Southern Illinois University Edwardsville

SPARK

Art Therapy Counseling Final Research Projects

Art & Design

Spring 5-2-2024

Communication Beyond Words

Anna Brough

Communication Beyond Words

By Anna Brough, Bachelor of Science

A Research Project Submitted in Partial
Fulfillment of the Requirements
for the Degree of
Master of Arts
in the Field of Art Therapy and Counseling

Advisory Committee:

Dr. Jayashree George, Chair

Shelly Goebl-Parker

Megan Robb

Graduate School
Southern Illinois University Edwardsville
May 2, 2024

ABSTRACT

COMMUNICATION BEYOND WORDS

by

ANNA BROUGH

Chairperson: Dr. Jayashree George

This research explores the definition and use of nonverbal communication within the
therapeutic setting and the treatment of selective mutism by clinical providers. A
phenomenological research method was used to interview three art therapists and two
therapists without art therapy training. These interviews were used to explore their
understanding and awareness of nonverbal communication within the context of providing
treatment to clients with selective mutism. The analysis of participants' discussions of their
experiences of treating those with selective mutism revealed four major themes: Nonverbal
Communication, Therapeutic Presence and Alliance, Art Materials and Interventions, and
Culture and Society. Findings suggest no significant differences between participants with or
without art therapy training. The participants emphasized the importance of patience,
attunement, and observation in building therapeutic alliances, and discussed the use of
various art materials and defocused communication techniques. Additionally, cultural and
societal expectations were identified within the context of the participants and how they may
affect their work as therapists and may impact the experiences of the clients.

Keywords: *Selective mutism, art therapy, nonverbal communication*

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

Art therapist and scholar Bruce Moon said, "I believe it is possible that our most significant work takes place without speaking at all" (as cited in Lazar et al., 2018, p. 6). While some verbalization comes naturally with artmaking, Lazar et al. (2018) asserted that the work done in art therapy is successful because it does not place a reliance on verbalization. Rather, the goals for expression are focused on what is said through materials and artmaking processes (Lazar et al., 2018). Segal (1984) stated that many people express themselves symbolically or in actions rather than verbally, with only skilled communicators able to put strong feelings into words. The symbolic possibilities in art therapy have been used to facilitate expression and communication for many populations such as children experiencing grief, those with language impairments from traumatic brain injuries and communication disorders, those in the deaf community, or those who are blind or visually impaired (Lazar et al., n.d.; Guay, 2018; Segal et al., 1984). Literature has also suggested the benefits of art therapy in cases of selective mutism (Erickson, 2012; Fernandez et al., 2014; Landgarten, 1975).

When I was thirteen, I sat silently across the room from the therapist who was referred to me by my school. I had only whispered a few words to her in the months we had worked together and spent our hour-long sessions fidgeting with my hair band, too frozen to make eye contact. This day, she sat up from her desk chair and sat next to me on the couch where I always sat. I could feel the tension in my shoulders begin to loosen and my eyes fixated on her large purple ring. The next thing I knew, she lifted her hand to gently show off the ring she was wearing, and after a moment she told the story of the store where she

discovered the piece of jewelry. I found my eyes no longer needed to fixate on my hair band but rather drifted between her hands and her eyes as I let out gentle smiles.

My therapist had brought me paints in previous sessions because my parents had told her I liked art. I painted my responses to the questions she was asking, such as my relationships with my family. I knew what the messages were in my paintings, but I was too frozen to translate what they meant verbally. Expressing myself through art was something I did regularly but my anxiety levels limited my ability to process them verbally, a process that art therapists and licensed therapists often rely on. It was not until my therapist purposefully changed her body language and our spatial relationship that we began to make a nonverbal connection.

The DSM-5 (2013) defined selective mutism as a childhood anxiety disorder in which the child fails to speak within specific environments or contexts (e.g. school) where they are typically expected to but speak articulately in contexts where they feel safe (e.g. at home with parents). Features of this disorder may include "excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior" (APA, 2013, p. 195). Elective mutism was a previously used term to name the disorder, but it is not currently used because it suggests that the child chooses when and where to speak or not to speak "voluntarily" (Ostergaard, 2018).

Though selective mutism is considered a rare disorder, with a prevalence between 0.3% and 1.9% based on small samples from various schools and clinics, it can have a significant impact on those afflicted (APA, 2013; Lorenzo et al., 2021). The onset of the disorder often occurs before the age of 5-years-old but can be delayed in treatment due to the disorder not being diagnosed until the children are of school age or are simply considered shy by caregivers (Lorenzo et al., 2021; Oerbeck, 2014; Ostergaard, 2018). While some children

may only experience symptoms for a matter of months, research has suggested that this anxiety disorder has a mean duration of nine years (Ostergaard, 2018). This diagnosis frequently co-occurs with other anxiety and language disorders; this in combination with delays in treatment impedes the cognitive, academic, and social development of the child (American Psychiatric Association, 2013; Ostergaard, 2018). The disorder is often considered resistant to treatment but relies on early interventions to prevent problems such as social development and learning (Stone et al., 2002). Adults who were diagnosed with selective mutism as a child have been reported to experience issues such as depression, impulsivity, and substance misuse, and "consider themselves to be less independent and less motivated and had fewer achievements compared with their counterparts" (Fernandez et al., 2014, p. 20; Lorenzo et al., 2021).

Though they may appear similar, the APA (2013) clarified the differences between the socialization skills of selective mutism and autism spectrum disorder. Autism spectrum disorder is a neurodevelopmental disorder that is characterized by persistent deficits in reciprocal social interaction and social communication (Muris & Ollendick, 2021). Autism spectrum disorder also exhibits deficits in nonverbal communication that range from abnormalities in body language and a lack of understanding of gestures to the total absence of nonverbal communication and facial expressions (APA, 2013). Selective mutism differs in that it is categorized as an anxiety disorder in which development is not typically disturbed (APA, 2013). Disturbances in communication for children with selective mutism usually only occur in specific settings and most often exhibit an appropriate use of social skills in other contexts. The APA (2013) asserted that differing from autism spectrum disorder, children with selective mutism may find means to communicate nonverbally or actively engage socially in situations that do not require speech.

Gap in Literature

The treatment of selective mutism is considered difficult and literature on treatment has been limited until recent years (Lorenzo et al., 2021; Oerbeck, 2014). Though empirical data for the treatment of selective mutism is beginning to surface, much of it consists of retrospective record reviews that may be subject to biases due to the use of a "broad variety of outcome measures" (Ostergaard, 2018). Most of this literature has used pharmacological, behavioral/cognitive-behavioral, and multimodal interventions for treatment (Lorenzo et al., 2021; Oerbeck, 2014).

There is a variety of literature on the use of expressive therapies (e.g. drama, play, or music) for treatment, but is limited in terms of art therapy. For example, Hanan (2023) demonstrated an arts-based and phenomenological study that incorporated expressive therapies with teachers who have taught individuals with selective mutism. Literature remains limited in the use of art therapy for individuals with selective mutism or how it is used by treatment providers. Since 1975, there have been three published case studies that examined the treatment of selective mutism; the most recent having investigated the use of the Expressive Therapies Continuum as a framework for treatment (Fernandez et al., 2014; Hesse, 1981; Landgarten, 1975). Zhao et al. (2023) examined how alternative therapies, such as art therapy, may be used to treat a variety of anxiety disorders, but failed to include selective mutism among those tested.

Research Aim

This research aimed to explore the treatment of selective mutism in children through both a therapeutic and expressive lens. I interviewed credentialed therapists (art therapists and non-art therapists) to investigate their implementation of nonverbal communication in their clinical practice. I was also interested in how therapists talked about the connection

between nonverbal communication and the process of artmaking and the sociocultural considerations surrounding verbal and nonverbal communication. How have therapists considered and implemented nonverbal communication within treatment experiences of selective mutism?

Definition of Terms

Operational definitions for this paper include art therapy, nonverbal communication, and selective mutism.

Art Therapy

"Art therapy [as] an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (AATA, n.d.). Hinz (2020) described the Expressive Therapies Continuum (ETC), a framework often used in art therapy that classifies "how clients interact with art media or other experiential activities in order to process information and form images" (p.4). She explained that this framework organizes media interactions into a hierarchical sequence of media processes from simple to complex. This is divided into components including kinesthetic and sensory, perceptual and affective, cognitive and symbolic, and the creative level.

Nonverbal Communication

Nonverbal communication was defined as "the transfer and exchange of messages in any and all modalities that do not involve [spoken or written] words" (Matsumoto et al., 2012, p. 4). Nonverbal communication can be implemented in defocused communication, a treatment principle that identifies the level of communication an individual is on and matches the style of communication to that level. This often includes techniques such as:

To sit beside rather than opposite the child; to create joint attention using an activity

the child enjoys rather than focusing on the child; to 'think aloud' rather than asking

the child direct questions; to give the child enough time to respond rather than talking

for the child, to continue the dialogue even though the child does not respond

verbally, and try to receive a verbal answer in a neutral way rather than praising the

child. (Oerbeck et al., 2014, p. 195)

Selective Mutism

Selective mutism was defined as a condition in which individuals show an inability to speak in certain situations or environments but show adequate or fluent speech in settings they are most comfortable, such as with family or at home (APA, 2013; Fernandez et al., 2014; Lorenzo et al., 2021). This is characterized as an anxiety disorder, which may be viewed as an extreme form of social anxiety, that is most often diagnosed in children and adolescents.

As an adolescent, my therapist learned to understand my need for nonverbal communication. Her respectful attunement formed the basis for our therapeutic alliance, which in turn led the way to more successful interventions for my treatment of selective mutism. There are many aspects of the therapeutic process for clinicians to consider within treatment. Due to limited research on selective mutism and the disorder's reputation for being resistant to treatment, it is important for clinicians to examine what techniques work outside of the verbal realm. This study will explore aspects of art therapy, psychotherapy, and nonverbal communication practices and techniques. These terms will be incorporated throughout the study.

CHAPTER II

REVIEW OF LITERATURE

This review examines the current literature on the terms "art therapy," "nonverbal communication," "selective mutism," and the intersection of these terms (see Figure 1). I further investigated these ideas by performing a search of art therapy and psychology literature using the following databases: PsycINFO, JSTOR, EBSCO (using ERIC, Academic Search Complete, ScienceDirect, Taylor & Francis Online, CINHAL, and PubMed Central), and Google Scholar. Alternative terms for these categories are provided in Table 1. I excluded literature that examined mutism or nonverbal communication associated with Autism Spectrum Disorder.

Figure 1

Intersection of Search Terms

Table 1

Alternate Search Terms

Art Therapy	Nonverbal Communication	Selective Mutism	Psychotherapy
Expressive Therapies	Nonvocal Communication	Elective Mutism	Talk Therapy
Expressive Therapies Continuum	Alternate Communication	Mutism	Verbal Therapy
	Silence	Social Anxiety in Children	Therapy
	Nonverbal Language		

Selective Mutism and Nonverbal Communication

Authors such as Zelinger (2010) and Schum (2006) agreed upon the importance of determining how children with selective mutism (SM) communicate to create a tailored treatment plan. According to Schum (2006), doing so involves being "sensitive to the signals the child produces during the first meeting" (p. 153) and noting the "frequency and types of nonverbal communication (NVC)" (p. 153) such as eye contact, smiling, or shaking of the head. The Selective Mutism Association (n.d.) clarified those with SM rely on nonverbal behaviors, like pointing, nodding, writing, and other forms of nonverbal communication to answer questions.

Malchiodi (2017) furthered Schum's (2006) earlier statement by describing the process as attunement throughout sessions that lend the ability to read other's rhythms and NVCs, such as "attending to eye signals, facial gestures, tone of voice, and even breathing rate" (p. 202). Hill (2020) described attending as the therapist physically orienting

themselves to the client, an NVC by the therapist that "lays the foundation" (p. 108) of verbal interventions. These NVCs can vary greatly from child to child, as some may have the inability to show variability in facial expressions or body movements in a way that may make them appear "frozen" (Melfsen et al., 2021; Zelinger, 2010). Melfsen et al. (2021) added that individuals with SM also show reduced auditory reflexes, in which they seem to ignore the voices of others. Thus, the significance of creating a plan that integrates the successful use of the individual child's mode of communication may promote expression and eventually lead to the use of more conventional forms of communication.

With this in mind, Zelinger (2010) asserted that treatment begins with activities that do not rely upon verbal communication or great physical skill. Activities may start by accepting alternate modes of communication from the child, "including gestures, nods, tugs, written notes, whispered speech, and pointing" (p. 366). The author also stated communication may be aided by the use of communication boards or premade index cards with word choices for children to indicate what they need to express without verbal communication.

Alternately, Schum (2006) argued in favor of counteracting the use of these aids or alternative communication methods, such as communication boards and sign language. He stated that treatment should develop the children's adequate modes of communication that they naturally engage in, to expand a range of contexts. The American Psychiatric Association (2013) described children and adolescents with SM as "not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation" (p. 195) and generally having normal language skills. Individuals with SM have the skills to engage linguistically and verbally, but they do not exhibit them in all social situations. This does not mean that they do not engage socially in situations in which they do not speak.

Schum (2006) argued that the therapist must observe what nonverbal modes of communication the child or adolescent will engage in naturally (e.g. gestures, writing, or drawing). He furthered his argument, stating that placing excessive demands for communication outside of their natural forms of communication may delay rapport building between client and therapist. Instead, Schum (2006) encouraged therapists to practice successful use of any form of communication clients engage in, and then gradually work in and practice other ways of communication in different settings.

Porges (2003) observed that research outlining the development of children's social behavior has often focused on the construct of attachment. It is with this observation that he introduced the theory of social engagement. This theory states that for social bonds to form, individuals have to be in close proximity. It is how individuals navigate their proximity that determines their social bond and provides elements of social cueing, such as nonverbal gestures, facial expressions, eye contact, and head orientation (Porges, 2003; Zelinger, 2010). In addition to physical distance, Porges (2003) asserted that proximity can be navigated through psychological distance, which in turn increases or reduces social engagement. He suggested that reducing this distance includes the use of eye contact, controlling facial expressions, rhythm and tone of voice, verbalizations, or orientation of the head. Navigating the proximity between the therapist and the individual with SM goes hand-in-hand with the effective use and interpretation of NVC. This is similar to the implementation of defocused communication, such as sitting on the couch next to the client instead of facing them head-on (Oerbeck et al., 2014). Therapists navigating their proximity to the client along with their ability to identify nonverbal forms of communication may help establish rapport with the client and their success in communication.

Selective Mutism and Silence in Culture

Slobodin (2023) described viewing individuals with SM and their silence within the level of the macrosystem and the cultural contexts that give meaning and value to silence. Similar to verbal communication, silence is patterned culturally and can be interpreted differently across cultures (Braithwaite, 1999). Individualistic and collectivist cultures, for example, find different values and expectations in speech and silence. Individualistic cultures often put value in verbal communication, seeing it "as an indicator of social engagement, competency, freedom, and power" (Slobodin, 2023, p. 12; Kim & Markus, 2002). American families who expect verbalizations while greeting may have feelings of ambivalence when met with silence (Braithwaite, 1999; Jaworski, 1993). Silence, on the other hand, is valued by collectivist cultures, who may find the abundant use of speech disrespectful (Slobodin, 2023). For instance, Japanese culture values silence as expressing one's inner truth, regarding introverted individuals as "honest, sincere, and straightforward" (Jaworski, 1993, p. 161)

These cultural differences may greatly influence the classroom environment, and thus the identification and treatment of SM (Slobodin, 2023). Western classrooms often perceive silence as problematic because they tend to view speech as indicative of learning, knowing, and socialization, whereas Eastern classrooms focus on the act of listening (Lee & Sriraman, 2013; Lyle, 2008; Nakane, 2007; Slobodin, 2023; Xu & Clarke, 2013). Teachers in classrooms that expect active verbal communication often have to make their interpretations of students' silence, often attributing it to shyness, uncooperative behavior, or a lack of knowledge or intelligence (Jaworski, 1993). Alrabiah (2017) stated that the acceptance or disapproval of silence or shyness may delay or promote treatment for those with SM based on cultural norms.

While silence is more widely accepted in Japanese culture, it can also be associated with holding the truth, seen when the individual wants to avoid social penalty. Jaworski (1993) stated the ambivalence of silence may be confusing to someone trying to interpret the behavior, often leading to misunderstandings. Sette et al. (2019) explained that quiet or shy children face social rejection or harassment from peers and may hold insecure attachments with adults in the school setting. Social rejection and cultural expectations may lend to "shy" children's connection to feelings of anxiety and an overall negative self-evaluation (Hedman et al., 2013; Sette, 2019). Sette et al. (2019) stated, "Shame and guilt both entail emotional responses to one's perceived behavioral transgression or social failure" (p. 230). A negative self-perception, such as seen in shy or quiet children, has been shown to lead to internal shame, which can motivate those children to avoid social situations (Hedman et al., 2013; Sette, 2019). The influences of culture and shame are among many factors that should be considered in the treatment of SM and the consideration of NVC.

Psychotherapy and Nonverbal Communication

Del Giacco et al. (2019) asserted that at the core of psychotherapy is communication. This communication is built upon the interactions of both verbal and nonverbal interactions, but clinicians have placed a disproportionate amount of emphasis on verbal communication (Del Giacoo et al., 2019; Foley & Gentile, 2010). Focusing on verbal communication limits the information gathered, as nonverbal behaviors are found to make up 60 to 65% of communication (Foley & Gentile, 2010). Clients' attitudes and emotions may be better represented through NVC because of its unconscious nature (Foley & Gentile, 2010). These nonverbal behaviors are subject to cultural differences and should be taken in the context of the client, wherein the therapist should be aware of and adjust their nonverbal behaviors to the client instead of expecting the client to adjust to them (Hill, 2020). Observing the clients'

communicative style creates a baseline that the therapist can adjust their interactions to and helps notice changes in behavior that could be significant in the client (Foley & Gentile, 2010).

Foley and Gentile (2010) observed that the client observes the therapist just as much as the therapist observes them. It has been found that the nonverbal behaviors of therapists greatly impact the perceived quality of treatment and communication within the therapeutic setting. For example, therapist eye contact, facial expressions, and posture have been related to higher ratings of rapport, empathy, responsiveness, and overall positive ratings of the therapist (Dowell & Berman, 2013). Hill (2020) explained the importance of balancing nonverbal behaviors such as eye contact, facial expressions, head nods, and body movements in a way that promotes attentiveness and support without being dominating or distracting. Foley and Gentile (2010) described three elements that influence rapport between therapist and client: attentiveness, coordination, and positivity-negativity. Attentiveness is the capability of individuals to focus attention on the present interactions, an element that can be facilitated through attending skills (i.e. being physically oriented towards clients) (Foley & Gentile, 2010; Hill, 2020). Coordination in the interaction by showing similarities in nonverbal behaviors that mirror one another's behavior. Lastly, positivity-negativity refers to behaviors that show how individuals are responding to the interaction (i.e. laughing or showing hostility) (Foley & Gentile, 2010).

Art Therapy and Nonverbal Communication

Morrell (2011) stated that both art and language serve similar functions in which they create external representations of internal processes. Collingwood (as cited in Morrell, 2011) delved into these concepts by laying out a framework that considers art and language to be equals and argued that both are external representations of internal processes. Though,

Morrell (2011) asserted that art goes beyond spoken language in ways that verbal communication often has difficulty accomplishing, as "art can function as both sign and symbol" (p. 4). The author explained this in Hagberg's (1995) terms, the "sayables" and "unsayables." This explained verbal language, the "sayables" as a primary form of processing that is discursive and linear, and the "unsayables" as a secondary form of processing that are non-linear and non-discursive concepts that hold even deeper meaning.

Morrell (2011) claimed that both primary and secondary processes can emerge from art making. This sort of making-as-expression focuses on the process and product of creating while shifting communication away from verbal communication, thus being less threatening to clients (Lazar et al., 2018). This shift to nonverbal forms of communication appears to better communicate connotation than conventional verbal communication does, while also reflecting information about the individuals that are creating and how they encounter the world (Wood, 2020). The creation process may open an opportunity for communication in ways that convey meaning and are more inviting than verbal communication alone.

Cox (2005) and Matthews (1999) observed children's drawings and their process of artmaking and meaning-making. In agreement with Matthews, Cox (2005) argued in favor of viewing children's art as a process of creating and communicating representational thinking through time, not just as a rigid or realistic depiction of what they see or hear. She described that the child may ascribe different meanings to their artwork as they go along, either triggered by external stimuli or by the image itself. Children's mark-making has also been seen as a visual conversation, with each mark made being a response to another (Cox, 2005). Matthews (1999) suggested that the sign in children's artwork is the process of exploring how images convey meaning, thus finding definitions of symbols in the process. The creation and interpretation of their artwork is dependent on expanding the context in which it is

created, finding meaning by seeing it as an active process of defining reality (Cox, 2005; Matthews, 1999).

Along with the understanding of visual communication and meaning-making, art therapists can use various methods to facilitate NVC in sessions. The very act of allowing communication to come into visual form "provides a starting point for approaching personal expression in the safe boundaries and comfortable mediator of the artwork (Riley, 1999). One tool is to make art alongside clients to develop a safe space that values expression due to any discomfort of being watched or allow the client to feel more control within the therapeutic relationship (Lazar et al., 2018). Perry (2017) outlined an example of this technique to connect with a young girl experiencing post-traumatic stress disorder. He had noticed the girl coloring when he entered the session and began coloring on his own, narrating his process. Eventually, the girl moved closer to him and directed him on what color to use. Having noticed their connection forming, Perry stated, "Once she came to me, I stopped talking. For many minutes more we colored together in silence" (Perry, 2017, p. 44). Additionally, Franklin (1990) described an instance where he created a clay sculpture alongside a "withdrawn and silent" adolescent client to create an empathetic depiction of "a girl that felt alone, sad, and in the dark" (p. 47). He asserted that creating empathetic art in the presence of the client may "deepen and enhance the client's communication" (p. 47).

Lachman-Chapin (1979) applied Kohut's (1966) theories to art therapy to argue in favor of the advantage of making art alongside clients. One such argument includes the mirroring that can occur between client and therapist. Mirroring can promote relationship and empathy, but it can affect how the client views the relationship, viewing the therapist as "almost a part of his or her self" (Lachman-Chapin, 1979, p. 5). Creating art alongside the client may also provide an opportunity for the therapist to showcase their abilities as artists.

With this, clients could "turn on us with envy because of our abilities as artists" (p. 8) or create moments of counter-transference for the therapist, thus invoking our need for careful consideration of the therapist's participation in artmaking (Klein, 1975; Lachman-Chapin, 1979).

The art therapist making art alongside the client or not, the creation of art opens the space for relational aesthetics, where art-based strategies ground aesthetics in the value of connections to self, others, the environment, and artistic objects (Moon, 2003). Aldridge et al. (1990) described aesthetics as appearing in the therapeutic relationship when the client communicates their inner realities by externalizing them through visual forms. They elaborated that, with permission, this aesthetic experience allows the client to share their world and to be heard by the therapist (Aldridge et al., 1990). Moon (2003) explained that relational aesthetics means to understand aesthetics through the context of the therapeutic relationship and as to view art as having the capacity to "promote healthy interactions within and among people and the created world" (p. 140). This concept of relational aesthetics promotes the idea that a level of understanding and human connection can be seen beyond verbal means of communication. Lazar et al. (2018) listed tools that may supplement the connection and expression of relational aesthetics through the use of activities and materials that may be incorporated to facilitate NVC. These include the use of physical and visual objects, avoiding open-ended questions, and incorporating music, gestures, and visual media into the process of artmaking.

Psychotherapy and Selective Mutism

Psychotherapy is widely implemented to treat SM. Stone et al. (2002) stated these treatments mainly include behavior therapy, cognitive-behavioral therapy, family systems therapy, and psychodynamic models. While psychodynamic therapies typically rely on verbal

means to identify the underlying conflicts behind behaviors, they also implement play or art to observe nonverbal expression. On the other hand, family systems therapy puts the family at the core of treatment to identify and modify patterns of communication and interaction within the family system (Stone et al., 2002). Though not as common, group therapy has also been implemented in the treatment of SM. Sharkey et al. (2008) described the success of group therapy for individuals with SM and their parents. Using methods of psychodynamic and cognitive-behavioral therapies, they found that groups provided children and parents with peer support and reported lower levels of generalized anxiety, social anxiety, and increased ratings of NVC (Sharkey et al., 2008).

It is behavior and cognitive-behavioral therapy that is most recommended by clinicians, a method that focuses on modification of the environment and cognitions that maintain problem behaviors (Ostergarrd et al., 2018; Stone et al., 2002). Interventions in this method include "contingency management, graded exposure tasks [in schools and public environments], modeling, shaping," (p. 998) as well as relaxation training and psychoeducation for parents and teachers (Oerbeck et al., 2018). Due to the limitations of speech and early developmental levels of children and adolescents with SM, it is recommended that adaptions be made to cognitive-behavioral interventions and that they should not be treated exactly like other anxiety disorders (Ostergaard et al., 2018). Oerbeck et al. (2018) suggested that behavioral components be emphasized in interventions to make cognitive and behavioral restructuring more feasible.

Art Therapy and Selective Mutism

Magagna (2012) described in her book, *The Silent Child,* that "the child is not silent, [they are] simply not speaking" (p. 30). Malchiodi (2017) described that in working with children with SM, the art therapist accepted the child's silence without judgment or forcing

them into conventional verbal communication. The art therapist also found that being present in the silence may create a sense of closeness, rapport, and acceptance that treatment and the therapeutic relationship benefit (Malchiodi, 2017). With this, it is to be known that art therapeutic work with those with SM is a process that involves extra time, trust, effort, compassionate understanding, and creative interventions (Fernandez et al., 2014; Magagna, 2012). Fernandez et al. (2014) highlighted this process in their work with the ETC to facilitate verbal communication for a boy with SM.

Expressive therapies such as art, music, and play therapies are often utilized in conjunction with other treatment approaches, such as speech-language professionals or psychologists (Camposano, 2011). Fernandez et al. (2014) argued for the necessity of art and expressive therapies in treatment as other therapies, such as behavior therapy, seem to only treat the surface level of the issue as they focus on providing an immediate solution to the silence of the child. Alternately, Schum (2006) described the use of behavioral therapy alone to show responsiveness and progress for children with SM with the caveat that there are no controlled studies that have been conducted to assess the claim empirically.

Art and expressive therapies are found to be effective in treating the deeper issues involved in cases of SM because they provide a modality for articulating feelings and fears that can be communicated outside of the verbal realm (Camposano, 2011; Erickson, 2012). Fernandez et al. (2014) referenced studies that discuss how art has been beneficial in opening up emotions that the children internalize and lessening the tension that is often found in the symptomatology of such anxiety disorders. Consequently, the use of art and expressive therapies for the treatment of SM has found that clients build the ability to talk with others through the improved ability to take risks and "give something of [themselves]" (Landgarten, 1975, p. 125).

This chapter discussed existing literature that explores the intersections between the research topics of art therapy, NVC, and SM. Additional literature on psychotherapy and culture was considered in the intersection of research topics to expand the breadth of understanding of the treatment of SM and how it may be viewed by society.

CHAPTER III

METHODOLOGY

The methodology chosen for this study was interviews with a phenomenological approach (Leavy, 2017). Creswell (2007) defined a phenomenological study as creating a description of the "meaning for several individuals of their lived experiences of a concept or a phenomenon" (p. 57). The phenomenon explored is the experiences of treating SM therapeutically and therapists' awareness and implementation of NVC within treatment. This was explored through semi-structured interviews with clinicians who have had experience in treating at least one individual with selective mutism (Leavy, 2017). Due to the limited research on the use of art therapy as a treatment for SM and the diagnosis' relative rarity, a phenomenological interview approach was best suited to help me explore this type of treatment.

I used an interpretive or constructivist paradigm due to how it examines daily interactions and the processes of making or interpreting meaning from those interactions (Leavy, 2017). This aligned with my intent to investigate the patterns of communication that occurred between client and therapist, how receptive the therapist was to that information, and how it impacted their procedures. Within this paradigm are Mead's (1934/1967) and Blumer's (1969) concepts of symbolic interactionism. The authors described symbolic interactionism as exploring shared symbols in verbal and NVC and how those symbols are used in conveying meaning (as cited in Leavy, 2017). This was useful in examining the materials and methods used between client and therapist.

Dramaturgy is another school of thought that may have been useful in the view of SM because of its metaphor of our social lives having a "front" and "back" stage that we present ourselves differently in the face of judgment from others (Goffman, 1959 as cited in Leavy,

2017). This metaphor helped investigate how individuals communicate within different ecological systems (i.e. with their family versus within the therapeutic environment) and how that may impact the therapists as well (i.e. cultural or societal expectations).

Participants

The inclusion criteria for participants included that they needed to have provided treatment for at least one individual with SM. Creswell (1998) recommended a sample of five to twenty-five participants for phenomenological studies and I intended to recruit six participants for this study. This was to include three trained art therapists and three therapists who did not have art therapy training.

I contacted school districts and agencies with both art therapists and licensed therapists who provide services for children and adolescents. I also posted this study's recruitment document (see Appendix D) on the American Art Therapy Association's (AATA) website listserv. Potential participants that I contacted helped provide snowball sampling, in which they suggested others from the community who share similar experiences or perspectives that may be useful in providing information (Leavy, 2017).

I was able to recruit five participants for this study, which included three art therapists and two therapists who did not have art therapy training. All participants voluntarily completed the demographic questionnaire. First, all participants identified as female. The three art therapists I interviewed were under the pseudonyms of Bethany, Molly, and Gia. Bethany was a Licensed Professional Art Therapist (LPAT) and a board-certified Art Therapist (ATR-BC) who had been in clinical practice for eight years. She is of Non-Hispanic White or Euro-American descent and aged 30-39. She worked with one client with SM early in her art therapy career after a referral at the private practice where she worked and eventually moved on to work in an educational setting. The second art therapist was

Molly, she was a Licensed Creative Arts Therapist (LCAT), (ATR-BC), and trained in somatic therapies (ISP and SEP). She had been in practice for approximately twenty years and had worked with five clients with SM. She was approximately 60-69 years old, of Non-Hispanic White or Euro-American descent, and primarily worked in a private practice and an educational setting. Lastly, Gia was a bilingual Licensed Marriage and Family Therapist (LMFT) and an Art Therapist (ATR) with five years of clinical experience. She was of East Asian descent and aged 50-59. She worked in an outpatient setting and had experience with two individuals with SM.

Additionally, I interviewed a counselor and a psychologist, whom I named Lucy and Lottie, respectively. First, Lucy was a Licensed Professional Counselor (LPC) with fourteen years of clinical experience in school and community settings and had a background in fine arts from her undergraduate education and regularly incorporates art in her practice. She was approximately 30-39 years old, of Non-Hispanic White or Euro-American descent, and had experience with two clients with SM within the school setting. Lastly, Lottie was a nationally certified school psychologist (NCSP), a Licensed Specialist in School Psychology in Texas, held a Missouri Department of Elementary and Secondary Education Certification (DESE), and was a member of the SM Association. Lottie was of Latinx or Hispanic American descent and aged 60-69. She had been in clinical practice for about twenty-eight years within public school systems and had worked with approximately twenty-five clients with SM.

Procedure

Upon receiving IRB approval (see Appendix A), participants were recruited through snowball sampling via direct email within the St. Louis, Southern Illinois, Central Indiana, and Southern Indiana areas and the AATA listserv. Upon recruitment, the participants were asked to sign a Participant Notification Form (see Appendix B) and a short demographic

questionnaire (see Appendix C). I conducted semi-structured interviews with each

participant, each lasting approximately 45 minutes to an hour (Leavy, 2017). I presented the

following phenomenologically based interview questions and statements:

1) Tell me about your knowledge of selective mutism and describe your

   experience(s) of providing treatment for individual(s) with selective mutism.

2) How would you define nonverbal communication?

3) If you are comfortable, please spend 15 to 30 minutes creating an artwork that

   reflects your experience and process of treatment for individuals with selective

   mutism.

4) Describe what success means to you when working with this population.

5) Without breaking confidentiality, could you tell a story about working with a

   client and the artistic and/or therapeutic techniques that worked or felt most

   successful? What are your go-to techniques? Is there a story of challenge?

6) What cultural values and expectations do you find you hold about verbal

   communication?

7) In the treatment you provided, could you describe what level of communication

   from the client you considered successful?

I documented information through audio recordings and photographs of artwork created by

the interviewees. I aimed to transcribe the interviews within 36 hours of the recordings. I also

documented thoughts and feelings I had during the interview in a dedicated notebook to

account for personal experience of the phenomenon that the interview may have triggered.

The transcripts were stored on a file on my personal computer with a secure password.

Alongside my transcripts, I kept written notes dedicated to documenting my internal dialogue

throughout the interview sessions and collection of literature.

Data Analysis

I analyzed in an ongoing fashion by highlighting statements, sentences, or quotes in the interview data that I found significant regarding my research question and the phenomenon (Leavy, 2017). The art made by participants was analyzed based on their interpretations of their art and included in the analyzed text. I wrote in the margins to lift out categories that the written text suggests. From these categories, I found themes about which I elaborated in a series of analytic memos. This information was then taken to develop "clusters of meaning" by developing significant statements, symbols, and metaphors into themes (Creswell, 2007). This was a part of conducting a thematic analysis, a method that incorporates "identifying, analyzing, organizing, describing, and reporting themes found within a data set" (Nowell et al., 2017, p. 2).

Trustworthiness

Trustworthiness was established through clear and traceable documentation of the research process (Nowell et al., 2017). These processes included data collection, examination of the data, and my rationale for choices made as researcher (Nowell et al., 2017). This was accompanied by documentation of my internal dialogue regarding the phenomenon of NVC and the treatment of SM. Additional documentation included external dialogues that occurred between myself and my research advisors. My trustworthiness is further demonstrated by my previous diagnosis and treatment of SM, which is explained through my stance as researcher.

Here is an example of how I dealt with my biases in the context of the interviews with Gia, an LMFT and art therapist. I experienced feelings of frustration and anger as I heard her explain her experience working with two individuals with SM and their families. I did not agree with her techniques and values, and I interpreted them as an attempt to take power away from the adolescent clients and that she was making negative assumptions. These

feelings did not sit well with me, so I had a peer and my research advisor read the transcript, and we then discussed the interview and my judgments. It was through my discussion with my research advisor, that I was able to reinvigorate my excitement for the interview with Gia to the level it was when she first contacted me. I realized that her "negativity" was her open ability to talk about the unpleasant, her direct language and approach were a strength to harness, and her approach to treatment was through a systemic lens rather than a disregard for the child. Her theoretical approach, techniques, communication, and experience differed greatly from the other interviewees, and I value her contribution to the study much more now than I did initially.

Stance as Researcher

My interest in the treatment of SM and the use of NVC stems from my personal experience of treatment and struggle with communication. At six years old, I began having difficulty speaking to adults at my school. Following treatment of a small speech impediment, I met with a speech pathologist weekly to be taught conversational skills. These lessons made me feel disparaged and less heard, as I already knew much of what they were trying to teach me. My quietness was largely denoted as "shyness" and a lack of social skills by the adults in my life.

Along with some peers, these adults would continually point out my lack of speech and seemed to make it a major part of my identity, increasing my negative self-image and "otherness." It was at twelve that I stopped speaking entirely in school and public spaces. I adopted various forms of maladaptive coping mechanisms to deal with my increasing anxiety, actions that would finally be the signal for me to receive treatment for my SM and social anxiety.

A lot of my curiosity about this subject stems from questions that were left unanswered about my own experience, treatment, and diagnosis. How would I have responded to expressive therapies rather than just talk therapies? What led my therapist to try new techniques? How come those who found fault in my silence saw it as a flaw or lack of skills instead of as a mental health issue or an ecological issue? How would my behavior and identity as a teenager and young adult have formed if I had gotten treatment earlier? In what ways do my experience and treatment affect my mental health and communication as an adult? Do other cultures enact the same pressures I faced as a child and adolescent?

I sought to explore providers' thought processes behind their treatment procedures and any biases or pressures that challenge them. My own biases have been impacted by my own culture's values that privilege verbal language skills that are often expected early in development, a seeming lack of comfort with silence, and my personal shame in my quiet and introverted nature. At the same time, my experience with SM has given me the value of finding a connection with others in more than a verbal form and not making those who fall silent feel less valuable. It has also given me my passion to pursue art therapy as a career and find my outlet for communication through art.

Due to my close connections to both sides of being client and therapist, I expected more of my feelings and biases to be uncovered during the interviews and review of literature. Additionally, to my knowledge, I do not know anyone personally who has had the diagnosis of SM or has gone through treatment for the disorder. Since this experience continues to remain somewhat private, I hoped to account for my vulnerability in listening to therapists' stories about their work with clients with SM by noting times when I might have felt triggered or found resonance. It was difficult to determine how this may affect me, but I intended to keep my awareness of my feelings and biases through a dedicated journal and

discussions with my research advisor. In this way, I planned on keeping track of any biases that may arise.

The use of these methods provided me with the opportunity to gain valuable data provided by the five participants I interviewed. Using the methods described, I additionally analyzed the data and will present my findings and themes in the following chapter. The quotes from participants include page and line numbers from the data to ensure trustworthiness.

CHAPTER IV

RESULTS

This chapter is organized into four themes that emerged from the interviews of three

art therapists and two therapists who did not receive training in art therapy. The four themes

include NVC, therapeutic presence and alliance, art materials and interventions, and culture

and society, along with several subthemes associated with each theme. The following table

illustrates the major themes and subthemes that are addressed in this chapter.

Table 2

Major Themes and Subthemes

Nonverbal Communication	Therapeutic Presence and Alliance	Art Materials and Interventions	Culture and Society
Definitions	Patience	Art Materials and ETC	Nonverbals in Cultures
Example Behaviors	Rupture and Repair	Interventions	Verbal and Nonverbal Expectations
	Attunement and Observation	Defocused Communication	
	Therapeutic Approach		
	Building Alliance in Various Spaces		

Nonverbal Communication

The theme of NVC naturally occurred due to the nature of my interview questions,

such as having the participants define NVC in their own words. I have included their

definitions as a subtheme, but I also noticed eloquent descriptions of the ways their clients

communicated nonverbally, which I featured in a subtheme labeled *examples of behaviors*.

Definitions

As part of my interview questions, I asked each participant to define NVC in their own words. This question aimed to gain insight into how the participants perceived NVC, how many behaviors or interactions they included under the umbrella of NVC, and how their definitions compared to the definition I provided earlier in the text. To begin, Molly described NVC in a variety of ways, she first highlighted that "some people really truly have trouble using language and it's hard for them to form words. And that can happen when you're distressed and anxious" (p. 3, line 47). Lottie mentioned a similar concept and described some clients exhibiting a "heightened sense of quiet anxiety" (p. 1, line 13).

Other participants defined NVC in a broader sense outside the realm of anxiety and distress, often describing it in terms of lacking verbal ways of language. Bethany discussed,

Communicating in other ways, that using your voice, even if it's a communication board or body language, or noises... some kids will just try to communicate, but it's just... not actually language" (p. 2, line 21).

Similarly, Gia asserted, "I think nonverbal just means that you have other ways to communicate with people. It doesn't have to be words" (p. 9, line 200). Lucy also mentioned the absence of the need for words within communication in her definition. She stated,

It's the communication without words, communication through behavior, through emotion, through your feelings... I think just behavior is communication... the variety of ways that we express ourselves in a nonverbal way. (p.7, line 136)

To further define how individuals communicate without words, Molly mentioned her ideas of "proximity and distance and how they use it. Movement to and from" (p. 11, line 240). Among other aspects, Lottie also defined NVC mainly through the lens of movement, saying,

There's all kinds of NVC. Of course, the simple, the pointing, the looking, the outward expression as far as movement. But there's also the subtle communication that when you read the body language when you can see a student may not move at all, but you just see their facial expressions change or their eyes or big body movements, they turn away... Or even when you just see them looking at a picture or something or asking them to draw. (p. 3, line 59)

Additionally, multiple participants mentioned the variety of ways NVC may appear, as "it's so individual and varied" (Molly, p. 19, line 494). As mentioned above, Bethany listed that NVC could be through "a communication board, body language, or noises" (p. 2, line 22). In her definition of NVC, Molly added that there are multiple layers in how NVC manifests. She stated, "It's the little things that they may make or do…making in parallel" (p. 11, line 243), "it was the materials they choose, where they choose to sit" (p. 12, line 254), "it's all in the eyes, in the face, or just their movements" (p. 19, line 423), and her attunement to countertransference: "am I also feeling their gut distress…am I having resonance with them" (p. 11, line 240). Gia expanded the list of individuality with the aspect of appearances:

You see people's outfit, they communicate with you, they wear glasses, they wear necklaces, they wear different things. You see that, you see their nails, you see their hair, you see everything that they're trying to communicate with you about who they are. (p. 10, line 224)

Lastly, two participants narrowed down part of their definition to one of the most basic and common forms of communication: observable behaviors. Lucy remarked, "I guess... all behavior is communication... the way that we have feelings with behaviors and actions." (p. 7, line 136). Likewise, Gia stated "any behavior has meaning... [The client's] body language is meaning to me" (p. 9, line 202). These definitions show a wide range of

ways one may communicate nonverbally, including a variety of behaviors that the therapist may continually observe. Along with the definitions, the participants were able to also provide examples of such behaviors.

Examples of Behaviors

Scattered throughout the interviews, each of the participants gave numerous examples of behaviors that were presented by the clients with SM during the time of treatment. I would like to discuss these behaviors in the form of poems to better illustrate the clients they discussed. These poems will be presented in the following tables, which are divided between the three art therapists, the psychologist, and the counselor.

Table 3

Art Therapist Poems of Nonverbal Behaviors

Bethany	Molly	Gia
Face the wall	Whisper	Upset
Lightly kick	More prosody…more volume	Can't communicate
Not talk to me the entire time	Still very shut down	grab my hands
Scratch himself and head bang	wheels turning…eyes are going	so desperate
Losing his mind…trying to talk to him	anxious, shy, and really in her head	Won't spit out his words
A whisper of yes or no		
Didn't show his face	shut down	sit on the 45 degree angle
Sit still	angry…wouldn't look at me	won't even wanna look at me
Just like whisper	sit with more body parts towards me	edge of the chair
		hoody on, mask on
Anxious in his body language	ask me more	whole time doesn't look
Looked angry		
Kicking the wall	wander over	shrinking herself
Scratches on his face	stood up and wielded it	invisible
Appeared to be upset	didn't even acknowledge	
A little more relaxed	me...body language	Eyes are red, starting to tear
Sit down and look	shut down	cover herself
Demeanor softening		withdrawn
Whispery-ish…head down	listen very carefully [to me]	won't move…won't move
He was understanding	shut down	anything
Sit and play	throw herself, her backpack	hoodies on, mask on
Warm up	lie there	won't even give me eye
Touching (the clay) with his finger	give me a finger (to help)	contact
Wouldn't even move, kick the wall		looking at different directions
[kick] the wall more aggressively		doing nothing
I'm going to be calm or angry		one pose
Black and white		

Table 4

Counselor and Psychologist Poems of Nonverbal Behaviors

Lucy	Lottie
Quiet and guarded	Isn't talking at all in school
shut down (certain people)	quiet anxiety
hesitant and guarded	they can't talk
Really talkative (one-on-one)	see that anxiety- kick up
doesn't engage	hide behind
dysregulated or completely shut down	just freeze
not moving talking or engaging	cross-arms
stand behind who she felt safest with	start crying
hiding behind them	just whispering
showing me her squishies and things	Couldn't move-
Engaging in	having to put him in a wheelchair
playing	
opening up	pointing to things
	whisper to
Flat affect	would point
never made eye contact with me	speak to me or point to me
expression on her face, like something	tapping me and pointing
shifted	No pointing, no talking, no nothing
face light up and change	making noises and whispering
physically kind of relax	a little anxious
visibly change her body language	
	Pulled my whatever I was wearing and whispered, "I know you"

Therapeutic Presence and Alliance

Therapeutic presence and alliance are some of the rudimentary principles of treatment that help build the foundations for success. Hill (2020) defined the therapeutic alliance as the "part of the relationship [between client and therapist] focused on the therapeutic work, and consists of the bond, an agreement on goals, and an agreement on tasks" (p. 35). Additionally, the therapeutic presence was defined as the way of the therapist being completely in the moment with a client, and making themselves available on physical, emotional, cognitive, relational, and spiritual levels (Geller & Greenberg, 2012; Geller, 2021). Common subthemes, such as *patience* or *rupture and repair*, helped paint the picture of how working with the population of SM often looks. Additionally, subthemes such as *attunement and observation* or *therapeutic approach*, showed how the participants built such

therapeutic alliances. Lastly, some participants explained how they were able to *build alliances in various spaces*.

Patience

When explaining the processes of treatment, the element of time was often the cause of frustration or showed itself as a necessary tool for the treatment of SM. All but one participant had this subtheme in their discussion. When asked what her biggest challenge was in working with her clients, Lucy stated, "I guess time... there's always time in a school setting the struggle to feel like people are often looking for a quick fix and it's not always possible" (p. 12, line 244). Likewise in the private practice setting, Molly mentioned,

> So it was a long time... I would sit and make my own art... they were sort of like just these interior worlds my own like just being with him. I tried to maintain a relatedness with him, but it was difficult...There were times when I'd be like, what is this? (p. 9, line 191)

While in the clinical setting, Bethany explained, "I saw him all the way from October until about June... but the first, like the first 2 months he wouldn't even come to my office" (p. 4, line 75). She additionally stated,

> I mean there was in between days too but the beginning... you feel like you're like wasting time like their time or your time but I guess it made him comfortable. (Bethany Follow-Up, p. 10, line 199)

The participants who mentioned time as part of their process did so through learning its necessity and subsequently integrated their learning into treatment. Some of the participants reflected on their experience of this learning. Lucy reflected on her thoughts, feelings, and self-doubts in reaction to the long time period it took to build an alliance with her client. She described,

Keeping my own stuff in check because it's not about me, it's about her but feeling like it's saying something the fact that it took so long and like that somehow… that is a reflection on me and my work when in reality it's just you know it was just her process and she you know opened- she opened up in the time that, as long as she needed. (p. 12, line 255)

Molly additionally told of her experience of the process. She stated, "I learned so much in that process of how long it may take someone to come out of their guardedness" (p. 9, line 189) and she "really had to learn to wait. I'd be like 'what's going on' and I would just wait and he would finally say something" (p. 5, line 92). Additionally, Bethany reflected on her gentle approach to her client's treatment. She stated, "I was extra like gentle with him kind of, and like extra patient" (Bethany Follow-Up, p. 4 line 65). Comparably, Lottie asserted her treatment goal with her clients is to take "little baby steps towards communication," demonstrating the extra time needed for working with this population. (p. 6, line 123)

I found two participants were aware of the extra time needed, and communicated their intentions for patience to their clients. Bethany described not pushing her client in his progression. She explained, "like not in like a punishment type of way just like, 'all right we'll try next time,' you know, so you kind of just kind of let him join you (Bethany Follow-Up, p. 10, line 195). Molly sent a similar message with a more direct use of language. She explained,

I said to him... "I notice that it's difficult for you to speak, or to articulate, to say things, and particularly things about emotions." And I said, "and that's okay with me. You can take as long as you want. (p. 5, line 98)

Rupture and Repair

Throughout the interviews, I noticed many of the participants described their need for patience around the time of the initial building of the therapeutic alliance or during what I or the participants identified as ruptures in the alliance. This illustrated what may have been perceived as a pattern of rupture and repair in the therapeutic relationship that will be highlighted in this subsection. Eubanks et al. (2023) gave general definitions of a therapeutic rupture, including "a deterioration in the bond" between the client and therapist, and "any disagreement on how therapist and client work together" (p. 5). They additionally defined rupture repair as the process of recognizing and addressing therapeutic ruptures for resolution within the therapeutic change process. Four of the participants reflected on the course of the therapeutic relationship and their perception of the client's progress in treatment. Bethany described what it was like to observe the progress of her client. She said,

> He was really difficult, so I kind of like, never knew what I was gonna get that day, like even when he started making progress I feel like it went backwards and forward a lot cause even after he said, talking if he was having a bad day, he would literally come in my office and face the wall, and lightly kick it and like not talk to me that entire time. (Bethany, p. 3, line 64)

Molly also recounted details of ruptures with her clients and her attempts at repair. She detailed, "It's every time he comes in I have to reestablish a relationship with him" (p. 6, line 133), "he was quite verbal but it kind of disrupted our relationship" (p. 8, line 162), "I did eventually get her to talk about stuff, but if I pushed anything, she just would literally, at about 11 or 12, she'd say to me, 'cupcake…' meaning, 'don't ask me anymore'" (p. 9, line 201). She also said,

He comes in the following week and he's like this (arms crossed and head down).

And he drew weapons and wouldn't look at me. That lasted, that rupture lasted a long

time- 6 months or more. He proceeded to draw more weapons. He then moved from

drawing weapons to making them out of balsa wood. I spent a year not really talking

to him, but he made weapons he would sometimes ask me for something, but very

independent, he wanted my computer on with Spotify between us as a barrier. (Molly,

p. 5, line 132)

In describing the ruptures that occurred with her clients, Lottie sought to normalize these

disruptions in alliances. She asserted, "you'll see a little regression, especially when there's a

push" (p. 14, line 312), and one of her accounts of a regression. She explained,

And then suddenly I would say about – this is August, maybe November-ish, they

both just stopped completely. No pointing, no talking, no nothing. We don't know

what happened. I was asking, did anything happen at home? Is there going to be a

move? Is there a divorce, any kind of trauma? Anything that happened at home that

could have caused this to happen? Mom said no. So, she proceeded to take the boys

out of school. (Lottie, p. 13, line 272)

While these ruptures and regressions are normal and are often mended, Gia described

her experience where it seemed the rupture may not have been given the chance for repair.

She said, "it was just not the right situation" (p. 6, line 121), "this 13-year-old basically just

rejecting and when they reject, there's nothing you can do about it" (p. 7, line 139), "I don't

know if I want to continue torture her to see my room five more times" (p. 10, line 217).

Three of the participants articulated how their ruptures were repaired. Bethany

described that the progress through their use of interventions (e.g. "play-doh and clay

activities," playing, and a "trauma narrative" (p. 3, line 50) made her "feel like during that is

when we got like a lot closer too" (p. 3, line 58). To clarify, trauma narratives are exposure-based cognitive-behavioral therapy interventions in which a therapist may provide a safe environment to engage in detailed discussions or recount a client's traumatic experience (Frank et al., 2021). On the other hand, Molly recounted the ways she promoted repair in her work with the client, "I would begin to articulate for him what he might be feeling, but I wouldn't comment too much. I would say, 'oh, look at you made the hill different.' This went on 9 months" (p. 5, line 138) and a moment of connection,

> I was gonna suggest to him that we use one of those charts, the emotion charts that I got when I was a student, and I used to use it. It was so funny, it was one of those moment of co-creation where he actually came in wearing the t-shirt of that. He said, "well, my mom, said 'I should need this.'" I don't know when in therapy it was, but there was a connection between us. (p. 6, line 119)

Lastly, one participant found an unexpected progression after a large rupture. Lottie stated,

> Then [their mom] brought them back in May, the beginning of May. School's out at the end of May. So... one month. It's like, I'll take what I can get. One month, the first day was really hard. By the end of the week, they were back to what they were doing before. (p. 13, line 280)

Finally, Bethany and Molly were the only two participants to provide artwork that reflected their experience in treating individuals with SM. Interestingly, both artworks seemed to align with how they viewed and navigated the process of rupture or regression with their clients. Molly provided a painting (see Figure 2) in reflection of one of her clients who would "show up every week and not speak or move" (Molly, personal communication, September 25, 2023). She explained artworks such as her painting were used to help her navigate the times of rupture and contribute to building a therapeutic alliance. She explained,

"They were done as a way to maintain my calm and distance and yet be with her while she was both silent and dysregulated. I remember that she would just watch me" (Molly, personal communication, September 25, 2023).

Figure 2

Molly's Artwork

Bethany additionally provided artwork (see Figure 3) to reflect how she felt her client's pattern of behaviors would appear in sessions and how she would often see two extremes of dysregulation rather than moments of regulation. She stated, "I feel like his baseline was just like, 'I'm going to be calm or I'm going to be angry today'" (Bethany Follow-Up, p. 16, line 317). In addition, she stated that despite these moments of

dysregulation, she continued to use her therapeutic skills and perceived progress in the end.

She further explained,

> I don't know if I did the black and white on like subconsciously like on purpose... I
>
> feel like he was very black and white... I guess it's like growth... he was like
>
> contained, but he ended up growing at the end. (Bethany Follow-Up, p. 15, line 303)

Figure 3

Bethany's Reflection Artwork

As shown in these excerpts and artworks, ruptures and regressions are a common occurrence within sessions and the therapeutic alliance. Also as common, is the work that is to be done to repair these ruptures and how they may lead to perceiving progress made by the client, even if progress is not linear.

Attunement and Observation

Attunement is defined as the ability to appropriately respond, sense, and understand the emotional, physical, or behavioral signals and needs of others (Schomaker & Ricard, 2015; Di Renzo et al., 2020). I have separated this subtheme into two additional subthemes of *Therapist Attunement* and *Co-Attunement*. The interviews gave me tremendous insight into the therapists' perspective of their attempts to attune to their clients. The participants also gave me a glimpse into the experience of their clients. A few spoke of times they felt or noticed their client attuning to the therapist, so I created the subtheme of client co-attunement in addition to the therapist's attunement.

Therapist Attunement. "I wish I can speak her language. Her silent language" (Gia, p. 9, line 192). In this quote, Gia expressed her desire to be attuned to how her client was communicating in a nonverbal way. The therapists' attunement to the client was a common theme expressed amongst all five participants. Along the lines of Gia, Lucy also acknowledged her client's "silent language," "I never saw her socialize with anybody besides her brother. But her willingness to communicate with me in other ways, I felt like that was a real celebration" (p. 9, line 193). Bethany noticed her client's progress through her use of attunement, "I know that even if they're not responding like verbally, I still think that they're getting something out of like our therapy sessions" (p. 7, line 137). Additionally, Molly highlighted a large part of treatment is "just being attuned to them and being present and being constant" (p. 11, line 233).

Three of the participants described how they observed their clients as a method to promote attunement. Molly stated, "for me and yeah, I watched his body language, I watched what he was doing" (p. 9, line 180) and "I would watch and it was really months of that… watching for these really incremental changes and how he was" (p. 9, line 185). Similarly, Lucy described, "I guess it was like using different materials, seeing how she responded with her affect" (p. 9, line 193). Lastly, Lottie mentioned, "it's really reading just body language a lot, especially with little kids" (p. 4, line 69).

Some promoted attunement through their knowledge of child and adolescent development. One of which was Molly, who asserted,

Well, I think that I just remain attachment aware. Aware of the signs of attachment... whether it's in the imagery or in body language... I think that with this girl who had a need to hit me... she would do it with puppets or then we played paddle tennis where she had to slam the ball at me and I... I think it was a way of testing me, testing the attachment, but also knowing that she trusted that she couldn't destroy me... I think of it really as attunement to their needs, attuning, being very attuned. (p. 14, line 299)

Moreover, Lottie considered,

The little ones, because it's that deciphering, is it a developmental problem, meaning they just haven't reached that skill yet, or is it truly impacted by some kind of anxiety, and teasing those out, like if you have a three-, four-, five-year-old, it's like, well, what is typical, and what is atypical… It keeps you on your toes as far as developmental milestones. And then trying to read... they'll start crying if they can't talk... what triggered that? So it's just neat to see how many ways a little kid can nonverbally communicate with you. (p. 4, line 71)

Two participants emphasized the importance of attunement and observation, as clients vary in many ways. Bethany stated, "I think it's knowing the individual better I think... because I mean it varies so much from person to person" (p. 5, line 101). Lottie highlighted this observation by offering an anecdote on how people learn to communicate in general, as a developmental sequence. She observed,

> Having kids of my own, when they're babies, you start learning how, you start seeing how they communicate... they don't come out being born saying, 'I'm hungry.' They cry. And then they start pointing and then they start verbalizing. So it's building on all of that. (p. 7, line 140)

This concludes the section on the perspective of attunement through the lens of the therapist. Though it is still from the account of the therapist, the next section speaks to attunement from the perceived lens of the client.

Client Co-Attunement. Along with the therapist's attunement to the client, I noticed that three of the participants reflected on their awareness that clients often attuned to the therapist and how the therapist may have presented themselves based on this awareness. Gia mentioned, "it's almost like she doesn't understand me anyway... that kind of thing" (p. 9, line 194) as a sense of disconnection she felt from her client. She additionally explained the importance of considering communication from both sides of the therapeutic relationship,

> You use their language, just communicate them, not just your own language. So to me, that's a co-communication. But from culture perspective, sometimes can be very insensitive, like... I can come out differently... so it's a guessing game sometimes (Gia, p. 15, line 331)

Furthermore, the other two participants described the attunement of their clients to reading the therapist. Bethany stated, "if you're frustrated, without even saying it, they already

know" (Bethany Follow-Up, p. 8, line 167) and "I feel like it's as if they know you too" (Bethany Follow-Up, p. 5, line 105). Additionally, Lottie asserted,

> They're very in tune to reading you very well. I think most kids are... kids can read you really well, then you kind of know how to act. And if you act silly at one point and you don't act silly the next time, they're going to say, like, what's wrong? So you... have to watch how you're acting with them. But I think as long as you stay genuine, they'll pick up on that. (p. 16, line 334)

Therapeutic Approach

In addition to these other factors, participants stated how they purposefully presented themselves in the therapeutic space through their choices in therapeutic approaches and how the participants may have responded. Participants highlighted their therapeutic approaches through statements or descriptions of their practice, a factor in how their therapeutic presence is shown in the therapeutic space. Two participants reflected a client-centered approach in their therapeutic presence. Lucy stated,

> I think... really basic, Rogerian, like person-centered reflection and just being present with them... and not trying to change anything or push anything, but just being really present and acknowledging like what, reflecting like what I am seeing and what I'm hearing about the situation... focusing on relationship. (p. 10, line 202)

Similarly, Bethany in her follow-up interview described, "there's not much I could do but I feel like just being present with him and having him know that like I'm not just gonna take you back upstairs to your mom" (p. 9, line 191). Alongside her art therapy training, Molly cited a more specific approach in the context of her client whispering, "I've been able to point it out to her because I'm a somatic therapist as well" (p. 1, line 20).

Two participants asserted a focus on behaviors, citing Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT). Lucy stated, "I do a lot of ACT, CBT kind of integrated stuff but I always integrate art or some sort of expressive thing" (p. 6, line 122). Lottie indirectly explained her behavioral strategies,

I would do a lot of diagnosing, testing, and helping the teachers write, mostly behavior plans, which is interventions for their IEP (Individualized Education Plan), and then hitting the roadblock on those true therapies if that's what they focus on…coming into the schools to help start bridging those gaps. (p. 1, line 20)

Conversely, Gia steered towards a systems approach and showed glimpses into her family therapy training throughout the interview. She stated, "everything was fine, but I think mom is frustrated and passive. So, I said, 'so have you ever like the pushing her a little bit'" (p. 3, line 53) "but I do feel like to set clear boundary, that's a totally different story. As clear as you can, in a nice way, in a manner. I think everybody needs that for communication. If you don't say it clearly, it causes more trouble" (p. 16, line 340).

Building Alliance in Various Spaces

One may have an assumption about how traditional therapeutic spaces may look. Four of the participants described how they built alliances in varying spaces (i.e. in the studio, the office, at home, or modifiable) that may be different from that assumption. For example, Molly showed how the studio space can be customized for the needs of the client. She stated,

I constructed most of [the box], but it was her idea and then she would use it. She would go inside and sit inside of it, as sort of the sensory deprivation chamber and you need space you can go in it... I felt like the other kid used the computer, and the

sound, the music…but it was like he was creating his own space within my space like

this. (p. 12, line 272)

Bethany built her alliance just outside of her regular therapeutic space and described, "first 2 months he wouldn't even come to my office" (p. 4, line 75) and "for 2 whole months I played Play-Doh with him like in the lobby... without even speaking, and then he finally agreed to come downstairs to my office after like a couple of months" (p. 4, line 79).

Due to different circumstances, two therapists were able to interact with their clients outside of the clinical or studio environment, which gifted them different perspectives of how the clients may interact in their different environments. In one of Lottie's roles as a therapist, she explained, "So not only would I test the students and I'd help write the IEPs, I was able to go into the home and work with them in that area" (p. 2, line 27). She additionally explained,

I was able to explain [SM] to the parents and help them with that in the home setting,

then how to transition through baby steps out into the school. (p. 2, line 35)

Similarly, Lucy was able to build alliances with her clients through different platforms. She described,

We had had some relationship already in the school... then... I went to find that she

has this thing and then people would kind of call me to so she could test in my

space... when the pandemic happened, I had a regular set time for every day. And I

think that that impacted her willingness to work with me or something. I could

imagine that that helped. (p. 1, line 20)

She then acknowledged,

So it was kind of a unique therapeutic situation that like because it's a school setting it

is a little bit more flexible for things like that it might be in a clinical space it wouldn't

be like appropriate... but I think it helped her feel safe and comfortable. I imagine that

that impacted her in a way. (p. 4, line 77)

These various spaces may not have only been other opportunities to work with the clients,

but another opportunity to build an alliance in an environment that may be more conducive to

doing so.

The theme of therapeutic presence and alliance relates to one part of treatment, the

part that is first established and the part that continually needs work. The following section

speaks to another, more technical, part of treatment.

Art Materials and Interventions

Art materials and interventions are the tools therapists hold to aid in the progress of

the client toward their goals. Some participants described the art materials they used within

sessions, much of which can be tracked on the ETC. Additional non-art interventions that

encompassed both verbal and nonverbal realms were established in the discussions.

Art Materials and the ETC

Many of the participants mentioned using art materials in the treatment they provided.

Interestingly, this included not only two of the art therapists but also the two non-art

therapists. Additionally, it was in the interviews with Bethany that I noticed a natural

progression in the use of art materials, and began to connect them with the ETC. This section

will be loosely organized on the structure of the ETC. First, Lucy, a talk therapist and school

counselor recounted what led to a breakthrough with one of her clients. She asserted,

Honestly, I think it was art. It was making together... at some point I was like, well,

this isn't working... Talk therapy is not, or this sort of modality is not what she needs.

So let's make some clay and then let's throw it at a tree. (p. 4, line 86)

Similar to Lucy, Bethany found clay to be a success in the beginning stages of treatment with her client, "at first, before he was talking to me, we did a lot of like play dough and clay activities (p. 3, line 50). From there, Bethany stated her client moved on to more fluid materials, "but he became really comfortable with [clay], and then I kind of moved up to like painting a little bit, which he also liked" (p. 3, line 52). Lastly working with rigid materials, "I think, since we were able to like, draw it and do a little… we would like play this game, or I would have like collage cutouts and they would like talk to each other" (p. 8, line 160).

On the other hand, Lottie and Molly highlighted successes for their clients using rigid materials, primarily through drawing. Lottie stated, "getting them to draw... that's always an icebreaker" (p. 3, line 66). Additionally, Molly declared, "[the client] proceeded to draw more weapons…he then moved from drawing weapons to making them out of balsa wood" (p. 5, line 111) and with a different client, "I got foam board I got in different colors we got like cool duct tape and different colors, like denim" (p. 12, line 269).

Lastly, Bethany acknowledged how she and her client were able to integrate multiple materials in treatment, "I feel like the ETC is like such like a natural kind of a thing, if that makes sense. Like, I use it with so many people, just because it's like safer" (Bethany Follow-Up, p. 12, line 256). She continued,

> It's ingrained... it also depends on like what that person's likes end up being too. With him he ended up liking some of the like tactile stuff like the clay, and like harder foam sand stuff. But I mean, I do think it was successful with him too... by the end, he was drawing actual images, following more in-depth directions. (Bethany Follow-Up, p. 13, line 261)

The participants discussed success with a variety of materials, including clay in an assortment of uses, rigid drawing materials, and collage. For some, these art materials are just part of a range of interventions used in the treatment they provided.

Interventions

All five of the participants described the types of interventions and prompts used within sessions with their clients. First, Bethany stated she mostly took a "very flexible" (p. 4, line 73) approach with her client, which she explained, "it wasn't even really like a specific like, active, like prompt or anything, we're more just like playing" (p. 3, line 51). She also commented on her success with her client, "because I use nonverbal directives... clay and materials so often that I feel like that's why the art therapy worked so well for him" (Bethany Follow-Up, p. 4, line 64). Molly also stated her use of nonverbal art therapy interventions along with the use of theory. She explained,

> Polyvagal theory and the ventral vagal and the dorsal vagal and how people shut down, disconnections and the expressive therapies continuum, you know the going from the lower to the limbic brain to the frontal lobe and you know sort of working that way. Using Cornelia Albrecht's work, guided drawing…Very much the use of the ETC. (p. 14, line 316)

Similar to Bethany, Gia stated her desire to have done more nonverbal interventions, "or do different activities, but I wish I can go for walk with her or go somewhere, play games or something, but I feel very limited" (p. 8, line 167), and described her attempts to implement nonverbal art therapeutic interventions. She explained,

> The option is I give you a different material, do you wanna do something for me? And then she will look at me and I said, do you want me to give you directive or you wanna just do it, whatever you want? And obviously that's difficult for her to answer.

She won't answer me, so either one or two, right? And she still don't, so I just leave it

there, and obviously there's nothing happening. (p. 9, line 188)

In contrast to nonverbal directives, two participants mentioned the promotion of

verbal language. Molly explained how she integrated language within the context of her

aforementioned consideration of polyvagal theory. She stated,

Then also just promoting use of language. Like even if they couldn't use language.

I'm consciously doing this with the 17-year-old now who can understand, "look, let's

try to at least articulate a little bit." I'm gonna do that with this younger girl too...to

consciously say you know you have trouble using language and it is a skill and when

you don't use it when you're younger or if you lose it when you're distressed, because

the primitive brain is kicked in and you're losing connection to the higher brain

function. It's important to try to develop some skills around it. (p. 14, line 308)

For one of her interventions, Lottie explained the specific model she has used to promote the

use of verbal language, "I started basically the progress model that, the communication

model that is in research based through Dr. Bloom (p. 12, line 255) and "basically what it is,

is you do start a student wherever they are. You meet them where they are, build rapport, and

then you start building, it's called the communication ladder" (p. 10, line 207). She then gave

an example of what these models look like. Lottie described,

[The client] started pointing and then one of the things you do when they start making

some effort to communicate is you get really exaggerated on your sounds like if

you're saying 'this is a Dog, what sound is the dog make?' You know, and you're like,

'woof, woof,' whatever. (p. 12, line 262)

Along with the type of language Lottie used, "the word brave, that is one of the things you use, like to use your brave voice. Not big voice and not big boy talk or you're a big boy. No, it's to use your brave voice" (Lottie, p. 14, line 293).

Two participants mentioned their participation in specific exercises done with their clients. Lucy expressed, "just some grounding techniques... feeling your feet and just kind of co-regulation that with the one that was a little bit more difficult" (p. 10, line 208). Additionally, Molly stated,

> I often work with her around doing ventral vagal exercises to sort of open up this whole area and I tell her why we're doing it and then I often will do things like, choose an emotion. Let's just, you know, identify emotions because she literally- her word for herself is stress. (p. 2, line 27)

Finally, three therapists explained how they eventually incorporated group therapy in addition to their clients' individual therapy. Molly articulated, "I started doing family therapy with them, and in family therapy he was actually able to express all the rage he had, 'you never, you don't let me be who I am'" (p. 7, line 160). Additionally, Bethany described how her trauma narrative led her to also incorporate some family therapy, "I think that since his was like related to trauma, I think that when he was able to process that and then share it with his mom and family is when like was my goal for him being discharged" (p. 7, line 150). Then, Lucy explained how she incorporated group work within the school setting. She described,

> There was a couple of the kids were in this... it was like a family sort of group, several families that were together. But then I threw her in there too, you know, the really sweet group of kids. It was more like a lunch bunch, like a positive pro-social group. (p. 8, line 162)

Defocused Communication

When reading the participant interviews, I noticed that each participant described at least one technique that they attributed to helping their clients with SM in particular. Much of these techniques, I realized, seemed to follow the approach of defocused communication, or techniques that take direct attention away from the child or their lack of speech. These techniques include creating joint attention, sitting beside the client, providing time for the child to respond, neutral responses in response to verbal responses, continuing dialogue even without a verbal response, and thinking aloud to avoid direct questions.

First, Bethany described sitting with her client in times of silence. She explained,

I also feel like just sitting there with him even when we weren't talking like he might have… Even on the days we like weren't doing anything and he was just sitting in there with me... it might have been nice for him to just like not be bombarded for 45 minutes you know what I mean like 'hey talk!' (Bethany Follow-Up, p. 11, line 219)

Bethany further discussed creating an alliance with her client through joint attention, "even though he wasn't talking to me yet, he got more comfortable with me, through doing art with me" (p. 2, line 36). Molly also explained how she finds an alliance with her clients through art. She stated,

They're making something I'll make something with the same materials and sometimes all a material that I'm using they will then choose. I see that often... Edith Kramer was my teacher and that borrowing ego strength... that, "oh, M does this, maybe I'll try that," right? It's not anything that they could ever art articulate. (p. 11, line 244)

Then, Lucy mentioned how the joint attention to art improved her understanding of her client's communication. She explained,

So there's like in this process of us doing this drawing together, I'm understanding

something that she is communicating to me and she is sharing that she appreciates it...

and I experienced her appreciation in her expression. (p. 9, line 186)

Finally, Lottie stated how she falls back on joint attention to reestablish comfort and alliance,

"that's where I would take the baby steps and introducing myself again and the drawing, the

writing, the sign language, whatever" (p. 3, line 51). Lucy additionally reflected on how joint

attention through art may have contributed to her client's participation and material

exploration. She reflected,

Being willing to work alongside that- parallel play... it ended up being a way for her

to, like me working, made her feel safe to participate... and try and get different

materials. (Lucy, p. 11, line 231)

Next, the participants considered how to communicate with their clients when they do

not give a verbal response, such as continuing the therapist's verbal dialogue and thinking

aloud instead of direct questions or pushing for answers. Molly provided several examples of

these concepts, first, she conveyed her expectations from the client, "[the client] came into

me and I said, "you know I'm an art therapist. You don't really have to talk with me. We can-

you could just draw and sometimes we may talk" (p. 4, line 73). Molly then described how

she used these techniques during art-making. She asserted,

I would with her, as with most of the kids I work with who are like this, I just would

speculate 'well, can I tell you what I think might be going on?' I would say

'sometimes when this happens to people, this is what they might be feeling.' (p. 9,

line 204)

Bethany gave similar examples as to what she did during nonverbal art-making with her

client to promote engagement. She described,

If you're not like processing the art, you're not talking as much, but I would... be like, "hey, your mom said this at school…this is the narrative we're going to start making..." I would talk and explain it. And I would still comment on his art, like, even though he wasn't responding, and give him feedback. (Bethany Follow-Up, p. 10, line 208)

Though defocused communication may focus on nonverbal interactions of the clients, it is also important to know how to react when the therapist does receive a verbal response from their clients. Lottie explained the need for more neutral responses, as she did for one of her clients' moments of progress. Lottie stated, "you can't act super excited, because then that kind of sets him back" (p. 13, line 288). She additionally explained how the way the therapist gives a response provides a level of evaluation to the client, thus the need for a neutral response. Lottie asserted, "You have to kind of just maintain calm because... they're aware of what they're not doing. So if you bring light to it, you don't want to stop that growth" (p. 15, line 329).

Ultimately, two participants described the importance of understanding the level of communication their clients are comfortable expressing and learned to begin on that level. Lottie conveyed this concept in her reflection on her work with clients. She stated,

the very first thing that I would work on with students with SM is it's not necessarily that we want to get them to talk. It's like, no, we want to listen to the anxiety first. Let's lessen that. We'll get them talking, but be open to meeting them where they are. (p. 5, line 96)

Similarly, Lucy stated from her experience, "meeting her where she's at, recognizing that certain things don't work, and then using what materials I had in the space and the resources, like her brother" (p. 5, line 103) and "I just found myself, like, meeting them where they

were at, and it brought some relief, I guess, or like a break, you know, where they didn't feel the pressure" (p. 16, line 331).

On the other hand, Gia described a different approach and experience from the other participants. Gia explained a more direct approach to try to engage with the client and the client's family after struggling to connect with her client. She stated,

I think I was trying to do is make sure that she's in a room with, and in this conversation and she is visible. I'm trying to make her visible and I'm trying to talk to her as a first person,... I'm feeling… I think, and mom, I think she will not feel good... I'm like trying to include everybody in this conversation. (Gia, p. 7, line 156)

However, her direct attempts to engage the family without leaving the client feeling left out were met with further struggle and disconnect between herself and the client. Gia expressed,

Mom would tell me and then the whole time, like in a room, I wanted to directly talk to her as she is in a room. But she made herself invisible... she won't talk, she won't make a sound. And a lot of times when I get more response from mom, then I will like talk to mom directly, but I want to make sure it's a three conversation, three people in the room, right? And so I will like try to like… provide some kind of empathy to the situation like, oh, I can see why client, this is trauma, I can see why she probably feel like. (Gia, p. 7, line 143)

Each participant gave insight into what techniques and interventions did, or sometimes did not, work in promoting the progress of their clients. Many of these were intentional decisions, such as their therapeutic approaches, or common techniques they happened upon. The following section discusses aspects of the clients' environments that they are not able to manipulate as they can in the therapeutic environment.

Culture and Society

The final theme of my analysis revealed how the participants noticed culture and society and its impact on NVC and how one is expected to communicate within certain cultures. The first subtheme outlines how NVC may appear in or be interpreted by some cultures. The second subtheme examines the pressures one may face to communicate verbally or nonverbally and how that may impact the treatment of individuals with SM and their mental health providers.

Nonverbals in Cultures

Four participants explained how NVC may appear in their own cultures and how their experiences of NVC may differ within other cultures they now live in or work with. Bethany, a White American, discussed the nuances of NVC interpretation and expression throughout culture. She first asserted, "I feel like when you get into like the nonverbal like it's more like universal" (Bethany Follow-Up, p. 8 line 163). Bethany then provided an anecdote about her experience when her NVC of waving toward herself was misinterpreted within another culture. She stated,

> I've taught in Thailand for a year and it's just interesting when you think about nonverbal things, like when you go, if we were at school and we'd go like this (waving her hand up in the air in back-and-forth motions towards her body), 'come on kids, come this way,' in Thailand, that means like, it's like a very aggressive, offensive symbol that means like 'bring it, come fight.' (Bethany Follow-Up, p. 8 line 169)

Further, Gia highlighted how communication differs in the culture of the United States and her native culture. She said,

We say communication. That doesn't mean verbal, right? There's a lot about how you dress, right... your hair and how your appearance does number one communication. And number two, is your manner. Is a communication of what type of family you came from. And then... language is big in manner as well... Also coming to the opposite direction, there's things you should not say. You should not give in direct answers. That's very frustrating. 'Oh, don't tell them why you wanted to eat because you might offend them...' ' don't tell them what you call you like because it might be different from there....' that's another type of communication we're talking there... Don't tell them. Don't respond to the emails... they might think differently... It's very frustrating to me that's not my way of communicating. So then in this culture I prefer is more direct, but direct can also hurt people's feelings a lot and then can cause people to have problems with you. (p. 14, line 315)

Additionally, Gia explained the different layers of communication outside of verbal language in her experience of her native culture,

I think from my Chinese culture, it's definitely not. I think when we say 5 different languages. Verbal is often not the heavy way to go. People are not very direct. We don't say I love you. I don't say I miss you... So writing is very interesting. My dad doesn't say much, but when he writes, it's beautiful. It's very emotional. It's eloquent, and you feel all those like very romantic emotions in his writing, but when he talk to you, like flat face, you know, don't have anything involved. We don't even touch each other. That's just not the culture, but then also don't say anything... also is not verbal. But we do things for each other, and when you do things for each other, when you buy things like, people like, oh, you're so thoughtful because I just mentioned about something and you remember now, you buy me these. So those are the like the

communication that they think you care about me because you pay attention to me and you do that in a silent way. You're showing your actions. So that's a different way of showing. (p. 16, line 345)

Two participants explained different perspectives on the differences in communication in Latinx communities and White American cultures. Lucy first stated one aspect of her experience with her clients who came from Latinx cultures,

Eye contact was actually a thing for both of them, but the one that I was closer with, eventually, that was a non-issue with us, but that was a really big deal for the other student because she, people saw it as disrespectful, like, she's disrespecting me, she's not about you. (p. 15, line 324)

Similarly, Lottie noted the discrepancies in the signs of respect through nonverbal behaviors between Latinx communities and White American cultures,

The not looking into anybody's eyes when you're talking to them, you know, out of respect you don't look at adults in their eye. Knowing that when you're meeting with a parent, you don't just sit down and start, like when I have meetings, I don't sit down and just start talking about the nitty gritty. You need to build rapport and ask how the family is and talk about, you know, everything and anything except what you're there for. So, understanding that there's different ways of doing things because growing up in a predominantly Hispanic culture and then exposed to White or American culture, how the norms are different. (p. 8, line 156)

Lottie then stated how her experience informed her work with clients from various cultures,

So growing up with that, then working with different cultures, just trying to be sensitive to what they're showing and not saying, well, that's disrespectful or why did

they do that? It's like, no... so they're doing this or they're understanding that or they said this. (p. 8, line 165)

Verbal and Nonverbal Expectations

All five participants spoke at least once on the subject of societal expectations surrounding the use of verbal communication and how that has impacted the treatment of individuals with SM and the people around them. Lottie brought to light differences in cultural expectations of speaking and the understanding of SM, and stated,

It's very hard for some parents to understand [the diagnosis], which brought into focus the cultural expectations. That's a big one on a lot of parents that I worked with... A balanced number of parents that I worked with, some were able to understand the concept of not being able to, to where some [people] of other cultures found it really hard to not understand why. It's like if you're a firstborn, if you're a male, you should be doing this, the expectations are high. So culturally, it was very hard for them to just say... he says he wants to do that and he doesn't, so I don't understand. (p. 5, line 108)

Lottie also spoke about the importance of cultural considerations when working with families of different cultures,

So just trying to be culturally sensitive, that played a large role, mainly because the population that was presenting a lot with SM was more of the Asian population, and their expectations on their children are very different, very high. And of course, anything from what they felt was out of as something's wrong with my family and it's a disgrace. So trying to be sensitive to that, to tell them, you know, you're not gonna tell them, no, it has nothing to do with you because that's what they feel. (p. 8, line 169)

Likewise, Lucy described her experience of how cultural expectations may surround behaviors for children and adolescents, and she stated,

> My situation and like my cultures coming together with me and my husband, my family and his family, and how different... even just expectations of kids, behavior... I'm a very White American mom and my first two kids are White American boys... my husband's... behavior expectation is so different and for like a reason... the kids all sat and ate the entire meal with everybody... and maybe this is like just the culture of his family too. It's not like all Mexican culture. I can't speak for, you know... the expectation that the kids... would greet the adults, say, 'hi, how are you? Do you need anything'... and sit with them. They're so polite to elders. And there's all so much communicated... and then I think of like my seven-year-old boys who are like running laps around the dinner table every night... it's like there's kind of different cultural expectations. (p. 14, line 283)

Others discussed times when cultural expectations of verbal communication impacted the families of their clients and the people around them. Bethany mentioned, "mom's goal was for him to start talking at school, because she was pretty much fed up with it" (p. 8, line 152) and "I think she was just very stressed out and wanted to see results, and was getting frustrated with him, not talking at school or to anyone else" (p. 4, line 83). Additionally, Gia also stated she observed frustration with her client's mother, "everything was fine, but I think mom is frustrated and passive" (p. 3, lie 53).

Also as a result of these societal expectations, participants discussed the pressures produced by the demands for verbal language. Bethany reflected on her perception of her client's experience,

I feel like he was so pressured all the time... By his mom, by school, like the rest of

his family to start functioning again that I feel like it was probably really for it was

definitely frustrating to him I feel like. (Bethany Follow-Up, p. 11, line 221)

Comparable to Bethany's client's pressures, Lucy stated,

Usually... I was called in to respond to a situation where an adult had pushed and

pushed and then the child is dysregulated or is completely shut down and is not

moving or talking or engaging with anybody verbally or non-verbally. (p. 11, line

239)

Relating to the client's experience of societal pressure, Bethany discussed how she

too faced the pressures of verbal communication. She first mentioned how the pressure from

her client's mother also affected her as the therapist, "the pressure from the mom to like-

made me more on edge" (Bethany Follow-Up, p. 11 line 218). She then spoke about her own

experience of being pressured to verbally communicate, "I used to get stickers... up until

second grade. Like if I would speak once in the day… I was just, didn't want to" (Bethany

Follow-Up, p. 11, line 234) and "I wasn't non-verbal... I wasn't mute or nonverbal. I was also

so shy. I just didn't like talking at school. But there's definitely a pressure" (Bethany Follow-

Up, p. 11 line 237).

Lastly, Molly spoke of her empathy towards those who have difficulty

communicating verbally and the shame that may manifest from their difficulty. She

explained,

I think it's their ability to communicate their needs and to begin to show that visually

and then to maybe begin to describe it somewhat and also to just feel better about

themselves because I think with SM, there's a lot of shame. And it's shame and

anxiety that prevents them from- it's not stuttering, but it's almost like stuttering. It

prevents them from like articulating and I know it because when I was younger I was

like that, and there's a part in me that really recognizes that. (p. 16, line 353)

Conclusion

The data collected from the interviews provide a glimpse into the experiences of

therapists and the treatment they provided for individuals with SM. Many participants

reflected on the effects culture and society have on the expectations of the use of verbal and

NVC, the treatment of those who may not meet those expectations (i.e. those with SM or

considered shy), and how those expectations may affect the treatment of or understanding of

the SM diagnosis. The participants additionally provided examples of how NVC may appear

in various cultures, their definitions of what NVC is, and an illustration of the nonverbal

behaviors of their clients through their accounts of their treatment experiences. The glimpses

into their treatment provisions were further clarified with explanations of specific therapeutic

interventions, defocused communication techniques, and art materials they used throughout

treatment. Lastly, the foundation for the use of these interventions and materials was laid

through the establishment of their therapeutic presence and alliances. This comprised of

adapting to various therapeutic spaces, setting their therapeutic approaches, navigating

ruptures and repairs, using patience, and the attunement and observation between the client

and therapist. The next chapter will further discuss these results and provide connections to

other related research.

CHAPTER V

DISCUSSION

This research explored how therapists considered and implemented NVC in their work through the retrospective examination of their treatment experience of individuals with SM. Further, I investigated possible connections between NVC and artmaking and the sociocultural considerations surrounding verbal and NVC. Within their interviews, the participants in this study illustrated examples of nonverbal behaviors that interacted with the development of therapeutic presence and alliance. These aspects of treatment were guided by the use of art materials and therapeutic interventions placed within the context of culture and societal expectations.

Upon reflection of the research, I found no significant differences between participants with formal art therapy training and those without. For those with formal art therapy training, Bethany and Molly, who felt they had successful treatment outcomes for clients with SM, attributed the success to the artmaking process and its connection to NVC. This was shown in Bethany's statement, "Because I use nonverbal directives and... like clay and materials so often that I feel like that's why the art therapy worked so well for him" (Bethany Follow-Up, p. 4, line 69). Though Gia may not have had the same outcomes as the other art therapists, she expressed her thoughts that artmaking may have provided better connection and expression for her clients. However, she felt limited in the activities she could provide or did not feel she could properly prompt artmaking without a strong therapeutic alliance. Though she is not an art therapist, Lucy, the school counselor, detailed similar experiences of artmaking and NVC as the art therapist due to her artistic background and regular use of art materials with her clients. Lastly, the school psychologist, Lottie, also found success with clients due to her specialization in SM treatment. With her specialization,

similar to the other participants, she had an attunement to nonverbal behaviors and even described the use of some expressive activities (i.e. drawing).

Major Themes

The analysis of this research resulted in four major themes. The first of these themes included nonverbal behaviors, where participants defined NVC in their own words and highlighted examples of nonverbal behaviors found within sessions. The second theme comprised therapeutic presence and alliance, which were narrated by subthemes of patience, rupture and repair, attunement and observation, therapeutic approach, and building alliance in various spaces. The third included the theme of art materials and interventions, as participants described the treatment, they provided through art materials and the ETC, interventions, and the use of defocused communication techniques. The last theme encompassed discussions of communication in culture and society that included subthemes of nonverbals in cultures and verbal and nonverbal expectations.

Participants' Definitions of Nonverbal Communication

As alluded to above, all participants exhibited an understanding of or attention to NVC. To explore participants' understanding of NVC, I asked them to define the term in their own words. Many of the participants' initial definitions aligned with Matsumoto's (2012) definition, "the transfer and exchange of messages in any and all modalities that do not involve [spoken or written] words," which they defined within the context of lack of the use of words or voice. Molly and Lottie placed their definitions within their observations of their clients, who they have seen lose their ability to form words or voice during times of dysregulation or anxiety, lending to Lottie's term, a "heightened sense of quiet anxiety" (p. 1, line 13).

However, some participants expanded their definition of NVC to much more than a "lack of," thus partially deviating from definitions like Matsumoto's (2012). For example, Lucy and Gia described it as a variety of behaviors that inherently communicate meaning. Gia also explained it through intentional ways of dress and appearance. Lastly, Molly found NVC through interactions and reactions between therapist and client (i.e. parallel play, countertransference, or proximity and distance). These broader definitions of NVC align with theories such as Porges' (2003) theory of social engagement, which emphasized proximity as a factor in social engagement and attachment. Andersen's (1999) explanation of using artifacts (i.e. ways of dress or decoration) to communicate identities or the interaction of monitoring each other's behaviors (i.e. visually tacking behaviors). Patterson et al. (2023) additionally explained that NVC often relies on multiple components to convey meaning, thus interpretation of some behaviors may rely on the context given by the various methods of NVC highlighted by the participants.

Patience and Process

As Molly emphasized in her definition of NVC, findings show the treatment of SM and communication is navigated through the interactions and reactions between client and therapist. The participants explained these interactions within the treatment setting as a process, which aligns with Fernandez et al. (2014) and Magagna's (2012) explanation that the treatment of SM involves extra time, trust, effort, compassionate understanding, and creative interventions. Most of the participants discussed the extensive time and effort that was taken to build an alliance with their clients. This topic of discussion listed patience as one of the fundamental traits for navigating the amount of time for treatment, navigating rupture and repair, and building alliances within various treatment spaces, thus coinciding with Fernandez et al. (2014) and Magagna (2012).

Attunement and Observation

Another attribute of building the therapeutic presence and alliance was the careful attunement and observation of nonverbal behaviors. Patterson et al. (2023) asserted that NVC is an imprecise language that is up to the interpretation of the reader. The latter statement highlights the importance of attunement and alliance, as these themes may promote a better understanding of those communicating. Findings also attest that this interpretation may go both ways, as participants mentioned that they noticed their clients' awareness and attunement to the therapist's nonverbal behaviors, which may greatly influence treatment and the therapeutic alliance. The participants' awareness of their clients' attunement lends to Foley and Gentile's (2010) assertion that the client observes the therapist just as much as the therapist observes them. These findings are also aligned with other research on the treatment of SM, which suggests the presence of patience, acceptance, and observation of obvious or subtle behavior changes to aid in successful treatment outcomes (Cook, 1997; SM Association, 2021).

Art Materials and Interventions

In addition to the formation of the therapeutic presence and alliance, participants noted various art materials and interventions they used throughout treatment, especially those that did not rely on the use of verbal communication. Using the ETC as a theoretical framework could track the art materials and processes used by all participants. Notably, Bethany and Lucy found the beginning stages of treatment to be best accompanied by clay or Play-Doh used within the kinesthetic or sensory levels, noting a playful interaction with materials rather than structured expression. This mirrored Fernandez et al.'s (2014) case study in which their participant found greater success in structured play at the beginning of treatment. However, Molly and Lottie found themselves using rigid materials and processes,

such as drawing. These differences in materials may be in line with Fernandez et al.'s (2014) other assertion that not all clients may benefit from a standardized method of beginning treatment but may find a better fit through choice of an array of expressive options.

Despite the type of material and processes the clients began with, most participants found a natural movement through the ETC that was client-led, rather than pushed by the therapist. As mentioned by Fernandez et al. (2014), these findings suggest that the ETC may be used as an assessment to track a starting point for intervention and observe what ways the client engages and expresses themselves naturally (Schum, 2006). I believe tracking the ways the client naturally engages and express themselves is the beginning of an answer to one of my original research aims, as to how therapists may understand the connection between NVC and art making.

When their clients were not exploring materials, findings show that therapists still implemented prompts or techniques, such as the trauma narrative or grounding techniques, to guide their clients and themselves. Many of these techniques were not obvious to me at first, as it came to me near the end of my coding when I noted a theme of defocused communication, one of the behavioral strategies recommended by the SM Association, was prevalent for all but one participant's treatment experiences ("Treating SM," 2021). Even when not trained in the treatment of SM or with the outright knowledge of defocused communication, most therapists integrated elements of defocused communication within their work and mentioned those elements to be part of their treatment success. Gia experienced different reactions from her clients when she was more direct with her communication rather than defocused, with the good intention of engaging the families without letting the client feel left out.

Nonverbal Communication, Culture, and Society

Gia addressed her direct communication style in the context of her native cultural context and the culture of the United States where she now resides and works. Many of the participants discussed how communication appears in the various cultures and societies that they have experienced. Much of their discussions were in synchrony with Patterson et al.'s (2023) assertion that NVC is not purely interpreted through universal or categorical meanings. Bethany noted her experience of some forms of NVC being interpreted similarly by multiple cultures, but also realized other nonverbal behaviors may be interpreted or contain meaning extremely different from one culture to the next. For example, Lottie and Lucy asserted that some Latinx clients may avoid eye contact not as a symptom of SM, but as a cultural expression of respect for others. While some communication may be understood in multiple cultures, the examples provided by the participants showed the importance of education and understanding of NVC within the context of culture and diagnosis.

Cultural and societal expectations additionally impact the expectations of how one communicates. Lucy and Lottie described how cultural expectations may impact how families may understand SM or how clients may be expected to behave and communicate within their culture and family. These expectations of behavior also translate to environments, such as schools, where individuals are expected to regularly verbalize. Bethany, Lucy, and Gia explained cases where adults and authority figures in the clients' lives showed frustration with their lack of verbalization and subsequently pressured them to provide the verbal response they expected, often leading to dysregulation in the client. This speaks to the general expectations of individualistic and collectivist expectations surrounding verbalization and silence, where individualistic cultures may value verbal communication and collectivist cultures may value listening without the heavy reliance on verbalization

(Slobodin, 2023, p. 12; Kim & Markus, 2002). In the context of introversion versus extroversion, Cain (2013) explained, that many schools in the United States are designed for extroverts, and introverts (those who are more silent) require different forms of learning and accommodations, and "very little is made available to that learner except constant advice on becoming more social and gregarious" (p. 459).

Lastly, under the subtheme of cultural expectations, Molly explained her empathy towards those who may feel shame from anxiety and their difficulty in articulating verbally. She then described her technique to reflect her empathy and give them an outlet to express themselves visually. This goes along with Cain (2013), who suggested when working with those who find anxiety in verbalization, to not make it the focus, normalize it as a feeling that one can learn to regulate, not shame them, or force them to verbalize because it may "increase apprehension and reduce self-esteem" (p. 466).

Much of the findings from the interviews align with related research and further expand upon the understanding of NVC in treatment settings and provide a glimpse into various ways of treatment provided by clinical providers. The following sections will discuss more about the research process, such as limitations and suggestions for further research.

Limitations

There were several limitations faced within this study. Though there were steps taken to lessen the influence of biases, qualitative research interviews are still subject to inherent biases and are socially and culturally constructed products "that combine memory, learned conventions, and narrative models for telling one's story, with selected life events and conscious or unconscious motivations" (Sandelowski, 2002). This study contained the voices of five participants, the minimum number of participants suggested in phenomenological

research, thus participation is confined, and therefore generalization is limited (Creswell, 1998).

Additionally, I gained valuable data from the interview process, but it was not without difficulty. I struggled with recruitment due to clinicians' rare encounters with SM and my learning curve of conducting a research method I had never before performed. It was through the process of making mistakes and the guidance of my advisor that I was able to warm up to the interview method as a strategy for gathering data. With this process, I had hoped to maintain my trustworthiness as researcher. Though it was not as extensive as I had originally planned, I continued to maintain my internal dialogue through comments on my transcripts and a dedicated notebook, as well as maintained an external dialogue with my research advisor. I hope to further my role as a researcher through the discussion of future research.

Recommendations for Future Research

This research focused on one perspective, that of the therapist. Future research may focus on the perspective of the client with SM to provide better insight into what they believe to be the most successful within their treatment. Further research exploring NVC within the treatment setting will help shed light on how it applies to the treatment of other populations and the development of the therapeutic alliance. Future studies should look for therapist participants who rely majorly on talk therapy or do not have specialization in the population of SM. In this study, some of the participants cited that talk therapy had not worked for their clients, by the clients' self-report. It would be helpful to study talk therapy to investigate how it is successful as well as the circumstances that make it break down. Such a mapping would be useful in terms of designing treatments specific to SM.

Conclusion

This research provided insight into therapists' experiences of treating individuals with SM and the use of NVC within the treatment setting. These phenomenological interviews explored themes such as nonverbal behaviors, therapeutic presence and alliance, the use of art materials and interventions, and nonverbal and verbal communication within culture and society. This study provided examples of the use and importance of NVC within treatment for some individuals who struggle the most with verbal language. This research was within the context of the diagnosis of SM, but it is just a step towards the understanding of the significant role NVC plays for both client and therapist in the field of therapy and counseling as a whole.

References

Alrabiah S. N. (2017). Superhero costumes as a method for treating children with selective mutism: A case study. In F. D. M. Fernandes (Ed.), Advances in speech-language pathology. IntechOpen.

Aldridge, D., Brandt, G., & Wohler, D. (1990). Toward a common language among the creative art therapies. *The Arts in Psychotherapy, 17*(3), 189-195.

American Art Therapy Association. (n.d.). About Art Therapy. Retrieved October 5, 2022, from https://arttherapy.org/about-art-therapy/.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Andersen, P. A. (1999) *Nonverbal Communication: Forms and Functions*. Mayfield, 181-258.

Braithwaite, C.A. (1999). Cultural uses and interpretations of silence. In Guerrero, L.K, DeVito, J. A., & Hecht, M. L. (Eds), The nonverbal communication reader : classic and contemporary readings (2nd ed., pp. 163-172). Waveland Press.

Cain, S. (2013). Quiet: The Power of Introverts in a World That Can't Stop Talking. United Kingdom: Crown.

Camposano, Lisa. (2011). Silent suffering: Children with selective mutism. *The Professional Counselor*. http://dx.doi.org/10.15241/lc.1.1.46

Cook, J. (1997). Play therapy for selective mutism. *The playing cure: Individualized play therapy for specific childhood problems*, 83-115.

Cox. (2005). Intention and meaning in young children's drawing. *The International Journal of Art & Design Education*, 24(2), 115–125. https://doi.org/10.1111/j.1476-8070.2005.00432.x

Creswell. (1998). *Qualitative inquiry and research design: Choosing among five traditions. Qualitative inquiry and research design: choosing among five traditions.* Sage Publications.

Creswell, J.W. (2007). Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Sage Publications, Inc.

Del Giacco, L. , Salcuni, S., & Anguera Argilaga, M. T. (2019). The communicative modes analysis system in psychotherapy from mixed methods framework: Introducing a new Observation system for classifying verbal and nonverbal communication. *Frontiers in Psychology, 10. https://doi.org/10.3389/fpsyg.2019.00782*.

Di Renzo, M., Guerriero, V., Zavattini, GC., Petrillo, M., Racinaro, M., and di Castelbianco, F.B. (2020). Parental attunement, insightfulness, and acceptance of child diagnosis in parents of children with autism: Clinical implications. *Frontiers in Psychology, 11*, 1-13. https://doi.org/10.3389/fpsyg.2020.01849

Dowell, N., & Berman, J. S. (2013). Therapist nonverbal behavior and perceptions of empathy, alliance, and treatment credibility. *Journal of Psychotherapy Integration*, 23(2), 158–165. https://doi.org/10.1037/a0031421

Erickson, D. (2012). *Selective mutism and art therapies*. The University of North Dakota.

Eubanks, C. F., Samstag, L. W., & Muran, J. C. (2023). *Rupture and repair in psychotherapy: a critical process for change*. American Psychological Association.

Frank, H. E., Last, B. S., AlRabiah, R., Fishman, J., Rudd, B. N., Kratz, H. E., Harker, C., Fernandez-Marcote, S., Jackson, K., Comeau, C., Shoyinka, S., & Beidas, R. S. (2021). Understanding therapists' perceived determinants of trauma narrative use. *Implementation science communications*, *2*(1), 131. https://doi.org/10.1186/s43058-021-00231-9

Franklin, M. (1990). The aesthetic attitude and empathy – a point of convergence. *American Journal of Art Therapy*, 29(2), 42-47.

Fernandez, K. T. G., Serrano, K. C. M., & Tongson, M. C. C. (2014). An Intervention in treating selective mutism using the expressive therapies continuum framework. *Journal of Creativity in Mental Health*, *9*(1), 19–32. https://doi.org/10.1080/15401383.2013.873706

Foley, G. N., & Gentile, J. P. (2010). Nonverbal communication in psychotherapy. Psychiatry (Edgmont (Pa. : Township)), 7(6), 38–44.

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy.* American Psychological Association. https://doi.org/10.1037/13485-000

Geller, S. (2021). Cultivating online therapeutic presence: strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly*, *34*(3–4), 687–703. https://doi.org/10.1080/09515070.2020.1787348

Guay, M. (2018). Impact of group art therapy on the quality of life for acquired brain injury survivors. *Art Therapy: Journal of the American Art Therapy Association*, *35*(3), 156–164.

Hanan, T. (2023). Israeli Teachers and Expressive Therapists Understanding of Selective Mutism. *Creative Arts in Education and Therapy (Online)*, *9*(1), 61–76. https://doi.org/10.15212/CAET/2023/9/8

Hedman, E., Strom, P., Stunkel, A., & Mortberg, E. (2013). Shame and guilt in social anxiety disorder: Effects of cognitive behavior therapy and association with social anxiety and depressive symptoms. *PloS One*, 8(4), e61713–e61713. https://doi.org/10.1371/journal.pone.0061713

Hesse, P. P. (1981). Colour, form and silence:(A formal analysis of drawings of a child who did not speak). *The Arts in Psychotherapy*, *8*(3-4), 175-184.

Hill, C. E. (2020). *Helping skills: Facilitating exploration, insight, and action* (Fifth edition). American Psychological Association.

Hinz, L. D. (2020). *Expressive therapies continuum: a framework for using art in therapy* (2nd ed.). Routledge.

Jaworski, A. (1993).The power of silence in communication. In Guerrero, L.K, DeVito, J. A., & Hecht, M. L. (Eds), The nonverbal communication reader : classic and contemporary readings (2nd ed., pp. 156-162). Waveland Press.

Kim, H. S., Markus H. R. (2002). Freedom of speech and freedom of silence: An analysis of talking as a cultural practice. In R. A. Shweder, M. Minow, & H. R. Markus (Eds.), Engaging cultural differences: The multicultural challenge in liberal democracies (pp. 432–452). Russell Sage Foundation.

Klein, M. (1975) *Envy and gratitude and other works 1946-1963*. Delta.

Kohut, H. (1966). Forms and transformations of narcissism. *Journal of the American Psycho-analytic Association,* 14, 243-72

Lachman-Chapin, M. (1979). Kohut's theories on narcissism: Implications for art therapy. *American Journal of Art Therapy, 19*(1), 3–9.

Landgarten, H. (1975). Art therapy as primary mode of treatment for an elective mute. *American Journal of Art Therapy*, *14*(4), 121–125.

Lazar, Feuston, J. L., Edasis, C., & Piper, A. M. (2018). Making as expression. Proceedings of the *2018 CHI Conference on Human Factors in Computing Systems*, 1–16. https://doi.org/10.1145/3173574.3173925

Leavy, P. (2017). *Research Design*. The Guilford Press.

Lee, K., Sriraman B. (2013). An eastern learning paradox: Paradoxes in two Korean mathematics teachers' pedagogy of silence in the classroom. Interchange, 43, 147–166. Crossref

Lorenzo, N. E., Cornacchio, D., Chou, T., Kurtz, S. M., Furr, J. M., & Comer, J. S. (2021). Expanding Treatment Options for Children With Selective Mutism: Rationale, Principles, and Procedures for an Intensive Group Behavioral Treatment. *Cognitive and Behavioral Practice*, *28*(3), 379–392. https://doi.org/10.1016/j.cbpra.2020.06.002

Lyle, S. (2008). Dialogic teaching: Discussing theoretical contexts and reviewing evidence from classroom practice. *Language and Education, 22*, 222–240.

Magagna, J. (2012). Extended family explorations using dreams, drawings, and play when the referred child does not speak. In J. Magagna (Ed.), *The silent child: Communication without words.* (pp. 117–137). Karnac Books.

Malchiodi, C. A. (2017). Art therapy approaches to facilitate verbal expression: Getting past the impasse. In C. A. Malchiodi & D. A. Crenshaw (Eds.), *What to do when children clam up in psychotherapy: Interventions to facilitate communication.* (pp. 197–216). Guilford Press.

Matthews, J. (1999) *The art of childhood and adolescence: The construction of meaning*. Falmer Press.

Matsumoto, Frank, M. G., & Hwang, H. S. (2012). Nonverbal communication: Science and applications (Matsumoto, M. G. Frank, & H. S. Hwang, Eds.). SAGE Publications.

Melfsen, S., Romanos, M., Jans, T., & Walitza, S. (2021). Betrayed by the nervous system: a comparison group study to investigate the 'unsafe world' model of selective mutism. *JOURNAL OF NEURAL TRANSMISSION*, *128*(9), 1433–1443. https://doi.org/10.1007/s00702-021-02404-1

Moon, B. (2016). Art-based groups and the ultimate concerns of existence. In B. Moon (ed.), Art-based group therapy: Theory and practice (2nd ed., pp. 161–180).

Morrell, M. (2011). Signs and symbols: art and language in art therapy. *Journal of Clinical Art Therapy, 1*(1), 25-32. Retrieved from: https://digitalcommons.lmu.edu/cgi/viewcontent.cgi?article=1015&context=jcat

Muris, P., & Ollendick, T. H. (2021). Selective Mutism and Its Relations to Social Anxiety Disorder and Autism Spectrum Disorder. Clinical Child and Family Psychology Review, 24(2), 294–325. https://doi.org/10.1007/s10567-020-00342-0

Nakane I. (2007). Silence in intercultural communication. John Benjamins. Crossref.

Nowell, Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16(1), 1–13*. https://doi.org/10.1177/1609406917733847

Ostergaard. (2018). Treatment of selective mutism based on cognitive behavioural therapy, psychopharmacology and combination therapy - a systematic review. *Nordic Journal of Psychiatry*, *72*(4), 240–250. https://doi.org/10.1080/08039488.2018.1439530

Oerbeck, Stein, M. B., Wentzel-Larsen, T., Langsrud, Ø., & Kristensen, H. (2014). A randomized controlled trial of a home and school-based intervention for selective mutism - defocused communication and behavioural techniques. *Child and Adolescent Mental Health*, *19*(3), 192–198. https://doi.org/10.1111/camh.12045

Oerbeck, Overgaard, K. R., Stein, M. B., Pripp, A. H., & Kristensen, H. (2018). Treatment of selective mutism: a 5-year follow-up study. *European Child & Adolescent Psychiatry*, 27(8), 997–1009. https://doi.org/10.1007/s00787-018-1110-7

Patterson, M. L., Fridlund, A. J., & Crivelli, C. (2023). Four misconceptions about nonverbal communication. *Perspectives on Psychological Science*, *18*(6), 1388–1411. https://doi-org.libproxy.siue.edu/10.1177/17456916221148142

Perry, B. (2017). *The boy who was raised as a dog.* Basic Books.

Porges, S.W. (2003). Social engagement and attachment: a phylogenetic perspective. *Annals of the New York Academy of Sciences, 1008(*1), 31–47. https://doi.org/10.1196/annals.1301.004

Riley, S. (1999) *Contemporary art therapy with adolescents.* Jessica Kingsley Publisher.

Robb. (2022). *Group art therapy: Practice and research*. Routledge, Taylor & Francis Group.

Schum, R. L. (2006). Clinical perspectives on the treatment of selective mutism. *The Journal of Speech and Language Pathology – Applied Behavior Analysis*, *1*(2), 149–163. https://doi.org/10.1037/h0100190

Sandelowski, M. (2002). Reembodying Qualitative Inquiry. *Qualitative Health Research.*, *12*(1), 104–115. https://doi.org/10.1177/1049732302012001008

Schomaker, S. A., & Ricard, R. J. (2015). Effect of a Mindfulness-Based Intervention on Counselor-Client Attunement. *Journal of Counseling and Development*, *93*(4), 491–498. https://doi.org/10.1002/jcad.12047

Segal, R. M. (1984). Helping children express grief through symbolic communication. *Social Casework*, *65*(10), 590–599. https://doi.org/10.1177/104438948406501002

Selective Mutism Association. "How to Help a Child with Selective Mutism in the Classroom | SMA." *Selective Mutism Association*, 10 Aug. 2021, www.selectivemutism.org/selective-mutism-in-the-classroom/.

Sette, S., Baldwin, D., Zava, F., Baumgartner, E., & Coplan, R. J. (2019). Shame on me? Shyness, social experiences at preschool, and young children's self-conscious emotions. *Early Childhood Research Quarterly*, *47*, 229–238. https://doi.org/10.1016/j.ecresq.2018.12.012

Sharkey, L., Mc Nicholas, F., Barry, E., Begley, M., & Ahern, S. (2008). Group therapy for selective mutism – A parents' and children's treatment group. *Journal of Behavior Therapy and Experimental Psychiatry*, *39*(4), 538–545. https://doi.org/10.1016/j.jbtep.2007.12.002

Slobodin, O. (2023). Beyond the language barrier: A systematic review of selective mutism in culturally and linguistically diverse children. Transcultural Psychiatry, 13634615221146435–13634615221146435. https://doi.org/10.1177/13634615221146435

Stone, B.P., Kratochwill, T. R., Sladezcek, I., & Serlin, R. C. (2002). Treatment of Selective Mutism: A Best-Evidence Synthesis. School Psychology Quarterly, *17*(2), 168–190. https://doi.org/10.1521/scpq.17.2.168.20857

Wood, A. C. (2020). Art as communication for young people. In M. Berberian & B. Davis (Eds.), *Art therapy practices for resilient youth: A strengths-based approach to at-promise children and adolescents.* (pp. 33–50). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315229379-3

Xu L., Clarke D. (2019). Speaking or not speaking as a cultural practice: Analyses of mathematics classroom discourse in Shanghai, Seoul and Melbourne. *Educational Studies in Mathematics, 102,* 127–146.

Zelinger. (2010). Understanding and generalizing communication patterns in children with selective mutism. In A. Drewes & C. Schaefer (Eds.), *School-Based Play Therapy.* (pp. 359–377). John Wiley & Sons, Inc. https://doi.org/10.1002/9781118269701.ch17

Appendix A
Southern Illinois University Edwardsville IRB Approval

#1987 - Communication Beyond Words

Protocol Information

Review Type	Status	Approval Date	Continuing Review Date
Exempt	**Exempt**	**May 15, 2023**	--

Expiration Date	Initial Approval Date	Initial Review Type
Apr 27, 2026	**Apr 28, 2023**	**Exempt**

Feedback

Approval Comment

PI: Anna Brough
Protocol #1987
On 5/15/2023, the IRB approved your request to amend your previously approved protocol as described in your Kuali Protocol Submission. You may continue your research with these changes. Please NOTE: You MUST include a statement on all recruitment advertising, including email notifications, that you have received IRB approval from the SIUE IRB and include the IRB protocol number and project title. This includes all recruitment emails and other electronic methods, flyers, etc. Please contact the IRB if you make any changes to this approved protocol.

Appendix B
Participant Notification Form

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

RESEARCH PARTICIPANT NOTIFICATION

1. Anna Brough is inviting you to participate in this research study.

2. The title of this study is Communication Beyond Words. The purpose of this study is to explore therapists' clinical treatment experiences of selective mutism and the implementation of nonverbal communication within clinical practice.

3. Your participation in this study will involve filling out a short demographic questionnaire and participating in a 1-1.5 hour interview to talk about your clinical experience, which will also include some art-making. You will also be contacted for a shorter, one half-hour interview at a later date to check in regarding findings.

4. There are no known risks in this study. Should any discomfort occur, you may stop or withdraw from the interview at any time.

5. The results of this study may be published in scientific research journals or presented at professional conferences. However, your name and identity will not be revealed and your record will remain confidential. All information taken from this study will be coded to protect your name and identifying factors. No names or other identifying information will be used when discussing or reporting data. If you decide to include names as part of the artwork, the investigator will mask all names. The investigator will safely keep all audio, notes, and artwork collected in a password-protected electronic file on the investigator's personal computer. Once audio has been transcribed and analyzed they will be destroyed. All photographs of artwork will appear in the completed thesis to which the participants have consented. No photographs will be maintained in any digital format other than the thesis.

6. Even as you may not experience any direct benefits to yourself, you will certainly be offering a benefit to the fields of art therapy and counseling. You and others participating in this study may have a better understanding of additional treatment methods for individuals with selective mutism or the implementation of nonverbal communication within treatment settings.

7. You can choose not to participate. If you decide not to participate, there will <u>not</u> be a penalty to you or loss of any benefits to which you are otherwise entitled. You may withdraw from this study at any time.

8. You will be audiotaped as part of your participation in this research study. These recordings will be listened to by members of the research team to transcribe, code, and analyze data collected for the study. We may present findings from the study in classroom and professional settings. Your consent in these areas is completely voluntary. Lack of consent will not affect your participation in this study. If recordings of you are used in any of these contexts, anonymity will be maintained. No identifying information (such as full names) will be used. In addition, if you agree to allow us to use the recordings for any of these purposes, we will keep the recordings for an indefinite period of time. If you do NOT consent to any of these uses of the recordings, they will be destroyed upon completion of the study.

9. If you have questions about this research study, you can call Anna Brough at 812-240-8300 or email at abrough@siue.edu. If you have questions about your rights as a research participant, you can call the SIUE Institutional Review Board at 618-650-3010 or email at researchcompliance@siue.edu.

Name_____ Signature _____ Date _____

Appendix C
Demographic Questionnaire

Demographic Questionnaire

1. What is your gender? Circle one.
    a. Male
    b. Female
    c. Nonbinary
    d. Other _____
    e. prefer not to specify
2. What is your age?
    a. 20-29
    b. 30-39
    c. 40-49
    d. 50-59
    e. 60-69
    f. 70-79
    g. 80-89
    h. prefer not to specify
3. Which of the following best represents your racial or ethnic heritage?
    a) Non-Hispanic White or Euro-American.
    b) Black, Afro-Caribbean, or African American
    c) Latinx or Hispanic American
    d) Asian American or Pacific Islander
    e) South Asian or East Asian
    f) Middle Eastern or Arab American
    g) Native American or Alaskan Native
    h) Other
    i) Prefer not to specify
4. What licensure and certifications do you hold? Please write in.
    a. _____
5. How many years have you been in clinical practice? Please write in.
    a. _____
6. In what setting do you practice? Please write in.
    a. _____
7. What populations do you work with? Please write in.
    a. _____
8. Have you worked with client(s) with selective mutism in your post-graduate practice?
    a. Yes
    b. No
9. If yes, how many individuals with selective mutism have you worked with in your post-graduate practice? Please write in.
    a. _____

Appendix D
Recruitment Document

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

RECRUITMENT DOCUMENT

Looking for participants in an interview study: The title of this study is "Communication Beyond Words."
The purpose of this research is to explore therapists' clinical treatment experiences of selective mutism and the implementation of nonverbal communication within clinical practice.

This study has been approved by Southern Illinois University Edwardsville's (SIUE) IRB, # 1987, on 04/28/23.

I am looking for credentialed therapists who have worked with at least one individual client with selective mutism within their post-graduate practice. Upon informed consent, your participation in this study will involve filling out a short demographic questionnaire and participating in a 1-1.5 hour interview to talk about your clinical experience, which may also include some art-making.

If you are interested in participating, please email Anna Brough at abrough@siue.edu to show your interest.