!" (after 22 minutes 44 seconds); "It's going down the slide" (after 25 minutes 48 seconds).

MM4. Session 15.

In this session we began to develop a more sustained dialogue about fruit as described in the transcription below.

Table A7.3 MM4

Time code	Tasha	Kate
29.20	*Tasha has taken the cup telephone around the corner of the room. She comes back and puts the mouse finger puppet in the plastic cup.*	*Verbal commentary on what Tasha is doing.*
29.31	"Mouse is cooking"	
29.33		Exclaiming "Mouse is cooking! Oh mouse that's great"
29.35		"What are you going to cook mouse, what do you feel like cooking today?" *General chat about cooking*
29.51	Sitting down holding the plastic cup "That's their cup"	
29.54		"Ok, that's good here's another cup" *More general talk about cooking then picking up the guitar and*
30.03		*singing* "What shall we cook? What shall we cook?"
30.10	"Carrots!"	
30.12		"Carrots, yes! Ooh look –holding up a ball- more carrots"
30.18		"And what about this one?" "I think that's a…."

30.22	"Jemmafruit?"-*something slightly incomprehensible*-	
30.24		"Ah, ok"
30.25		"What else have we got?" –holding up a yellow ball
30.27	"tsigum?" –*another unclear word*-	
30.28	*Thinking for a while*	"Uh, ok. What's that?" –holding up a blue ball
30.36	"Apple"	
30.37		"Apple! In it goes"
30.38		"Yum yum!"
30.40	*Thinking hard with her finger on her lips*	"And a…?"
30.46	Quietly "Two apples"	
30.48		"Two apples!"
30.50		"Lots of apples. Two apples are in there"
30.52	"Grape!"	
30.53		"A wha?"
30.53	"Grape!"	
30.54	*Quiet, sporadic words and short phrases as part of the play until the end of the session*	"Cor yum! That's a nice big one!"

MM5. Session 16. Punky 'Twinkle twinkle'.

This moment shows how Tasha rapidly progressed into even more confident singing and actually shouted the words to nursery rhymes.

Table A7.3 MM5

Time code	Tasha	Kate
21.00	Leans over and says “Ha!” loudly	*Playing the guitar quite loudly*
21.01	into the microphone which is on	“Ha” then sung
21.02	the floor	“Ha ha haa ha ha”
21.04-	Spoken loudly and harshly “Ha”	Singing “Ha ha ha haaa” as a sung
	then repeated in a steady pulse	accompaniment to the words
21.09		Slightly gentler bluesy vocals and guitar
21.20	Exploration of the guiro	C Major guitar with no vocals
21.23	Into the mic muffled “Hello?”	Sung “ooooooooh”
21.27	Experimental vocal sounds like a parrot and then lower sounds	
21.35		“Twinkle twinkle …etc”
21.41	Looking across at me and joining in “what you are” into her microphone	
21.43	In synchrony singing “up above the world so high…etc” Quite loud	“Up above the world so high….etc”
22.00	Emphatic “What you OOOOOh” in a high screech	“What you are..”
22.12		I pick up a kazoo and suggest a noisy version

22.16	Singing the notes of 'Twinkle twinkle' copying my random percussion accompaniment	'Twinkle twinkle' through the kazoo with guitar and additional percussion Following T's high pitch
22.40	Ending up at a high pitch	Loud sung "Twinkle twinkle"
22.44	Almost shouting and speaking version of "Twinkle twinkle" with strong accent on every beat	
23.12	Final "are" extended into long dramatic ending	Joining in with long ending
23.20		"The wheels on the bus…etc"
23.22	Joining in "go round and round….. etc" almost shouting	
23.30	"All day looooooonnnng" Loud and shouty end	
23.35		"The bell on the bus goes…"
23.37	Shouting "TING TING TING!!!"	
23.42	High pitched screamy sing "All day long"	
23.45	Long screamy "aaaaah"	
	This style of punky singing and shouting continues for the rest of the verses of 'The wheels on the bus'	

At the end of this session (Table A7.3 MM5 above) Tasha talked to me in long, albeit quiet sentences and we had an extended conversation about Tasha not wanting to go back to class.

Post-summer holidays

After the six week break for the summer holidays the therapy was marked by a number of issues that hindered progress: two separate weeks off both planned and for sickness; Tasha was made homeless; potential child protection issues including a stressful abuse investigation. Throughout sessions 17-22 Tasha didn't use her voice to speak although she laughed, sang, vocalised and remained very engaged in improvising music in the sessions.

MM6. Session 22. Bubble tube colour speech.

In session 22 we made significant progress through taking a playful change of direction by pretending to use the kazoos as spy glasses.

Table A7.3 MM6

Time code	**Tasha**	**Kate**
		We are sitting near the bubble tube with our kazoos as 'spy glasses' looking at the different colour bubbles. The mood is playful and light-hearted.
36.30	Giggling	In a playful tone: "Ooh……Now what colour's that?"
36.38		"Ooh, it's changing again!"
36.40	Another loud giggle	
36.42		Giggle as well
36.44		"What colours are they Tasha?"
36.46		Into my kazoo "do, do, doooo!"
36.47	Quite quietly "Orange!"	
		"Orange"

36.48		"And now it's?...Oh my goodness! Quick, what colour's that?"
36.52	Very quietly "Green"	
36.53		"Green!"
36.54		"Oooh, it's gone darker green now. Wow!"
36.57		Horsey noise into the kazoo
36.58		"Wow, what other colours...what colour's that Tasha?"
37.01	Very quietly "Blue"	
37.02		"Blue! Wow, they're little blue squealey things"
37.08		"What colour are you going to be
37.12	*Quietly cutting in to my question* "Purple!"	n(ext)"
37.14		Delightedly "Purple, wooow!"
37.17	*Cutting in again, a bit louder*	"What colour's it going to b(e)"
37.18	"Pink!"	
37.19		"Pink, oh wow!"
		This game continues on for another couple of minutes in exactly the same way and then Tasha says:
39.16	"You can see the sea!"	
		We continue to name more colours then I suggest bringing the puppets over to the 'sea' and ask:

40.10 **40.12**	 "All of them!"	"Which ones should we bring over?"

MM7. Session 23. Chatting.

Table A7.3 MM7

Time code	**Tasha**	**Kate**
		We are sitting next to the wall of wellington boots which are part of the sensory room equipment. This
23.30	"My baby little sister have 'frozen' boots	*sparks a discussion*
23.39		"Oh, really"
23.40	"But I don't got some and my big sister don't got some"	
23.46		"But do you think you need some wellies for jumping in puddles?"
23.49	"Yes!"	
23.50		"Definitely"
23.52	"And I don't have black puddle or brown puddle only I have blue puddle"	
24.02		*Affirming* "Hmm" "Yes, there's lots of different colours aren't there. Lots and lots of different colour wellies, I think I would like….."
24.10	"I would like pink!"	

24.12		"You like pink. I think I would like ye…."
24.16	*Interrupting* "Because my favourite colour's pink"	
24.17		"Yes" "I think I like pink annnnd I like yellow but you know what? they will show the dirt and they'll look mucky won't they?"
24.27	"My" *thinking* "my big sister likes purple aaaand me like pink and yes, my little sister like orange"	
24.41		"oh" "so these –pointing at the orange wellies- would be for your little sister except they're toooo big!"
24.48		"How old is your little sister?"
24.50	"Ermm, she's four like me"	
24.53		*Surprised* "Have you got a sister who is four as well?"
24.57	Nods	
24.58		"Ahh, ok!"
25.00	"We have the same face"	
25.01		"Ha, you're twins??"
25.02	Nods	
25.04		"Have you?, really?" "I saw your little tiny sister, and she does look like you…"
25.14	*Thinking hard*	"But she's younger than you isn't she?"

25.16 **25.18** **25.23**	"I've got two babies!" "It's three thirty" *The conversation then continues for the rest of the session, discussing colours around the room and matching the scarves to the colours in the bubble tube and generally playing, talking and having fun together.*	"You've got two babies, you've got one who's younger than you and one who's a baby?"

MM8. Session 29. "I want friends".

For a few weeks I attempted to recruit support from the staff team to plan a programme for generalisation of Tasha's speech into the classroom. The staff team confessed to being too overstretched to release anyone to attend or even pick up Tasha from her sessions. However, after struggling with this Tasha requested to have friends in the therapy sessions, thus providing a natural way forward for the generalisation process. Therapeutic processes often function best when directed by the client's needs and in this extract (Table A7.3 MM8) Tasha spoke, I clarified and then discussed how we might put her suggestion into action.

Table A7.3 MM8

Time code	**Tasha**	**Kate**
	The small karaoke machine is playing a song and we are playing along with the song using percussion instruments	

	Almost inaudibly, under the background sound of the karaoke machine	
07.35	"I want friends"	
		Turning off the karaoke machine so
07.38		*that I can hear:* "What's that darling?"
07.40	"I want some friends to play with me"	
07.43		"Do you? Do you mean in here or in your classroom?"
07.48	"Here"	
07.49		"In here. Do you want to bring friends along?
07.51	Nods	
07.52		"Who would you like to come along?"
07.54	"Tyreese"	
07.56		"Is he your friend?"
		I then go on to explain the process of asking for permission which Tasha expresses frustration about and struggles to understand and accept

Peer work

Over the next few weeks we added Tyreese in session 31 and then Mary in session 35. Tasha had specifically chosen both of these classmates to be part of her therapy sessions. They had greatly contrasting characters that together formed a mutually beneficial

therapy group. When the children first attended Tasha was initially reserved but then quickly managed to engage in conversations with them.

Tyreese was introduced first in session 31 and was a whirling ball of energy. The staff team and I had initial concerns about him attending as he was a looked after child with complex emotional and behavioural issues, however Tasha was very clear about her choice and we decided to follow her lead as we suspected that she had an emotional rationale for this choice and that Tyreese would benefit from being chosen to play this role.

Mary was a more emotionally secure child, with a sweet nature, an interest in ballet and a clear sense of right and wrong. Together the group formed a very close bond resulting in some special Goodbye rituals that celebrated this bond when they were reluctant to leave the sessions.

Transdisciplinary work

Over this time I continued to attempt to engage staff in thinking about how Tasha's speech might be generalised into the classroom setting but with little success. Consequently I was also considering how many more classmates could practicably be added to the therapy session before Tasha was able to speak to her whole class across different settings.

****Contextual moment. MM9. Session 36.**

In session 36, James, a trainee Speech and Language therapist, interrupted our session to inform us that Tasha was due to attend a review meeting alongside her parents. I negotiated adequate time to bring the session to a satisfactory close and then take Tasha to the meeting. After this point James and I began frequent communication through meetings and emails in order to discuss and plan ongoing therapeutic provision for Tasha. One immediate suggestion was that James provided a similar session on another day each week with the aim of creating more momentum in therapy and hopefully increasing the rate of progress. Another rationale for this was that James was on site throughout the school week and hopefully could become a 'conversational partner' for Tasha and employ 'sliding in' techniques to generalise her speech throughout the school. The session was to take place in the same room, with the same children, for a similar amount of time and using a similar structure but with James to take the lead on employing techniques and

activities that he was comfortable with. After considerable intense planning James sensitively carried out a session with great success as shown in the email below.

Hi Kate,

I'd been meaning to email you as I actually had a session with them both on Monday and I started outside the room and I then opened the door and came in with Tasha's permission and she was very relaxed and talkative. It was actually quite amazing how much the 3 of us were speaking, Tasha told me about her weekend and why she had been feeling sad that day.

Based on this session do you think I should do another session today but, like you suggest, stay outside the room?

Let me know what you think and looking forward to talking in more depth about it tomorrow,

Kind regards,

James.

After session 37 there was a longer planning meeting with James and the main Speech and Language therapist (SLT) based in the school. A switch to intensive work was decided with James providing twice weekly sessions and a class teacher working with the group up to three times a week. James and the SLT also considered a psychoeducation session about Selective Mutism to be a high priority for the full school staff team.

****Contextual moment MM10. Around the time of session 47.**

In this case the process was hugely successful. To evidence this final stage in the therapy I share another email from James describing the final stage of generalization as we came towards the end of the summer term.

Hi Kate,

I just wanted to give you an end of term update on how our sliding in sessions have been going with Teresa (cc'd): Tasha's new teacher. We did two sessions outside in Reception with Teresa present and Tasha by the second one was very relaxed and talking relatively freely, we left Tasha and Teresa to work together and they have started to develop a nice connection, with Tasha speaking to her. Following on from the success of this we asked Tasha if she would like to do our next session upstairs in Year 1 and she nodded and seemed very excited about this, and we carried this out on Monday. Tasha was very excited to be up in year 1 (as were a

few of the others in our group!) and was speaking, even though there were at points older children in the room. She seemed very intrigued by her surroundings and wanted to explore a lot.

I spoke to Teresa this week and apparently during a welcome activity into the new class (for 'meet the teacher day') she introduced herself in front of the whole class, which was obviously a really big step.

Anyway, just wanted to let you know where we were at and to thank you again for all the support,

Kind regards,

James.

Appendix 7.4 Transcribed meaningful moments on Maria's Path into Speech

MM1. Session 1.

Throughout the whole of the session Maria played many different instruments in quick succession but did also engage in some clear non-verbal communication. Although this comes towards the end of the first session, this moment (see Table A7.4 MM1) gives a sense of Maria's high anxiety levels and initial manner of engagement.

Table A7.4 MM1

Time code	Maria	Kate
25.14	Playing the gato drum with 2 beaters	Playing the ukulele in time with Maria's drumming
25.24		Singing "we are playing music
25.26	Stops briefly then	together"
25.27	starts drumming again	
		"
25.29	Stops and stands up and walks over to the dhol drum.	
25.32	Taps the drum 7 x	
25.36	Picks up and shakes the hand bells	
	Puts them down and stands up	"
25.39	and finds the tambourine	
25.43	Plays the tambourine briefly	
25.49	Picks up and hands me a recorder	"
25.50		"Thank you" On the recorder 'toot toot tootoot te toot toot toooooot'

25.57		Then back to singing and playing the ukulele. “She’s very very busy today”
26.00	On a green (different!) recorder ‘phooooooooo’ ‘phoo ooo ooooo’	‘oo oo de de fathera fathera da da oo oo’ Reflecting Maria’s recorder playing
26.08	Shows me the fish woodblock in a questioning sort of way	
26.10		“It’s a fish. Give it a hit”
26.14	Gets a beater and gives the fish a hit x 10	Overlapping with her hitting ‘oo oo oo oo oo oooo’
26.18	Looks at me and smiles briefly	‘o o o o o o o’
26.21	Plays the recorder Puts it down	‘Blooow blow bloooow blow’ ad infinitum
26.30	Plays recorder again	
26.35	Finds the cow bells and plays them *In just over a minute, Maria plays 8 different instruments.*	In time with the cow bells “Blow blow blo blo blo blo blow bloo bloooo’

MM2. Session 2.

Maria enjoyed playing the cymbals loudly and indicated through her enthusiastic playing at the end of sessions that she would perhaps like to stay longer. Maria seemed to sense that this intervention was going to be helpful to her. This moment (Table A7.4 MM2) shows Maria's rapid engagement in the sessions and her emerging louder, more confident playing.

Table A7.4 MM2

Time code	**Maria**	**Kate**
	Maria has been for a toilet break in the middle of the session. This moment happens when she comes back into the room at the beginning of the last 10 minutes of the session.	
20.00	Finds a beater	
20.03	Crashes loudly on the cymbal	
20.04		"wow!!"
20.09	Crash	
20.10	Crash	
20.11	Crash	
20.12		Crash on the cymbal
	Brief silence	
20.18	Crash	
20.20		Quiet cymbal
20.21	Crash *mf*	
20.23		Crash *mf*
20.24	Crash *mf*	

20.26		Crash *mf*
20.27	Crash *mp*	
20.28		Crash *mp*
	Walks off and goes to explore in	
20.32	*the tub of small percussion*	I pick up the tambourine and start a brief improvisation using a soft beater
	Looks around but nothing really interests her and so she walks back, finds another beater and then	
20.50	Crash *mf*	
20.51	Crash *mf*	
20.52		Crash *mf*
20.53	Crash *mf*	
20.54		Crash *mf*
20.55	Crash *p*	
	Stands with her back to me for a bit holding the drum stick in her hand.	Continued crotchet 2 quaver beat on tambourine
21.00	*Then turns around and*	Sung "wow that was so loud"
21.03		Crash
21.06	Crash	
21.07	Crash	
21.08		Crash
21.09	Turns away from the cymbal and then does a little circle	*Singing*- "That was really good and loud"

MM3. Session 4.

Already there were much more connected musical interactions between us together with the emergence of humour and giggling. This extract (Table A7.4 MM3) is very playful in tone with lots of sustained eye contact and smiles.

Table A7.4 MM3

Time code	**Maria**	**Kate**
	Big intake of breath and a long loud blow on the wooden train whistle.	Picking on the guitar and attuning to
6.19	'Phoooooo'	any specific sounds. *Singing*:
6.20		"woo ooo oooo"
6.22	'Phooooo'	
6.23		"wooooooo"
6.25	Stands up and finds a big beater for the cymbal.	
6.28		"Oh wow!"
6.32	Confident cymbal crash	
6.33	Looks directly at me and makes a pleased face	Big strum on the guitar and arm up in the air reflecting the crash
6.35		*Spoken* "Cer rash!"
6.36	Sits back down and picks up the train whistle again.	
6.39	"phoo pho"	
6.40	Puts it down	*Sung* "woo oo woo, woo oo woo"
6.44	Grabs and plays the	
6.45		

6.46 **6.48** **6.55** **6.57** **6.58** **6.59** **7.00** **7.01** **7.02** **7.03** **7.04** **7.05** **7.06** **7.07** **7.08** **7.09** **7.10** **7.12** **7.13** **7.16**	Rainstick- making some mouth movements Brief Silence Putting hand up to mouth A couple more beads fall. Looks at me, giggles with her hand in front of her mouth Holding the quiet rainstick and looking at it. Brief silence Giggling with hand in front of mouth. Picks up the train whistle again and "Phoo" mis-blows silently then "Phoo" Looks at me and smiles and giggles Then just giggling whilst 'wiping' her mouth with her hand	Strumming the guitar, attuning to the rainstick singing "It's raining, it's pouring,……" fading my strumming with the last bit of 'rain' Brief Silence Picking & attuning to the final few beads "hee hee hee" Gently, "It's raining, it's pouring" Gentle guitar Silence Giggling Guitar and singing "The old man is snoring" "Wooo" simultaneously Giggling with her More giggling

MM4. Session 5. Physical components: 'Shaking up the bubbles' Song and Dance.

Dancing and physical components were key forms of expression for Maria as she seemed to channel and transform her anxiety through intense physical playfulness. Having a few minor mishaps also seemed helpful in providing natural cues for spontaneous vocalisations (Table A7.4 MM4 25.42; 25.54).

Table A7.4 MM4

Time code	**Maria**	**Kate**
	Maria has gathered together all the pots of bubbles that she wants to use in order to shake them up. To do this she jumps up and down and this turns into a dance.	*I am sitting on the floor and so I lift my arms in the air to join in with the dance and sing loudly* "shaky shaky shaky shaky shaky shaky "
25.22	Jumping up and down with the 3 pots of bubbles	
25.25	Gathers them together more securely	
25.27	Starts jumping up and down again Dancing and moving her arms up and down and giggling "	*Shout/singing* **"**wa wa wa wa, shaking shaking bubbles up" "shaky shaky shaky shaky shaky shaky bubbles" "ooh shaky shaky shaky shaky shaky shaky bubbles" *ad infinitum to the rhythm of the dancing*
25.29		
25.31		
25.39	Slows down a bit	Slower and calmer
25.42	Drops a pot of bubbles and exclaims loudly "aaaaah"	"Oh whoopsie"

	Picks them up and continues.	
25.54	Hits her hand when dancing “ow”	

MM5. Session 6. Fighting animals & dramatic play.

Expressing something about hitting and fighting seemed important for Maria. I accepted it without feeling the need for a deeper interpretation. However, upon reflection perhaps it was a way of summoning positive energy or power to take a risk and communicate and assert herself or to share something more difficult within her life. Children with SM have often suppressed a range of feelings within the school environment and it is important that these are expressed freely.

Table A7.4 MM5

Time code	**Maria**	**Kate**
00.00	*Sitting down, getting settled for the beginning of the session.*	*Sitting down on the floor with the guitar ready to sing ‘Hello’*
00.18	Picks up some puppets	
00.19		“A little doggy and another
00.20		doggy…aah”
00.21		Starting to strum the Hello song
00.28		*Sung* “little doggy”
00.30	Looks at me and shakes her head	
00.31		“No? it’s not a doggy?” laughing
00.32	Putting the puppets thoughtfully on the ocean drum	Continuing to strum
00.40		“Lets sing ‘Hello doggy’ today”

00.42	Looks up at me, smiling, a bit unsure	Strumming, but not singing
00.43	Bounces one dog puppet onto the other dog puppet	"
00.45	Continues with this but constantly checking in through eye contact with me	"Oooh, one doggy is being naughty to the other doggy?"
00.48	"	"Haaaa!"
00.50	"	"Ooooh, naughty rabbit as well!"
00.56	Gets the rabbit puppets to join in as well.	Exclaiming "Haaa! Oh no!"
00.57	Eye contact and smiles.	
01.00	Continuing with the fighting "	*Singing* "Hello Animals"
01.05	Looks up and sneers indicating the puppets are being 'bad'	*Spoken* "Oooh, bounce, bounce, bounce"
01.07	Stronger bounce/fighting on the drum	*Sung* "How are you today?"
01.10	Looks up, really smiling and pleased with herself	
01.12	Sniggering	Sniggering too
01.14		"Haaa!! he crashed the other doggy!"
01.17	Bouncing the puppet up and down	"He squashed him!"

	Forceful crashing with the puppet	
01.18	Bash	"Crush, crush,
01.19	Bash	crush" in time with Maria
01.20	Bash Bash	"crush, crush" repeated
01.21	Bash Bash	getting faster with Maria
01.22	Bash bash bash	"Biff, baff"
01.23	Bash bash bash	"Biff, baff, biff
01.24	Stops	baff, biff, baff"
01.25		"haaaa" descending
01.26	*The play continues in a similar vein for about another 30 seconds*	*Close 'same time' attunement with the dramatic play alongside Maria.*

MM6. Session 6. Brave lions roaring.

This next moment (Table A7.4 MM6) occurred just pre-speech in the sessions. Vocalisations and single words happened in session 7. In this extract Maria seemed to want to tell me to continue dancing but communicated this through roaring instead. This also provided a strong imagery of a 'brave' lion roaring. Bravery and 'brave talking' is a concept that is much embraced in U.S behavioural programmes for SM. In this extract Maria is 'brave roaring' before talking in the next session.

Table A7.4 MM6

Time code	**Maria**	**Kate**
	We have been engaging in an energetic dance, jumping around the room with shakers and are pausing as we are 'tired', lying down on the floor	
11.28	Starts dancing again	**"**Oh no she wants to do more dancing!"

11.30	Dancing, jumping, smiling and	
11.32	laughing at me- full eye contact	Dancing and jumping with the shakers and pretending to stop “la la la la, uuh” with tiredness
11.48	Really laughing loudly	
11.54	Drops onto her knees in a dramatic fashion	
11.57		I drop down too
11.58	Jumps up and ‘roars’ at me loudly	
11.59		I ‘roar’ back at her, shaking my head a bit like a lion
12.03	Smiling and laughing at me	
12.05	Long loud ‘roar’ back at me, close to my face	“raaaaah, ha ha ha”
12.07	Starts dancing again	

In sessions 7 and 8, there are lots of examples of vocalisations that are creeping closer to speech: “uh oh”, “oh” and single words “Hello” and “no” but it isn’t until the end of session 8 that full sentences appear. However, in this session the video recorder ran out of power at this precise moment and I certainly didn’t want to interrupt the flow of the session to rearrange recording at that moment.

MM7. Session 9. Single words into full sentences.

In order to demonstrate the process of physically sliding into speech and achieving full sentences, I transcribe here a longer section from session 9 where Maria used single words and then quickly into full sentences. I also appear to have employed an element of teasing in this extract to elicit speech. This process of sliding into speech had also happened the session before. For a few weeks it appeared that in every session the process of moving into speech started back at the beginning of the process again but moved more swiftly along into full sentences producing an overlapping staggered process of progress.

Table A7.4 MM7

Time code	Maria	Kate
	Building a pile of cushions to make a 'slide'	*Attempting to assist with the 'slide' but M doesn't always want me to help*
11.24	Pats the last cushion that she has put in place	
11.26		Mischievously drumming on the top plastic cushion
11.27	Brushing my hands away to stop me drumming and shakes her head	
11.28		"No? I'm not allowed to touch it!"
11.30	Smiling and shaking her head and touching the top cushion	I put my hand back on briefly "No?"
11.31	Starts giggling	
11.32		I continue to touch it and say "No?"
11.33		
11.34		"No?!"
11.35		
11.36	"mmmmm"	
11.37	"mmmmm"	
11.38	"Noooo!"	
11.39		Giggling but still with my hand on the cushion
11.41	"Mmm mmm mmm!" Shaking her head –no-	

11.42	Giggling	"Oh ok, all right!"
11.43		"Huh" One last playful touch of the cushion then taking my hands away laughing
11.45	Ignores me and picks up another cushion	
11.47	Drops it down	
11.48		"Ooh, that one there!"
11.50	Picks up a shiny scarf	*Singing* "De de dee de dee"
11.51		"Shiny shiny scarf"
11.53	Puts it on the 'slide'	Spoken "Can I help with the scarves?"
11.55	Nods 'Yes'	
11.56		"Yes?"
11.58	Jumping and clapping her hands	
11.59	together in joy at the slide	"Woooo, yeeaas!"
12.02		"Do we need more slippy scarves?"
12.03	Looking for more scarves	*Singing "la la la la laaa"*
	Picks one up and says	
12.07	'Pink'	
12.08		"Beautiful pinky pinky oooh"
12.12		"ooh beautiful scarves"
12.13	Swaying the scarves from side to	
12.14	side	Joining in with the swaying
	"	
12.15		*sung* "la lalaa la lalala laaaa"
	Looking at me	

12.18	Shakes her head looking slightly dismayed at my dancing	I stand up to dance around the room with the scarves
12.20	More swaying with the scarves	
12.21		"No?"
12.22	"	*Sung* "De de daa de fathera da daaa" in time with the swaying
12.26	"	"
12.28		"woooooo"
		"yay"
12.33	Starts to put the scarves on the slide again	
12.34		"wow"
12.35	Playing with the scarves	*Sung* "Beautiful, beautiful scarves"
12.38	Spoken loudly "Red!" showing me the red scarf	
12.39		"Red scarf"
12.41	Puts the red scarf over her head	
12.43		Putting the orange scarf over my head "Orange!!"
12.44		
12.48	Walks up to me with the scarf over her head saying "ghost!"	
12.50		"waaaaahhhhaaa" *ghostly noises*
12.55	"No, you're not a ghost"	
12.56		"No? I'm not a ghost. Ok, I'll take it off…"

MM8. Session 9.

The communication then gradually built up with Maria using longer and more frequent sentences. The next extract shows a longer conversation 4 minutes later when Maria wanted to do some gymnastics in the room.

Table A7.4 MM8

Time code	**Maria**	**Kate**
16.47		**"**What shall we do?"
16.48	*Thinking* "Errrrm"	
16.50	*Maria attempts a cartwheel on the floor*	
16.52		"Oh wow Maria! You're good at gymnastics!"
16.54		"Let me get you a bit more space!"
16.55	"I need more space!"	
16.57		"You need more space for your gymnastics"
17.00		"And you need things to land on. Look…"
17.04		*Putting plastic cushions on the floor* "Can you land on these things?"
17.06		"You can do a roly poly or something?"
17.08	"No, I can do this!"	"Ok"
17.11	Attempts a rolling activity but it goes wrong and she lands on her bottom.	
17.14		
17.15		Gentle laughter "That was good"
17.16	"No no, that was wrong!"	

17.17		"That was wrong"
17.18	"I need three of them"	
17.20	"And one pillow"	
17.21		"Ok"
17.23	"Lots,	
17.24	ooh a big one!"	
17.25		"Ok and a big one as well"
17.28	"Oh"	
17.29		"Where's that one gonna go?
17.30		At the end?"

Appendix 7.5 Transcribed meaningful moments on Rabiyah's Path into Speech

MM1. Session 1. Same time game.

Although Rabiyah appeared slightly nervous at the beginning of the first session she quickly engaged in musical communication. In this extract (Table A7.5 MM1) Rabiyah took the lead in a 'same time' game. We were sitting cross-legged on the floor, facing each other.

Table A7.5 MM1

Time code	Rabiyah	Kate
	Sitting cross-legged on the floor, facing each other	
12.43	Enthusiastically shaking a rainstick up and down holding with 2 hands near the top. Full eye contact and big smiles.	Strumming a repeated chord about half the speed of Rabiyah's shaking. Looking directly at Rabiyah, meeting her gaze and smiling back.
12.50	Stops. Still looking directly at me and smiling.	
12.52		Stopping 2 beats after Rabiyah and letting the sound of the guitar hang in the air.
12.54		I look around in over-dramatic suspense, wide-mouthed and put my hand up to my ear.
12.56	Quick shake of the rainstick then stops	
12.57		Quick reflective strum on the guitar
12.58	Little quiet chuckle in the silence	
12.59		Bringing my head lower in reflection of the chuckle and smiling at her

13.00 **13.01** **13.02**	Starts shaking the rainstick again. Another little chuckle and continuing to shake the rainstick	I start strumming the guitar in quick response, making a funny face and laughing as if she is trying to catch me out.
13.05 **13.06**	Stops playing	I stop too but the guitar rings out and again I make an open-mouthed dramatic face waiting to start again. I join in almost immediately
13.09	Plays again briefly	And stop at the same time.
13.11	Stops	I join in again but this time don't follow her so precisely and hit the cymbal with my hand in a gap her R's playing.
13.15	Plays again but watches me carefully and decides to continue when I continue too. *This same time game continues for a long while with Rabiyah playing many different instruments*	

The chuckle and use of voice this early on in the therapy felt like a positive indication of how the therapy might develop. Later in the session Rabiyah's expressive confidence shone through when she initiated playing the 'same time' game again. She stopped playing, looked at me and waited for me to stop and give her full attention before smashing the cymbals again when I once again reflected and played 'together' with her on the guitar. This first session gave the sense of a girl who had some inner confidence but perhaps hadn't had the opportunity or means for this to be expressed.

MM2. Session 3. Singing and talking.

After session 2 Rabiyah had taken a kazoo home to practice on and in this session she was able to sing through it. Later she also sang "Jingle bells" with me using the karaoke microphone on a harmony setting. After this she was able to use her voice to name different animal finger puppets as we took them out of a bag (Table A7.5 MM2)

Table A7.5 MM2

Time code	Rabiyah	Kate
25.45	*Singing* "Old Macdonald had a farm, e i e i o" into the microphone	*Singing* "Old Macdonald had a farm, e i e i o" and playing guitar..*spoken quickly* "ooh what's in the bag?"
25.50		*Sung* "And on that farm he had a..?"
	Taking a frog puppet out of the bag.	
25.56	*Into the microphone* "Rabbit!!"	
25.57		*Deliberately mishearing her*- "Yes, it's a froggie which goes 'Ribbit, ribbit'"
25.58	Singing "e i e i o"	Singing "e i e i o"
26.01		"With a ribbit ribbit here and a ribbit ribbit there etc"
26.03		Spoken "well done!" *More 'Old Macdonald'*
26.13		"What other animals does Rabiyah know?"
26.19		"Do you know what that one's called?"

26.21	"It's a panda!"	
26.23		"Oh, they're really cute pandas! Have you seen them on tv? They have really cute babies!"
26.33		Singing "e i e i o" Spoken "and they don't really make noises they just chew bamboo!"
26.48		Singing "what else can she find?" getting quieter "e i e i o"
26.58	Taking a doggie puppet out of the bag	Spoken "What's that?"
27.00	Whispering "It's a doggie"	
27.02		*Spoken* "It's a doggie!!"
27.05	*Singing* "With a woof woof here and a woof woof there " etc	*Singing* "With a woof woof here and a woof woof there" etc

MM3. Session 7.

At the beginning of this session Rabiyah had been singing a 'rocket' song that she taught me and then answered questions about the colours on the didgeridoo and other objects. In this session Rabiyah spoke spontaneously for the first time when she exclaimed that a ball had become stuck in the didgeridoo. She simply said "It's stuck". This short phrase was then developed into a little game involving the badger puppet whereby the ball is repeatedly put into the didgeridoo and Rabiyah was then able to repeat her phrase as part of the game. Following this we had a conversation through the didgeridoo (Table A7.5 MM3), again with me taking the lead and asking questions but this time with a wider variety of topics and some longer responses from Rabiyah.

Table A7.5 MM3

Time code	Rabiyah	Kate
		I pick up the didgeridoo so that I can talk down it.
28.08		*With a silly voice* "Hello Rabiyah, how are you? You ok?"
28.14	*Talking down the didgeridoo* "Yes!"	
28.16		*Still in a silly voice* "Are you having a nice day?"
	"Yes!"	
28.18		
28.20		"And how old are you?"
	"Five!"	
28.22		
28.23		"Wow, you're five?" "Oh, you're tall. Ok..."
28.28		"What's your teacher called?"
	"Miss Griffiths"	
28.30		
28.33		"Oh wow, that's a nice name and do you have a teaching assistant…"
	Shakes her head	
28.38		
28.40		"No, ok" "What's your best friend called?"
	"Elikem and Amima"	
28.44		

28.46	Nods	"You've got two!"
28.48		
28.49		"You've got two best friends"
28.51		"And do you have any brothers and
	"Yes"	sisters?"
28.54		
28.56	"Niymet & Ikram & Yusef"	"And what are they called?
28.58		
29.01		"Ooh, they sound nice, how old are
		they?
	Rabiyah seems confused here and	
29.03	*shrugs her shoulders.*	
29.19		*I make 'badger' play a note on the didgeridoo to break the tension a little bit and exclaim* "Badger!!"
		"That was cheeky!"
29.28		"What did you do in the holidays?"
	"Watching TV"	
29.31		
29.32		"Ooh, that sounds nice"
		"Did you go out any here? Did you go
	"Yes"	to the shops?"
29.38		
29.42		"Did you go…to the park?"
	"Hmm, yes"	
29.44		

29.45		"That's nice. Jolly good. And what else did you do? Did you help around the house?"
	"No"	
29.54		
29.56	"No"	"Did you play with your sisters?"
29.58		
29.59		*In exaggerated disbelief* "Nooo?!" "You didn't play with them? Not at all?" *Chuckle*
30.05		"Ok, fair enough, did you play on your own?"
	"I played with Mardola"	
30.11		
30.15		"Who's that? Is that a friend?"
	"She's from nursery"	
30.19		
30.22		"Aw nice, that's nice!"
30.29		"And that's your friend from nursery...that's good. Lovely"
30.32		"And do you want to ask badger a question?"
	"No"	
30.35		
30.40		*Laughing* "She doesn't want to ask you any questions badger!" "erm"
30.48		*Asking badger a question…* "Who's your favourite friend?" "Foxy?"

30.51 **30.57** **30.58** **30.59** **30.02**	*Picks up the didgeridoo independently and gives a good effective blow down it* *Continues to play it whilst I talk about the next session and then holds it up in the air.*	"Right, I need to see what time it is Rabiyah because it might be nearly time to….." "oh!" "Wow, that's so loud! Brilliant!"

MM4. Session 9.

These next two moments describe the initial level of vocal engagement in the session and the subsequent emergence of perhaps more challenging feelings in the therapy.

Table A7.5 MM4

Time code	**Rabiyah**	**Kate**
1.08 **1.10** **1.15** **1.16** **1.20** **1.22** **1.30**	*Into the karaoke microphone on the harmony setting* "ooh, ooh, oooooh, ooh ooh oooooh" Continuous singing in the harmony of the Hello song. Ascending melody Brief pause in singing	*Starting the 'Hello' song in harmony with R's singing-* "Hello, Rabiyah" Interjecting with speech "Lovely!" Singing again "How are you today? How are you today?" Joining in with ascending melody Short laugh Singing and copying R's melody "Laa la la laa la la laa"

1.33	Singing a high, 4 note repeated phrase "oooo o oooo o"	
1.36	"oooo o oooo o"	Joining in with R "oooo o oooo o"
1.39	"oooo o oooo o"	"oooo o oooo o"
1.43	With slight variation "oooooo o oooo o"	Accompanying "oooooo o oooo o"
	Rabiyah continues to improvise with the mic in her mouth for another 3 minutes	Continuing to reflect and improvise vocally alongside Rabiyah. After 3 minutes gently starting to sing her 'rocket song'.
5.02		"Where shall we go in the silver
5.05	Joining in with the 2nd phrase "Where shall we go in the silver space ship?"	space ship?" etc "Where shall we go in the silver space ship?"

MM5. Later in Session 9.

We had been exploring some other objects in the room and Rabiyah discovered a toy pig.

Table A7.5 MM5

Time code	**Rabiyah**	**Kate**
27.50	"Pig"	
27.51		Quietly commenting "There's lots of books and things, oh a pig"
27.56	"He's poo pooing"	
27.59		Exclaiming "Oh no! is he? oh yuck!
28.01		Eerr"
28.03	"Eerrr"	
28.08		"Is he doing a poo?"

28.10	Holding the pig over me "He is pooing on your head!"	
28.12		"Oh no, I don't want him to poo on my head!"
28.17	"He's pooing here!"	
28.19		"On my back!"
28.20	"Yep" Laughing	
28.22	"He's pooing here!"	
28.25		"Oh no!"

This exchange seemed quite playful but it felt as though there had been a change in the dynamics with Rabiyah perhaps experimenting to see if she could share some different issues in the therapy sessions. Around sessions 9-12 Rabiyah's class teacher and others reported the increase of speech firstly within the playground and ultimately into the classroom setting.

MM6. Session 12.

By session 12 Rabiyah was using confident speech in the therapy sessions and appeared to explore how this perhaps have her a feeling of power. The next extract shows the 'edginess' present in the sessions and then Rabiyah playing at being a teacher.

Table A7.4 MM6

Time code	**Rabiyah**	**Kate**
	We are sitting near a giant abacus and some other toys in a 'home corner' area of the room.	*I am playing the guitar and chatting and listening to Rabiyah talk about a range of different things.*
13.30	"My mum buys hot chocolate!"	
13.33		"Does she?!"

13.34	"Yeah!"	
13.35	Swinging a metal play jug and accidentally bashes it on the play kitchen.	
13.36		"Ooh!"
13.37	Deliberately bashes it again	
13.38		"Ooopsie!"
13.39	And again! "Not me!"	
13.40	Laughing	"Ooh no!"
13.41	Bash	
13.42	More laughing	"I think it is!"
	Short pause	
13.46	Bash	
13.47		"It's not a drum!"
13.49	Shouting "It's coming from outside!!" Gesturing for me to look towards the window.	
13.51	Bash	
13.52		"Crash, bang, wallop!"
13.53	"It's not me!" "It's something outside!"	
13.59	Bash	
14.00		"Is there a little monster outside?!"
14.03	"Noooo!"	
14.05	"The rain is making that noise!"	
14.07		"The rain can't be…"
14.09	Bash!	

14.10		At a higher pitch “making <u>that</u> noise!”
14.12		“Aah Rabiyah you might break it!”
14.13	“Nooo!” “I’m not doing that, I’m just doing this!”	
14.17	Bash	
14.19	Laughing	“You’re smacking the thing into the…”tailing off to play the train
14.23	Bash	whistle “Phoo” Mirroring the energy a bit. “You might get into trouble!”
14.27	Lighter bash	
14.28		Quieter, more serious “You might break it”
14.33	Bash	
14.35	Bash	
14.36		To distract her a little bit “So Rabiyah how are you doing in your class this term?”
14.38	“Fine!” Laughing	
14.43	In a singy, teasy voice “I put the cup on the flo oor”	
14.50	Threatening to push the giant abacus over on the floor, but then trying to pick it up.	Noticing “Oooh!”
14.54		“Oooh, what are you going to do with that?”

14.56	"I'm gonna put it on the carpet!"	
14.58		"Oooh, okay"
	Busy moving it	
15.07		"You're going to take it over there?"
15.09	"I'm going to leave it over here"	
15.14		"Are you going to teach some counting to the children?"
15.17	"You're…you're the children and..	
15.20		"You're the teacher?"
15.22	"Yeah!"	
	Then follows quite a few minutes of Rabiyah teaching me counting on the carpet but threatening to call the police when I do it wrong.	

MM7. Sessions 14, 15, 18. A barrage of challenging feelings.

Over the remaining few sessions Rabiyah seemed to explore some more challenging or perhaps ambivalent feelings about the therapy itself, the imminent ending and also me – the therapist. There was also a sense that she has perhaps been bullied or verbally abused as she used some insulting language in the sessions. The following are brief verbal snapshots to present the main features of the last sessions.

Table A7.5 MM7

Time code	**Rabiyah**	**Kate**
Session 14		*I am still singing the 'Hello' song but Rabiyah is chatting about different things.*

2.34	Singing into the didgeridoo “Na na ne na na!”	
2.36		Singing “Na na nanali na”
2.40	“I hate you!	
2.41		Shocked “Huh!”
2.42	Brief silence	
2.45	“I’m joking!!”	
2.46		“Oh?!”
2.48	“I hate you!”	
2.50	“I’m joking!”	
2.52	“I hate you!”	
2.55	“I’m joking!”	
	This goes on for another 30 seconds and then	I decide to respond by singing about it and saying that I don’t know what to think.
3.23	“I like you!	
3.25		Spoken “Oh that’s ok. I like you too.”
Session 15		*We have been writing on the board together and I am looking around for another activity.*
19.01		“Do you want to see these walkie-talkies?”
19.05	In a very loud voice “No!”	

19.06		"Noooo?"
19.07	"You stupid girl!"	
19.09		"Huuu?, oooh maybe you can go back to class?"
19.11	Shouting "No!!"	
19.16	"You dumb girl!"	
19.18		"That's not very nice"
	Short silence	
19.28	"Where's the paper, you dumb girl"	
19.31		"Hm, maybe I'll pack up and go?"
19.35	"Where's the paper you dumb girl!"	
19.38		"Do you want to go back to class?"
19.41	"No! You dumb girl" Laughing loudly.	
19.46		"That's not a very nice thing to say"
19.55	"I'm going to beat you up you dumb girl!"	
Session 18 - last session		*I have given Rabiyah a recorder as a take home present. After this she negotiates taking kazoos home as well which I have to limit to 2.*

28.39		"Let's just sing the Goodbye song Rabiyah and then we can go back"
28.41	"Noooooooo" "Noo" Noo"	
28.45		"You don't want to sing the Goodbye song?"
28.47	"Yeah, I hate it!"	
		I don't insist on the Goodbye song and just walk with her back to her class room.

Appendix A7.6 Transcribed meaningful moments on Mark's Path into Speech

MM1. Session one. Anxiety shown in mouth movements and inability to actually play instruments once picked up.

This moment was the first few moments of the first session. I hadn't had time to set the session up yet as Mark was scooted in to the room with me by his class teacher. Not wanting to cause any further disruption to Mark, I decided to incorporate setting up as part of starting therapy.

Table A7.6 MM1

Time code	**Mark**	**Kate**
		I have flung a piece of fabric on the ground and put a small basket bag of instruments on the floor in front of Mark. My instrument trolley is next to me.
00.00	Mark is playing with the mouth organ in the box. Quite pursed lips and little mouth movements. Sits down just out of camera shot.	I adjust the camera angle and exclaim "Wahee, wahey" "Next time I come I'll have it all set out before. It's fantastic though to have a helper" I unpack the karaoke machine. "Do you reckon you might want to play the cymbal? Shall we get the cymbal out?"
00.35	Mark nods agreement	"The cymbal's great 'cause it's really loud"
00.46		I proceed to get out the ocean drum.
00.51	Mark finds the cow bell in my small instrument bag and gets it	

	out. Kind of looks at me and shows me.	"Now that one is called the cow bell.
1.07		I find a yellow beater and hand it to him and demonstrate how it works. I accidentally tap his finger –very
1.11	Mark rubs his finger on his T-shirt.	lightly- and I exclaim that I got his finger.
1.21	Takes the yellow beater but doesn't play the cow bell. Kneels down on the floor near the bag.	
1.25	Explores in the bag and finds the green recorder.	"woo, cor that cymbal" I continue to set up the cymbal
1.30	Expressive facial movements at this point with wide eyes.	"Oh wow, that's the recorder!"
1.40	Finds a piece of a kazoo and hands it to me. Makes a little vocal sound to get my attention.	
1.43	"hm"	"hm, hm, hm, hm" I explain about how the kazoos sometimes fall apart. I find another one and play it briefly explaining how they work in a casual manner. I continue chatting and
02.05	Puts the green recorder in his mouth but doesn't play it.	demonstrate the echo mic too and then go to put the do not disturb notice on the door.

02.10 02.20 02.35 02.48	Looks at the train whistle and looks as if he might try playing it but then puts it down Mark hits the echo mic a few times with his hand to make it sound. Puts the echo mic to his mouth and mouths very briefly and gently and then quickly puts the echo mic down	 I explain that I am going to sing the Hello song Then I exclaim that the guitar is really out of tune

For the remainder of this session there was reasonable exploration of instruments and in particular the Walkie Talkies which were played as an instrument, using the bleeping button, rather than to talk into. Later in the day the class teacher reported that Mark spoke to her, which felt somewhat miraculous although it was then subsequently un-sustained.

MM2. Session 2. Oral instruments.

Session 2 has a sequence of events that shows rapid and sustained development within the therapy. This moment shows the start of his ongoing interest in the mouth organ.

Table A7.6 MM2

Time code	**Mark**	**Kate**
10.40 10.50	Takes the mouth organ out of the bag. Watches me then	I comment that it is the mouth organ. “shall I show you how to play it. Let me see if it sounds the same”. I play the mouth organ.

11.02 11.11 11.28 11.39 11.58 12.09 12.40 13.00 13.39 13.45	Joins in with one little blow. Picks up the mouth organ tentatively. Plays the mouth organ again. Keeps going until Stops Starts again. Picks up the recorder and plays it. Uses his fingers and plays quite nicely. Picks up and tries the Swanee Whistle. Recorder blow Mouth organ again.	 I sing about playing the mouth organ, accompanying myself on guitar. I switch my reflective singing to be positively about this and quickly play the mouth organ again too. Continue playing the mouth organ and playing a steady beat. “ I add in the odd playful ting on the cymbal

MM3. Session 2. Vocalising.

This next moment shows the emergence of vocalisations around 5 minutes later using the echo mic and the Walkie Talkie (WT).

Table A7.6 MM3

Time code	**Mark**	**Kate**
18.00 18.09	Picks up the mouth organ and plays it then picks up the echo mic.	Just singing and vocalizing.

18.11 18.23 18.39 18.46 18.50	"ooh ooh" into the echo mic. Slightly fiercer noises Takes the WT and looks at it. Uses the ringing sound. "Hmm" not really anywhere near the WT "Hm"	 I hand him the Walkie Talkie (WT) and encourage him to make lion noises. Sung "can you make a lion noise?" I use the ringing sound too. I reflect back. "hmm" "Hm" "Hmmmmm"

MM4. Session 2. Louder oral and vocal sounds.

This last moment from session 2 shows the loud finale of the build-up on the oral instruments.

Table A7.6 MM4

Time code	**Mark**	**Kate**
27.40	Picks up the recorder, takes a deep in-breath and then plays *ff*. Long loud sounds on the recorder. Pointing the recorder up in the air.	Playing a beat on the tambourine and recorder Continuing to repeat this rhythm on tambourine.
28.30	Distracted by bleeping the WT for a bit.	Reflecting the bleep sounds vocally.
29.43	"Hmm hm" into the WT. Looks across at me.	I reflect back then try to get the WT's on the same channel so that

		we can 'talk' to each other on them. I continue to sing and play guitar "Hello Mark are you ok?" into WT.
30.04	Loud "hmmmm!" into the WT	
	Makes a funny face in response.	I continue to sing and play guitar.
30.12	Lots of "hm hm hm" into the WT	
30.30	Swanee whistle in the air	

MM5. Session 4. Star Wars drama - kazoo force!

In this moment Mark used his voice in order to play the kazoos. I then enfolded the kazoos into the drama by suggesting that they were the 'force', referencing 'Star Wars' and also symbolically employing the concept of power and energy. The dramatic concept fully engaged Mark's imagination and he was able to vocalise loudly at me through the kazoo.

Table A7.6 MM5

Time code	**Mark**	**Kate**
24.10	Finds a kazoo but it doesn't work.	I play one whilst he finds another.
24.19	Finds a red one and still can't make it work.	I describe how to play the kazoo.
24.26		I check that it has the paper in and then show him how to do it on the
24.39	Makes a little sound into the kazoo.	other end of the same kazoo.
24.43	Makes a powerful sound into the kazoo.	
24.55		Sung "Oh no he's got the red force. I've got the blue force"

25.00 25.05 25.10 25.16 25.39	Great loud kazoo battle. Does it towards my face and moves his arms back into a dramatic attacking posture. Takes a deep breath then: Loud Kazoo at me And again-same gesture Goes for another rummage in the bag Uses the echo mic for a similar battle.	Both at the same time, fortissimo. "I think we're about equal, equal on the kazoo force!" I use kazoo then echo mic.

MM6. Session 4. Mouth organ battle/duo.

This brief moment is a clear example of Mark's powerful initiation and use of both drama and music in his sessions. In this moment he was once again using oral instruments as the means of expression. There was also a sense, with the discussion of the sticker chart and the playing near the door, that Mark would have liked his efforts to be recognised outside the session.

Table A7.6 MM6

Time code	**Mark**	**Kate**
29.30 29.55	Passes me a mouth organ like a weapon! Has a mouth organ as well and gets it out and plays it.	"wow, I've been given a gift! Wow, it looks like a harmonica" Playing mouth organ and drum-quite medieval sounding.

30.20 30.55 30.56 31.20- 31.50	Quickly stops and points to a sticker chart. We discuss it and whether he would like one as well. "Hmm" like yes. Some shakes and "hmm"s We decide to make one for him. Loud, sustained playing of mouth organ, walking around the room then playing near the door.	General discussion of the sticker chart "Would you like one?" More general discussion Playing mouth organ and drum (sounds very musically engaged)

MM7. Session 8. (Taster session) pair work.

This meaningful moment is from a 'taster' pair session that provided the first contact with Mark after the summer holidays and the transition from his nursery to his reception class. There had been considerable preparation for the session through contact with the reception class teacher that included information and resource sharing about SM and creating a supportive, enabling environment.

Mark was initially reluctant to attend individual Music Therapy. After witnessing Mark's progression into confident verbal play with his friends I felt that this reluctance was understandable considering that playing with peers was where he was making progress. With this in mind I made an impromptu, 'improvised' decision to invite Mark and his friend Jacob into the Music Therapy room, just to see it and think about whether they might like to attend together. Jacob was also a child with SM but had not been prioritised for this last case study due to also having English as an additional Language (as had been the case for the previous five cases). Therefore, it also felt quite clinically valid to include him in these sessions.

Both boys presented as being very shy and quiet when they first entered the room. This persisted for around 5 minutes and then they both appeared to relax.

Table A7.6 MM7

Time code	Mark	Jacob	Kate
	Gentle exploration of instruments	*Gentle exploration of instruments*	*Commenting, supporting and exploring, singing and playing guitar*
5.25		Plays Cymbal	
5.26			Guitar strum
		"	
	Out of shot playing	"	"
	Star Wars with	musical	
6.08	powers/force "tsch tsch"	conversation/turn-taking with a combative element	"I need some music powers to give me some extra powers" Gato
6.10		Loud cymbal	drum series of notes
6.19		More powerful cymbal	Simultaneous strong guitar
			Alternating guitar & gato
6.40-7.00			Continuous guitar
7.00		Continuous loud cymbal	Quiet then whispering "wow, very good loud
		Quiet	
7.10	Whispers		playing!"
7.12	"Ghostbusters"		
			"did you say 'ghostbusters?'"
	Nods		"oh my goodness,
7.25			now I'm scared!"

	Dramatic running around as a 'ghostbuster'	More extremely powerful, continuous cymbal	Loud guitar and singing "ghostbusters"

MM8. Session 9. Shy beginnings then speech.

This moment shows Mark moving quickly into speech after 'attacking' me – or perhaps the talking lion puppet- in the drama. Again it seemed that finding some inner strength was helpful to moving into speech. Another battle then appeared to ensue between Mark and Jacob who seemed perhaps envious of our dialogue and tried to undermine it with the loud bleeping sound of the Walkie Talkie (WT).

Table A7.6 MM8

Time code	**Mark**	**Jacob**	**Kate**
6.30 6.47 6.57 6.59 7.49 8.00	Pretend fighting with me. He may be attacking the lion puppet who was talking on the phone. Says something in response to my question "Another star wars" Lots of chatting about the game.	Playing with the bell on the WT- keeps it on Jacob seems like he could be deliberately trying to disrupt the conversation with his little blips on the WT. Puts the WT in our faces.	"Oh my goodness is it ghostbusters or star wars?" "Do you have light sabres in this one?" "So which characters shall we have in it? Shall I be the girl one?"

MM9. Session 9. Talking to me, talking to each other, talking over each other.

In this moment they had both just established more confident speech within the session and were trying to navigate and establish the rules of conversation when the expressive act of speech itself must have felt like a relief. They talked to me, then each other. After this Mark seemed aware of Jacob's need to speak and gave him space to do so, as this confidence has come a little later than his own. However, Jacob did not reciprocate this kindness and once again –either consciously or unconsciously- undermined Mark's attempts to participate in the conversation through continuous speech, loud crackle sounds on the WT and then loud ocean drum sounds. This resulted in me taking some action to direct the session and Mark also became more assertive and used other techniques such as hand signals to let Jacob know that he wanted to speak. Eventually they managed to converse with each other once again. If harnessing their inner power through dramatic fighting and role play was helpful in eliciting speech then managing that combative drive within a conversation must have been a difficult and somewhat confusing leap to make so quickly. After this session the class teacher reported that Mark had been speaking a few words to her.

Table A7.6 MM9

Time code	Mark	Jacob	Kate
25.00	Mark talking to me.		
25.02		To me "Your ears are broken"!	
25.05	Mark smiles and comes over and pretends to attack me.	Jacob attacks too.	"At the end of the session when I'm all broken and you've beaten me can you make me better?"
25.08			
25.16	"No"	"No"	

25.35 25.44 25.50 25.55 25.58 26.06 26.14 26.20 26.25 26.33	"Why are you always using your light sabre then?" "What, Darth Vader doesn't have a light sabre?" "No he just uses this and this" gesturing "When I saw it on the TV, he had a light sabre" At same time as J "when I was watching…" Mark tries to say something but looks at Jacob talking and stops talking himself and waits for a bit for J to stop.	Smiling "My one doesn't even have a light sabre!" "He doesn't even have a light sabre" "He just has some (…) and some (..)" "But he does have some…" "Well, I didn't watch that one" At same time as M "I sawed on…" Jacob keeps talking. "It's similar to these but it just has a light bottom but…er…"	 "The one that you watched? no, I think that sometimes he does have powers?" I put my hands up to try to make them aware that they are talking at the same time. "did you?"

26.45 26.58 27.07 27.18 28.37 28.38	At the same time as Jacob “also there’s Winston, Allego and Willie and..(pauses as J is continuing to talk over him, seems a bit exasperated,) aargh” hits his mouth with his hand Pauses Tries again, this time moving into Jacobs personal space “erm erm” Waits again “um…um” trying to cut in. “oh Winston was a….Winston was a….” Puts his hand up to Jacob to indicate that he needs a space to speak. Finally gets a chance to tell me about ghostbusters. “nooo”	Keeps on chatting seemingly oblivious to Mark’s attempts to speak “….he has a different one” gesturing at the walkie talkie Jacob ameliorates Mark’s speech using the crackle sound on the WT. Jacob stops the WT but switches to the ocean drum which is also noisy. “no”	 I reply to Jacob “is it the Avengers you’re talking about?” Very lightly “take it in turns” I respond to Mark’s speech. “so do you guys play ghostbusters as well?” “so what do you play?”

28.48 29.00	"no, I was actually playing shoe-force at the gala before" "…"	"We play shoe-force hammers" "And then bat-man had a weapon..."	

Contextual moments.

Over the next few weeks the content of the sessions remained fairly similar but there was clear progress in the speech outside of the session.

- After session 9 there was some speech with the class teacher.
- After session 11 Mark started talking a lot to a teaching assistant.
- After session 12 he was talking to the class teacher normally, another teaching assistant and all children.
- After session 15 Mark's mother reported that Mark had had a very successful birthday party in which they invited the whole class to their house. He was shy at first but then was quickly talking to everyone. Mark's mother was delighted.
- Jacob's mother also reported that she has seen huge improvements in Jacob's confidence.

MM10. Session 16. Musical drama.

In this moment the boys had moved into a comfortable, relaxed place with their speaking and drama. Music seemed to become important again in a supportive, enabling capacity, enhancing their play. They had also made an additional 'creative space' under the table.

Table A7.6 MM10

Time code	Mark	Jacob	Kate
00.00 4.30	*Lots of chatting* Starts playing	*Together about who is going to be what* Starts playing	*I try to support them and engage a little bit in their discussion.*

5.08 6.17 6.30	They both go into their 'space ship' under the table Conspiratorial style whispering and giggling with Jacob Train whistle	Swanee whistle Some sporadic hitting of claves They come out from under the table and the drama changes slightly.	Chocolate power ranger recorder playing Piano accompaniment to their drama. Steady chordal pulse with quaver dyad melody. Gaps and chords to emphasize dramatic events. Spanish-style Guitar accompaniment

MM11. Session 16. Brief Oral instruments improvisation.

This brief improvisation felt like a group celebration of different elements of the therapy process. Mark provided a steady, grounded chord on the mouth organ and reached out to include Jacob in the improvisation by finding him the same instrument, which also happened to be one of Mark's favoured instruments throughout the sessions. It felt as if they had come full circle and were now enjoying playing simply for the pleasure of it rather than it being linked to any other purpose.

Table A7.6 MM11

Time code	Mark	Jacob	Kate
11.19 11.48-12.10	Slow crotchet pulse on mouth organ with breath	 Out of shot- Jacob experiments with	Recorder tune in quavers over the M.O pulse

	Finds M.O for Jacob- continues playing a pulse	playing another mouth organ that Mark has found him.	Gradually more elaborate melody.

MM12. Session 16. Stealing my music power/trio improvisation.

This short moment shows how 'music power' had become a strong theme in the work with Mark and Jacob. It began with 'kazoo force' in session 4 but gradually expanded to become an intrinsic aspect of the drama. This dramatic concept then transformed briefly into a lively improvisation as a trio. These moments of focussed musical attention also provided brief pauses in the busy dramatic play of the rest of the session perhaps like recitative and aria in Opera.

Table A7.6 MM12

Time code	Mark	Jacob	Kate
18.50	Mark and Jacob steal my guitar away from me.		Talking to the guitar "be careful who you give your powers to!"
18.56	"Both of us!"	Is holding the guitar	
19.05	Comes to 'fight' me again.		"Oh no, I can hear my guitar being used, by the enemy!"
19.19	Starts playing the swanee whistle.	Detunes the guitar	Reflecting swanee whistle vocally and playing piano chords across range of piano, then arpeggiated chords
19.30	One note pulse, quite breathy sometimes.	Strumming the guitar	
19.50		Sits down to play guitar more easily	
20.10		Fast strum, experimenting with both hands	

20.22	More slidey notes- quite a slow pulse Mark continues for a bit	Jacob jumps up	Little riff emerges I keep playing piano- pentatonic tune

MM13. Session 16. Music power.

This is another brief, musical moment but seems important as it is the first time that Mark had initiated playing the piano and as such feels like it signifies a real sense of inner confidence and power. Jacob joined in at the piano and I supported on a much quieter instrument - the metallophone. Mark then moved over and joined me in a gentle interaction on the metallophones. The sense of conflict in the drama continued when Jacob decided to start kicking the metallophone that I was playing.

Table A7.6 MM13

Time code	**Mark**	**Jacob**	**Kate**
24.30	Improvises on the piano		"Oh no, he's got music power!"
24.40	Continues on the piano	Joins in on the piano	Very free improvisation on the metallophone- reflecting the piano duet
25.10			Quite free and
25.24	Mark comes over to join in with me using the metallophone.	Starts to kick the xylophone.	flowing musical interaction with Mark.

MM14. Session 17. Dramatic music.

This final moment is a further example of the role of supportive, accompanying music in the dramatic play for Mark and Jacob. The playful piano music seemed to lift and augment their play and provide a tangible sense of excitement which, in this final session, was experienced in a very positive and celebratory way.

Time code	Mark	Jacob	Kate
9.40 9.50 9.56 10.00 10.13 10.15 10.18 10.21 10.55	 Throws lion to Jacob and falls over, smiling. Goes to thrown the lion and then falls over. Picks himself up. Throws it back to Jacob- smiling lots “	“Try and get the tiger!” “Mark!” Throws the lion to Mark Then back to Mark Throws the lion back to Mark Throws it back to Mark Throws it back to Mark but it goes into the corner of the room and is difficult to retrieve	Black and white movie style piano accompaniment Joyful overdramatic music with the throwing I continue with the music whilst they retrieve the lion and finish with a flamboyant flourish

Appendix 8.1 Summary of themes (mind maps) from individual case studies

Figure A8.1a Themes from Daniel's case study

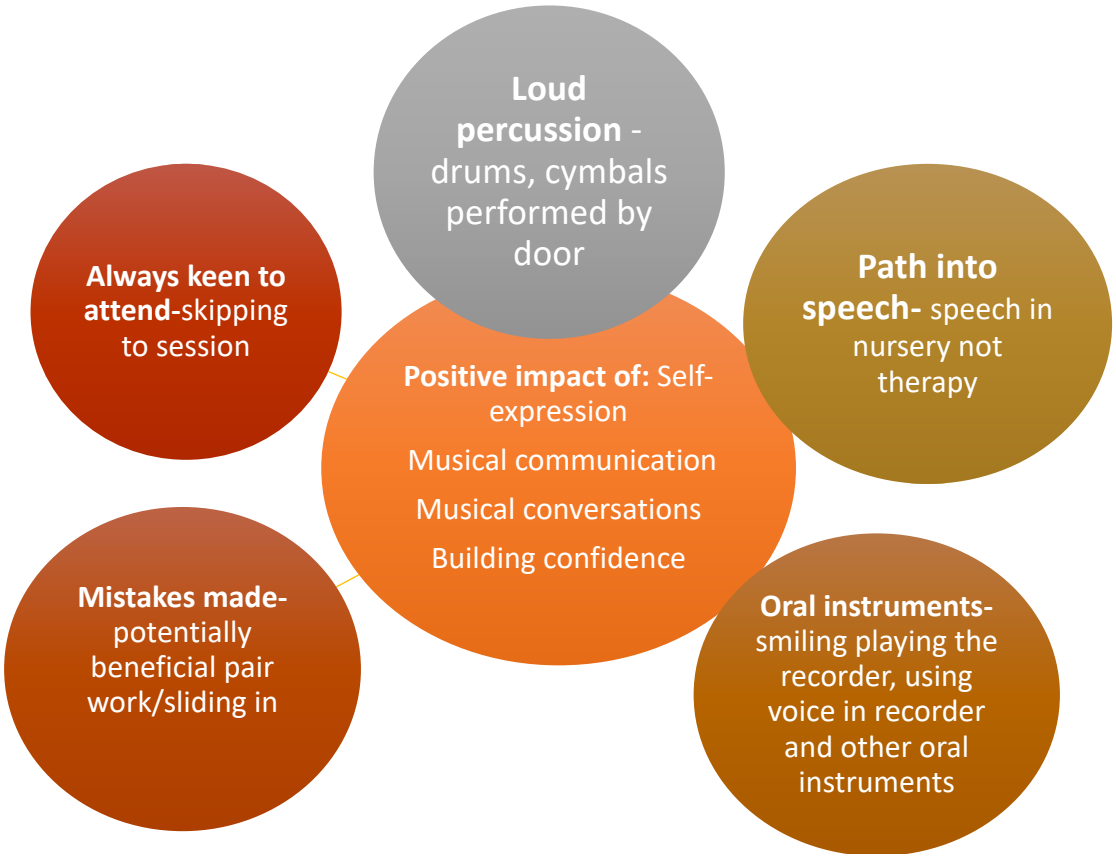


Figure A8.1b Themes from Pilar's case study

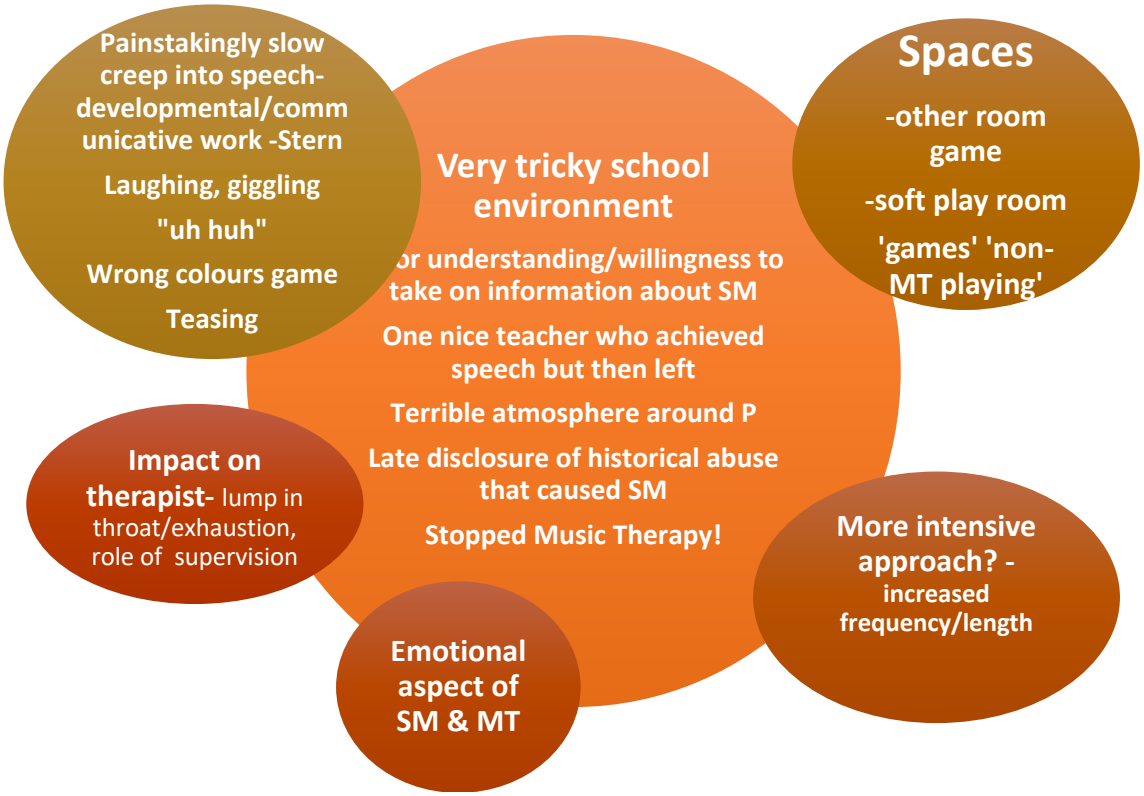


Figure A8.1c Themes from Tasha's Case Study

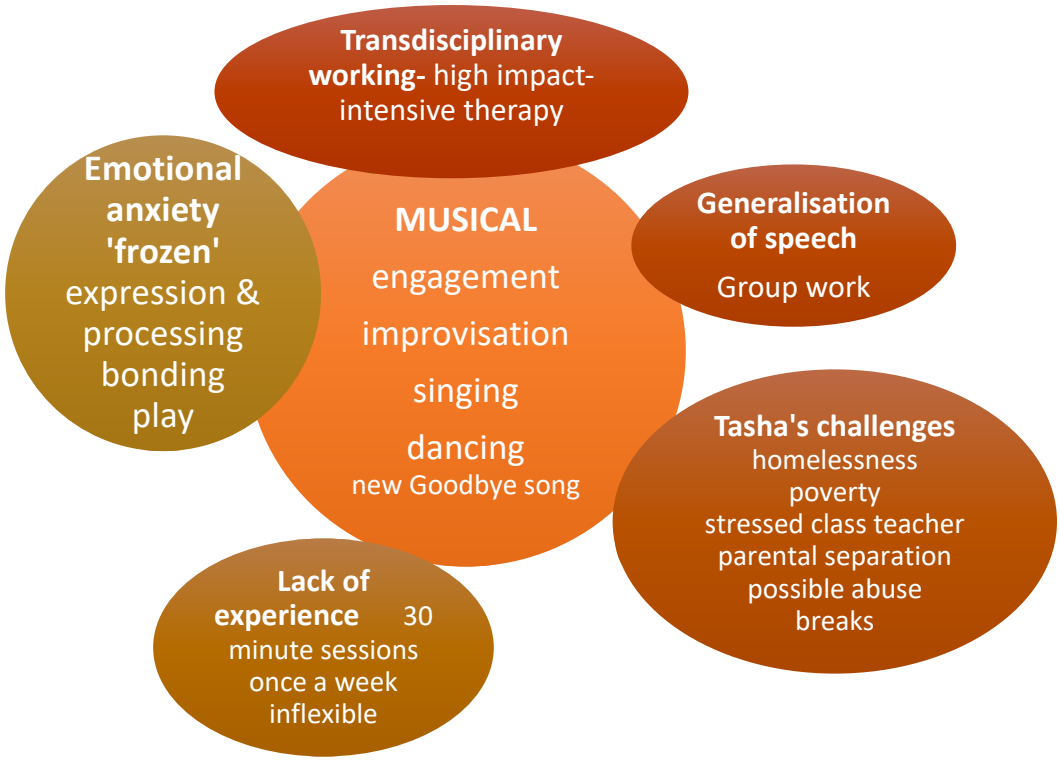


Figure A8.1d Themes from Maria's Case Study

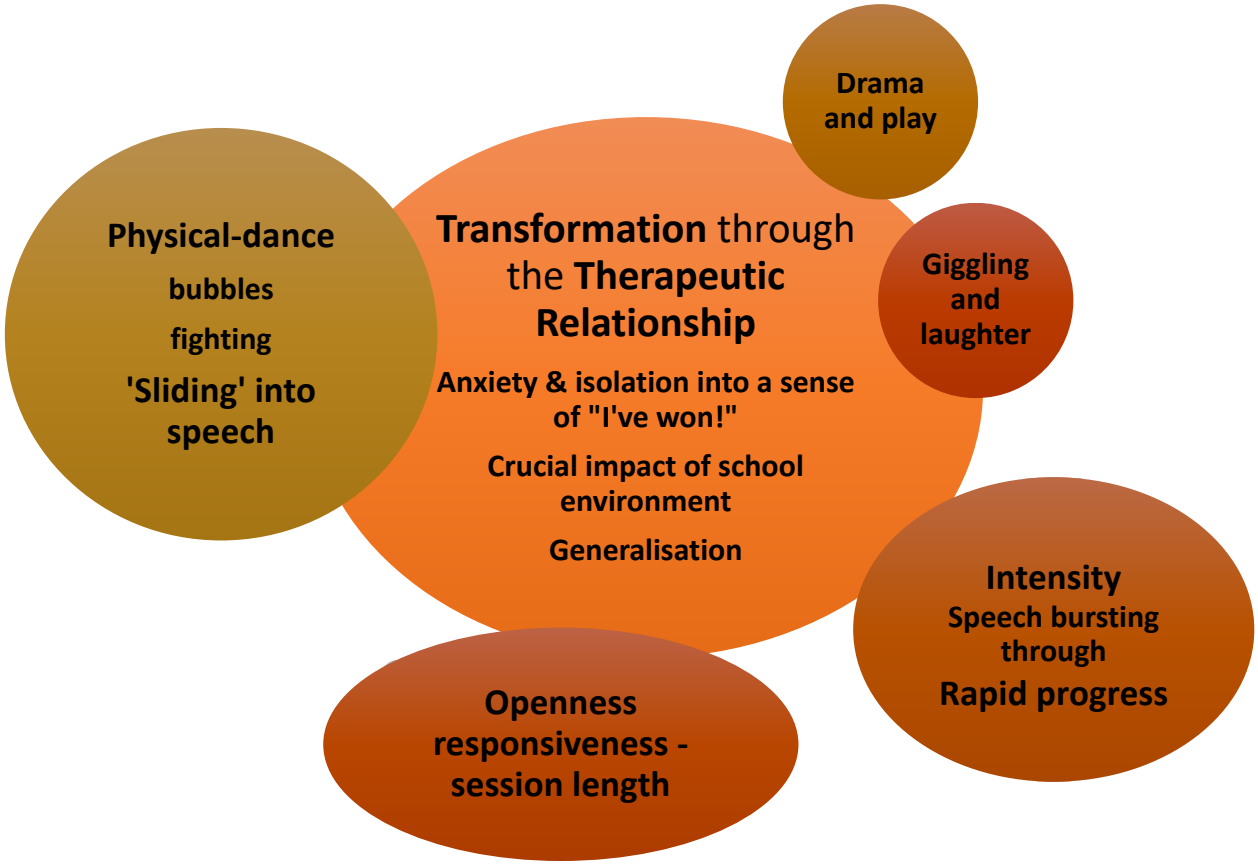


Figure A8.1e Themes from Rabiyah's Case Study

Figure A8.1f Themes from Max's Case Study

Appendix 8.2 Stages of thematic organisation

Figure A8.2a Themes from all case studies before grouping

Figure A8.2b Emerging key themes

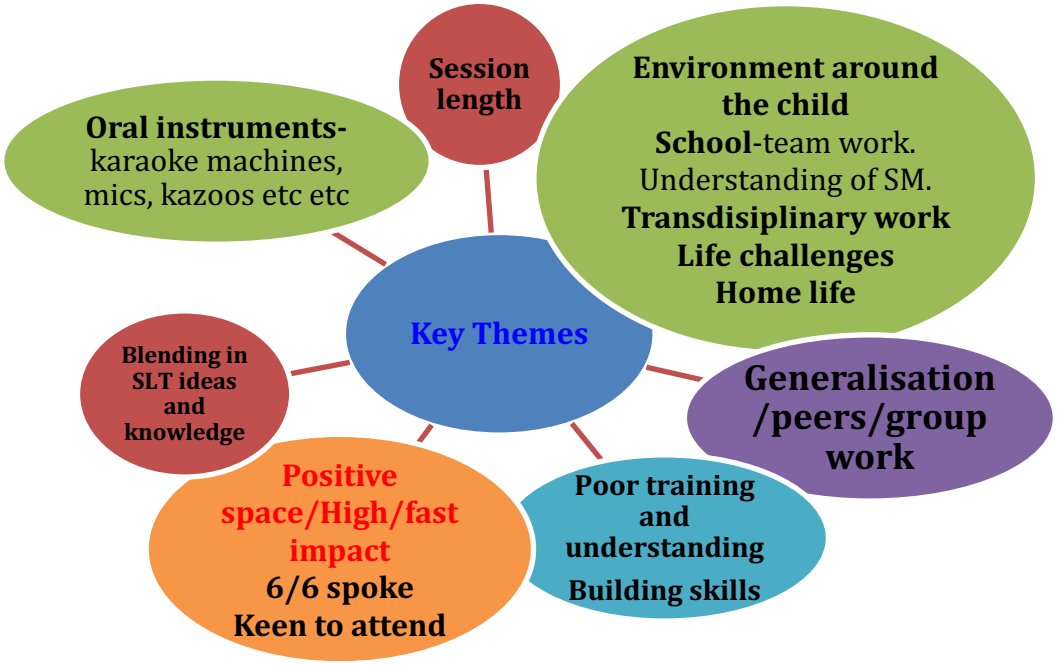
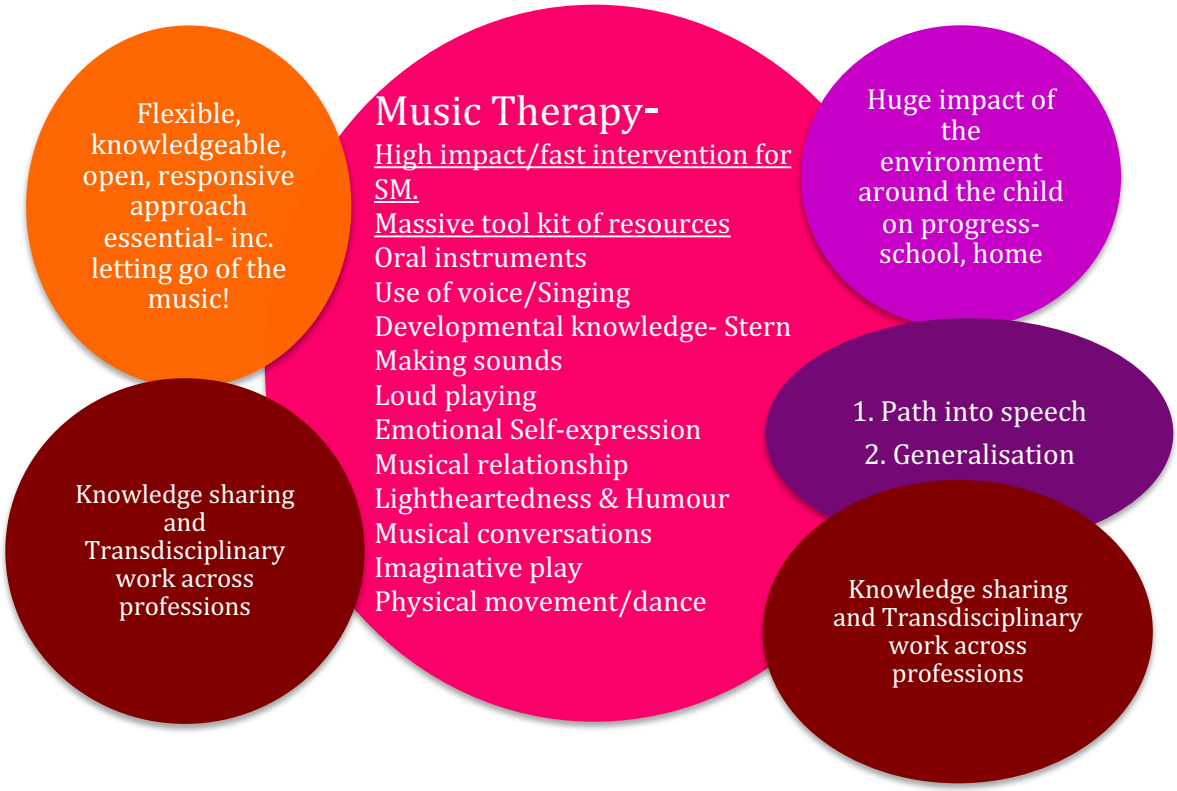


Figure A8.2c Diagrammatic sketch of ideas for final framework



Appendix 8.3 Themes and subthemes from each case study placed on the theoretical framework

Figure A8.3a Daniel's themes and subthemes placed on the Theoretical Framework

Big mistake- should have let the friend into the therapy session. Poor understanding of how speech in nursery could overtake speech in therapy and why and how this could add further pressure. More training, supervision and preparation would have been good. Good in a way because it sets quite a low baseline. Issue more with me and MT rather than him.	**Therapeutic process** **Daniel** / **Parallel layers of communi-cation**	1. Offering a potential space **Always keen to attend- skipping to the session-** appeared to be a positive and useful space for him. Swift positive response.	2. Manifesting anxiety – having it contained and processed	3.Gradual build-up of trust and contact through listening and accepting – 'no pressure approach' Potential pressure to talk felt in MT due to speech in other places but not in therapy where he perhaps wanted to talk?	4. Gradual development of shared, meaningful communication and 'playing' Vigilance and awareness of opportunities to progress therapy.	5. Need to end therapy – healthy, confident separation
	a) Musical	Positive impact of self-expression, musical communication, musical conversations /Bi-directional interaction, musical relationship. **Oral instruments- hugely important, smiling playing recorder, using voice in the recorder. Other oral instruments** Drums and cymbals played by door. Loud playing. Interactive drumming.				
	b) Physical	Control and expression in the physical realm lead to control of the voice				
	c) Emotional/ social d) Speech	**Therapeutic relationship** parallels mother/ infant interaction = emotional/ social communication Speech in nursery rather than therapy. Gradual build up with friends then adults. Speech in therapy then no speech in therapy. Ability to kazoo then not being able to kazoo.				
		Environmental factors- took place in **familiar** nursery school- **positive staff** relationships- **good understanding** of how to support SM. **Strong team work**. Can overtake speech in therapy due to every day contact. Needed more **flexible boundaries**. Friends in session/was playing at the door with the cymbal and drum				

Figure A8.3b Pilar's themes and subthemes placed on the Therapeutic Framework

Lack of support/knowledge/need for more/better quality supervision. Lump in throat and exhaustion. Huge pressure on both myself and Pilar. " non-MT" play –using whatever motivates them. Open, flexible approach.	**Therapeutic process** / **Pilar** / **Parallel layers of communi-cation**	1.Offering a potential **space.** This was hugely important particularly as it was constantly under threat. Conjoined room space. Imaginative space.	2. Manifesting anxiety – having it contained and processed found it hard to play the bells wet herself	3. Gradual build-up of **trust** and contact through listening and accepting –	4. Gradual development of shared, meaningful communication and **play- lots of imaginary play/dramas/magic and games** **length of the path into speech**	5. Need to end therapy – healthy, confident separation Generalisation needs to be on here somewhere-very tricky and complex in Pilar's case
	a) Musical	Very important initially and then throughout and again towards the end. Self-expression- so important. Loud cymbal crashes, oral instruments, repairing xylophone bars.				
	B) Physical	Working in the soft play room was great to move the energy around, throw balls/cushions, have fun and shriek/laugh				
	c) Emotional/ social/Stern	(Historical abuse. Frustration/aggression, throwing shaky eggs. Self-expression. Pressure) This could all be part of the top layer really. The process? But the social/emotional aspect was perhaps also key for Pilar as with all the apparently non-musical aspects had a basic developmental component.				
	d) vocal! Inc. speech e) play/drama and non-typical 'MT stuff'	Slow and painstaking process may have been improved by a more intensive approach? longer or more frequent sessions? 'ah' S5, giggling S13, 'ding dong' S18 'yeah S24. Repeated words S38, Speech beg-end S46. Correcting colours. (Actually I think that this is really all –e and perhaps d- part of a sub-set of c) .d) more like the outcome but also part of the process					
		TEAMWORK- The environment around Pilar was hugely fraught and she/we were undermined constantly by teachers poor understanding or willingness to support and engage. Weird demands and meetings/pressure. And one nice teacher left after a term. **Broad MDT work would have helped as well. Links with drama therapy/SLT. Psychology. Strong team.**				

Figure A8.3c Tasha's themes and subthemes placed on the Theoretical Framework

	Therapeutic process **Tasha** / **Parallel layers of communi-cation**	1. Offering a potential space	2. Manifesting anxiety – having it contained and processed **FROZEN**	3. Gradual build-up of trust and contact through listening and accepting – 'no pressure approach' **Close therapeutic relationship**	4. Gradual development of shared, meaningful communication and 'playing'	5. Need to end therapy – healthy, confident separation Generalisation- adding in peers- **positive group work. Transdisciplinary work- high impact- intensive therapy- "I want to do it every day"**
Lack of experience- 30 minute sessions- really wanted longer- more than once a week. Should have brought children in earlier rather than try to use staff.	a) Musical	Musical engagement- so important for T. improvisation- so good at this. Singing.				
	b) Physical	Control and expression in the physical realm lead to control of the voice Dancing				
	c) Emotional/ social d) Vocal/Speech	Therapeutic relationship parallels mother/ infant interaction = emotional/ social communication				
		External challenges: homelessness, poverty, stressed class teacher, parental separation. possible abuse, breaks in therapy				

Figure A8.3d Maria's themes and subthemes placed on the Theoretical Framework 'I've won!'

Knowledge- Openness, responsiveness. Lighthearted, playfulness. Therapeutic freedom. Could have benefitted from more experience and making confident therapeutic decisions like lengthening the session, perhaps providing more than once a week, also being more quick to add another child to help support generalisation in the classroom. Confidence to just be a therapist in the room, using games and almost doing an element of ' teaching' towards the end.	**Therapeutic process/ relationship Length & Speed Intensity** **Parallel layers of communi-cation**	1.Offering a potential **space. I felt that Maria sensed that this was going to be a useful space and that she desperately needed therapy.**	2. (Manifesting anxiety – having it contained and processed) Anxious energy seemed to be **transformed** in the therapy into self-expression	3. (Gradual) build-up of **trust** and contact through listening and accepting – **Actually the process was FAST & INTENSE**	4. (Gradual) development of shared, meaningful communication and play **Quick jump to 4! Missed 2 and 3. ☺ And speech, lots of it emerged in the session.**	5. Need to end therapy – healthy, confident separation Generalised quite fast to the classroom but then had to leap the Summer break- but was fine Pair work to consolidate therapy and generalisation. Sense of a self-confident, happy child, who had 'won'.
	a) Musical	**Oral instruments-confidence building. Loud cymbal conversations.**				
	B) Physical	**One of the most important elements for Maria: Dancing, literally 'sliding' into speech, gymnastics. Bubbles.**				
	c) Emotional/ social	**Dramatic play/drama- power & confidence- accessing it. Fighting. STERN-** developmental/communicative aspect. Eye contact/smiles, turn-taking. Timing.				
	d) vocal! Inc. speech	**Humour, giggling, laughing. Roaring. Exclaiming, shouting. Single words. Longer sentences. Very chatty.**				
		Environmental factors- Isolation of SM for a young child. Missing out on playing. Vulnerable to bullying. **TEAMWORK- Crucially important for Maria to have an experienced and responsive new CT that supported her wholeheartedly in her new class after an awkwardly timed break for the Summer hols- just post-speech session.**				

Figure A8.3e Rabiyah's themes and subthemes placed on the Theoretical Framework

	Therapeutic process / **Rabiyah** / **Parallel layers of communi-cation**	1. Offering a potential space Annoyed at session length	2. Manifesting anxiety – having it contained and processed	3. Gradual build-up of trust and contact through listening and accepting – 'no pressure approach' **This was fast path into speech rather than gradual**	4. Gradual development of shared, meaningful communication and 'playing'	5. Need to end therapy – healthy, confident separation Fast and easy generalisation Difficult ending- when something has been powerful.
Blending in more SLT knowledge re colours, numbers, naming things. Session length. Could have brought peers in.	a) Musical	**Oral instruments- mouth organ, swanee whistle, karaoke machine & microphone. Didgeridoo. Singing- free and structured.** Enabled path into speech.				
	b) Physical	Control and expression in the physical realm lead to control of the voice				
	c) Emotional/ social	**Interesting change in power dynamics? once speech is achieved. Power to express difficult or challenging issues or different sides of personality that have been suppressed. Feeling of power with words. Feelings about having SM? Annoyed at length of session.**				
		Positive school environment. CT knowledge of SM and supportive of techniques. General attitude and approach is kind and supportive.				

Figure A8.3f Mark's themes and subthemes placed on the Theoretical Framework 'We are in that world right now!'

Knowledge- Therapist's knowledge and experience stands for a lot. How I approached Mark was different from the 1st case study. I was much more **open and flexible** and aware of different issues and how to think about them. This was particularly true when inviting a friend into the therapy room, which worked so well. Lots of pressure on me, perhaps from nursery teacher perhaps self-inflicted. Need to be wary of this and have good supervision.	**Therapeutic process** / **Parallel layers of communi-cation**	1. Offering a potential **space. An enabling space.** Change of spaces made a space for change. Also, a sense of being **very keen to attend** MT, that it was the right thing. Also **imaginative 'space'** was important.	2. Manifesting anxiety – having it contained and processed. Emotional process about harnessing power and inner resources – took away my music powers	3. Gradual build-up of **trust** and contact through listening and accepting	4. Gradual development of shared, meaningful communication and **play- Imaginative play was another element and resource and 'space' in the therapy** **Quick jump to 4! Missed 2 and 3. ☺** **And speech, lots of it emerged in the session.**	5. Need to end therapy – healthy, confident separation. Yes, They were ok to do this and talking about generalising aspects of their play with other children. **'Sliding'** play and speech with adults back into the classroom. Took ending chart into class. Deciding to unwrap presents at home all felt like sliding and generalising.
	a) Musical	**Oral instruments-absolutely key, mouth organ, kazoos, swanee whistle, ocarina- linked to voice- warming up** **Dramatic music**				
	B) Physical	Jacob - throwing things and leaping around. Superhero play was quite physical generally.				
	c) Emotional/ social d) vocal! Inc. speech	**Dramatic play/drama- power & confidence- accessing it. Fighting. Peer relationships also very important. Helped to develop speech with other adults.** Immediate vocalisations and speech with CT. Loud breathing, mouthing. Then lots of vocal sounds. Intense chatting. Can't stop. Relating. "Stop talking" Importance of Speech in Imaginative play. Speech boosting in pairs. "I am trying to speak young man!"				
		TEAMWORK- Hugely important. Relationships with different personalities of teacher, v influential on the child. Also with parents and other children. TAs				

Appendix 9.1 Invitation to parliamentary Selective Mutism awareness raising event

Lucy Powell MP (Shadow Secretary of State for Education) and Nigel Evans MP for the Ribble Valley
and
Selective Mutism Information and Research Association (SMIRA)

request the pleasure of your company at an event to raise awareness of selective mutism (SM) and of the work of the charity SMIRA as a support and information service for those with SM, their families and professionals

from
1pm – 3pm on Wednesday 6 July 2016
In Dining Room A, Palace of Westminster

Access through Cromwell Green entrance.
Please bring this invitation with you and allow time to pass through security
Smoking/e-cigarettes not permitted on site
No parking facilities available on site

Please RSVP to smira@redleafpr.com by Monday 20 June 2016

SMiRA
Challenging Selective Mutism