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Israeli Professionals Understanding of Selective Mutism

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ISRAELI PROFESSIONALS UNDERSTANDING OF SELECTIVE MUTISM

A DISSERTATION
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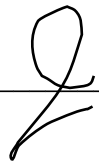
SIGNED: 

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I remember sitting in an IKEA store 9 years ago, at the coffee corner, with my father. He said, “You should pursue a doctorate degree,” and I replied, “I don’t know if I can do it.” He then said, “You should tell your story, so that others can learn from you,” and that was the start of my journey, the one that I told and retold to myself and now others, many times. Many people inspired me, helped me, read my notes in the middle of the night, and this is the place to thank them. I’m sorry if I forgot someone.

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This dissertation is dedicated to every person who felt speechless at one point in their life and to my children Jhonattan and Arielle.

I hope you will find this helpful.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Figure

ABSTRACT

This study employed art-based research with phenomenological qualitative inquiry to understand the perspectives of professionals who are working in the Israeli school system with children diagnosed with selective mutism. Selective mutism (SM) is a disorder originated in anxiety in which a child, between the ages of 3–5, does not speak at school but does speak at home (APA, 2022). In this research, the researcher facilitated a professional workshop based on Dillon's work (2016) and a similar workshop conducted by Harwood and Bork (2011). The aim was to broaden the knowledge and investigate the opinions of professionals working with children diagnosed with SM. The researcher met with 13 participants, who learned about the disorder and then created artwork illustrating their feelings about working with these children. Participants were interviewed regarding their feelings, fears, and success stories in a group setting on Zoom software during the COVID-19 lockdown. Outcomes showed participants felt isolated and alone and found that the group setting held a space for them to be able to better understand how to work with children with SM. Participants shared that they wished they had more support from the school, agreed that knowledge on the disorder is scarce, and they wished they had supervision. Awareness was brought in how to employ art therapy as an intervention method. The study revealed that communication style is an important component that can help a child to begin speaking and learn how to communicate in and outside of school.

Keywords: Selective mutism, professional workshop, communication, teachers, expressive art therapists

CHAPTER 1

Introduction

Selective mutism (SM) is described as an ongoing failure to speak in specific social situations. In Israel and the United States, 0.03% - 1.9% of children are diagnosed with SM (American Psychiatric Association [APA], 2022). Children with SM are not observed speaking at school but speak freely at home and in other environments (APA, 2022; Cohan et al., 2006). According to Cohan et al. (2006), not speaking at school can lead to withdrawal from social activities.

The onset age of SM, between 3 to 5 years old, most often coincides with entrance into preschool or elementary school (Hung et al., 2012). Features of the disorder include: shyness, isolation in social situations, clinging behavior, compulsive behavior, tantrums, control and oppositional behavior (APA, 2022). These symptoms resemble those of Autism Spectrum Disorder (ASD) and other developmental problems (Hung et al., 2012). However, SM is distinguished from these other disorders in that SM is believed to be a symptom of anxiety as categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5-TR; American Psychiatric Association, 2022). The etiology is thought to be related to communication problems within the family, genetics, and history of immigration (Hung et al., 2012). Researchers recommend early therapeutic intervention in order to improve the prognosis (Boo, 2014; Cohan et al., 2006; Dillon, 2016; Hung et al., 2012).

SM creates many difficulties for children. SM can be underdiagnosed if parents do not take their child for psychiatric evaluation. When untreated, children with SM are likely to show deficiencies in academic, social, familial, and personal functioning (American Psychiatric Association, 2022; Lang et al., 2015). Since they are not speaking in school, it is hard to assess

their learning, though they often communicate in nonverbal means such as writing. These children can act shy, be socially isolated, show negativism in their thinking, have temper tantrums, or show oppositional behavior. Parents of children with SM are often described as overprotective and controlling (APA 2022). Children with SM often suffer from severe impairment in the school including harassment and bullying.

` Many children outgrow SM, and the longitudinal course of the disorder is not known. Children with SM are not diagnosed before they start school and are not diagnosed with SM if they have a separate communication disorder or Autism Spectrum Disorder (APA 2022). SM is diagnosed when symptoms are observed for one month as long as that month does not coincide with the first month in school (APA 2022). Children with SM do not initiate a conversation and they do not respond when they are being spoken to by others in specific environments. Children with SM are often diagnosed with anxiety as well as SM since SM is often comorbid with other anxiety symptoms (APA 2022).

The differential diagnosis distinguishes between speech and language disorders as these conditions are not restricted to social situations (APA 2022). SM differs from Autism Spectrum Disorder because a child diagnosed with SM understands social cues (APA 2022). There is a comorbidity between SM and specific phobia, oppositional behavior, and communication delays (APA, 2022).

In the past, SM was perceived as a deficit where a child was actively choosing not to speak (Amir, 2005; Cohan et al., 2006; Dillon, 2016; Hung et al., 2012). The disorder was known as "elective mutism;" the name was changed after research suggested that the child does not choose when to speak (Amir, 2005; Cohan et al., 2006; Dillon, 2016; Hung et al., 2012).

Art and music can help children with SM better understand and express themselves, allowing their voices to be heard. In my previous pilot study, I interviewed parents of children diagnosed with SM going through art and music experiences alongside their children (Hanan, 2019). Parents reported that the professionals in their children's school were not sufficiently educated about SM. This led me to search for data on professionals' knowledge about SM. Unfortunately, I could not locate any information in the Israeli literature. As a result, I decided to explore the experience of Israeli professionals working with children diagnosed with SM in the Israeli education system.

Personal Background

When I was a child, I had difficulty speaking out loud. In essence, I lost my voice. I remember only parts of that time period. It was in Arts Apprenticeship class during the first year of my doctoral program, taught by Dr. Mitchell Kossak, when I remembered that as a child I did not speak. Dr. Kossak asked us to create the entrance to our home and I started painting a child with something covering her throat, unable to speak (see Figure 1). Suddenly, long forgotten memories from when I was a child started to resurface and for the first time in my life. I chose to share my experiences with my cohort. I zoomed into the little girl with the wounded throat and this wound emerged. I called this painting "The Wounded Artist," not knowing yet that I would investigate deep into its origin over the next six years. Trying to reconnect to the emotions that were part of my world, I decided to delve into a creative process and paint my emotions (see Figure 2).

Figure 1

The Wounded Artist

Figure 2

The Sore Throat

During this time of remembering my past, creating art was important to remember and relive the emotional state from when I was a little girl. It was not an easy process, but art helped revive my memories and emotions. However, it was difficult to be in touch with my emotions from so long ago because I had repressed and blocked them. I remembered feeling alone and unable to reach others although I wanted to. The painting in Figure 2 portrays my throat as hurting because I want to speak on behalf of the little girl that could not do so. The throat is sore and hurting since it is a reflection of the emotional difficulty that was caused by a painful experience that represents my struggle.

Rachel Bluwstein (1930) wrote a poem that emotionally resonates with my childhood feelings. These words illustrate how I craved connection with others, but my internalized lost voice and fears prohibited and limited me from socializing.

Locked Garden

Who are you? Why is a reaching hand,

Not meeting a sister hand?

And eyes, waiting but a moment,

Are already turned down in embarrassment

Locked garden. No path to it, nor way.

Locked garden – Man.

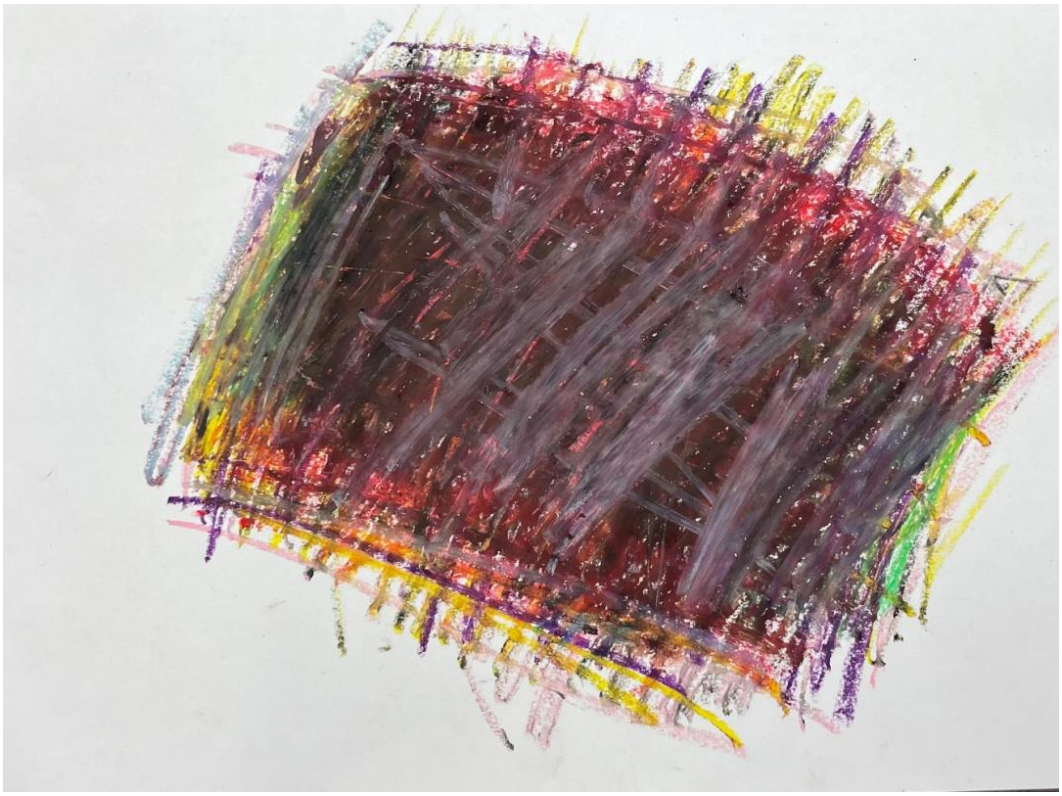
Should I walk away? Or strike the rock

Until blood is shed? (p.9)

Later (see Figure 3), I made another painting. This painting is reflecting a wound that had been inflicted which contained anger, sadness, and disappointment. These emotions hid under my unspoken words, yet they were concealed and sometimes would emerge unexpectedly. Only once I began to speak out loud and express emotions could I better control them. I only became aware of these emotions as an adult, when reflecting on the creative process I underwent painting the artwork presented here.

Figure 3

Anger



This wound is in the process of healing. New skin is slowly emerging on what was once bleeding and active. Through the process of writing this dissertation I realized that healing is a mutually beneficial process where the healer becomes empowered by helping others heal. This exchange can be characterized as a transformative process where the healer develops a sense of sensitivity to others' process, becomes more aware of childhood memories, and is able to have a stable internal voice and share that with others. In this research study I led a Zoom online workshop and helped others think about healing through expression. This workshop proved important in my understanding and perceptions of the field and of myself. Because of my voice, the individuals were able to grow. When I saw them being able to navigate their hardship with their students, I grew even more because I understood my voice mattered and I have the ability to

help change others' perspectives. Speaking is a sign of well-being, and it is essential to have the ability to speak about old traumas and to distill them. Old wounds will leave a scar, but they can heal.

As I was in class and this drawing emerged from within, it allowed me to reflect on my past. I remember when I was a child being very shy and speaking in a quiet voice in class. When the teachers repeatedly asked "Could you please repeat that? Can you speak up? I don't understand," I don't remember if I replied. I was silent for a long time in school, from the second grade to the beginning of junior high school. I only remember segments of that time, but I remember that if a friend would come and ask me to join her, I would respond. I remember moving to a new school in seventh grade. I remember when a boy came up to me and said "Hi," I did not reply. The shame stung. I was so alone, and no one knew why I was not speaking. This was in the early 1990's in Israel, when SM was not yet known. I was called shy, and not treated in a supportive way. One day I met a girl named Meital. When she said "Hi" I felt confident enough to respond, so I did. Being friends with Meital helped me to step out of the bubble of silence in which I was living. She sometimes would be the voice I did not have, and at times she understood me without words. As a child it was challenging to speak, and art became my language to express my thoughts and wishes.

Today, I am an adult. I have regained my voice. I have been practicing art therapy in the Israeli education system for 11 years. During this time, I have worked extensively with children diagnosed with SM. Because of my childhood experiences I feel that I can relate to their feelings of not being able to speak even though they want to and to all parts of life that SM affects. While conducting a former study, one of the adult participants said he had to actively step out of his

comfort zone and choose to speak with others in order to overcome his SM symptoms (Hanan, 2019).

Another outcome of the former pilot study was that parents of children who are diagnosed with SM expressed concern that teachers are not educated about the appropriate tools to work with their children. Therefore, in this dissertation I chose to focus on the experience of teachers and expressive art therapists working in the Israeli education system treating children diagnosed with SM. In my experience working in the Israeli educational system, teachers and expressive arts therapists have minimal training in working with children diagnosed with SM. In addition, there is currently little research about these professional's understanding about SM.

Prevalence of SM

Kopp and Gillberg (1997) surveyed a sample of children aged 7-17 years old in west central Gothenburg, Sweden for prevalence of SM in order to extrapolate a rate for SM in the general population. The researchers specified that the population was representative of Gothenburg in terms of demographic factors All teachers in west central Gothenburg completed questionnaires to evaluate if a child: (1) never spoke in the classroom; (2) spoke in a low voice that was often impossible to hear; or (3) would read aloud text, but not respond orally to questions. A follow-up study was conducted the following year.

Kopp and Gillberg (1997) found in their first study that 30 out of 2,793 children had SM. The diagnostic criteria used in the study stated that the child had not spoken in school for eight months; yet all children diagnosed in this study had not spoken in school at least two years. The female to male ratio was found to be 1.5 to 1. Children diagnosed with SM were generally from low and middle class families. No recent major life events were reported prior to the appearance of SM. Twenty-five children were reported with mild SM were reported to speak only in a soft

voice or recite from a manuscript but were otherwise silent. They were reported having problems speaking out in class and were shy and did not speak often. It was not described how long their symptoms lasted. Five children had severe SM; they had been completely silent at school for at least 2 years.

Based on these findings, Kopp and Gillberg (1997) surmised that the frequency of severe SM was 18 in 10,000. It highlighted that SM is not an uncommon disorder since 89 in 10,000 children had SM in this study. This prevalence was "considerably higher than the 8 in 10,000" Fundudis et al. (1979) reported more than 15 years ago.

Diagnosing SM

Although SM was first characterized as a disorder in the 19th century, it is still often misdiagnosed and poorly understood. Sharp et al. (2006) explain that there is debate how to classify SM, and often it is confused with other mental disorders.

Despite the criteria shown in the DSM-5-TR (APA, 2022), according to Oerbeck et al. (2011), SM is a perplexing disorder with the key feature being that children do speak at home but not in social situations like at school. While the researchers do not explain why this happens, they argue this discrepancy in speaking behavior justifies the SM diagnosis. Martinez et al. (2015) highlight the difficulty of caregivers in recognizing their child's distress as different from shyness causing caregivers to not seek help. Additionally, the child usually speaks in their home setting, confusing the caregiver and delaying appropriate diagnosis and treatment.

According to Sharp et al. (2006), a child in the United States can spend up to 4 years not speaking in the school system before receiving treatment, suggesting a need for better screening and identification of children with SM. There are different age ranges of onset of SM, with some researchers estimating that SM could emerge as early as 2 years old, when the child begins

attending preschool (Sharp et al., 2006). Sharp et al. (2006) explained, “It has been hypothesized that variability among these estimates may be a function of differing diagnostic criteria used in each study and the age at which the children were sampled” (p. 569).

Receiving Services in the School Setting

There are two ways in which a child can receive eligibility for therapy by an art therapist in the Israeli education system. The first way is to place the child in an inclusive Special Education class, which includes additional supports such as art therapy and teacher assistance (Israeli Ministry of Education, 2019). Another way is for the child to be diagnosed with certain psychiatric disorders including anxiety disorder. This is referred to as Law 0201 in the Israeli Special Education laws (Israeli Ministry of Education, 2019). After a child is diagnosed, a special committee inside the school discusses their case. If the child qualifies, they are approved for receiving art therapy treatment at school. These children are referred to as “differential students” (Israeli Ministry of Education, 2019). Most of the clients I work within the Israeli school system are differential students diagnosed with anxiety disorder and SM.

In the United States, special education is regulated by the Individuals with Disabilities Education Act - the IDEA Act of 2004 (Department of Education, 2004). The U.S. Congress amended the IDEA through Public Law 114-95 (Department of Education, 2004). The U.S. Congress (Department of Education, 2004) stated that it is part of their policy and essential to improve the educational rights of children with disabilities in order to supply them with equal opportunity, to ensure their participation, so that they can live independently and be free to work and support themselves. The IDEA Act is parallel to the Israeli special education regulations (1988), as it enables children diagnosed with anxiety and SM to receive expressive arts therapy in the American school system.

Previous Research

From my previous research, I learned that children with SM could benefit from art therapy treatment when they engage in art-based experiences alongside their parents (Hanan, 2019). The main effect resulted from building bridges for communication through their parents' support and modeling with them how to communicate (Hanan, 2019). From 11 years of professional experience, I have observed how a teacher can emotionally affect their students by enabling their self-esteem to grow and through mentoring. My previous research also revealed parents' criticisms of the Israeli education system (Hanan, 2019). Mainly, parents expressed concern that their child was not being properly diagnosed and not being treated in accordance with their disability. This has caused them to spend time and money taking their children to alternative treatments that were not appropriate. Parents of children with SM in a former study reported that when the diagnosis of their children with SM is done after the age of 3-5 years old, it causes them disappointment and reduces their faith in how the school can help their child (Hanan, 2019).

Treating SM During the COVID-19 Pandemic

The year 2020 was a challenging time as the world began facing the COVID-19 pandemic. Pfefferbaum and North (2020) described it as a time of global uncertainty, including severe shortages of testing and treatment, as well as social distancing restrictions. They concluded that these phenomena will contribute to widespread emotional distress and increased risk for psychiatric illness in the future. They stressed that "health care providers have an important role in addressing these emotional outcomes as part of the pandemic response"

(p. 510). Thus, these researchers defined the COVID-19 period as a "public emergency" (p. 510) that can affect the sense of security and stability with people and communities.

While there is no current literature on the effects of COVID-19 on the treatment of SM, it is challenging to treat children diagnosed with SM in the school system during lockdowns, or when a child with SM is sick and cannot come to school, as some of the children with SM will have a hard time building trust with teachers and other staff members once they return to school. These breaks from their daily routine at the school can cause regression in a child with SM's behavior. Causes of regression can be a lack of treatment when the child is isolated because of sickness or because of familial stressors at home.

Purpose of the Study

The goal of this dissertation was to explore more deeply what teachers in Israel know about SM, especially regarding its diagnosis and treatment, and to inform them how art therapy within the school system has the potential to help their students. From my experience as an art-therapist working in the Israeli education system, school staff members may not always know enough about how to treat and help their students diagnosed with SM. Moreover, they may not be familiar with art therapy as a treatment method and its potential to help their students. The research entailed giving a workshop for teachers to experience using art in order to experience the art and expressive therapy process. The goal of the workshop was not to train the teachers in art therapy, rather to broaden their understanding of art therapy and its potential in helping treat children with SM. The overall intention of the workshop was to encourage a better degree of trust in art therapy as a treatment method, as well as better interdisciplinary collaboration when treating children with SM.

The research questions were:

- How does participating in a professional workshop influence the way teachers and expressive art therapists interact with children diagnosed with SM that are present in their class?
- What are teachers and expressive art therapists' perceptions of art therapy treatments for children diagnosed with SM after participating in a professional workshop?
- What are teachers and expressive art therapists' perceptions of themselves after participating in a professional workshop?

During the time frame of this research study, the international COVID- 19 pandemic changed the way people think about and live their daily lives. From my personal experience I have seen a rise in the number of students with anxiety disorders and SM that are referred to treatment in the Israeli school system. Many teachers have stated to me that they are scared they cannot handle the many new cases of SM and are looking for knowledge and guidance. As one teacher (who did not participate in this study) described, "every teacher wants to help their child in any way he or she can, but if we lack the professional knowledge of what a treatment can do for him, we are at a loss" (S. Assulin, personal communication, May 30, 2020).

There is a growing need for supervision for professionals working with children diagnosed with SM. In my workplace I try to educate and advise professionals requesting support that are working with children diagnosed with SM. It is my hope that reading this work can help them to seek supervision from a professional who knows how to work with these children and their families.

This research aims to help both professionals and parents become more aware of this disorder and the unique ways of communicating, along with different methods of working with

children, so that they can begin to understand part of the mystery involved in the journey towards communicating.

Chapter 2

Literature Review

This literature review focuses on the special circumstances and dilemmas of working as an art therapist in the Israeli education system and specifically what teachers working in Israel know about SM. Primarily, this review addresses the teacher's role in building bridges of communication with a child diagnosed with SM and why that role can be predominant in the relationship a teacher forms with such a child. Israel is also a country with ongoing trauma, and the connection between trauma, anxiety, and SM is reviewed.

Art Therapy within the Israeli Education System

Freilich and Shechtman (2010) advocated the use of art-based interventions to help children with learning disabilities (LD) regulate their behavior in the school setting. These researchers noted that children with LD experience a high rate of socioemotional problems and sought to find if art therapy improved the children's social adjustment. The authors believed that exploring and connecting to feelings could help to change a student's behavior. As a nonverbal method of treatment, art therapy could help students with both learning and language disabilities. Frielich and Shechtman split 94 children (7–15 years) in two groups: One group (n = 42) received art therapy; the other group (n = 52) received academic assistance. All treatments were provided in a LD treatment center.

Frielich and Shechtman (2010) measured the treatment results in three time points: pre-, post-, and three-month follow-up. Results showed a greater decrease in LD symptoms for children receiving art therapy compared with children who received only academic assistance; a change before and after the art-therapy treatment for children with LD behavior (Z = 2.82, p < .01 vs. Z = .11); and no change in behavior for children receiving only academic assistance.

Further, there was a greater decrease in behavioral problems for the group treated with art therapy (Z = -2.82, p < .01) than for the group who only received academic assistance (Z = -0.36, p = ns). The researchers concluded that children treated with art therapy showed better outcomes in their LD symptoms and behavior, and that both groups had similar results in academic improvement. Limitations include the study's small sample size and short follow-up period. Nevertheless, this research is important because it shows that art therapy has efficacy on children when conducted in the school system.

Belity et al. (2017) advocated for art therapy as a method that can increase children's self-esteem and reduce their anxiety levels in the Israeli education system. They advocate the use of art therapy, since it is part of the emotional support system in the United States since 1990. Art therapy can improve learning skills, decrease anxiety levels for children, help in the expression of emotions, and enable group socialization for teamwork to develop. Belity et al. (2017) explained that art therapists working in the education system in Israel face difficulties, including physical working conditions and lack of art supplies and problems maintaining client confidentiality, upholding a regular and consistent schedule, and building relationships with clients' parents. They noted the two most prominent challenges as

> [o]bstacles to effective communication with staff members due to the workload of both teachers and therapists and issues related to the position of art therapists in Israel, who are often employed by a number of educational facilities simultaneously and find it hard to meet the needs and demands of all workplaces. (p. 97)

Belity et al. (2019) examined the perceptions of Israeli art therapist supervisors, who have broader and different viewpoints about working in the Israeli education system. They interviewed 15 supervisors, of whom 12 were art therapists and three were dance, music, and

drama therapists. Their years of experience ranged from one to 18. The researchers conducted semi structured interviews, asking about participants' experiences regarding the therapists they supervise and their relationships with the Israeli educational system. Their findings showed benefits to working as an Israeli art therapist in the school system. Specifically, most participants said that many children would not otherwise receive treatment if they were not treated in the school system, particularly when the students' economic backgrounds are dire.

Another result of this study, is the importance of a child receiving treatment in the child's natural environment (Belity et al., 2019). Art therapy can mediate relationships in the classroom between children and their peers and teachers. It can improve communication and change teachers' perspective on how to make the educational environment better suited for their students' needs. Another important aspect of their study is the "difficulties arising from the relationship between therapists and the school staff" (p. 101). There is a lack of collaboration between teachers and therapists, and most participants emphasized the relevance of teamwork to providing better therapy results and "bridging the gap" (p. 101) between the educational and therapeutic discourse.

Teacher Knowledge of SM

There has been some research on teachers' knowledge and opinions of SM in general, but nonspecific to Israeli professionals. Dillon's (2016) study surveyed 281 teachers and 138 school psychologists in New York. The survey, composed of 27 items, was specifically designed for the study; and checked teachers' knowledge of symptoms, treatment, and general knowledge of SM. Overall teachers had poor knowledge of SM. Participants scored an average of 11.01on the Selective Mutism Scale (SMS), Psychologists received an average score of 18.68 and knew 69.19% of the scale items.

Dillon (2016) conducted a correlation to determine whether there was a relationship between professional experience and SMS scores. The correlation between teacher's experience with students with SM and student SMS scores was statistically significant, showing a positive correlation between variables. It seemed that because teachers did not know enough about the disorder and had difficulty teaching children with SM. In other words, teachers knew significantly less about SM than did school psychologists, and their lack of knowledge influenced their interactions with children with SM. For instance, teachers who did not know that SM is related to an anxiety disorder believed that the child was actively choosing not to speak; thus, they were less empathic toward the child. Teachers displayed a lack of knowledge about SM as displayed by a high number of questions to which they answered, "I Do Not Know." This is important as this means that teachers do not know enough about SM, and this is one of the factors that makes them uncapable to interact with a child diagnosed with SM.

The wide range and high prevalence of misperceptions about SM among school professionals is alarming. No study like Dillon's (2016) has been conducted in Israel to show the opinions and knowledge of teachers about working with children diagnosed with SM. However, according to Harwood and Bork (2011), SM onset coincides with school entry and happens mostly inside the school. This is the reason that educators have an important role in helping children with SM overcoming their fear of speaking and to gradually find their own voice.

Addressing this lack of knowledge of SM among teachers, Harwood and Bork (2011) specified that children diagnosed with SM are often mistakenly portrayed as stubborn, unsociable, or extremely shy. This may cause adults to react poorly to children with SM, which can cause the mute behavior to be worse. Harwood and Bork (2011) stated that a professional development workshop might be an adequate tool and a first step to help equip educators with

enough knowledge on the disorder. They described professional development as an "interconnected, ongoing, circular process that is impacted by one's beliefs, experiences, choice of professional development and efficacy of that professional development" (p. 139). In order to test that idea, the researchers facilitated a workshop for teachers to give them tools for teaching children with SM. The workshop included creativity-oriented tasks and addressed how this new knowledge builds upon teachers' existing knowledge, but focused primarily on knowledge about SM and its specific features. This included information on how SM effects a child's development, and the prevalence, onset, and common misconceptions of SM. They also discussed the results if the disorder is not identified while the child is between the ages of three and five years.

Harwood and Bork's (2011) study included 22 participants. Most were teachers, but some were childcare experts. The postworkshop questionnaire tested whether participants' knowledge increased after the 2-hour workshop and delved into their beliefs on the efficacy of the targeted classroom-based strategies to support children with SM. Harwood and Bork (2011) had anticipated that participants' level of knowledge would increase after the workshop.

Results of Harwood and Bork's (2011) study indicated the need for a more formalized approach because there is a gap in the treatment of SM in the school setting. Although the results showed that experienced educators were interested in acquiring more knowledge to meet the needs of all children in their class, 53% of participants had little or no knowledge of SM, 33% of participants were somewhat familiar with SM, and none said felt they had expert knowledge. Further, 73% said they did not feel prepared to meet those children's needs. There was no correlation between the teachers' years of experience and how informed they felt about SM. On the preworkshop questionnaire, 60% of participants said they were not comfortable working with

children with SM. After the workshop, most said they felt fairly confident working with children with SM.

In this current dissertation study, I was building on Dillon's (2016) work and on Harwood and Bork's study (2011), using art therapy as a form of expression instead of the SMS questionnaire that was used in Dillon's study (2016). By using a new service method, in the form of an art intervention to replicate a previous finding, and perhaps to improve the results, it was hoped that art can be an effective modality and method of intervention (Curry and Kasser, 2011; Hanan, 2019).

Challenges in Working with Children Diagnosed with SM

Working in the Israeli education system can be challenging, and both teachers and art therapists can face difficulties when working with children diagnosed with SM. Gellatly et al. (2018) asked 103 community therapists to record up to 60 sessions conducted with youth and child clients, specifying engagement challenges they encountered with the participants. Gellatly et al. (2018) hypothesized that "limited client engagement would be associated with reduced therapist ability to deliver the evidence-based practice as planned" (p. 59). The participants submitted online surveys reporting on their sessions within one week of each session. Their clients had externalizing behavioral problems (e.g., attention/hyperactivity problems, disruptive behaviors/conduct problems); internalizing problems (e.g., mood, anxiety), trauma, and other problems (e.g., substance use, autism).

Gellatly et al. (2018) examined the interest levels of clients in the therapeutic sessions. They found that teenage clients were more likely to be reluctant participants in therapy and may express this through limited in-session engagement, particularly when they did not initiate therapy. As a result, they suggested that therapists, especially in community mental health

settings, often feel burnout when the child with SM they are working with provide little to no feedback. This finding can be related to the challenges teachers and therapists face when working with individuals with communication problems and especially those with SM.

Stressors Affecting Teachers

Research on teacher burnout and resilience showed that teachers in Australia often retire due to mental illness and inability to physically work. The authors mentioned teachers' workload, unsupportive workplaces, and problems communicating with colleagues (Howard & Johnson, 2004). Howard and Johnson (2004) suggested that teachers who experienced burnout due to stress triggers felt personally helpless and that their work accomplishments were meaningless. These researchers focused their study on schools in disadvantaged parts of Adelaide, Australia. The 10 teachers who participated in the study were chosen because they had some experience coping with stress in their daily work. The authors described examples of stressors, and the ironic aspect of their description implies that educators and school professionals are so used to violence, such as children attacking school staff that they describe these affairs in a calm fashion. On top of theses stressors, they pointed out that the teachers who handled stressors well were flexible, resilient, and had good working relations despite the challenges they faced. For example, they pointed out that teachers who deal with stressors well manage their time well and can react to their student's personal problems in a productive way without being emotionally involved.

Howard and Johnson (2004) also highlighted the need to cope with aggressive parents as a stress-inducing factor and the importance to establish boundaries. Some meaningful results show that these teachers were successful in their internal belief in their own agency. In addition, when mistakes at work happened or when teachers made errors, they chose to learn from them

and move on. The researchers described teachers' empathetic behavior in challenging circumstances and advocated for the use of their workplace as a supportive group, stating that part of the strategy was to find many supports from different groups in their lives. Resilient individuals were characterized by having good connections with friends and family outside the school. They did not talk much about troubles they had at work with their partners and felt supported by their group of peers at the school. They felt capable and had a high level of self-efficacy.

Vesley et al. (2013) noted that teachers are prone to high stress levels, burnout, and dissatisfaction with their workplace, and those factors can lead to negative outcomes and early retirement. Vesley et al. argued that emotional intelligence can help build strong character and resilience in teachers to help them decrease stress levels in everyday work with the school system. Those authors claimed that emotional intelligence can be learned, and that it improves teachers' self-efficacy. They referenced the term "good teacher" or "good teacher avenue" (p. 73), meaning a teacher with a capacity for self-efficacy. According to Vesley et al. (2013), efficacy can be either external or internal. External factors include both feeling supported and being able to fulfill duties and responsibilities. A teacher with good capacity for self-efficacy and high levels of emotional intelligence will see a challenge in what others view as a threat. Internal factors include good communication skills and the ability to be empathic. These authors recommended that teachers undergo professional workshops to improve their emotional intelligence skills.

Creasey et al. (2016) researched the challenges that teachers working in urban school settings face. They were interested in intentions, barriers, and self-efficacy of teachers in urban schools and tried to predict what obstacles can harm motivation to work in that setting. They

mentioned ecological theories that presume obstacles in the school climate can result from a lack of support system and advocated self-efficacy as an important ingredient in teacher's well-being.

The study Creasey et al. (2016) conducted of students majoring in Teacher Education indicated that teachers base their self-efficacy on their experience in the field. Teachers who shared concerns about their personal needs did not understand the school's climate. Creasey et al. (2016) explained that mostly the male participants expressed concerns about not having enough support systems at the school but did not explain how so. Teachers that had a decrease in self-efficacy tended to feel more burnout and found their teaching job more challenging, confirming that levels of self-efficacy were related to the stress levels that were felt by the teachers.

Communication Problems

Green (2017) researched diversity between eight working professionals (five of American origin and three of Latino origin) at an urban American school, predominantly in relation to communication problems. This qualitative research initially aimed to study the outcome of a new program for English language learners using eight participants. However, the voices of members of minority groups were not heard in in-group discussions regarding the children and their families.

Green (2017) concluded that for communication to be collegial, friendly, and productive, diverse colleagues involved in group work must be culturally sensitive and attuned to one another so that all voices have access and equity. From a former study (Hanan, 2019), it was found that communication between staff and families that have a child with SM can present difficulty. It is difficult to create a treatment plan because the child with SM cannot explain themselves; therefore, clinicians and parents often argue with one another out of frustration. Essentially, it was found in this study that the clinician, parents, and teachers feel helpless and

cannot assist as long as the child cannot communicate their needs. The child again is the minority who is being silenced by the parents, teachers and clinicians.

Another theme that arose in Green's (2017) study was that the Latino teachers were more empathic and protective toward their students than were the American teachers. Green attributed this gap to the fact that the Latino teachers themselves spoke English as a second language and therefore could relate better to their students' experience. One mentioned that he could empathize with a child in class who had not spoken the previous year because the child did not understand the spoken language. Therefore, the teacher participant chose to teach English using Spanish, which enabled his student to speak freely in class.

Green (2017) explained the difficulties in communication between the two groups of teachers as due to differences in mentality and culture and mentioned different communication styles as a factor that caused communication problems. In the case of that study, the English-speaking teachers could not relate to how their students felt not understanding the Spanish language, but the Spanish-speaking teachers could. Further, dual language and English learner education teachers felt unable to understand and keep up with their colleagues, who talked too quickly, which made it harder for them to fit in. Although they wanted to be a part of the school's climate, they felt helpless when they did not fit in. Because the teachers were divided between English and Spanish speaking, it became difficult to communicate verbally and emotionally. For the teachers, these verbal and emotional inconsistencies caused much frustration and burnout. This research is important as it sheds light on teacher's ability to help their student and be an agent of change on their student's lives, despite not having experienced their student's limitations. Just as teachers do not have to have SM to be able to connect to their students and lead a process of change for them.

Building Bridges as a Method for Communicating

A previous study discussed the importance for parents of children with SM to model how to properly communicate with others (Hanan, 2019). Hanan (2019) named the term "building bridges" (p. 43). It can be interesting to further investigate how teachers can "build a bridge" to communicate with their students with SM, with the help of a professional workshop that can build teachers' knowledge on the disorder using expressive arts interventions.

Perednick and Elizur (2016), explained the importance of raising Israeli professionals' awareness about the disorder. They provided intervention suggestions using a cognitive - behavioral approach and an ecological approach that emphasized treating the children in their homes, where the child can be verbal and gradually work their way to other surroundings, such as the school and the outside world. Cognitive behavioral therapy uses gradual exposure, systematic exposure, shaping, modeling and behavior modification that result in a decrease in symptoms, hence the child begin to speak. The emphasis is on changing the behavior that is interfering with the child's ability to live a normal life (Perednick & Elizur, 2016).

Similar to what was termed in a former study, "parents as bridges of communication" (Hanan, 2019., p.28), Perednick and Elizur (2016) recommended working alongside parents, as children look to their parents to provide modeling for how to communicate. Perednick and Elizur did not recommend art therapy. They wrote that many parents and children engage in treatments that are not suitable to the unique characteristics of SM such as play therapy and expressive arts therapies. Perednick and Elizur (2016) also claimed that SM is not trauma-based. In the Israeli education system, there is a need for more research and information about SM through expressive arts therapies. Such information can educate professionals who are thirsty for more knowledge to promote the well-being of children with SM. I chose to use art therapy as a

modality in this study as I believe it is useful in helping service providers to connect to their experience in working with children with SM.

Greenboim-Zimchoni (2019) illustrated the important effect that a good relationship between a teacher and a student can have on a student's well-being, even later in life as an adult. Greenboim-Zimchoni conducted a study of 12 Israeli adults (ages between 18 and 31 years) with LD about their childhood classroom experiences as revealed in the way they created art. All participants studied in Israeli special education or in inclusive education classes between third and eleventh grades. Her work showed the importance of a good learning experience with a teacher who could understand the child's mental state. Greenboim-Zimchoni explained that all the participants who were in special education as children and two participants from inclusive education classes experienced growth in their confidence levels due to their relationships with their teachers. Some exclaimed that their relationship with their teachers got them through school. Though Greenboim –Zimchoni (2019) did not use the term *building bridges*, this research suggests that teacher -student communication can be crucial for students feeling supported in their disability and for accepting help from others.

Developing Communication Skills

According to Bloom et al. (2020), there are limited opportunities for both students and professionals to develop skills of communication. The authors specified that "practitioners are often unsure how to carry out the requirements, due to a lack of guidance and training" (p. 2) predominantly due to a lack of research. They advocated utilizing emotional reactions of children with communication problems to build a route for communication. They explained that anxiety and anger can decrease motivation to learning, and anxious children are more likely to show aggression. Bloom et al. (2020) tried to teach professionals to use their voice to discuss their

emotions regarding their student and to teach communication skills to both students and teachers. Participants were 20 children from six schools in the United Kingdom. Results suggested that:

(a) talking about emotions in a nonverbal way was easier for children with communication problems

(b) the nonverbal method called Your Voice Your Voice (YVYV) was structural and allowed most students to overcome cognitive deficits

(c) the YVYV tool reduced participants' anxiety because it was easy to follow

(d) photographs helped the children who struggle with eye contact to avoid it:

(e) an important aspect was to build trust and relationships between the facilitator and the children participating in the study.

It was difficult to assess the efficacy of this study as there are no replications of this research design; thus, research is needed to base a broader body of knowledge on this theory.

Shipon – Blum (2007) describes the ideal class setting for a child with SM and she emphasizes that a teacher should be accepting and educated on the different reasons that a child with SM does not speak. Teachers and therapists should aim their efforts to enable a child with SM to gradually move from non-verbal communication into verbal one. Art can be a modality that can help a child with SM through this process.

Trauma

Trauma in Israel

Research on trauma in Israel is relevant because I work at a school in the center of Israel, and the children with whom I work are sometimes exposed to daily missile attacks. Bitton and Laufer (2018) explained that children who live in Israel can suffer from posttraumatic stress disorder (PTSD). Israeli children can have a decreased well-being as Israelis are often exposed to

stressors that are connected to the complex life situations that can arise when exposed to external threats and the overall tensions present in the Middle East. In the new classification of SM in the DSM-5-TR (APA, 2022), the disorder is listed among the anxiety disorders. This suggests that children with SM are anxious of speaking. Therefore, it is imperative to review research supporting the connection between anxiety and SM.

Bitton and Laufer's (2018) research used a representative sample of 152 mothers and their children who had been exposed to missile attacks. Another 155 dyads who had not been exposed to missile attacks served as the control group. All participants completed the Child Posttraumatic Stress Reaction Index, a self-report questionnaire that tests for PTSD in children (Bitton & Laufer, 2018). Participants also completed the Child Behavioral Checklist, they used this one time measure to monitor changes in the child's anxiety, fear, and social behaviors over time. The children's total PTSD scores ranged from zero to 60 (M = 13.66, SD = 11.84). Classification by clinical categories revealed that 77 (52.0%) children were categorized as doubtful, 47 (31.7%) as mild, 18 (12.2%) as moderate, five (3.4%) as severe, and one (0.7%) as suffering from very severe PTSD.

Bitton and Laufer's (2018) research indicated that children in Israel suffer from PTSD to at least some extent. Both the control group and the exposed group suffered from PTSD and emotional problems, but the rates were much higher in the exposed group. Although the control group had a lower score than the exposed group, it was nevertheless above average. This study is relevant as it shows the many cases of PTSD in children living in Israel, and according to the DSM-5-TR there is a comorbidity between PTSD and SM (APA, 2022).

Baum (2005) stated that one does not need to be exposed firsthand to a terror attack to experience the results of trauma. Being exposed to bombing attacks when staying in a safe room

or even to the media coverage can also cause trauma. A person not directly exposed to trauma can still experience indirect or secondary trauma, and in Israeli society many people will avoid public places, shopping malls, places of entertainment, and even playgrounds and will not use public transportation out of fear.

The Israeli government sponsors the National School Intervention Project and is concerned for students' and staff members' well-being due to the ongoing trauma that results from the stress caused by terror attacks. Interestingly, Bitton and Laufer (2021) examined whether participants in their study would feel more resilient emotionally to COVID-19 because they had already developed resiliency due to terror and other traumas. They stated that fear due to an uncertain threat is the most apparent aspect of COVID-19. They were looking to see if Israelis that were exposed to security threats, experience the COVID-19 as more frightening.

Bitton and Laufer (2021) explained that COVID-19 and terror attacks share similar elements; both affect communities and interfere with everyday life by inflicting fear. The difference lies in the appearance—terror attacks are visible, but people cannot see what is inflicting COVID-19. The COVID-19 pandemic is different from constant security threats because it is an unfamiliar situation, that is accompanied by uncertainty and lack of knowledge. Bitton and Laufer (2021) recruited 615 participants (260 men, 355 women) for their study, facilitated during the first lockdown in Israel, in 2020. Of them, 250 were the research group living in conflict areas of Israel, and 364 served as a control group. Participants answered the Connor-Davidson Resilience Scale and COPE Scales questionnaires regarding their concerns from COVID-19 implications and terror attacks, allowing the researchers to determine differences in their resilience.

Their results revealed that participants exhibited higher COVID-19-related fear than terrorism-related fear (Bitton & Laufer, 2021). Specifically, fear for family was greater than fear for oneself, women exhibited higher levels of fear than men, and overall fear was higher in conflict areas than in other parts of Israel (Bitton & Laufer, 2021). The authors proposed that the COVID-19 pandemic posed a new situation in which respondents could not rely on their experience. Their results indicated that participants were not capable of dealing with the COVID-19 threat. The heightened anxiety as a result of COVID -19 is a risk factor for SM.

Trauma, Anxiety, and SM

The DSM-5-TR (APA, 2022) lists anxiety as one of the behaviors that children who have PTSD exhibit. A change in the DSM-5-TR added four criteria for children aged 6 years or under for PTSD:

- Criterion A. A stressor is needed either by direct exposure, witnessing the trauma, or indirect exposure to the trauma.
- Criterion B. The traumatic event is experienced as unwanted and upsetting memories, nightmares, flashbacks. emotional distress. or physical reactivity.
- Criterion C. The child exhibits one or more of the following avoidance symptoms: avoidance of activities; avoidance of people; frequent negative emotional state such as fear, shame, or sadness; or decreased interest in activities the child used to enjoy.
- Criterion D. One or more of these changes in the child's arousal or reactivity: increased irritable behavior or angry outbursts, hypervigilance, exaggerated startle response, difficulties concentrating, or problems with sleeping.

The DSM-5-TR (APA, 2022) specifies that children with PTSD, specifically at school age, may have a hard time concentrating at school, have difficulty sleeping, feel guilty or ashamed, or feel anxious or fear in a variety of situations.

Specific Fear for Children Diagnosed with SM

According to Vogel et al. (2019), children diagnosed with SM have a comorbidity with anxiety disorders such as social phobia and generalized anxiety. Clients diagnosed with social anxiety often fear performing in front of others, interacting with others, and getting observed by others. According to Vogel et al. (2019) children diagnosed with SM have fears from social interactions of speech, fear of the unexpected, and fear of losing control over a situation. These findings led Vogel et al. (2019) to research the specific fears that children with SM may be experiencing. 124 Children diagnosed with SM answered an open-ended questionnaire about their fears and a survey regarding their fear to speak in social situations. They also completed the SPAI -C questionnaire that evaluates the somatic, cognitive and behavioral aspects of social phobia in children to determine their social phobia severity. Their parents rated their child on the Frankfurt Scale of Selective Mutism - FSSM tool which validate the quality of a child with SM speaking in order to determine his SM related symptoms. Using a MANOVA, they found these fears existing in children diagnosed with SM: 66.7% have fear of gaining attention while speaking; 40% have fear to give incorrect answer, 35% fear that others react negatively to the individual's spoken word, 23% fear that others evaluate the individual's because of his spoken word, 12% fears are related to an individual's language (i.e., grammar, pronunciation), 12% fear of getting attention from others while speaking, 12% fear of social interactions, 7% fears are related to the sound of an individual own voice, 5% fear that others might notice individual's anxiety symptoms. Vogel et al. (2019) suggested reducing the anxiety symptoms in children

diagnosed with SM by fear-related cognition and daily exercise to enhance their performance in school. The importance of this research is that it was the first research study on the fears of children with SM, which can inform the treatment of children with SM.

Trauma and Language

In trauma, people rationalize through language (Lacan, 2019). They use words to rationalize everything in their everyday lives. A fantasy is built through language and through the symbolic order. The fantasy is not something imaginary per se, but the story people tell themselves, what they are, what is special about them. Language and words construct this narrative, and the subjective order of what Lacan (1959/ 2019) called the real causes of trauma. The real accedes symbolization and that for which people have no words. In trauma, people cannot use words to rationalize the narrative; it is past their symbolic ability.

Lacan (2019) coined terms like the real, the symbolic register, and the imaginary register. The symbolic register is the object itself without interpretation or meaning, the imaginary register is the meaning words have in a certain langauge, while the real is the discourse itself. For him, speech is a chain of signifiers, and a signifier alone means nothing unless it is placed in a relationship with other signifiers. People are not free to say what they wish; instead, the unconscious is accountable for what they say. Lacan viewed trauma relative to how the unconscious interacts with the traumatic event. A traumatic experience is unique because it causes a loss of words, which is always connected to an unexpected event that disrupts the continuity of life. The real is in a relationship with the symbolic and the imaginary. Wright (2020) described the real as something that cannot be predicted or spoken about. Lacan (2019) called it “troumatisme” meaning “hole” (p. 239), because trauma tears a hole in the very fabric of our meaning.

As opposed to *the real*, which is an undifferentiated unit, trauma has no linear time. In language, people use representations of symbols that create meanings for them, but in trauma there is no meaning or order. Bistoen (2016) explained that language divides the world into meaning, composing our reality. These symbolic systems are never complete, and they are different in every culture.

Trauma and Cortisol Levels

According to Oresta et al. (2021), cortisol is a neurotransmitter that is associated with trauma when a high level of it is present in the human body. When trauma occurs, it creates more cortisol in the human body. These researchers further stated, "Situations of chronic or extreme stress could lead to long-term disrupted functioning of the HPA axis, hypothesized to play a role in development of psychiatric disorders" (p. 1), specifying that exposure to adversities in childhood or adulthood can cause anxiety. The HPA axis is the system that is activated in stress. It produces the hormone cortisol and transfers information to the amygdala, which is responsible for the fear response. Cortisol is a regulator of the HPA axis and responsible for terminating the reaction to the stressful condition. Because acute stress exposure causes a rapid increase in cortisol levels, extreme stress can disrupt HPA-axis activity and lead to psychiatric disorders, such as anxiety.

Oresta et al. (2021) measured cortisol levels in the hair of 1,166 participants from the Netherlands (74.1% women; M_{age} = 47 years). Participants donated their hair, from which the researcher extracted the cortisol in a lab-induced process. Participants also answered the Childhood Trauma Interview, a face-to-face interview, and the Recent Negative Life Event Questionnaire, in which they specified the extent to which they suffered childhood negative life events, including separation from their parents and other forms of abuse. Almost 51.7% of the

sample reported being diagnosed with anxiety; 19.4% using antidepressants; and 51.7% experiencing at least one negative life event. The median hair cortisol was 3.26 pg/mg, and men had higher cortisol levels. The researchers considered their most notable finding to be that childhood traumas are associated with increased hair cortisol. They explained that adversity does not always alter cortisol levels, they propose further research to be done in order to reveal the biological mechanisms related to adversity exposure.

Trauma and Neurological Mechanisms

Since prehistoric times, humans' neurological systems worked in a specific way when facing a threat (King et al., 2019). King et al. (2019) explained that cognitive identification of emotions is governed by the cortex and subcortex in the brain, and two sets of systems are responsible for stress and lack-of-stress situations. One is the parasympathetic system, which operates most of the time to regulate body mechanisms, such as digestion and heart rate. When a person responds to a threat, their hypothalamus regulates cortisol hormone release, and the sympathetic system goes into action. This system is responsible for the flight-fight-or-freeze mechanism and reacts the same to real and perceived threats. These systems most often work concurrently to keep the body at a "set point" level (p. 153). In the presence of a stressful stimulus, such as a traumatic event, cortisol levels increase, the body enters a situation of high arousal, and the set point is altered.

The amygdala, located above the cerebellum, is involved with cognitive and emotional processing (King et al., 2019). According to Suvrathan et al. (2014), prolonged stress can cause changes in synaptic response. Suvrathan et al. exposed 11 male rats to stress factors and examined the rats' brains after exposure to a stress-provoking stimulus. They examined 11 cells from six rats in the control group and 10 cells from five rats in the stress group. Their findings

suggest that the stress altered something in the plasticity of the neurons path. Predominantly, the glutamate and glycine binding sites went through a persistent strengthening of synapses; that is, patterns of synaptic activity that produce a long-lasting increase in signal transmission between two neurons. This pathway produces a long-lasting fear reaction in the lateral amygdala. Moreover, there was less activity of the Gaba neurotransmitter, which causes the formation of memories related to fear.

According to Debiec and Sullivan (2014), infants and children are affected by their parent's emotions, specifically in fear situations. This is called "social learning" (p.12222). The child looks for nonverbal cues in their parents' behavior, and pathological fears can transfer to the child from their parents. This happens in humans and in nonhuman primates. These researchers explain that this is happening in posttraumatic stress disorder (PTSD) or in specific phobias. These researchers hypothesized that humans and rodents demonstrate social-fear learning in similar ways; in both cases, the amygdala and the basal nuclei are involved. In their study, Debiec and Sullivan (2014) checked for social-fear learning in rats and their pups. Specifically, they showed the female rat a stimulus that provoked fear (i.e., they electrocuted her foot while she smelled peppermint) and then they exposed her to the same smell when she was near her pups. They then examined the brains of the 13 pups.

Results show that there was no difference in the pups' behavior that were in the control group, if they just smelled the conditioned stimuli (CS) when their mother was not around them (Debiec & Sullivan, 2014). A significant effect was found meaning that the experimental group that was exposed to the CS while staying close to their mothers froze more than the control group. This means that social fear is transferred to offspring from their mother. Results showed that mothers treated their pups roughly while exposed to the CS.

Debiec and Sullivan's (2014) results showed brain activity in the amygdala, with significant differences found throughout the amygdala nuclei: The results showed massive brain activity in pups that were next to their mothers while they were exposed to the CS, especially in the amygdala nuclei compared with the control group. "This pattern of findings indicates that the infant's amygdala plays a role in the mother-to-infant transfer of fear" (p. 12224). This is valuable information because it shows that the amygdala has a significant role in the fear response. Children diagnosed with SM have specific fears and anxieties (Vogel et al., 2019) which might indicate involvement of neurological systems and hormonal effects outlined above. This is relevant to children with SM as they can learn this fear response from their mothers. As Vogel et al. (2019) mention this happens with baby rats learned fear response, and as mentioned in the former study (Hanan, 2019), when working with the families of a child with SM it is important to declutter and deal with these fear responses. Below a link between how art can be critical in addressing trauma and lowering the cortisol levels will be discussed.

Art Therapy and Trauma

Art Therapy and Reformulation of Traumatic Memories

Sarid and Huss (2010) explained how traumatic memories are useful because they are experienced in vivid fragments. They advocated using art therapy to change the coding and recall of a traumatic event. In art therapy, the client and therapist reformulate the traumatic event through a creative process in which the emotions conveyed in the traumatic event are experienced differently and thus allow clients to gain more control over their emotions. Sarid and Huss specified three stages in this process:

> [1.] The physical agitation of the client was modulated through the manipulation of different art materials.

> [2.] The experience of self-anger was reframed through contextualizing in a larger self-concept.
>
> [3.] Emotions were thus given control through symbolization on the page and reframing of their impact. (p. 10)

They explained that these three stages together are effective in reformulating traumatic memories.

Art Making Effects on Lowering Cortisol Levels

As stated above, Kaimal et al. (2016) explained that cortisol is a hormone associated with stress and its levels are high in stress-provoking situations. These researchers wanted to explore what happens to cortisol levels following a creative process facilitated by an art therapist.

> The hypotheses guiding our study were that artmaking would result in reduced cortisol levels; greater changes in cortisol reduction for those with prior art-making experience; and greater changes in cortisol reduction for participants who used art media such as clay compared with participants using more structured media such as collage or markers (p. 155).

Participants were 39 students, staff, and faculty ages 18 to 59 years from a large university in a municipal area (Kaimal et al., 2016). There were 33 women and six men. Eighteen participants stated they had limited experience with art-making, 13 described some experience, and eight reported extensive experience. The researchers collected saliva samples before and after the artistic process and later checked the samples for cortisol levels. Paired sample *t* test results showed that cortisol levels were reduced for 75% of the participants following the art-making. Mean scores for cortisol levels pretest and posttest varied significantly.

This is important as it shows that creating art can help in reducing cortisol levels, meaning art is helpful in reducing stress.

Trauma, Art, and Neurological Connections

According to Vaisvaser (2021), embodied sensations can change a traumatic memory and help a person to cope with a traumatic event. In everyday life the brain makes decisions in a top-down process, where it anticipates what kind of stimuli the body will perceive in a bottom-up process, but errors in prediction can occur. In this expectation process, three brain mechanisms are involved: the hippocampus that supports associative memory, the amygdala that processes emotions, and the ventral striatum that integrates affect and reward or motivational information. In trauma and anxiety an error in the brain judgment can lead to a somatic response (i.e., anxiety symptoms such as a response to a non-existing threat). Creative Arts Therapy (CAT) can promote health through the relationship formed between the therapist and the client. The client can experience new ways of sensing stimuli input and reshape their internal beliefs. Vaisvaser (2021) noted that CAT can supply the individual a secure and accepting relationship while the brain with its neuroplastic ability changes and new learning of a positive relationship experience is formed.

Soler (2005) explained trauma from a Lacanian point of view. Trauma can denote helplessness, the real, meaning the traumatic event "falls" on the unexpecting person, and he cannot do anything to protect himself, only deal with the traumatic consequences. Accordingly, the traumatized person is trying to forget the event that caused their trauma but is unable to do so. A traumatic event can play a part in dreams and in vivid memories.

Symbolic resources can help a person cope with trauma. Lacan (1967) said that the unconscious is "not remembering what you know," (p. 49) meaning people do not recognize

themselves in their traumatic memories. Instead, according to Lacan, the symbolic is entered by the traumatic *real*, named "*jouissance*" (p. 6). The discourse is then invaded by tormented memories that can be traumatic on their own.

Lacan (1967) explained that trauma can be caused by everyday life triggers, such as tension and war, and that trauma can become a consensus and part of a nation's discourse. That is, if the discourse of a nation is traumatic, then a subject can experience trauma merely through living there. When significations that organize social relations are unified and stable, then one can experience less trauma; but when there are "signals that the discourse leaks" (p. 75)—meaning the discourse is unstable—the subject is more exposed to trauma and anxiety. Living in Israel, a country with ongoing trauma, both professionals and their students are exposed to various triggers, which can evoke trauma. According to Baum (2005), Israeli society is exposed to increasing cases of terror attacks, sometimes on a daily basis, which can cause trauma or stress to large parts of the population, and it is hard to estimate to what extent.

Themes in Art Created by Children who Experienced Trauma

Goldner et al. (2021) suggested that at every second, a child is exposed to violence, but only 70% of them are willing to discuss their trauma with professionals. In their research, Goldner et al. asked 97 children and adolescents to share their views on child abuse through painting. Those researchers advocated the stance that painting encourages verbalization of a traumatic experience because the artists can see themselves from outside of themselves and contemplate their memories. "Children's drawings, particularly those done during a time of crisis, can overcome children's language limitations" (p. 2). The researchers provided participants with a printer-size paper and crayons and asked them to draw without a time limit and to share their narratives. Goldner et al. explained that painting provides both visual and

audio explanation of one's relational experience. They used coding and a chi-square analysis to interpret meanings and narratives.

According to Goldner et al. (2021), there can be dissociation in children who experienced abuse either at school or within their families. They used a multimodal approach to find narratives within their participants' drawings. One aspect they considered was

> [w]hether the drawing included dissociation, was detached, did not address the pain (i.e., included positive objects such as flowers, hearts, or nonrelated objects; contained only words; or did not follow the instructions, thus bypassing the painful meaning of the abusive scene) (p. 4).

Traumatic memories can be resolved through painting, by providing artwork with a clear and cohesive narrative. Unresolved traumatic experience can manifest in an emotional, incoherent, and detached theme provided within the person's artwork. In their research, Goldner et al. (2021) coded the narratives in the paintings and found that: children in elementary school showed more helplessness in their drawings and symbols of physical injury when compared to adolescents' drawings. Adolescents' drawings showed more injury symbols in comparison to younger children.

Goldner et al. (2021) reported that most of their participants illustrated violence in different ways in their artwork, and some did not include themselves directly in their painting. "About half of the narratives were coherently organized, whereas the rest were either restricted or chaotic, revealing dissociation, distress, sadness, and loneliness" (p. 6). Lev-Wiesel et al. (2005) mentioned that children who experienced direct exposure to violence tended to include themselves in their drawings. Among them, emotional abuse manifested in their artwork.

Children who experienced an indirect exposure to violence often try to protect themselves emotionally from consequences of the indirect violence and avoid the emotional pain it inflicts.

According to Carr and Hancock (2017), traumatic experiences become embodied because time does not heal, but instead conceals, trauma. Trauma can be expressed through art therapy and portraiture is a valid way to deal with trauma when one is engaging in art therapy (Hanan, 2019).

Portraiture has been used to combine science and art together for research purposes (Lahman et al. 2021). Lahman et al. (2021) addresses portrait making as a way of knowing something regarding one's experience through art-based research. Participants in this research study stated that their clients and students omitted body parts when drawing self-portraits during the sessions held in the school. Omitted body parts in the drawings of children with SM also were present in self-portraits drawn by parents and their children diagnosed with SM in an earlier study prior to this research (Hanan, 2019). Lev-Wiesel et al. (2005) researched such omission of body parts with people who stutter. Children who stutter exhibit low self-esteem and inhibited social capabilities. Lev-Wiesel et al. (2005) used a sample of 20 participants with stuttering onset between two and seven years of age, and a control group of 20 people with the same educational backgrounds but without speech difficulties. Participants were given a printer-size paper and were asked to draw themselves. Their artwork was assessed by two art therapists to analyze how obvious were the parts seen in the self-portrait.

Body parts included in the research were ears, which "provide sensory data for dealing with the external world" (Lev-Wiesel et al., 2005, p. 4); eyes, "considered to be windows of the soul and to reveal inner feelings… [They] permit the ego to deal with the world. Hollowed, shadowed, piercing, or omitted eyes may indicate hostility and suspiciousness" (p. 4); mouths,

"considered to represent the verbal ability, sense of taste, and oral needs. Emphasized or shadowed mouths may indicate strong oral dependency needs, hostility and anger, and difficulties in expressing oneself" (p. 4); chests, "considered to represent breathing and heart. Emphasized, enlarged, or shadowed chest may indicate emotional difficulties, lack of control or lack of confidence (p. 4); and throats, which are "responsible for swallowing and vocal expression. Narrowed, shadowed, or omission of throat may indicate eating disorders or verbal difficulties" (p. 4). The difference between both groups showed emphasis on drawings of ears, eyes and throats, but did not differ significantly in mouths, noses, or chests. Stutterers tend to draw larger mouths and eyes than do nonstutterers due to social anxiety.

Lev-Wiesel et al. (2005) advocated for using expressive arts therapy to implement other ways of communicating that are nonverbal. She said that in communication, we use the mouth ears and eyes, and when stuttering adults paint, they emphasize these organs.

Omitted Body Parts in Artwork by Children Diagnosed With SM

In a former study, the participants tended to omit body parts in their drawings (e.g., they drew bodies without eyes, a nose, a neck, or arms; and sometimes just the head appeared; Hanan, 2019). Little research exists about this style of drawing when it comes to children diagnosed with SM. Other research on self-portraits can shed some light on these results. Blanke (2007) analyzed the works of famous painters from a neurological viewpoint. He claimed that painting a self-portraiture is a mental experience that resembles an out-of-body experience. Some portraits by famous artists resembled ones that were made by patients who suffered some kind of neglect in their life (Blanke, 2007). These paintings omitted body parts, such as eyes, noses, throats, and parts of the limbs. Some of the participants in this study wondered how the senses, especially kinesthetics, are involved in SM.

According to Jaroenkajornkij et al. (2022), abusive experiences can cause trauma with children and change their brain structure and cognitive ability. Jaroenkajonkij et al. (2022) explain that omitted body parts in children's painting are related to trauma and anxiety. Jaroenkajonkij et al. (2022) compared the body images of Indian, Israeli, and Thai children and found no difference between them. Omitted body parts are also a sign of anxiety according to these researchers.

Fairies and fantasies appearing in drawings by children with SM was discussed in Boo's (2014) case study depicting a 6-year-old girl with SM sand tray creations. The narrative appearing in the child's artwork grew out of fantasies and portraying the "Little Mermaid" story. Her client was obsessed with the Little Mermaid because both the client and the mermaid were dealing with the loss of their voices. In another case study of a child suffering from SM and preoccupied with the Little Mermaid, Case (2011) mentioned that her client was diagnosed with trauma and would hardly speak to anyone other than her family. Case described her client's difficulties and her own effort to persuade her to speak: "To articulate can be painful but allows one to enter a world of shared communication" (p. 341).

Feelings and Language

Langer (1980) discussed the relationship between feelings and language. In her trilogy, *Mind: An Essay on Human Feeling*, she explained that feelings are a sensory stimulus since individuals can feel the changes in themselves caused by their feelings. An experience can be felt subjectively, depending on who the person is. In her work, *Philosophy in a New Key*, Langer (1942) proposed that a philosopher's role is to debate not what the world is, but how people can know what it is. She explained that our experience formulates our perception.

Langer (1942) differentiated people from animals because humans use symbols, which makes them “the lord of the earth” (p. 20). She called the act of using symbols “symbolization” (p. 20). Her work is important as she advocated the use of symbolization, and the spoken language. Humans are different from animals because humans use language and symbols to make meaning out of their world in a subjective way. From a Darwinist viewpoint, Langer (1942) said, we use symbolization, because it makes us stronger and is a survival mechanism, in which we tell our story in words; that is, we add our experiences to those of other people to create a narrative. Langer is much different from Lacan, as she puts the spotlight on our ability to imagine and use symbols to create a wide understanding of the world surrounding us and denote meaning from the way we perceive ourselves in the world using a uniform set of references. Thus, according to Langer, the use of signs is the beginning of intelligence. She compared the use of sign language to the physical development of sense organs and synaptic nervous system because both serve a purpose of self-preservation.

Animals learn how to respond to their environments. They respond to a stimulus in their surroundings, much like when a dog hears a bell ring and has learned to think about food. If an animal’s limitations lead him to respond in a fixed manner, then the animal can act confused in the presence of multiple stimuli because “he cannot receive many signals to begin with” (Langer, 1942, p. 23). People use certain “signs” among themselves that do not point to anything in their surroundings, and most words are not signs in the sense of signals. Words are used to talk about things rather than to direct senses (eyes, ears, and noses) toward those things. Instead of being announcers of things, words are reminders. Unlike animals, which use signs, human beings use symbols and the spoken language to fulfill their basic needs.

Langer (1957) developed a comprehensive understanding of feelings, suggesting that it is impossible to separate between the form and its meaning. Thus, art creations ignite a process that involves emotions and cognition in what Langer called “apparition,” which directly affects people’s senses and minds. Symbolization is an important aspect of the conscious activity because the symbol forms a new reality. This means that art represents substance that cannot be exhibited any other way.

> Symbols differ radically from signals. A signal is comprehended if it serves to make us notice the object or situation it bespeaks. A symbol is understood when we conceive the idea it presents. (p. 26)

Langer (1967) also advocated that the artistic creation and the internal process unfolding for the viewers connects them to their emotions. “A work of art is like a metaphor to be understood without translation or comparison of ideas” (p. 104). According to Langer (1957), “works of art are projections of felt life. . . They are images that formulate it for our cognition” (p. 25). Without art, it is impossible to express and connect to internal emotions, identity, and cognitive, behavioral, social, cultural, and historical backgrounds. Langer coined the term import to describe the meaning that art conveys. That is, art is a nondiscursive symbol; it possesses a process of individuation and mirrors individuals’ internal worlds. We have an immediate meaning making when we see a picture. It can make us feel in a certain way, immediately. Langer (1957) claimed that artists transform subjective reality, supplying a new perspective on subjective emotions.

Summary

This literature review focused on the unique circumstances and dilemmas of working as a teacher or therapist with children diagnosed with SM in the Israeli education system. As demonstrated in the literature, art therapy is an intervention method that can help children in an inclusive class.

Research showed that art therapy helped children with learning disabilities to connect to their emotions and show fewer symptoms of LD (Ferlich & Shectman, 2010). Art therapy can also help increase students' self-esteem, as shown by Beilty et al. (2017). They also showed that the child's environment at school could change for the better due to the art therapy the child receives. This literature review also emphasized that teachers' knowledge of selective mutism is often poor (Dillon, 2016). This, in turn, can influence the relationship between the student and their teacher. A poor relationship between a student with SM and a teacher can be problematic. However, teachers can also be very influential, and they have a pivotal role in helping their students with SM to step out of their shells and out of their silence (Bork, 2011).

Another point that this literature review revealed was that a relationship with teachers is important to children diagnosed with SM. A good relationship with their teacher can help a student raise their self-esteem (Greenboim -Zimchoni, 2019). Building bridges to communication is a term I named in a former study (Hanan, 2019). It refers to the ways children with SM are influenced by their environment, and look up to parents, and teachers to learn communication skills. Specifically, teachers can learn to improve their skills and build bridges through professional workshops (Harwood & Bork, 2011).

This literature review focused on the link between trauma and selective mutism as children living in Israel reportedly have PTSD at a high rate (Bitton & Laufer, 2018). Selective

mutism can be triggered due to one's genetic backgrounds well as experiencing a traumatic event (Hanan, 2019). According to the DSM-5-TR (APA, 2022), there is comorbidity between trauma, social anxiety, and SM selective mutism.

Overall, this literature review emphasized that training teachers to learn how to work with selective mutism is crucial, as teachers and caregivers are important and have an integral role in helping children diagnosed with SM. The literature also shows that art therapy can help children with SM to improve their condition, and that anxiety is a problem that is best dealt at a young age, even on a biological level. Living in Israel presents unique challenges in terms of trauma, and art can help decrease the symptoms of anxiety. These are the reasons why this research was conducted and why it is important to facilitate workshops that can educate teachers and caregivers.

According to Langer (1942), the ability to symbolize is what differentiates us from animals. Langer says, artists have an ability to transform reality through the artistic process. Nonverbal techniques, such as artistic creation, can help both teachers and students to communicate better (Bloom, 2020). This does not mean that the road will not be laced with challenges, as Gellatly et al. (2018) found in their research: burn-out can cause professionals working in the education system to not meet the goals they set out when first starting to work with clients or students. It is important to understand that there are many challenges that can be met during the working process with children diagnosed with SM.

Drawing from the topics discussed in this literature review, this dissertation focused mainly on professionals' experience after participating in an AT-based professional workshop and how it changed the way they perceive themselves.

CHAPTER 3

Method

The research design for this study combined art-based and phenomenological qualitative inquiry. Kossak (2013) defined art-based inquiry as "the use of artistic process, and the actual making of artistic expressions in all the different forms of art, as a primary mode of understanding and examining experience by therapist, client, researcher and research participants" (p. 20). In this study, the data collected consisted of participant interviews conducted during three workshop sessions and observations of group discussions about participants' experiences teaching or helping a child who is diagnosed with SM after they have been exposed to the knowledge shared in the workshop.

According to Brinkmann and Kavale (2015), phenomenology is a method to describe the data as precisely and completely as possible and to describe and observe rather than analyze. The methodology used in this study enabled me to understand the participants' lived experiences. According to Moustakas (1994), phenomenology is a method of gathering knowledge of the experience by relying on "intuitive and a priori sources of knowledge and judgment" (p. 58). This method focuses directly on people's experiences, self-evidence, and inner perceptions to understand a phenomenon.

The "Van Kaam method of analysis" (as cited in Moustakas, 1994, p. 120), was utilized in this study, which is to: (a) list and preliminarily group every expression that is relevant to the experience, deciding if there is a moment in the experience that is sufficient to understand it; (b) label them; and, (c) cluster the same constituents related to thematic labels and construction for each participant, creating a textural structural description of the meanings and essence of their

experience. These will become the core themes of the experience to help answer this study's three research questions:

Research Questions

- RQ1: How does participating in a professional workshop influence the way teachers and expressive art therapists interact with children diagnosed with SM that are present in their class?
- RQ2: What are teachers and expressive art therapists' perceptions of art therapy treatments for children diagnosed with SM after participating in a professional workshop?
- RQ3: What are teachers and expressive art therapists' perceptions of themselves professionally after participating in a professional workshop?

Ethics

Lesley University's Internal Review Board granted permission to conduct this study (see Appendix A). Participants were provided an overview of the project and told that they could withdraw from the study at any point for any reason. All participants signed an informed consent form that specified that their participation was voluntary, they could leave the study at any time, and that all their details and data collected would remain anonymous and confidential. They were also asked to approve the use of their artwork in the research. See Appendix B for English/Hebrew informed consent forms for participation and display of artwork.

All data were kept confidential. Revealing details and personal information were altered (e.g., using pseudonyms). The art therapist and the Dance /Movement therapist (DMT) practitioner who served as consultants did not know the identity of the participants.

Participants

The participants were recruited through an advertisement created on Facebook that invited participation in an art-based intervention for teachers who have a child with SM in their classroom. Advertisements were also published on an Israeli expressive arts group on WhatsApp and on the researcher's Facebook page and sent to the researcher's Facebook friends with a request that they share the post on their threads. The advertisement read:

> Hi, my name is Tal, and I am a graduate student at Lesley University. I am looking for teachers who have a child diagnosed with Selective Mutism in their class and who are willing to take part in a study entailing art-making for three weeks. Please message me if you are interested and for more information about the study.

Recruitment was closed after one week after receiving sufficient inquiries to meet the requirements of this study. The recruitment was conducted on a first come first served basis.

The final sample of participants were 6 teachers with teaching certificates in Israel who had a child diagnosed with SM in their class and 7 expressive art therapists who had a teaching certificate. There were six teachers, six AT, and one Drama therapist taking part in the research. Participants were randomly assigned into two groups: One group was comprised of six participants, and the other group included seven participants. This was done in order to keep the groups small. The uneven number was a result of the researcher's decision to accommodate a 13th participant who was initially unsure about whether they could commit to the research study, but expressed significant interest and committed to the study.

Demographic Data

Demographic data (see Table 1) were collected from all participants. Ages ranged from 30 to 62 years, with a clear majority being between 45 and 62 years. Nearly 50% of the

participants were from Israel's central district; 50% worked in secular schools, 25% in religious schools, 8.3% at both secular and religious schools, and one participant worked at a school located in a psychiatric hospital. Their years of experience teaching and facilitating expressive arts therapy ranged from one to 31 years, with eight participants shared that they had only one or two cases of a child diagnosed with SM throughout their years of experience. Although most participants shared that they had between 10 and 14 years of experience working in inclusive classrooms, the participant with the most experience working with SM had only 6 years.

Member checking was conducted in order to explore the credibility of results and get different perspectives that can add to the body of knowledge, I asked an American dance movement therapist (DMT) and an Israeli art therapist to give their opinion. regarding the art work involved in the study. Loren, the DMT has 20 years of experience as a therapist, and currently maintains a private clinical practice. Shirly is an Israeli art therapist and private clinician with 15 years of experience.

Table 1
Participants' Demographic Information

Participant (pseudonym)	Age (years)	Gender	Religious Affiliation	Occupation	Years of experience	Native tongue	Area in Israel
Anna	33	Female	Orthodox	Teacher	10	Hebrew/ English	South
Britt	30	Female	Secular	Teacher	1	Russian	Central
Claire	45	Female	Secular	Art therapist	1.5	Hebrew	Central
Emily	53	Female	Orthodox	Teacher	31	Hebrew	North
Irene	48	Female	Secular	DMT	20	Hebrew	North
Mary	56	Female	Secular	Art therapist	14	Hebrew	North
Maya	39	Female	Secular	Art therapist	7	Hebrew	Central
Madeline	47	Female	Secular	Art therapist	15	Hebrew	Central

Michele	34	Female	Secular	Art therapist	7	Hebrew	Central
Moly	44	Female	Orthodox	Teacher	20	Hebrew	South
Nina	56	Female	Secular	Teacher	26	Hebrew	Central
Oliver	62	Male	Orthodox	Teacher/ Drama therapist	29/4	Hebrew	North

Workshop

Demographic data were collected before the first session began via a self-report questionnaire (see Appendix C). The questionnaire included questions about age, religious background, working environment, years of experience, and experiences teaching children diagnosed with SM. Additionally, participants' opinions about teaching were gathered.

I then facilitated a three-hour workshop divided into two 90-minute meetings, followed by a 30-minute follow-up meeting. The first two meetings were held one week apart, and the third (follow-up) session was held two weeks after the second meeting. All meetings were held on Zoom due to the COVID-19 pandemic and the need for social distancing. The Zoom software provided a unique password that was shared only with the participants in order to keep the data confidential and all the Zoom meetings were recorded. All the participants completed the entire program.

First Meeting

The first meeting included an introduction of the participants, followed by a didactic presentation on the current research and theoretical knowledge about SM, such as disorder onset, prevalence, and treatment. It focused on teacher's knowledge about SM. I facilitated the discussion, asking participants questions such as, "Can you please share with the group what you

know about SM? There are no right or wrong answers. This will establish a basis of knowledge of the phenomena."

After the discussion, a case study of a young boy who was diagnosed with and treated for SM at age 15 was presented by the researcher. The case study (see English translation in Appendix D), included a newspaper article I had written (Hanan, 2019). This boy created a self-portrait using clay, wood and plaster. The boy did not speak most of the sessions, but he expressed his feelings through art, until one day he chose to share that he feels like the old person he created with clay: "old and watching life pass." By the end of the year, he shared that his father had a psychotic breakdown when the boy was 3 years-old and since he lost his words only to find them again during therapy. He then wrote a story specifying that he learned to face his fears during the creative process. This case study was sent as a link to the participants on a mutual WhatsApp group opened for the research purpose. Participants were given 15 minutes to read the article and another 10 minutes to ask clarifying questions and that ended the session.

Second Meeting

The second workshop meeting had two goals: first, to make the participants feel comfortable in making art and holding the space for them to create; second, to facilitate an art-based intervention that focused on the participants' beliefs and opinions specifically on the difficulties or challenges in working with children with SM. The researcher asked the participants, "How can you take care of a child diagnosed with SM who is in your class, and what will this entail for you emotionally?"

The first art experience allowed participants to use printer-size paper and soft oil pastels that were supplied in advance by mail if they chose to use them. Although materials were provided, it was not required to use them, and some participants preferred to use their own

supplies. These materials were selected so that participants could experiment artistically in a soft and flowing manner, using the oil pastels on paper. The participants were asked to make marks or symbols on paper as they considered their client or student or the child from the case study presented in the first meeting.

Participants then uploaded their art creations onto the group chat via the Zoom software. The artwork was saved on my computer for later use within the research study. Following this, a group discussion took place about the art experience; I asked questions such as, “What image did you create?”; “Can you explain and elaborate?” and “How does your image connect to your experience of teaching a child diagnosed with SM?” While each participant discussed their art, I asked them to share their screen so that all participants could see their art creations.

Participants were asked, as part of the discussion:

1. Think of a child diagnosed with SM with whom you work or have worked. What image(s) did you create and why? How do those images connect with your experience of teaching a child with SM?
2. What are the difficulties or challenges of working with a child diagnosed with SM?
3. How can you take care of a child diagnosed with SM in your class? What will this entail from you emotionally both internally and externally?
4. What has changed for you in your experience of working with a child diagnosed with SM after you participated in this workshop?
5. Do you feel the workshop enabled you to develop professionally? If yes, how?
6. What more would you like to learn about art therapy and working with a child diagnosed with SM?
7. What do you need for yourself to be able to work with a child diagnosed with SM?

Third Meeting

The third group meeting, held two weeks after the second meeting, was a follow-up meeting of 30 minutes. During this meeting, participants viewed the group's artistic creations in a PowerPoint presentation and then reflected on their artworks. Probing questions were asked to determine if the participants viewed their art differently or if an aspect of the drawing stood out more in this follow-up meeting than it had in the second meeting, when they had created it.

In this meeting, the art-based inquiry focused on the participants' artistic experiences from the workshop and what they learned through the experience. In the PowerPoint presentation, all images made by participants were presented, as well as my own artistic reflective creations inspired by theirs. There was a final discussion about the participants' experiences, views on the art-making, and how they perceive themselves as professionals of children diagnosed with SM.

Data Analysis

Following Kavale (1996), meaning making was derived from the interviews, bringing the participants' understanding to light, providing new perspectives to the phenomena, and recontextualizing their written and spoken sentences in the analysis process. The data were viewed through a holistic lens, noting the social, interpersonal, and emotional aspects of the participants' experiences.

Phenomenology is a tool that helps researchers understand the lived experience of participants. In their explanation on how to analyze interviews from a phenomenological viewpoint, Brinkmann and Kavale (2015) illustrated the importance of describing the data as accurately and thoroughly as possible. Describing is preferred to explaining or analyzing the

content of a participant's descriptions. Those authors also advocated a "phenomenological reduction" (p. 235), which means halting all judgment when one is describing a phenomenon. An interviewer should know how to extract meaningful themes from the words participants speak and pay attention to facial expressions and gestures.

In this light, I transcribed by hand and then analyzed the data by reading and rereading the content and then clustering it into themes with meaning using the ATLAS.ti software. With ATLAS.ti the researcher can use codes and graphically organize all the verbal information into units of meaning while categorizing the interview data into subcategories, allowing themes and subthemes to emerge from the participant responses. Observations and participants' responses were analyzed to determine how the participants saw the images they created as metaphors for their teaching students with SM. Following the "Van Kaam method of analysis" described above, the participants' expressions that were relevant to their experiences were first listed and grouped, and then labeled.

Using Kavale's (2015) method, in which analysis starts in the moment the researcher thinks about their research questions, I then clustered the same constituents that are related to the thematic labels and construction for each participant, creating a textural structural description of the meanings and essence of their experience. According to Kavale, meaning condensation is the first step in analysis. That is, the researcher first categorizes the interview data into subcategories, which allowed themes to emerge from the data.

Further, I listened to the participants' discussions, which became my inspiration to create my art-based reflection on the discussion. All art made throughout the sessions and shown in the PowerPoint presentation (during the third workshop session) served as a reflective tool, allowing me to better understand the participants' experiences during the research.

Analysis From a Dance Movement Therapist and Art Therapist

To hear the impressions of professionals who could provide a different viewpoint than mine, I asked an American dance movement therapy practitioner to provide a viewpoint of a professional from a cultural background other than Israeli. The intention behind this was to see if she might observe biases that I may not be aware of and contribute a multicultural perspective. It was also vital that I engage the viewpoint of an Israeli art therapist, who could shed more light on things that I could have missed while analyzing. Both art therapist and dance movement therapist were given copies of the art and responded in writing to the art image they observed.

Chapter 4

Results

Analysis revealed 14 themes, presented in a word cloud in Figure 4. A summary of results are presented in this chapter; their applicability to the research questions and extant literature is discussed in Chapter 5.

Figure 4

Themes and Subthemes Presented in a Word Cloud

Note. This illustration was produced using the Atlas-t software. It graphically presents the relative number of times a theme or subtheme emerged in the qualitative analysis.

Thematic Results

The three research questions yielded 14 main themes: learning to communicate, building bridges, breakthroughs, challenges, negative emotions, miscommunication, communicating with children with SM, gaining perspectives, applying the learning, recurring themes in paintings, community engagement, evolving knowledge of SM after participating in the study, results of participating in the research, and resources in the field. There is an overlap between the different themes and the research questions, so sorting the themes according to each different research

question was done predominantly to facilitate presentation. Figures 7 –19 illustrate examples of participants' artwork (see also Appendix E for a complete list of participant's artworks).

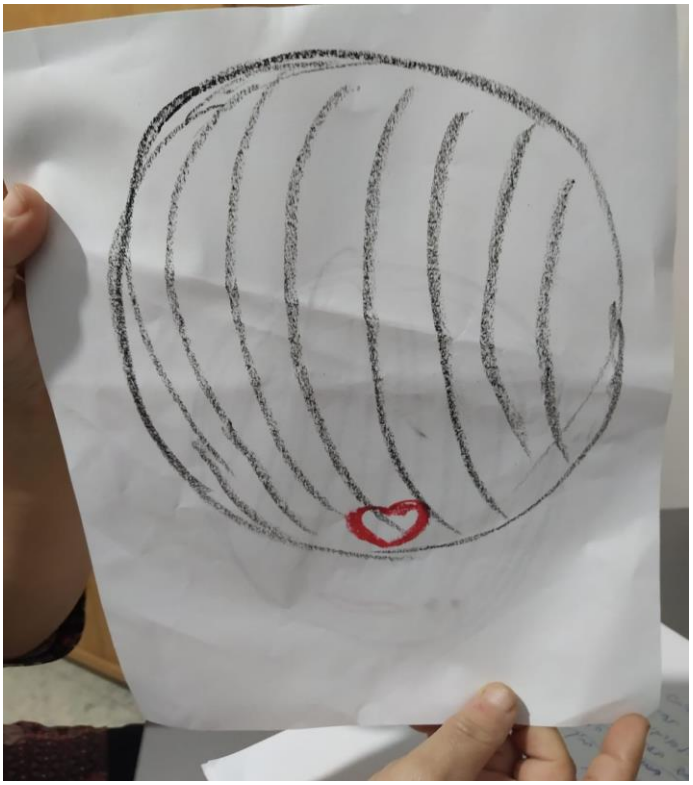
Theme 1: Relearning Communication

The participants expressed their process of learning to communicate with their clients or students mostly in the third (follow-up) session. For instance, Mary described how her client started to communicate nonverbally when Mary started texting her through WhatsApp. Another example is when Emily explained why she painted her student's mouth in the shape of a heart (see Figure 5):

> Her hair is constantly hiding her face. I imagine that her hair acts as prison bars. Behind them is her heart or her mouth, both of which are locked, and anything she is not saying is locked deep within her heart.

Figure 5

The Girl with the Heart Shaped Mouth: Emily



Nina explained that if she does not take an active role in communicating with her kindergarten student diagnosed with SM, then the child refuses to speak. This leaves Nina feeling alone and frustrated. This pattern appeared commonly among the participants. Moly said,

> Everyone in the group [of participants] discussed the element of silence when working with children diagnosed with SM. I feel that I need to constantly ignite the conversation by speaking, while sitting across from a child who does not speak at all. It's almost as if my student is in a bubble that I need to pop in order to get through to her.

Some participants expressed becoming so frustrated with their students with SM that they give up on alternative methods of communication. Mary, an art therapist, articulated that she likes to speak with her client's teacher to help her speak up in class. However, as a result of the

teacher's exhaustion from trying to talk with Mary's client, she often ignores her and therefore does not value art therapy. Claire explained how she formed an alternative way of communication:

> I've worked with my client diagnosed with SM for 2 months. It's been a nice experience overall; I'm okay with her being silent. She intrigues me. Once we did a "squiggle," and she painted without saying a word. She said nearly nothing about the characters she made, so I tried to interpret what she may have wanted to say. I was feeling unsure and insecure, wondering if I am letting her down in case my interpretations were not correct, was she testing me? On the other hand, I do feel she is expressing so nicely through art, so I don't miss the words most of the time. I do feel that a relationship formed between the two of us.

Nina believed that professionals should be educated about the styles of communication that children diagnosed with SM may use: "Educators need to realize that the communication style is not verbal, as they often don't use words."

Mary described a change that emerged in the way her clients increased communication with her during treatment. She felt excitement as her client started to share intimate narratives for the first time after the many years of their therapy relationship:

> I'm surprised and happy to share with the group the tension I once felt from my client alongside a stiffness and shutting down, is now replaced with her coming out of her shell, she shares intimate things about her internal world, she's being more spontaneous, and at ease that I never witnessed from her.

Mary described experiencing a breakthrough in therapy when she started to communicate with her client using WhatsApp,

> We were supposed to meet, and my car broke down, I wanted to conduct the session over the phone. Problem is, she does not talk to me outside of the therapy room. She was willing to text me, so I suggested she record a message, after being inspired from the content that you taught us in the first session. I asked her if it's okay [for me to] send her a text message and she will reply, but she said no. So I said, what about if I write one word, and then you can answer back and tell me what you heard. She agreed. I wrote her name in the text message, and she whispered it back to me in a voice message. I heard her voice for the first time. Then I sent her a recording of the sound of a music tool, and she recognized it. When it was her turn to send me a voice message, she sent me a recording of the wind, and I was so moved by it.

Theme 2: Building Bridges of Communication

In a former study, I saw that the parents of children with SM serve as models of communication for their children (Hanan, 2019). When the children examined the way their parents interacted with the researcher and with them, they learned how to better communicate with others.

One of the unanticipated results of the research was that participants asked for guidance on how to work with children with SM and their parents. Although it was not part of the original workshop design, I decided to educate the participants in the first session regarding this aspect of working with children diagnosed with SM and their parents. I recommended that they work alongside and reach out to parents to ignite a process of what I call "letting go," meaning the parents could learn to respect and trust the participants (educational staff) and would want to cooperate with them, ("להשתחרר" is the Hebrew word that means letting go, but it also means breaking free, like out of jail. This was the exact word participants used, and its double meaning

gets lost in the English translation). With that, I predicted that the parents' communication style could be more open and receptive and, accordingly, their children's style of communication would begin to transform. The participants shared some experiences after trying this method in between sessions.

Both teachers and therapists shared that they have problems in communicating with the parents of their students or clients. They specified reasons such as lack of time, being afraid to open up to parents, and even COVID-19 rules preventing parents from entering schools or meeting in person. I encouraged the participants to invest time in building trust and not being afraid to communicate with parents because they can serve as a bridge for communication, and model open communication for parents of clients.

Nina said that her client started talking with the kindergarten staff as soon as Nina succeeded in forming a bond with her client's parents. Then her client started texting Nina's phone:

> It was a process of letting go. Even though COVID-19 rules prevented her parents from going inside our school, I decided to let them come inside whenever they wanted to, so that trust could be formed. That was the exact point [at which] we started collaborating, and things started to click. The breakthrough happened once my three-year-old client started texting me and sending me voice messages. She used her parents' iPhone. Her parents cooperated, too, and all that transformed our relationship. The next step was for my client to start to speak in class.

Madeline initially shared that her client creates art, but her client does not know what she made. In our third session, Britt pointed out that she had been inspired by the process she went through in the research. I asked, "What do you need emotionally to be able to continue to work

with children diagnosed with SM?" Britt answered that she wants to be more encouraging and to allow her client to step out of her comfort zone. Madeline took an assertive stand, saying she expected her client to state her desire in therapy clearly and, surprisingly, it worked. Britt said she was surprised that it worked as she did not have self confidence that she could be assertive in front of her student and participating in the workshop helped her to be more confident in her abilities.

Maya said she usually starts her first session with a new client by laying out her expectations. "You don't have to speak to me," she tells them. "I know that if you want to, you can talk. I know how to get along without using words at all. But as time passes, I will expect you to speak." Maya shared that within three sessions, children diagnosed with SM usually speak with her. She said she did not feel as though children diagnosed with SM are in a bubble they need to pop. Instead, she felt as though these children were exposed:

> They are so exposed that everything touches them; this transforms into anxiety, meaning their anxiety is not internal but external. I aim to form a relationship. I offer them help, and I demand that they be active within the session, and it works.

Moly, a writing specialist, said that having her student's cousin as her teaching aide helped in building bridges with her student:

> The teaching aide helped her to write and communicate in a nonverbal way. Before that, she would sometime leave the sessions not having written one word. I feel that we are taking baby steps because my student does not confide in me yet, but we will get there eventually.

Britt said that her student with SM cooperated with a new math teacher, after sharing that she was afraid her student would skip class. When another participant asked Mary what helped her student build the bridge, she responded:

> It was the letting go part we talked about. Last week, I phoned her parents and asked questions that I never dared to ask before, partly because I didn't know how and what to ask. I was very surprised they answered. I know this doesn't sound like much, but it was a big deal for me; it helped to make me feel more at ease.

Children with SM look up on their teachers or expressive arts therapists and imitate the way they communicate too. Ten of the 13 participants reflected on this type of modeling.

For example, Nina said that texting her client's parents led to her client to text her, too. This was the first step for communication between them. Soon after, her client started speaking to her and, after some time, began to speak at school. The whole time Nina's client looked up to her, watched how she interacted with others, and mimicked her actions.

A positive change happened for Meggie and her client after Meggie asked her client to speak more often and proposed actions that would enable her to step out of her comfort zone: "She used to wait for my proposals, which was constantly challenging. I felt I had to reinvent myself all the time." I suggested that Meggie use this influence to motivate the student to engage in speaking more often. Meggie later reported that she tried it, and it worked. These are just a few examples of how teachers and therapists were able to build bridges in order to positively impact their students and clients.

Theme 3: Breakthroughs in Working with Children Diagnosed with SM

There was an epiphany moment in which participants experienced a breakthrough in their relationships with children with SM. Subthemes here relate to consequences of using the

"building bridges" method. Subthemes within this theme are: Breaking Through Your Comfort Zone, Experiencing Breakthroughs, and Reaching Out.

Subtheme 1: Breaking Through Your Comfort Zone. Britt described that participating in the study helped her step out of her comfort zone:

> When we talked about demanding [participation] from my student, I mostly tried to do that in class. On the other hand, I looked at myself from the outside while I was doing that. And I paid attention to what it is that I demand and what I don't. Then, I felt as if I learned a little bit better how to be attuned to my student and demand whatever she is able to do—not to demand too much of her, but to demand a little bit more than she can chew on and still be able to do that… I felt as if I had done a lot of good. I felt that I stepped out of my comfort zone, and I was able to push my own boundaries. [When arranging small groups in class] I didn't place her with her best friend with whom she talks. I placed her with somebody that she doesn't know. Then, I examined to see. I waited, and I closely looked. Is this working? If it didn't work, I tried something else. This enabled me to hold a space for her….

Nina shared with the group that she stepped out of her comfort zone when she asked the parents of a child with SM who was in her preschool class to come to class and play with their daughter. She said that she felt uncomfortable inviting parents to the school during the COVID-19 pandemic. However, she learned that the mutual play time was important to allow for trust to develop between Nina, the child's parents, the child with SM, and the preschool staff. Nina said:

> I think this was getting the parents involved in the classroom. Although there is COVID raging, I wasn't afraid to let them inside my class. This was where they built their trust

> and when we officially started working together and building a communication with each other.

Nina stepped out of her comfort zone, encouraged by the first session in the workshop, where I suggested that participants reach out to parents and build communication and trust. Nina, like many other professionals, was afraid of inviting parents to see how she worked. She was accustomed to sending text messages to parents but never invited them to visit her classroom, and there was also a real concern about getting sick with COVID-19. By overcoming her fear, Nina shared with the group that she enhanced her self-confidence in collaborating with parents.

Subtheme 2: Experiencing a Breakthrough. Participants discussed experiencing breakthroughs in their relationships with the children diagnosed with SM. Moly described how her student with SM whispered in a session she facilitated. She painted her student dressed as a baby deer, a costume the child was planning to wear for the Jewish holiday of Purim. Moly exclaimed that the relationship between them had been hard to establish: The student had a frozen attitude, was very distanced and reserved, showing no emotion or facial expressions. Moly said she learned the importance of establishing trust and focused on that. She described how her student took off her facial mask and whispered for the first time her plans for Purim. Moly felt they were on the right track of building their relationship.

Britt described experiencing a breakthrough with her student diagnosed with SM on our last session:

> I had a great week. I called my student's mom after the second session we had in the research. I wanted to ask her how the one-on-one session with the new Math tutor was. I even talked to my student, and the conversation went well. You can guess how surprised I felt today when I couldn't make her to stop talking during class. This happened during

> music class. ... I don't know what made today so special that I had to shush her. It's a very special day. I feel very happy and excited.

Claire asked if I could shed some light and give an example or a case study of a successful treatment session, so she could feel some hope in working with children diagnosed with SM. Oliver shared that letting his client's friend join a session proved successful because the friend mediated between the parties. All of these are examples of experiencing a breakthrough that participants experienced.

Subtheme 3: Reaching Out. Maya described the dilemma she faced as part of an educational staff. She said she often feels hesitant when making a connection to a child with SM because there is something intimidating—they do not make eye contact, which makes it difficult to bond with these children. She described that the hands and the fog she drew in her painting expressed the effort she made to connect with children with SM. She reminded herself that even though she felt hesitant to form a connection, deep in her heart she knew that children with SM want to be helped and need relationships in their lives.

Theme 4: Challenges in Working with SM

Multiple participants described children with SM as challenging: "It's a challenge understanding what they mean when they don't talk;" "I feel as if I need to pop their bubble;" "I want her to be more spontaneous, she's so rigid;" "I feel enmeshment with her; it's like I am aware of the rational thing to do, and I end up texting her mother every day to see if she's okay."

Subtheme 1: Stumbling Stones. Participants responded that they felt like stumbling stones in their process of working with SM. Claire painted her student in a womb (see Figure 6), which could be seen as a haven. But she felt that it was not a safe place for her client because it was filled with sharp objects. She shared, "Learning to speak with others is like rebirthing,

except it is not an easy birth." Madeline explained that the child with whom she works is in the fifth grade, was diagnosed since she was in preschool, and they had been working together for two years.

> There is humor in our relationship, and movement and color, but these characteristics do not show outside the therapy room, not in class and not at school. It's like she's built a wall that separates her from the outside world.

Figure 6

A Baby Inside a Womb: Claire

Madeline went on to describe that she and her client often created mutual art, and that her client admitted she wanted to step out of her silence but did not know how.

Moly described the silence in the room, as her student in a bubble—a description that participants brought up many times. Emily explained,

> Insubordination is one of the most challenging characters of SM. My student is not willing to comply with anything, unlike the other students in her class. She will not even

nod her head to help me realize if what I'm expecting of her is acceptable. She sits in her place silently and does nothing. She is not willing to put on a face mask.

Subtheme 2: Environmental Factors. Participants shared feeling an expectation and pressure from the school and parents of children diagnosed with SM to communicate. This put considerable strain on them as professionals to perform a "magic intervention" and "fix" the child. Michele said the expectation that her client speak is from mostly external sources, such as wishing that the child could speak so that teachers can understand her intentions. Anna described the most challenging aspect as,

> [w]hen parents demand that the child begin to talk. Can you just let it go? He will speak when he can, and there's nothing you can do about it. The school staff is putting on a lot of extra pressure too. So big deal. Let's say the child will not ever speak. What's the worst-case scenario? It's a poor starting point to put these external expectations on the child, that are not ours to begin with. It's aggressive.

Subtheme 3: Extra Responsibilities. As professionals, the participants appeared to take on extra responsibilities in engaging with their students or clients. Meggie debated how far to push her client, what she could demand of her, that might sway her out of her comfort zone. She said she wanted her client at a better starting point when she began Junior High at a new school next year. Britt aspired to help her student acquire new friends, as a personal obligation, and was upset and preoccupied with it:

> I'm debating how to make my student feel at home in class. How can she make new friends? I work in a school where the most important aspect is the social one and not pedagogy. Students are constantly actively making friendships. She isn't, and she pays a price for being silent. One of the goals she had at the start of the year was making new

friends. I want to help her to create a space for herself in the group, but I don't know how.

Theme 5: Negative Emotions

Participants discussed negative emotions they felt while communicating with their clients and students diagnosed with SM, primarily feelings of frustration and helplessness.

Subtheme 1: Feeling Frustrated and insecure (Professionals). Most participants expressed a feeling of frustration when communicating with children diagnosed with SM. Madeline described feeling frustrated in the presence of her client's silence. She wanted to help her client and constantly guessed what she wished for, but the unknown intentions were frustrating. Moly said:

> At first, I felt very frustrated. There were sessions I didn't know what to do. I'm a teacher, and I was supposed to teach her how to read and write, and it's impossible to read together when the other person doesn't speak. At Hanukkah, I asked her to tell me about an experience she had during the holiday. I could see she was excited and wanted to write, but she couldn't say a word. I was trying to ask her questions. "Where did you go?" She didn't answer back. It was very frustrating, I felt it was going nowhere.

Nina said that over time the frustration made her feel like a failure when she couldn't reach out to her student.

> You know there's a primitive place you go to when you first become a mom. I'm constantly feeling that she is my baby. She's crying, but nothing I do seems to calm her down… I feel helpless, as if in all the years I spent going through my undergraduate and graduate school gaining knowledge, I learned nothing. All the knowledge in the world

can't help me when I'm with her. No matter how many years of experience I've got, it still doesn't cut it.

Emily said she felt more frustrated trying to communicate with her student when they are in class than when they have a one-on-one session. Overall, participants said their feelings of frustration led to them to feel insecure.

Subtheme 2: Feeling of Helplessness (Children and Professionals). Participants believed that the children with SM with whom they engaged felt helplessness. Anna said she wished she could choose a material other than oil pastel and paper; she wanted to create something three-dimensional that could show how these children felt helpless: "Like they want to break free from the wall closing in on them. I can see it in their eyes; they are saying, 'Please help me, I can't speak,' but instead they only gesture with their head." Oliver said he first felt that his client had little presence but then he realized how helpless the client may feel. That made Oliver reach out to him. Maya said she was unsure of whose hands were in the picture she painted—her own or her client's (see Figure 7).

Figure 7

Artistic Expression: Maya

However, some participants said they feel helpless when engaging with children diagnosed with SM. Nina said the communication made her struggle, and Emily said she felt frightened to supply information about her client. She felt her client had many challenges that did not have to do with her student not speaking, and that it was a complicated case. Maya said she felt anxious whenever she had a meeting with her client; she felt a void that she had to fill with words. Madeline felt that her insecurity made her very cautious, as though walking on eggshells.

Theme 6: Miscommunicating

Not being able to communicate was said to be more than not speaking by participants. Participants talked about difficulties that made communication in all its aspects impossible. Mary said she was having trouble communicating with her client's teacher, who was unwilling to meet with her to discuss her student's emotional state. The teacher declared such a meeting to be a waste of time, and that the child should not be in her class. Meggie said, "It's hard to understand what children with SM want. They don't communicate, so they are hard to read. I don't know what my client feels or wants. It's a challenge."

Theme 7: Communicating with Children with SM

Most participants said they felt that there was an alternative form of communicating when engaging with children diagnosed with SM that is a nonverbal form of interaction. For example, Mary shared that her client was not speaking with her but texting via iPhone. She said it did not interfere with the substance coming up in the therapeutic session because her client shared personal information and there was a connection and trust between them. Irene said that, in the past, she had wanted her client to speak, but now it was irrelevant because she was aiming for her client to find a supportive and contained environment. Both Madeline and Moly described that their students whispered, which made it very difficult to understand what they were saying.

On the other hand, Claire said that meeting with her client through the Zoom software helped her client to feel more reassured and speak more.

Subtheme 1: To Mediate Between all Parties Involved. Participants shared that they felt as though they needed to mediate between all involved parties—the child, parents, and other school staff. They said that struggling to communicate and having to mediate between other parties made it even harder—and many times set off a chain reaction of miscommunication. For example, Britt said one of her students wanted one-on-one attention for Math. However, Britt did not think it would be beneficial because she wasn't sure how to communicate with her student. Britt was required/ felt obligated to mediate between all parties and find a solution that works for everybody.

Theme 8: Gaining a Different Perspective

During the research, participants went through a process wherein they gained new information and knowledge about building a relationship with the child diagnosed with SM in

their class. They reported changing their viewpoints on working with children diagnosed with SM following the workshop lecture. For instance, Nina said she looked at her student differently; she felt less unsure and uncertain. Irene also said that she now sees her client differently: “I’m no longer focused on the negative aspect of my client’s personality, but on the good sides, and my painting exemplifies that.” Oliver expressed that he went through a personal transformation. He acknowledges that to succeed in treating a child with SM, he needs to work in a multimodal method, mediating between all parties involved.

This theme also was a result of the process in which participants gained a new perspective, which led them to be active and to take action when interacting with their students and clients. Nina recalled experiencing a call for action when she participated in the research:

> I became familiar with art therapy in the last couple of years. We only had behavior shaping at school, as this was the fashion. Behavior shaping is true in only some cases. Through participating in this research, I experienced firsthand the benefits of art therapy, and I feel it’s a great loss we don’t get to have expressive arts in our school. There is this void that the school’s psychologist and behaviorist can’t answer, and I don’t mean only about SM, but a very large scale of incidents I think art therapy can help with.

Theme 9: Applying the Learning

Some participants shared that they applied the learning and information gained in the workshop when they went back to their classes or therapeutic spaces. For example, Claire said:

> I played music in our last session, I wanted to experiment with what I learned from you in our first lecture. It was a nice change. My client didn’t understand why after 1.5 years, I’m trying something new. I played a quiet mediative music, and it truly changed the

> atmosphere between us. I started to pay attention to when my client spoke and encouraged her to do so.

Theme 10: Recurring Themes in Painting

Participants said they feel insecure in their art-making. For instance, Nina noted that all other participants had painted their students' mouths. Because Nina had not, she felt she must have done something wrong (see Figure 8). Maya said,

> I was painting and thinking of a fog. It is in the yellow part on the top. It was funny—I used gray pastel, the light here is very dim, so instead of gray it turned out yellow. I painted a lock on her mouth, it now reminds me of a Band-Aid.

Whereas Mary said her client often painted fantasy and fairies, Michele painted a mandala (see Figure 9) for a client she had had for 2 years, first in a group and then in a one-on-one setting.

> We had a rough start; it was challenging to motivate her. She was silent most of the time, and she was unsure of what she wanted to do when we worked together. I suggested we paint mandalas, and it was the only thing we did. She would draw little flowers using very slim markers. She would never use oil pastels.

Figure 8

The Eye: Nina

Figure 9

Mandala: Michele

Subtheme 1: Omitted Body Parts. An interesting finding was the theme of omitted body parts in students' and clients' artwork. The participants reported that children with SM often omit body parts, such as the head, mouth, ears, eyes, nose, legs, or hands, from their paintings. For example, Mary shared that her patient drew a figure without both eyes and with omitted eye and hand. In two other paintings there was a body missing and no ears.

Subtheme 2: Flower Imagery. Some participants' drawings repeated flower imagery. For instance, Britt painted her student and described her painting (see Figure 10).

> She has a pink lock of hair. I worked throughout the lock down because I work in special education. I painted her with flowers on both sides of her character. One is a bud, the other is a predatory flower. She a timid demeanor; she never smiles. I remember being nervous about it, but then I let that go. The bud is her in class, but then her mom says she is very different at home—she has tantrums, an entire aspect of hers I do not know at all.

Figure 10

The Girl with the Rose and Predator Bud: Britt

Theme 11: Community Engagement

Participants reported that being a part of a community of other professionals dealing with the same challenges—such as the group that met for this study—helped them in their process. Nina felt the group had a certain power dynamic that was effective for her process. She had a place to gain more than knowledge; she relied on other participants stories and felt supported. Emily felt encouraged to share, that the Zoom call felt like a container. She said, “I know this is not supervision, but being able to share with others who know what I’m going through makes me feel reassured.”

Subtheme 1: Support. Emily said she could not obtain sufficient support in the school where she works. She described her student scratching the table in an anger tantrum and holding a pencil like a knife. She said, “I am afraid of her when she behaves like that.” Mary confessed to reaching out for support but still feeling very much alone.

Theme 12: Evolving Knowledge of SM After Participating in the Study

In speaking of the relevance of early diagnosis of SM during the first workshop session, none of the participants had knowledge of it. However, in the last session, all participants agreed on the importance of diagnosing SM early, between the ages of three and five years. Nina said that she had thought her student was just shy, but that was not the case. She recognized the treatment time they lost without a diagnosis for her student. Anna said her friend reached out to her and said she thought her child had SM: "I'm debating what to do, whether to encourage her to get early diagnosis, or not. I don't want to break the news for her, but I'm worried about time lost." Nina also expressed the importance of early diagnosis: "If a student reaches age 15 with undiagnosed SM, I believe that early diagnosis would [have gotten] him treatment at an earlier age, and he would be in a different place today."

Subtheme 1: Psychiatric Diagnosis. Although most participants knew that SM is an anxiety-based disorder, they felt unsure what to do with the psychiatric definition of their student or client and the referral process. During the workshop, participants asked questions regarding this aid: What kind of prescriptions do children with SM receive? Who diagnoses SM? Can a psychologist diagnose SM? (In Israel a psychiatrist can diagnose SM and a drug named "Prisma" is often prescribed to treat SM; in the USA it is called "Prozac" also known as "Fluoxetine")

Mary shared that after receiving the information, she sent her client for evaluation at one of Israel's psychiatric hospitals, where she was diagnosed with SM.

Subtheme 2: Reinvention. Because there is no specific model for working with those diagnosed with SM, participants felt they had to reinvent themselves. Some shared the methods they had advocated with their students or clients. Mary described that her client goes to a "white room," a stimulus-free room. She said she felt there was a physical aspect to SM that is not

discussed. Both Mary and Mia felt they first needed to establish trust to be able to connect with their clients. Moly shared how when she worked with her student, they used voice recordings: Her student recorded her voice next to photos of her leisure activities, and then she and Moly would listen to them together.

Subtheme 3: SM Behavior. Participants were curious about the age range and prevalence of SM. They gave vivid examples of their students' behaviors, some of which was aggressive. Irene mentioned that her client was violent at home, leading to hospitalization in a psychiatric ward. Emily said her student did not comply with school rules and would not wear a COVID-19 face mask. Mary said her client often seemed angry.

Many participants said they felt anxious when teaching or treating children with SM. For instance, Claire described feeling anxious when she was with her client for 45 minutes and they did not engage in conversation. Oliver said he felt desperation when with his client. Nina said:

> I see my student struggling. I can tell she is experiencing a difficulty; she does not make eye contact often, but when she does, I can see how I let her down when I do not understand her. It is devastating.

Mary said her client calls herself "the odd duck out." The doctor advised her parents to start drug treatment, but they refused. Instead, they gave their daughter Omega-3 supplements. The client did not speak at school, only at art-therapy sessions and at home. Her client has tantrums, scratching her table with her fingernails. Emily mentioned that her student also exhibited tantrums, causing the school staff to isolate her out of fear. On the other hand, Claire said her student had a "timid demeanor." Anna wondered whether having SM had to do with hearing mechanisms and vestibular problems. The participants experienced a range of behavioral and emotional transference with their students and that affected the emotional feedback.

Theme 14: Results of Participating in the Research

Britt said she felt it was a rare fortune to be included in the research, and Irene desired continued support. Mary said she now feel more grounded:

> There is a growing awareness to SM these past years. I first heard about SM only 2 years ago. There is lack of knowledge about SM, specifically with expressive arts professionals. There are many cases diagnosed, and this research was really on time, as I was not even sure my client had SM until I heard your lecture. Then I sent her to go get diagnosed.

Claire expressed feeling more secure after participating in the workshop. Oliver said he felt more attuned to his client and that he gained new perspective. Some used the phrase "magic intervention" to describe the intervention presented in the workshop; hence they were helpful. Maya said she would never again look at a mandala or coloring book the same way.

Subtheme 1: Finding Their Voice. Participants brought up the theme of finding their voice many times. Madeline began the sessions feeling unsure of her place as an educator. She underwent a process in which she said she found her own voice and could set boundaries more naturally:

> Last week I met with my client. I told her that I can hold the space for her, and she can bring more of herself to our sessions. I asked her to specify her expectations from me and how I can help her, and I feel now surer of my place as a professional.

Britt said her perspective changed, and she can let things fall into their place. She learned through this experience to trust the process and herself. Finding her own voice helped her not to skip on her student's turn to talk, even when the student chose to be silent.

> I find it challenging to be demanding of my student, as I am not sure how far I can push her. My school pays attention to developing social skills. We have a tradition at school that students teach a class, and she is the only one who has not done that yet. I know it is possible to do this without speaking, since I have one more student who was able to do it. But since my student with SM is shy, she is having trouble stepping out of her comfort zone. I do not want to push her too hard. What good would that do? So, whenever we sit in a circle and talk and it's her time to share, I ask her, "Do you want to add something?" And she nods. So, I don't push, but I'm not sure how to help her to speak.

Subtheme 2: Silence. Some participants talked about their artwork in terms of the silence shared with children diagnosed with SM. Maya (as discussed above concerning Maya and her drawing in Figure 7) said she felt a constant fog between herself and her client, and that silence is like a Band-Aid on his mouth. Claire (see Figure 6) mentioned that if she did not speak, her client would be silent. Moly (see Figure 11) coined the term, "witnessing the silence," and Oliver (see Figure 12) said, "silence as disappearing," meaning his client did not speak to diminish himself.

Figure 11

A Girl in a Bambi Costume: Moly

Figure 12

Behind Bars: Oliver

Theme 14: Resources in the Field

The data revealed three subthemes under the theme of 'resources in the field'.

Subtheme 1: Raising Awareness. Participants said they wanted to implement what they learned in this research when they go to practice their knowledge in their professional field. Moly said she wanted to study expressive arts and become an art therapist. "My goal is to start one-on-one sessions with my student and try out the different ideas you talked about, create mandalas and play music. I hope that she will speak with me by the end of this year."

Subtheme 2: Educating Parents. All participants agreed that parents of children diagnosed with SM need to be educated about how to approach their child. Some mentioned that after participating in the study, they found it easier to approach parents and discuss their children's diagnoses. Anna said:

> I think many parents are not aware of their child's diagnosis, and professionals don't know what to look for, the signs and symptoms. My friend suspects her first-grade child

has SM, but her child's teacher is unfamiliar with the disorder and doesn't know what to look for. She believes the child is just shy and doesn't have an anxiety-based disorder.

Irene said that her student's parents needed guidance on how to deal with their daughter's tantrums. Nina said school staff could benefit from the workshop and interacting with a subject matter expert, who can educate both parents and school staff on how to work with these children.

Subtheme 3: Educating Professionals. Participants unanimously agreed that knowledge is needed on what SM is and how to work with children who have it. Maya expressed a need for a broad explanation. She said she was not aware of small details, such as how immigrants cannot be diagnosed with SM in the first year after immigrating to a new country as their language deficits can be based of not knowing the language and not trauma or anxiety. Additionally, where she worked, many children who had immigrated to Israel were falsely diagnosed. Claire advocated the importance of acquiring knowledge: "Knowledge is missing. Unless you go and look for special courses teaching SM, you don't study about the disorder in school." She said she watched movies portraying two girls with SM, and it had an immense effect on her. "If I weren't in this study, I wouldn't go looking for these movies. I wish all my peers can watch these." Anna proposed a need for more lectures about SM and accessible knowledge taught everywhere because SM is frequently mistaken for shyness and to ensure parents and professionals learn the importance of prescription drugs that can improve the children's quality of life.

Nina said that she wished someone as experienced as the researcher could be with her in the field because part there is a problem of lack of expertise. Britt contemplated how to broaden her toolbox of skills: "I feel I gained a new perspective, and I want to expand my knowledge. Problem is, I am not sure what is out there. I can't believe this is the end of the road." Britt also acknowledged that she heard about this research study by chance and felt lucky. However, she

hoped that SM education could more organized and accessible in the future. Participants also used the research platform to share knowledge on the aids their students can receive in the school.

Researcher's Response

The participants inspired me to create my own art-based reflection on the discussions that arose during the study. The art they made throughout the sessions served as a tool to reflect and better understand their experiences during the research.

I painted with oil pastel on a printer-size paper. I first painted three flowers and thought, "Oh my gosh, this is too optimistic." Then my painting transformed into a circle. It reminded me of the "bubble" in which some participants described their students and clients. The bubble transformed again, as though I had no control over the process unfolding.

As I painted in layers, repressed memories surfaced. I remembered the image of myself as a little girl. Every day, I felt as if I had survived a battle. I slowly started sketching the face of a girl—me—but this girl was no longer a child. This once open wound blossomed into a tree (see Figure 13).

From the wounded little girl transformed a healer, a strong and capable woman, rooted in the ground. She is in bloom. It is spring for her, and she is blessed, for she can finally speak up and she give her voice to others who are speechless. They may be children who cannot speak or adults facing their own anxiety when they see others unable to speak. I thought, "Oh! now I am able to breathe again. I am complete as the process continues to unfold.

Figure 13

Researcher's Response to Participants' Artwork

Reflections of Participants' Artwork by Other Professionals

As previously stated, a DMT and an art therapist were enlisted to help minimize bias and provide additional perspectives on the art and themes that emerged. Because this study was conducted during COVID-19 lockdown, face-to-face meetings were not possible. Thus, all photos of participants artwork were taken by the participants themselves during the study. The images presented and discussed in the next section have not been altered in any way and are presented here in the same way they were sent to the researcher using WhatsApp. The researcher

created the caption wording during the analysis process. They portray what the participants expressed about their experience working with children diagnosed with SM.

Analysis From a Dance Movement Therapy Practitioner

To hear the impressions of a professional working in a modality different from mine—that is, to get a second opinion from someone with another perspective—I asked Loren (pseudonym) an American dance/movement therapy (DMT) professional working in the United States to look at the participants' drawings.

I provided her with all the photos of the participants' artwork in a slide show, and she gave her feedback/impressions of each drawing. Then, we discussed the various perspectives. She felt there was a shared theme: the need for boundaries. Loren's responses are detailed below with the reactions of the art therapist.

Analysis From an Art Therapist

I also showed the participants' artwork to Shirly (Pseudonym), an Israeli art therapist to see what someone who is Israeli would think and feel when viewing these drawings. Shirly and Loren were a peer reviewer and did not participate in the workshop and she looked at participants' artwork after the research was terminated. I was interested in reducing potential bias, as I am so enthusiastic about SM. So, I asked them to evaluate my findings in order to neutralize potential bias. I was specifically interested in whether the professional's cultural background would make a difference when she saw these art expressions and wanted to obtain viewpoints from more than one expressive arts professional. The researcher assigned titles to participants' artwork based on the participants' descriptions of their artwork. Shirly and Loren were unaware of these titles. As part of the method for the research part of the study, the

researcher relied on the comments of Lauren and Shirly in order to reduce bias. The participants' drawings were shown to the Shirly and Loren to gain further insight and reduce any personal bias. (I used Loren's own words as she discussed each participant in English, and had to translate and paraphrase Shirly's words as they were originally in Hebrew).

Maya

In response to Maya's work (see Figure 9), Loren said that she felt that Maya's painting portrays three people falling because the world is upside down and that they cannot break free. Shirly said that she feels that something is amputated. They both agreed that the world is being broken into pieces.

Claire

Both Loren and Shirly agreed that Claire feels like there is an intrusion and feels frustrated about being interrupted. Both agreed that somebody is being locked in a bubble and is startled by the intrusion, as if somebody else is trying to break into the bubble. They felt desperation existed in the drawing and that is hard to get into the middle of the bubble.

Irene

When Loren and Shirly looked at Irene's painting, they both agreed that there is loss, tragedy, and unfairness in her painting, and Shirly said that she felt helplessness, guilt, and desperation (see Figure 14).

Figure 14

Black Flower: Irene

Madeline

When Loren and Shirly looked at Madeline's drawing, they both had different opinions. Loren felt powerful and beautiful, and Shirly mentioned the bubble motif, feeling that there was minimal communication existing in the drawing (see Figure 15).

Figure 15

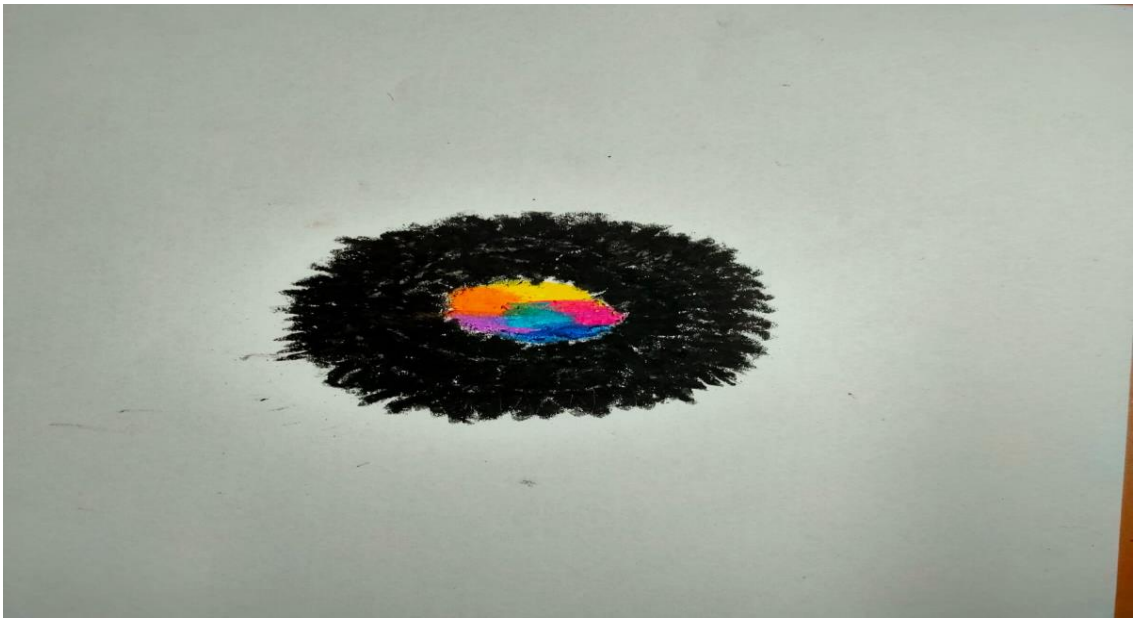
Living Inside a Bubble: Madeline

Meggie

When Loren and Shirly looked at Meggie's drawing, they both agreed that it looks like a bubble. Shirly added that it is hard to penetrate the outside layer to get into the middle (see Figure 16).

Figure 16

Cocoon: Meggie



Anna

Both Loren and Shirly agreed that there is a bubble motif in Anna's painting, and they both agreed that they felt violent and invasive trying to get into this boundary.

When they looked at Anna's second drawing, Loren said that she felt safe in their space. Shirly said nothing, and she did not explain why she chose to be silent (see Figures 17-18).

Figure 17

Breaking the Wall of Silence: Anna

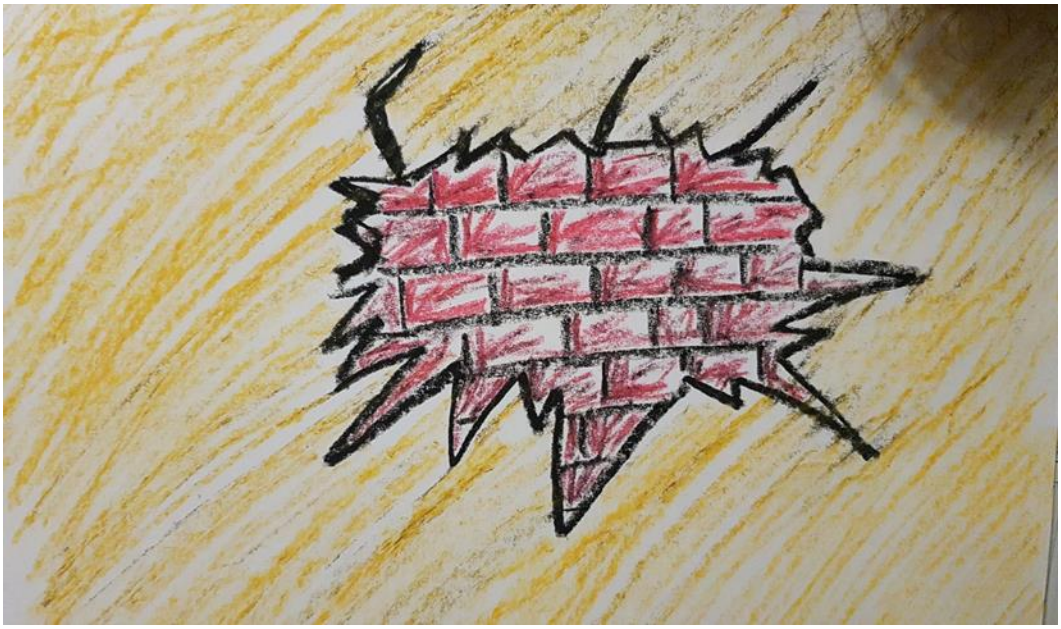


Figure 18

Breaking Free: Anna

Michele

When they looked at Michele's painting, Shirly talked about the bubble motif, and Loren described the qualities of the bubble. She said that the drawing made her feel withdrawn and introverted but content (see Figure 9).

Moly

When they looked at Moly's painting, they both agreed that it represents a forest-like child. They both described that they felt that they could not speak but they were allowed to see magic if they can stay quiet and listen carefully (see Figure 11).

Nina

When they looked at Nina's painting, they both agreed that there is an inner image that is spreading its rays to the outside world, and they felt inadequate and apologetic for shining so bright (see Figure 8).

Britt

Looking at Britt's painting, they disagreed Loren felt that the drawer is forceful and competitive. Shirly felt that there was a smaller figure that felt vicious and eminent (see Figure 10).

Emily

Loren and Shirly looked at different elements of Emily's painting. Loren looked at it and thought about it as a ball, and Shirly thought that it was a bubble. Shirly also mentioned that this reminds her of omitted body parts (see Figure 5).

Mary

When Loren and Shirly looked at Mary's painting, they talked about being able to move on and not stay with this drawing because they felt somebody is angry at them (see Figure 19).

Figure 19

Selective Mutism: Mary

Oliver

When Loren and Shirly looked at Oliver's painting, they both agreed that there is a dissonance between the bars and the figure in the painting that looks safe and happy. Loren said that she felt that she is invited to play a game, and if she is good at it, then it is okay for her to go into the safe, sunshine area (see Figure 12).

Chapter 5

Discussion

Thirteen special education teachers and expressive art therapists participated in a guided workshop that introduced them to SM. As part of their participation in this research study, these professionals participated in a workshop introducing them to interventions, art therapy, and specifics of SM. The participants were divided into two groups that met via Zoom over a four-week period. The first session was a professional workshop in which the researcher explained what SM is and specified about art-based interventions that can be used with children who have SM. In the second meeting, the participants were asked to create an artistic expression while thinking about their student / client with SM. In the third session, they were asked what their experience making their art was like. In the fourth session, the researcher asked about their experience taking part in the research and what each one thinks the field needs in terms of professional development.

The results outlined in the last chapter addressed the following research questions:

- How does participating in an interactive professional workshop influence the way teachers and expressive art therapists interact with children diagnosed with SM that are present in their class?
- What are teachers' perceptions of art therapy treatments for children diagnosed with SM after participating in a professional workshop?
- What are professionals' perceptions of themselves after participating in a professional workshop?

The discussion will follow selected themes and subthemes found in the research: (1) Relearning communication; (2) building bridges; (3) breakthroughs; (4) challenges, (5) negative

emotions, (6) miscommunication, (7) communicating with children with SM, (8) gaining perspectives, (9) applying the learning, (10) recurring themes in painting, (11) community engagement, (12) evolving knowledge of SM after participating in the study, (13) results of participating in the research, and (14) resources in the field. A discussion of these themes will follow, and connections were drawn where relevant to the literature.

The intention of this research was to understand the experience of professionals working in the Israeli education system with children diagnosed with SM as they learned new concepts about the disorder and how to treat children with SM. The participants experimented in art making and then shared their experiences with the researcher. This study also aimed to answer questions about what is missing in the field of knowledge about SM and allow these professionals to explore art therapy in order to raise awareness of art therapy for children with SM in the Israeli school system.

Discussion of Findings

Theme 1: Relearning Communication

Many of the participants in the study said that they were feeling frustrated because the individuals they work with were not speaking, and they were unsure if they should be persistent when they communicate with them or if they should just let go of the conversation and not make an attempt to talk or just be quiet. They also wondered whether they should be addressing the individual with SM or just ignore them. They expressed that they felt desperate and isolated because they were engaging in a one-sided conversation. They said that they did not know if they could treat the children that they work with the same way that they treat every other child. They expressed that they were walking on eggshells, and that made their communication very challenging. The researcher encouraged the participants to treat children with SM the same way

they treat other students and to make every attempt possible to ensure open and direct communication.

Harwood and Bork's study (2011) showed that teachers felt afraid and unprepared to work with children with SM. The professional workshop in this current study gave the teachers and caregivers an opportunity to prepare themselves mentally and supplied them with theoretical knowledge to help them deal with their feelings of insecurity and to encourage them and support them in their sessions working with children with SM. This is important because this was never done before, and it yielded positive results.

The main difference between the target crowd in Harwood and Bork's study (2011) and participants in this study, is that all teachers in this study were teaching while going through the professional workshop, while Harwood and Bork's participants were mostly teaching veterans with years of experience. Hardwood and Bork's research inspired me to facilitate a workshop for Israeli teachers with less experience. When participants in the Harwood and Bork's study tried, nonetheless, to initiate communication with their students with SM, they were surprised of the results. From my research, it appears that children who had a good relationship with their teacher or therapist did well at school and were able to fit in, which was not surprising based on my experience.

Theme 2: Building Bridges of Communication

This study showed that good communication is helpful when building a relationship with children diagnosed with SM. The researcher encouraged participants to practice "letting go" and invest time in building a relationship with children and their parents. This was done on the basis of Hanan's (2019) bridges of communication concept. Based on what the participants said, I learned that when a teacher or a therapist is present with a child with SM along with their parents

or either with one of their friends that they talk with, and the teacher or therapist decide to meet all of them together, the child with SM will probably talk, as they feel comfortable. Since the child communicates openly. Then, teachers and therapists can invite other staff members that the child does not talk to. In doing that, they can make the circle of people that the child talks with bigger. The participants from my research who did this succeeded in building a relationship with their student diagnosed with SM. The research showed that when the participants invited friends of a child with SM to participate in a class or in a therapeutic session, it improved the communication as the child with SM interacted with students and teachers. The data from this study highlight that when a child with SM is presented with people that they know, they talk with them.

Perednik and Elizur (2016) research also supports this method. They explain that children learn through modeling. According to Perednik and Elizur (2016), when parents of children with SM show avoidance when they sense their child's anxiety, their child is going to react with more silence, greater resistance, and more avoidance. Perednik and Elizur (2016) emphasize it is important that parents of children with SM show them that they are not stressed about their child with SM anxiety. These elements of art therapy can be beneficial to improve outcomes when working with clients who have SM (Hanan, 2019), in contrast to Perednik and Elizur's (2016) stance.

Theme 3: Breakthrough in Working with Children Diagnosed with Selective Mutism

Subtheme 1: Breakthrough Your Comfort Zone

This finding supports Harwood and Bork's (2011) study that found that participating in a professional workshop can help teachers navigate their way better in the classroom when facing a child with SM. The data from this study support the idea that professionals are not well

educated on how to work with students with SM. It appears from what the professionals in this study said that when they are educated in how to work with students with SM, their self-esteem and sense of capability to work with these children increase. Once they start to believe in their own capabilities, they obtain good results, and their self-confidence increases. This finding also supports Harwood and Bork's (2011) contention that participating in a professional workshop can help teachers navigate their way better in the classroom when facing a child with SM.

Subtheme 2. Experiencing a Breakthrough

As a result of this study participants reported having had various breakthroughs when working with their students with SM. For example, Moly's student with SM spoke in class, and Britt's student spoke fluently in front of her cohort. Oliver included his student's friend in a session, and it turned out to be a successful one.

It seemed that the participants who stepped out of their comfort zone were able to build a good relationship with their students, which helped to increase their students' well-being. This is partly the reason for the good results they witnessed inside the classroom. It may also be that exploring art therapy helped to establish participants' and students' self-esteem (Belity et al., 2017) and could do so for future children diagnosed with SM. Stepping out of their comfort zone required the participants from this study to treat the child with SM just like they do with any other student they had, and based on my experience this can cause the best results, and can help establish a good relationship with a child with SM. This means that just because these students do not speak it does not mean that one should not try to find ways to build a relationship with them in order to promote healing and change. This is also mentioned by Shipon-Blum (2007) when she described the ideal circumstances of a classroom for a child with SM would be

an inclusive class and have a teacher who recognizes that their student is longing to be a part of a relationship with their peers.

Teachers are often apprehensive and fearful to step out of their comfort zone, and SM is a commonly misdiagnosed misinterpreted disorder. For this reason, facilitating professional workshops is important, to supply both teachers and therapists and other professionals with the knowledge and ways to enable them to step out of their comfort zone and allow them to have a good experience, as indicated in this research study. A different viewpoint and the knowledge to help them cope with challenges is vital for working with children diagnosed with SM. Part of the reason of the children are not willing to speak in certain situations has to do with their level of anxiety changing from one location to another (Shipon- Blum, 2007).

It is important to understand that children with SM are not just shy, oppositional, or defiant, and they are commonly misdiagnosed. Selective mutism is an anxiety diagnosis and should be treated as one. Participants learned of the importance of accurate assessment and diagnosis for a child with SM, that is done by a psychiatrist, and that some children with SM need to be prescribed medication to be able to overcome their anxiety (APA, 2022).

Teachers and therapists must work together to promote the right classroom setting for a child with SM, to provide lowered anxiety levels, building of self – esteem, increased social comfort, and ongoing progression of communication, which is the building bridges technique (Hanan, 2019). This is also supported by Shipon–Blum (2007) in her idea of the ideal classroom for a child with SM. The most important idea, that is also supported by Shipon-Blum (2007) and based on previous research (Hanan, 2019), is that all efforts of professional staff members should promote the advancement from nonverbal communication to verbal communication. Teachers should learn to be accepting and caring when a child with SM does not initially use verbal

communication, and that is something that was communicated in the professional workshop in this research study. In this study, once the behavioral characteristics were explained it was easier for participants to be more accepting of students and try new ways of communicating. It was also emphasized in the workshop that a teacher and expressive art therapist should not just aim to settle for non-verbal communication, but also aim higher, to build verbal communication with a child with SM.

It was also emphasized in the workshop from this study to form a good relationship with a child with SM's parents, to enable formation of trust between all parties involved, that can later lead to trying new ways of teaching the child with SM in the classroom, or interacting with them in the therapy room. It was also communicated and discussed that the emphasis within treatment sessions for a child with SM should also focus on lowering anxiety levels, building self- esteem and working on communication skills in all social settings. This is also supported by research (Boo, 2014; Martinez et al., 2015; Shipon-Blum, 2007). These studies also emphasized that the goal in working with a child with SM is to encourage them to speak in class and maintain communication with their teachers and peers. This goal was reached in my research, as it helped provide a model for building bridges to help children diagnosed with SM to communicate their voice in class and outside of the classroom.

Subtheme 3: Challenges in Working with SM

Participants in this study expressed a wish that they could speak to their students with SM, be able to hear their voices, and be engaged in conversation with them. They said it was hard to speak in a void, when no one is talking back to them, wishing they could pop "their bubble." Some also talked about how they interpreted their students' behavior as insubordination and expressed the challenge involved. The professionals in this study also expressed a feeling of

loneliness, of feeling alone with their problem of how to work with a child with SM and said it was overwhelming and is one of the large reasons that a professional workshop (Harwood & Bork, 2017) that can increase professional's knowledge of SM is needed. It was also surprising to find that no research has been done on the aspect of loneliness in teachers. Loneliness may be one of the reasons why being a part of a group of peers in the same situation was a meaningful experience for the participants. The group dynamic enabled the participants to share their feelings of solitude and being part of a large group of peers helped them to feel less alone and isolated, as they heard other's stories and learned from other's experience.

It was also notable that participants felt burned out, as they described that there was no support at the schools where they worked, which was part of the challenge they experienced. This is also reflected by Howard and Johnson (2004) and Vesley et al. (2013). Howard and Johnson (2004) explained that teachers withdraw from their work as a result of weariness and burnout, due to stressors in their workplace (e.g., communication problems) and often feel lonely. They denoted the feeling of being a part of a large group of peers as a motivation to stay at the school as it builds a resilience and self-efficacy in teachers. Vesley et al. (2013) claimed that teachers are vulnerable to high stress and burnout. They recommend the use of professional workshops to help raise their sense of resilience and self-efficacy. Cressy et al. (2016) mentioned that lack of support at the workplace can affect a professional's self-efficacy and the workshop helped provide support to teachers and expressive art therapists working in the Israeli school. Future goals would be to run this workshop in more schools to enable more professionals to be educated on SM and make them feel that the whole school is engaged and that they are not alone.

Subtheme 4: Negative Emotions

Participants felt helpless and frustrated when unable to talk to their students. Madeline described it as walking on eggshells. She felt that she always needed to be careful when asking questions not to annoy her student so that she would cooperate and not show defiant behavior. Other participants shared they had problems communicating with the school staff around the topic of how to communicate with their student with SM who did not always participate in their class or showed defiant behavior. Mary asked about the difference between Oppositional Defiant Disorder (ODD) and SM because her student showed oppositional behavior in school, and the staff felt helpless. The DSM-5-TR (APA, 2022) specified that a child needs to show avoidance behavior as a criterion for SM, which could be the reason why a child with SM can show defiant behavior. Mary shared that she is experiencing problems in communication with her colleague based on a lack of knowledge of SM. Lack of teachers' knowledge of SM was also found in previous research (Dillon, 2016; Harwood & Bork, 2011) and is one of the reasons teachers are often frustrated.

Theme 4: Communicating with Children with SM

A child with SM requires an alternative form of communication. Their silence is present in class or in the therapy room, but there are other ways that one can communicate with a child who has SM. Talking can manifest in many ways, such as: whispering, recording voice messages on WhatsApp, and even talking over virtual platforms like Zoom. It is important to be creative and new ways to communicate. This study enabled teachers and therapists to communicate about the many ways that they interact when communicating with children diagnosed with SM. They learned from other professionals' experience and implemented them in their class. In the

workshop they were encouraged to try different ways to communicate with children in their class, such as using their phones.

Theme 5: Gaining a Different Perspective

The participants in this study gained a different perspective after attending the workshop. Nina shared she was starting to see "the big picture" about the disorder. Some of the participants shared they were exposed to AT for the first time, and they were curious to learn more about it. Bielity et al. (2017) explained there is a growing need to raise awareness about the advantages of AT to Israeli teachers. One of the most exciting outcomes of this research study was what participants said they learned in the workshop at the school.

Theme 6: Evolving Knowledge of SM After Participating in the Study

Nina said that she now realizes how crucial it was to diagnose SM as early as possible in order to effectively treat a child, and Irene, Oliver, Britt, and Mary agreed with her. Early diagnosis is explained by the DSM-5-TR as very helpful as it can allow for early start of treatment, which can in turn produce good results for children with SM (APA, 2022; Cohan et al., 2006; Sharp et al., 2006). According to the DSM-5-TR (APA, 2022) only a psychiatrist can diagnose SM. Participants in this study felt unsure whether to refer a child with SM to a psychiatrist, as it is not an easy task to inform a child's parents that they need to see a professional, and there was also a lack of knowledge about who can diagnose a child with SM. Some shared that their student was showing aggressive behavior, and that was one of the factors that eventually made them ask that their student get evaluated, diagnosed, and be prescribed medication. However, this research suggests that it is important to work with teachers on being comfortable to make the necessary referrals and raise awareness to art therapy as a therapy method that can help children with SM.

Another aspect of SM is the possibility that trauma is also involved in the diagnosis, as part of the criteria that the DSM-5-TR (APA, 2022) portrayed. Irene described her client who suffered from trauma due to an abuse she experienced as a child by her father, who left the country shortly after Irene's client stopped speaking in pre-school. Trauma has been researched by many practitioners, and it seems that traumatic memories are experienced through vivid fragments (Sarid & Huss, 2010). Cortisol is the human hormone that is active in trauma (Deibac & Sullivan, 2014), and it triggers a fear response (Oresta et al., 2021). Fear can be learned by infants when they merely watch their mother being afraid (Deibac & Sullivan, 2014) as in the case of Irene's client who also witnessed her mother being abused. Lacan explained that trauma is always unexpected (2006) and can be triggered by everyday events (1967). Art making can reduce cortisol levels as Kaimal et al. (2016) explained and this means that art-based interventions can be helpful for children with histories of trauma who have SM. This study shows that AT can be helpful in helping children diagnosed with SM to communicate with the staff working in their school.

Theme 7: Results of Participating in the Research

Participants said they wanted to have extended support beyond the realms of the research study. Some said they felt more grounded. Participants were encouraged to paint with oil pastels and play classical music with their students. This is based on Hanan's study (2019) where participants painted their self-portrait while listening to Mozart's *Symphony No. 9 in C major*. Participants in a former study expressed they felt more relaxed and could focus their attention better when they were listening to this kind of music.

The participants were also trained to work with mandalas, and Britt called this experience she learned during the research "a magic intervention." This intervention was introduced because

mandalas have been shown to reduce anxiety (Curry & Kasser, 2011) and one of the goals in working with children with is SM is to reduce anxiety levels to promote communication. This was taught in the professional workshop and is based on previous research (Hanan, 2019; Shipon-Blum, 2007).

There was also a mutual feeling that the participants felt more comfortable with their voice through the research process and that they learned to embrace the positive changes in their self-esteem. They also gained a new perspective on SM. These findings match the ones that Harwood and Bork (2011) found, in which they specify the importance of professional workshops to increase scholars' knowledge about SM. Therefore, it is important to train professionals while working in the school system and to educate and train them while they are in graduate school on how to work with children who are diagnosed with SM.

In addition, in this research study participants underwent an intervention that lasted only four sessions, and they shared it was meaningful and had a big impact on their self-esteem and capabilities on working with SM. They did specify that they wished to have more sessions, but the reason that these four sessions were so impactful was that participants learned what is most influential and important when working with SM: that one should strive to work in ways that can reduce anxiety as research shows that SM is an anxiety-based disorder (APA, 2022; Kaimal, 2016). This can be done by using interventions to lower anxiety levels (e.g.: mandalas, relaxing music).

It was also stressed that participants should focus their attempts on building their students' self-esteem while establishing a social environment that can meet the child's needs and most importantly help the child with SM to communicate. Because participants learned to use all these four principles, the workshop was perceived to be helpful.

Theme 8: Resources in the Field

Participants spoke about three important aspects that are outcomes of this study. One is the need to educate parents about SM. The second is to continue to teach other professionals how to work with children with SM. The third one related to their wish to be given supervision by a professional who knows how to work with children with SM, and who has a background in expressive arts therapy. Teachers in the current study said that up until the time they participated in this research study, they did not know anybody from the field of expressive arts who knew how to work with children diagnosed with SM. A surprising finding was that expressive arts professionals taking part in this research said that they wish for supervision by a professional from the expressive arts field who can supply them with working methods for SM. There is a growing need for supervision for teachers and other professionals to obtain success in working with children diagnosed with SM.

Israeli Culture

Israel's culture is informal, Israelis communicate differently then Americans do (Lautmen, 2018).

According to Lautmen (2018), Israelis are usually informal and straightforward. These characteristics are also visible in Hebrew, the language spoken in Israel. Different cultures express themselves in different ways and that can affect communication style (Lautmen, 2018). A straightforward style of communication includes being direct and clear, using a candid style of speech, rapid shifts from one subject to the other, and sometimes crossing of personal boundaries (Lautmen, 2018). In the United States, a country that typically uses more diplomatic styles of speech and values tactfulness, communication style is different. Accordingly, the ways to communicate with children who are diagnosed with SM will be different, as well. This variation

in communication styles may have affected the workshop and results may have varied if this workshop would have been conducted in the USA.

The workshop in this research was mainly focused on educating the participants on changing their communication style. This was based on the "bridges of communication" concept (Hanan, 2019), that children with SM look up to their teachers and parents and learn their communication style. Once communication changes, the relationship and trust between these parties will begin to transform and the child will ultimately begin to speak in public. The emphasis here in this study was on advocating a straightforward and open communication style. Because cultural norms usually dictate the way we communicate with others, as does our language, this workshop would be administered differently in the U.S., where communication style is different.

Conclusion

Selective mutism is described as an ongoing failure to speak in specific social situations (American Psychiatric Association, 2022). This research study focused on the experience of professionals who work in the Israeli education system and treat and teach children diagnosed with SM. The study aimed to specifically explore that phenomenon from a professional's viewpoint because it has not been covered in the existing literature.

Thirteen participants took part in this art-based study. All were recruited through a Facebook advertisement asking them to take part in a professional workshop followed by an artistic experience that I facilitated. I was surprised at the interest from potential participants; recruitment was completed in one week. The overwhelming response indicates that the topic was relevant and needed, as was the support I provided to participants during this insightful process. At times, I feared the sessions might cross the delicate line from an art-based research experience

into supervision. However, I could sense and explicitly hear that this research was needed and chose to establish boundaries and keep wearing the researcher's hat.

The myriad of sensations that arose during this experience for both the participants and me were interesting. I sometimes felt a lack of confidence, especially when talking about the literature review associated with SM and hearing the participants respond that this was imperative because that they were not sufficiently educated on SM. As one participant said about taking part in this research experience, "We have won the jackpot." They also asked to continue to learn from my knowledge and were reluctant for the study to end.

Two important aspects of the emotional experience the participants shared were how isolated they felt and the responsibility they chose to take on when working with children diagnosed with SM in the Israeli education system. It seems that the education system does not supply professionals with knowledge on how to approach children with SM, which leaves them exposed and feeling unsupported in the classroom. It is essential to educate professionals on the existing literature and to assure them they are not alone but are part of a group. That was one of the factors that helped participants feel more validated and affirmed during the research. Another surprising and important finding was that the workshop as part of this study worked and is a breakthrough in helping professionals working with children with SM. Since a workshop is short-term and inexpensive to conduct, it can easily be implemented in schools across Israel and to professionals worldwide.

Contribution to Field of Expressive Arts

Because I am an art therapist, there was no other way for me to conduct this study than to use the expressive arts. Where words end, art can continue as another form of communication. When working with children with SM, one often can feel speechless. Art aided me to dive deeper

into the participants' and their students' and clients' shared experiences and shed light where there was darkness. Creating art helped me to stay connected to the feelings and emotions and to my own childhood memories so that I could speak up for the little girl that was inside me. I created art to help me explore my emotions. Creating art also helped the participants in this study to reconnect to their emotions in their work process with children with SM. Art is a universal language that can help students overcome anxiety related to SM and is a unique tool for working with SM. This is the reason it was so necessary and important to facilitate this workshop and to teach expressive arts therapist how to work in this method so that they could also facilitate similar workshops to help and educate other professionals, that do not have artistic background. Art therapists are thus uniquely capable of facilitating workshops and providing support to teachers and parents, and it is imperative that art therapists be at the forefront of helping to understand and treat SM.

Limitations

Although I was able to receive valuable information from most of the participants, I had difficulties communicating with some participants due to technical problems over the Zoom software. This limitation may have affected the overall communication in the research. For example, participants said they were afraid to miss out on important information due to internet problems. There were questions that they addressed to the researcher in private that the rest of the group could have learned from had they asked them during the group time. They chose to consult with the researcher outside of the group setting, which created differences in the level of knowledge because not all participants were exposed to the same information. The researcher

tried to confront this bias by sharing these questions with the group during the workshop sessions.

I am enthusiastic about treating SM. Therefore, another limitation is that there can be potential bias in the research study. I can be passionate when I discuss the phenomena, causing the participants to be more optimistic than is reasonable. This bias might have been better addressed if I would have employed a co –facilitator who is neutral, who would perhaps have provided a more objective perspective. This should be considered for future research.

Moreover, this research was conducted in Israel. As earlier discussed, Israel's culture can be informal in its norms, and communication is often straightforward, open, and direct. It may be the case that in other cultures where communication norms are more ambiguous and indirect, results of a similar study may be different.

Recommendations for Future Research

It is important for research in this field to continue and explore the different subsets of this phenomenon. More research is needed on how art therapy can supply children diagnosed with SM with the ability to increase their self-esteem by exploring non- verbal aspects of their being so that they can find words to describe how they feel.

It would be important to continue to educate professionals on working with children diagnosed with SM particularly in answering these questions. The professional workshop conducted in this study tried to answer these questions. Nevertheless, one workshop is a good start. Future research is needed to explore the common misconceptions of SM in order to provide a more guided workshop that is precisely developed.

It would also be interesting to examine other aspects that were revealed in this study, such as omitted body parts in drawings by children with SM, professional support systems, and

the special features that are seen in participants drawings, such as flower imagery and the bubble motif, and it would also be interesting to further explore them in another research and examine if they are also seen in children diagnosed with SM's art.

Further research is needed to establish the nature of the relationship between trauma and SM in order to understand whether or not a traumatic event could cause children diagnosed with SM to show typical SM behaviors. This could help professionals understand the different body mechanisms that are involved in trauma that could also be connected to SM and provide additional avenues for interventions. In addition, more research is needed on the etiology, causes and medical aspects of the disorder so that additional interventions, beyond workshops can be developed. This can be one time workshops for professionals working with children with SM discussing case studies and focusing the scope on ways that a professional can work facilitating art and art therapy that are important to help portray the unspoken emotions that a child with SM feels. Also conducting longer workshops that can help a professional to reconnect to their own emotions, including fears and implementing art as a way to research their own felt experience in working with children diagnosed with SM, might prove to be useful.

Final Thoughts

While I was facilitating this research study, it felt meaningful that the knowledge taught was important and relevant. There is a demand in the field for supervision and support and, by facilitating this study, I felt like I helped others find their own voice as I had found my own some time ago. At times, I was afraid that the participants would be bored with the content. I felt insecure and, due to technological difficulties, sometimes struggled to hear the Zoom recordings. I also did not like the sound of my own voice, which interestingly is common in children diagnosed with SM (Bar-Haim et al., 2014). But most importantly while conducting this research

I was able to provide closure to my own experiences as a young child, of not talking, I found my own voice and stepped out of my own bubble and doing so, I had the power to do so for others. I feel as through writing this dissertation I have grown mentally. I am not the same as I was. Being able to find my own voice enabled me to let go of the past and be at peace with it. Even through it hurts to remember who I used to be, it also supplies me with the ability to see into other's vulnerability, and to help them see into their own wounds.

This journey is not over for me. It is merely a beginning. What started for me as a dream more than 20 years ago is now shaping who I am becoming personally as well as professionally.

Working with children diagnosed with SM in the Israeli education system is a complex task. Often, teachers and expressive arts therapists in the schools are not provided the necessary education and support to work with this population. I feel it is imperative to continue to educate professionals to help them feel more grounded and to help raise their self-esteem as they fulfill their everyday tasks. I am happy to have developed a workshop that has shown preliminary results of helping professionals working to support children with SM and helped build a network of professionals with greater knowledge and resources, and hope to continue to spread this knowledge while developing a stronger understanding about the under- researched disorder.

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APPENDIX A

Institutional Review Board Approval

02138

29 Everett Street
Cambridge, MA

Tel 617 349 8234
Fax 617 349 8190
irb@lesley.edu

Institutional Review

DATE: 10/29/2020

To: Tal Hanan

From: Robyn Cruz and Ulas Kaplan, Co-Chairs, Lesley IRB

RE: IRB Number: 20/21-005

The application for the research project, “Exploring Israeli teachers’ knowledge, opinions, and experience on working with children diagnosed with selective mutism (SM) in the Israeli education system” provides a detailed description of the recruitment of participants, the method of the proposed research, the protection of participants' identities and the confidentiality of the data collected. The consent form is sufficient to ensure voluntary participation in the study and contains the appropriate contact information for the researcher and the IRB.

This application is approved for one calendar year from the date of approval.

You may conduct this project.

Date of approval of application: 10/28/2020

Investigators shall immediately suspend an inquiry if they observe an adverse change in the health or behavior of a subject that may be attributable to the research. They shall promptly report the circumstances to the IRB. They shall not resume the use of human subjects without the approval of the IRB.

APPENDIX B

Informed Consent Forms

29 Everett St., Cambridge, MA 02138

Informed Consent

You are invited to participate in the research project titled, “Exploring Israeli Teachers’ Knowledge, Opinions, and Experience on Working with Children Diagnosed with Selective Mutism (SM) in the Israeli Education System.” The intent of this research study is to understand the experience of teachers in an inclusive class in the Israeli education system who teach a student diagnosed with selective mutism (SM). A second goal is to expose the teachers to expressive therapies to broaden their knowledge about this treatment method so they will be motivated to refer their students for expressive arts therapy. Selective mutism is a situation provoked by anxiety in which a child has difficulty talking in social situations, such as talking with peers, teachers, and others, but may talk with their parents and at home.

Your participation will entail participation in three weekly Zoom group meetings. The first session will include a case study about working with a student diagnosed with SM using art therapy. In the two other meetings, you will take part in a group experience involving expressive art. Each meeting will last 90 minutes, and the study will take place over 3 weeks.

In the first meeting, you will be asked to introduce yourself to the other participants, followed by a didactic presentation of the theoretical knowledge about SM, such as disorder onset, prevalence, and types of treatment. The researcher also will present a case study of a 15-year-old boy who was diagnosed with SM. You will be asked what you think about teaching in an inclusive classroom.

In the second session, you will be asked to engage in artmaking. You will be asked about the difficulties or challenges in working with children with SM, how you can take care of yourself, and what kind of emotional resources it entails from you. Using printer-size paper and soft oil pastels mailed to you in advance of the session, you will be asked to think of the child with SM presented in the case study and to draw some marks or symbols on the paper. You will be asked to upload your art creations onto the Zoom chat-box, and we will discuss your creations on Zoom during the second session. The researcher will save the art creations on her computer for later use in the research study. This will be followed by a short group discussion about the experience you just had during the professional workshop in which you participated for the research.

The third session will be a follow-up session of 30- to 60-minutes. You will view a PowerPoint presentation in which your artistic creations will be presented and be asked to describe if anything changed in your professional experience working with children with SM. Each session will take place over two consecutive weeks; the follow-up session will be held 2 weeks after the second session. All sessions will be held over Zoom software. You will be asked to give your consent for the sessions to be recorded for analysis purpose.

In addition

You are free to choose not to participate in the research and to discontinue your participation in the research at any time without facing negative consequences.

The researcher will keep your identifying details confidential. Data collected will be coded with a pseudonym. The researcher will never reveal your identity, and only the researcher will have access to the data collected.

All your questions will be answered at any time. You are free to consult with anyone (e.g., friend, family) about your decision to participate in the research and/or to discontinue your participation.

Participation in this research poses minimal psychological risks. It is possible that you may encounter unpleasant feelings, thoughts, or physical sensations while engaging in the art or music experiences. To minimize potential risks, I will first ask for your agreement to any experiences taking place. Furthermore, it will be made clear that you may terminate your participation according to your own free will. This is to ensure that you will not be forced to engage in any art if there are any signs of discomfort. Furthermore, the researcher will provide participants with emotional support by taking breaks and allowing you to share your feelings. The researcher also will remind the participants that they have the option to withdraw from the study at any time. If you wish to withdraw from the study, all data related to you will be erased and discarded immediately. The researcher will adhere to ethical standards of clinical and research practice to maintain the safety of all participants.

If any problem in connection with the research arises, you can contact the researcher, Tal Hanan, at +972-54-744-4777 or by email at thanan@lesley.edu, or the Lesley University sponsoring faculty, Dr. Mitchell Kossak at 617-349-8167 or by email at mkossak@lesley.edu.

The researcher may present the outcomes of this study for academic purposes (articles, teaching, conference presentations, supervision, etc.)

I am 18 years of age or older. My consent to participate has been given of my own free will and I understand all that is stated above. I will receive a copy of this consent form.

Participant's signature	Date	Researcher's signature	Date

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairpersons at irb@lesley.edu

29 Everett St., Cambridge, MA 02138

Consent to Use and/or Display Art

CONSENT BETWEEN:

_____ and_____.

Researcher's Name Artist/Participant's Name

I, _____, agree to allow

Artist/participant's name Researcher's Name

to use and/or display and/or photograph my artwork, for the following purpose(s):

Reproduction and/or inclusion within the research currently being completed by the expressive arts therapy doctoral student.

Reproduction and/or presentation at a professional conference.

Reproduction, presentation, and/or inclusion within academic assignments including but not limited to a doctoral work, currently being completed by the expressive arts therapy doctoral student.

It is my understanding that neither my name, nor any identifying information will be revealed in any presentation or display of my artwork.

This consent to use or display my artwork may be revoked by me at any time by informing the researcher. I also understand I'll receive a copy of this consent form for my personal records.

Signed_____Date _____

I agree to keep your artwork safe, whether an original or reproduction, to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession. I agree to return your artwork immediately if you decide to withdraw your consent at any time. I agree to safeguard your confidentiality.

Signed _____ Date _____

Researcher's Signature

Tal Hanan, Atikva Street No. 17, Apt. 10, Ra'anana Israel

054-744-4777

טופס פנייה להשתתפות במחקר והסכמה מדעת

שלום רב,

אני מבקשת ממך להשתתף במחקר בנושא "חוויותיהם של מורים של ילדים עם אילמות סלקטיבית המשולבים במערכת החינוך בישראל", במסגרת דוקטורט שנלמד בתואר השלישי באוניברסיטת לסלי, בקיימברידג' מסצ'וסטס, ארה"ב.

השתתפותך במחקר עשויה לתרום בצורה משמעותית להבנת הנושא.

חשוב לנו להבהיר כי אינך חייב/ת להשתתף במחקר, ולאי הסכמה לא תהיה כל השלכה עליך ולא תפגע בך בכל דרך שהיא בהמשך.

במסגרת המחקר תתבקש/י ליצור לפי הנחיה ולענות על שאלות. משך ההשתתפות כשעה וחצי על פני שלושה מפגשים אשר יערכו ויוקלטו בתוכנת זום.

במחקר זה אין כל סיכון למצבך הפיזי או הנפשי. אם תרצה/תרצי בכך תוכל/י להפסיק את השתתפותך במחקר בכל שלב שהוא, מבלי שתהיה לכך כל השלכה או פגיעה בך בכל דרך שהיא בהמשך.

כל הנתונים המזהים במחקר ישמרו חסויים ולא יהיו זמינים לאף גורם מלבד צוות המחקר.

תודה מראש על שיתוף הפעולה.

בברכה,

טל חנן

- פרטי קשר של החוקרת לפניות:

1. שם: טל חנן דוא"ל: thanan@lesley.edu טלפון:0547444777

- **אישור השתתפות במחקר בנושא** "חוויותיהם של מורים של ילדים עם אילמות סלקטיבית המשולבים במערכת החינוך בישראל",

אני _____ מאשר/ת שקראתי את המידע שהוצג בפני ושהוסבר לי אישית על-ידי החוקרות, אשר התחייבה בפני בכתב, להבטיח סודיות בכל הנוגע לפרטיי האישיים וכל פרט אחר, שעלול לחשוף את זהותי.

הוסברה לי מטרת המחקר וחשיבותו, והוסבר לי כי במחקר זה לא כלול סיכון. הובהר לי כי ההשתתפות הנה מבחירה בלבד, ואם אסרב להשתתף לא תהיה לכך כל השלכה לגבי בעתיד. הובהר לי כי אני יכול/ה להפסיק את השתתפותי בכל שלב שהוא, ולא תהיה לכך כל השלכה לגבי בעתיד.

אני מסכים/ה להשתתף במחקר זה ומוכנ/ה שייעשה שימוש בראיונות ובציורים לצורכי מחקר בלבד.

תאריך: _____

APPENDIX C

Demographic Questionnaire

1. Age: what is your age?

_____

2. Gender: male/ female
3. What region of Israel were you born?

a. Central Israel
b. HaSharon area
c. North Israel
d. South Israel

4. What is your native tongue?

_____

5. What is your religious background?
6. At what school do you work? Secular / orthodox?
7. How many years of teaching experience do you have?
8. What kinds of experience do you have teaching children diagnosed with SM?

_____-

_____

_____

9. What is your opinion about teaching in an inclusive classroom?

_____

_____

_____

10. What are the three things you know about SM?

11. What are you hoping to achieve from participating in the workshop?

_____

שאלון דמוגרפי

אודה לך אם תקדיש/י את הזמן לענות על השאלות הבאות.

1. מה גילך?
2. מגדר: האם את/ה זכר/נקבה?
3. מהי שפת האם שלך?
4. מאיזה אזור בארץ את/ה?

1. מרכז
2. השרון
3. צפון
4. דרום

5. מהי שפת האם שלך?_____

6.כיצד את/ה מגדיר/ה את עצמך מבחינה דתית?

1.חילוני

2.דתי

7. באיזה מסגרת אתה עובד?

1.ממלכתי

2.ממלכתי דתי

8.מהם שנות הנסיון שלך בהוראה?

9. מהו הניסיון שלך בעבודה עם ילדים עם אילמות סלקטיבית?

_____

_____

_____

10.מה הניסיון שלך בעבודה עם אילמות סלקטיבית?

_____

11.מה הניסיון שלך בעבודה עם כיתת שילוב? או ילדים דפרנציאלים?

_____

_____

12.מהם שלושת הדברים שאת/ה יודע/ת על אילמות סלקטיבית?

1._____

2._____

3._____

13. מה את/ה מקווה ללמוד בסדנא?

_____

_____

_____

APPENDIX D

The Case Study of D': A Child With Selective Mutism

A young child, D', gets up in the morning looking for his dad. D' loves going to nursery school. He adores his mom and dad. He is certain his dad can do anything. Today, Daddy did not return from work, and Mommy seems worried. She is talking on the phone, saying that Daddy is not feeling well and won't be back home for quite some time.

"Why doesn't anyone let me know what is going on?" the child asks himself.

Twelve years later, D' is a grown boy. He is 15 years old and hardly speaks at school or with his teachers. He has only one friend in whom to confide. Yet, D' speaks freely at home.

When I first started working at the school where I met D', he was referred to be treated with art therapy (AT) due to a diagnosis of selective mutism (SM), a psychiatric disorder connected to anxiety disorders. In SM, the child does not speak in the education system but does speak freely at home. It was once assumed that the child actively chose not to speak; but today, we know this is not true.

What Do We Do in AT When a Client Does Not Speak?

Words can be redundant. We often engage in speaking when we try to describe how we feel, but what is the case when we don't know how we feel, when we are blocked emotionally? In the case of a traumatic event, our brain codes the information from the event in images in a nonverbal way. D's father suffered from a nervous breakdown when D' was a child. That was about the time when D' became speechless and silent at school. In therapy, D's mission was to express himself creatively without using the spoken word. Only then was he able to find words to express how he felt.

So, Does Creativity Promote Recovery?

Yes, it can promote recovery. Art therapy can help clients express their feelings in a nonverbal way. D' was treated with AT over 1 year, divided into three periods:

In Period 1, which lasted 2 months, D' felt very anxious and embarrassed. He was having a hard time creating and needed my intervention. In Period 2, which lasted 6 months, D' began working with wood. He crafted an old man sitting on a bench watching his life go by. In Period 3, which lasted 4 months, D' began writing his story, how he felt when he was younger and had no words to describe how he felt.

How Does Creativity and AT Help to Engage in a Traumatic Experience?

Very often, the artists' personal experiences are portrayed in their artistic creations. For example, Frida Kahlo's illness and the medical procedures she went through are presented in many of her creations. The same happened for D' in therapy. D' slowly started to realize how he felt as a child as he progressed with his artistic expressions. Gradually, he started feeling better.

Creativity is connected to parts of the brain related to cognition, language, planning, and emotions. So, it is reasonable that when D' was engaged in artmaking, his brain started to work differently and allowed spoken words to be heard.

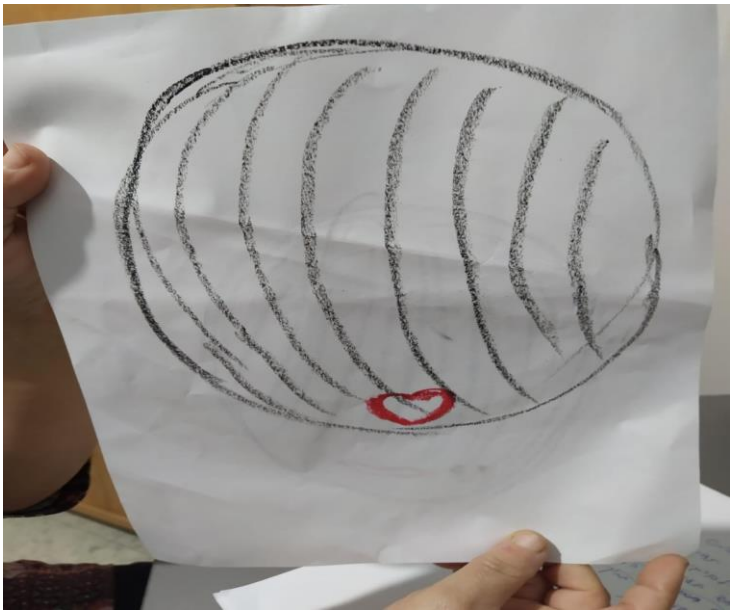
The original Hebrew article from Haaretz newspaper can be accessed through this link here:

https://www.haaretz.co.il/wellbeing/health-blogs/kids/eitangilormiller/BLOG-1.4841873#commentsSection

Appendix E

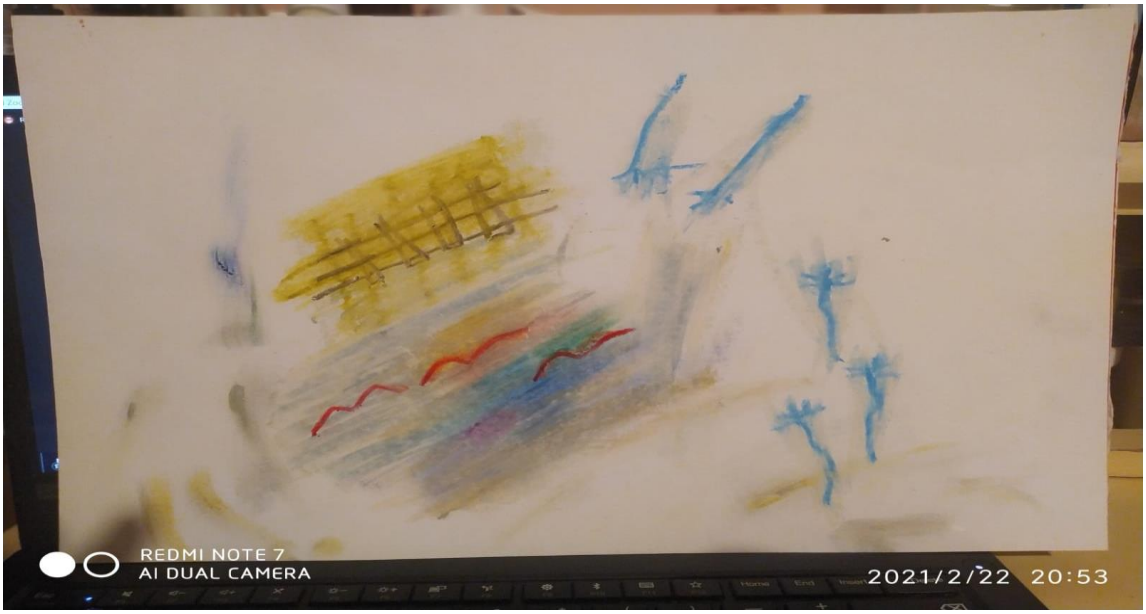
Participants' Artwork

Emily's Artwork



Claire's Artwork

Maya's Artwork



Nina's Artwork

Michele's Artwork

Britt's Artwork

Moly's Artwork

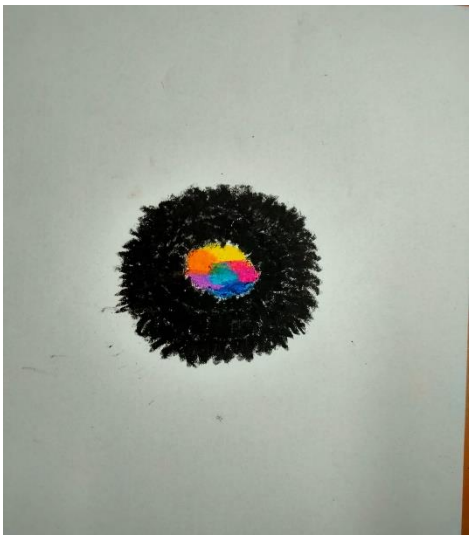
Oliver's Artwork

Researcher's Response

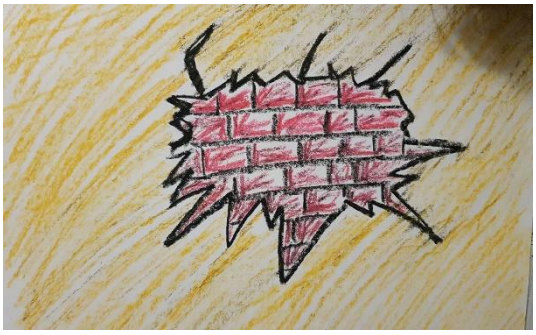
Irene's Artwork

Madeline's Artwork

Meggie's Artwork



Anna's First Artwork



Anna's Second Artwork

Mary's Artwork