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## Expressive Arts Therapy and Therapeutic Relationship with a Child with Selective Mutism: Development of a Method

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Expressive Arts Therapy and Therapeutic Relationship with a Child with Selective Mutism:

Development of a Method

Capstone Thesis

Lesley University

May 21, 2022

Sophie McLaughlin

Specialization: Expressive Arts Therapy

Thesis Instructor: Lee Ann Thill, PhD, ATR-BC, LPC

***THESIS APPROVAL FORM***

**Lesley University  
Graduate School of Arts & Social Sciences  
Expressive Therapies Division  
Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA**

**Student's Name: Sophia McLaughlin**

**Type of Project: Thesis**

**Title: Expressive Arts Therapy and Therapeutic Relationship with a Child with Selective Mutism: Development of a Method**

**Date of Graduation: May 21, 2022**

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

**Thesis Advisor: Lee Ann Thill, PhD, LPC, ATR-BC**

## **Abstract**

Selective mutism (SM) is a rare, yet severe, anxiety disorder that affects primarily children. SM is characterized by a failure to speak in certain social situations (i.e., school), despite being able to speak comfortably in other settings (i.e., home). There is an ongoing effort to understand this diagnosis and best treatments are being debated. The therapeutic relationship is argued to be one of the greatest predictors of positive treatment outcomes, regardless of the diagnosis or treatment method; however, the failure to speak that characterizes SM impacts the development of a therapeutic relationship and that alliance cannot be formed using typical methods. Despite its significance, this topic has not been explored in the current literature. Expressive arts therapy offers many modes of nonverbal expression that could be beneficial to the development of therapeutic relationships with this population. Using the expressive therapies continuum as a framework for therapeutic activities, a method was designed to develop a therapeutic relationship with an 11-year-old girl with SM. Implemented in a therapeutic school setting, the method was conducted over six 30-minute sessions. Observations of the client and therapist suggest that expressive arts therapy may be beneficial in the development of a therapeutic relationship with a child with SM. Further research on this topic could improve treatment outcomes for children with SM.

*Keywords:* selective mutism; expressive arts therapy; expressive therapies; therapeutic relationship; children

*The author identifies as a cisgender, white woman from Boston, Massachusetts, with Latinx and European ancestry.*

## **Introduction**

Selective mutism (SM) is a childhood disorder that the medical and mental health community is still working to comprehend. A diagnosis of SM “is characterized by a consistent lack of speech in specific social situations in which there is an expectation for speaking (e.g., at school), despite speaking freely in other situations (e.g., at home with close family members)” (Oerbeck et al., 2020, pp.754-755). Selective mutism is a rare yet serious diagnosis that occurs mostly in childhood. Children with SM commonly experience severe social and academic impairment that may have long-lasting effects on their functioning (American Psychiatric Association, 2013). Despite its grievous impact, SM remains under-researched.

While further research on different treatment modalities for SM is necessary, the lack of literature on building therapeutic relationships with this population needs to be addressed. The therapeutic relationship, which can be defined as the alliance co-created between the therapist and client, is built on the following three constructs: collaboration, bond or attachment formation, and the creation of common goals. Research has found that the therapeutic relationship is a predictor of change for the client, regardless of diagnosis, population, and treatment methodology (Fernandes, 2022; Hartley et al., 2022; Norcross, 2010). The formation of the therapeutic relationship typically requires language-based communication by both participants; therefore, building this relationship with a client with SM requires different tools and strategies than those typically needed to form such an alliance. Literature on this topic will enrich any treatment method and could lead to improved treatment outcomes for children with SM.

There is potential in the use of expressive arts therapy (ExAT) with this population, as it offers various modes of nonverbal expression. ExAT is an intermodal approach that is defined by

its use of visual arts, dance and movement, drama, poetry and creative writing, and music in the context of health care, counseling, or psychotherapy (Malchiodi, 2005). ExAT's application to the SM population is underexplored in the current body of research; however, several case studies highlight its potential. This thesis aims to explore the use of expressive arts therapy as a tool for therapeutic relationship building with clients with selective mutism, a topic that is under-researched in the current literature.

A method was developed to begin the exploration of this topic. A series of ExAT interventions were used with an 11-year-old girl with SM, with a focus on the cultivation of the therapeutic relationship. Implemented in a small therapeutic school in a suburb of a northeastern city, the research took place over six 30-minute sessions. Observations of the therapeutic relationship and the client's affect, mood, and behavior were made and collected as data. This research will begin to explore the potential benefits of expressive arts therapy for individuals with SM, and its effects on the therapeutic relationship with this population.

### **Literature Review**

This review examines the current literature on selective mutism, expressive therapies, and the therapeutic relationship. The literature review informed the development and implementation of the method described above.

### **Selective Mutism**

The diagnostic criteria for selective mutism include "consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations" (APA, 2013, p.195). This disturbance must persist for a minimum of one month, not limited to the first month of school, and interfere with communication, socializing, and/or school or work-related achievement in order to meet the diagnostic criteria.

When making a selective mutism diagnosis, it is important to determine that the lack of speech is not better accounted for by limited knowledge and comfortability with the language (APA, 2013). There are several associated features that support a SM diagnosis including “excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior” (APA, 2013, p.195).

Selective mutism is a rare disorder, occurring in 0.03% to 1% of children. The prevalence of this disorder does not appear to vary by sex, race, or ethnicity. It does, however, vary by age, as it is more likely to develop in young children than in adults or adolescents (APA, 2013). SM typically develops before age five, however, it often does not receive clinical attention until entry into school, when performative and social expectations increase. The persistence of this disorder is highly variable, and because of this, SM’s longitudinal course remains unknown. It is common for individuals to “outgrow” selective mutism; however, in many cases where there is comorbidity, symptoms of social anxiety disorder remain after the SM subsides (APA, 2013).

### ***Classification***

It was not until 2013 that selective mutism was recognized as an anxiety disorder with the publication of the DSM-5 (APA, 2013). Prior to 2013, SM was classified as an “Other Disorder of Infancy, Childhood, and Adolescence,” highlighting the lack of understanding about the disorder (American Psychiatric Association, 1994). At one point, SM was argued to be a specific phobia of expressive speech (Omdal & Galloway, 2008). Fortunately, the reclassification with the DSM-5 provided some clarity around the mysterious disorder; however, there is an astounding amount of information that remains unknown about selective mutism.

Although SM was reclassified as an anxiety disorder, the fears behind the anxiety related to SM remain unclear due to a lack of research. In fact, “SM is the only anxiety disorder in the

DSM-5 for which concrete fears have not been specified so far. This leaves the cause and, therefore, the target of particularly cognitive interventions of SM symptomatology open” (Vogel et al., 2019, p.1169). Attempting to address this unknown, Vogel et al. (2019) compared the responses of an online survey on potential fear-related cognitions of children with SM, children with social phobia (SP), and typically developing children (TD). The responses from children with SM and children with SP were consistent with one another; the only difference found was a fear of having a “funny-sounding voice” from some of the children with SM. The extreme similarities found suggest a connection between the two diagnoses (Vogel et al., 2019). This study provides valuable insight that gives reason to believe SM and SP may be closely linked.

### ***Differential Diagnoses and Comorbidities***

The DSM-5 notes several differential diagnoses, including anxiety, communication, neurodevelopmental, and psychotic disorders. The main distinguishing factor for SM is the ability to speak in some situations (typically at home) (APA, 2013). These differential diagnoses have also been observed as comorbid conditions, especially anxiety and neurodevelopmental disorders (APA, 2013; Oerbeck et al., 2018). One study that evaluated 54 children with SM found that 74.1% met the criteria for another anxiety disorder and 68.5% met the criteria for a developmental disorder. These numbers are significant when compared to the control group of 108 children, for which the prevalence of anxiety disorders was found in 7.4% of the group and the prevalence of developmental disorders was found in 13.0% (Kristensen, 2000). Another study of 97 individuals with SM found that 63% had a dual diagnosis with autism spectrum disorder (ASD) (Steffenburg, et al., 2018). According to the DSM-5, the most common comorbid condition with SM is social anxiety disorder (APA, 2013).

### ***Prognostic and Risk Factors***

Researchers have not determined if there are any genetic factors related to SM. SM has occasionally been found to run in families. In one study, familial SM was found in eleven of the 30 participating families (Oerbeck et al., 2018). The notable overlap of SM and social anxiety disorder suggests that these conditions may share genetic factors, giving further reason to believe that there is a genetic component involved in SM (APA, 2013). There are several studies that attempted to show that prognostic factors could be found in family history: “A family history study of 38 children with SM reported a clear excess of the personality trait of taciturnity in 1st-, 2nd-, and 3rd-degree relatives” (Oerbeck et al., 2018, p. 997). Furthermore, excessive taciturnity in the family has also been found to be a severity indicator of SM, as has immigrant status (Steinhausen et al., 2006). Also of importance, bilingualism, which is considered to be a vulnerability factor for SM, has been an overrepresented quality in the participants of several studies on SM; however, it does not appear to impact treatment outcome negatively (Oerbeck et al., 2018).

### ***Cognitive Behavioral Therapy (CBT) Treatment***

There has been a consensus in the field that CBT is the recommended treatment for SM (Oerbeck et al., 2018). This may be because CBT is the treatment that has been most researched with this disorder. Even so, several studies have found CBT to be effective in symptom improvement for SM, both in group and individual treatment models (Oerbeck et al., 2018; Sharkey et al., 2008; Vecchio & Kearney, 2009). There are crucial flaws in the current body of research on the use of CBT with SM. The efficacy of this treatment remains inconclusive as “many studies have only described the effects of treatment in a single case or just a few children with SM, which of course hinders the generalization to other youngsters suffering from the

condition” (Muris & Ollendick, 2021, p.161). Additionally, there is a lack of long-term outcome studies.

One study attempted to address the flaws in the literature on this topic. Researchers in a 2018 Norwegian study developed a randomized controlled treatment study that included data from one-year and five-year follow-ups, on the efficacy of school-based CBT treatment for children with SM (Oerbeck et al., 2018). The study used a sample of 32 children with SM between the ages of three and nine at inclusion, all of whom had participated in the treatment program. The CBT treatment was limited to a maximum of six months due to the feasibility of the study. Two of the 32 families did not respond to the 5-year follow-up invitation and thus their data was not included in those results.

The goal of the study was to track the long-term outcome of school-based CBT treatment for SM. Several outcome measures were used, including the diagnostic status of the child and responses from teacher- and parent-rated selective mutism questionnaires. At the 5-year follow-up, 70% of the children spoke freely in school and were considered to be in full remission, as they no longer met the diagnostic criteria for SM. Seventeen percent of the children spoke freely in some, but not all, settings at school and were considered to be in partial remission. The remaining 13% of the children continued to meet the diagnostic criteria for SM and maintained their diagnosis. Age was found to be an outcome indicator, with more significant improvement in younger children. Baseline severity, as assessed by the parent- and teacher-rated questionnaires, was also determined to be an outcome indicator, with greater severity causing a negative impact on the outcome (Oerbeck et al., 2018).

Some limitations of the research should be noted. Although reasonably large within the context of SM research, the sample size was limited. Additionally, the loss of two children for

the 5-year follow-up may have skewed some of the data. Despite these limitations, this study shows promising results on the long-term outcome of CBT treatment for children with SM.

There are some practitioners who argue against the use of CBT for children with SM. Psychologist Dr. Kurtz (2017) offered the opinion that for children with anxiety disorders, including SM, CBT treatments are contraindicated. Kurtz explained that many children, especially those under the age of seven, “cannot access the meta-cognitive skills required for cognitive restructuring, for example. SM further complicates the picture such that even if they could conceptualize the irrational thoughts, they cannot articulate them due to the SM” (2017, n.p.). Kurtz’s opinion has not been popularized; however, it offers a perspective that is worth further consideration and research. Relevant to the current research, a more general critique of CBT for the treatment of any disorder is that it does not provide adequate opportunities for the development of the therapeutic relationship (Fernandes, 2022).

### **Expressive Therapies**

Expressive therapies, which can be defined as “the use of art, music, dance/movement, drama, poetry/creative writing, play, and sandtray within the context of psychotherapy, counseling, rehabilitation, or health care” offer a treatment option that could be used either in conjunction with CBT or as an alternative therapy (Malchiodi, 2005, p.2). Malchiodi (2005) argued that expressive therapies create space for clients to explore issues that may not be tolerated in verbal form, and there is a “belief that bringing these issues to light will lessen the need to utilize mute behavior” (Fernandez et al., 2014, p. 21). Though there is not extensive research on the use of expressive therapies for SM treatment, several case studies on the topic have been published with promising results.

Under the umbrella of expressive therapies, there are unique disciplines such as music therapy, dance/movement therapy, art therapy, and drama therapy that involve the use of a single artistic modality. Alternatively, expressive arts therapy (ExAT), also known as multimodal expressive therapy, creative arts therapy, intermodal expressive therapy, or integrated arts therapy, is an intermodal approach. As its own treatment modality, ExAT is rooted in the idea that the arts are interrelated. ExAT uses an integrated approach with a variety of arts modalities to foster growth and healing (Estrella, 2005). This multimodal approach can take on several forms, “at times working with the arts in sequence, at other times using the arts simultaneously, and at still other times carefully transitioning from one art form to another within the therapeutic encounter” (Estrella, 2005, p.183). ExAT could be a valuable approach for individuals with SM as its multimodal application offers many different outlets for nonverbal expression.

### ***Expressive Therapies Continuum***

One tool available to expressive therapists is the expressive therapies continuum (ETC). A framework and theory created by psychologist and art therapist, Hinz (2020), the ETC “represents a means to classify how clients interact with art media or other experiential activities in order to process information and form images,” and creates a framework for the “organization of assessment information, the formulation of treatment goals, and the planning of art therapy interventions” (p.4). Organized in a developmental hierarchy, the ETC breaks the creative process into the following four levels of increasing complexity:

1. Kinesthetic/Sensory Level
2. Perceptual/Affective Level
3. Cognitive/Symbolic Level
4. Creative Level

The first three levels are made up of two complementary elements, each representing the “two ends of a continuum of information processing. The extreme ends of each level represent possible pathological variations in visual expression on that level” (Hinz, 2020, p. 4). The creative level, which ranks highest in the developmental hierarchy, can represent two things: the effective integration of components or “optimal functioning” (Hinz, 2020, p.4). Reaching the creative level is not the goal of expressive therapies work as each level offers its own unique properties and uses.

**Kinesthetic/Sensory Level.** Ranked in the first level of the developmental hierarchy, the kinesthetic/sensory level represents information processing at its earliest stage. Based on the primary way infants process their environment, no words are required to process or produce art at this level. Information is gathered through the senses, one's own body movement, and the internal and external sensations in the body (Hinz, 2020).

**Perceptual/Affective Level.** The next developmental level may or may not require language. On the perceptual side of the continuum, images begin to take form, often with a focus on the visual elements of expression. The attention on form is replaced by raw emotional processing on the affective side, commonly expressed through color versus shape (Hinz, 2020).

**Cognitive/Symbolic Level.** The third level of the ETC is more nuanced and advanced, as planning, cognition and intuition are necessary at this stage. Verbal language is often needed “to gather meaning about the complex cognitive operations or the multidimensional symbols involved on this level” (Hinz, 2020, p.5).

**Creative Level.** The creative level can be reached with any single component or level of the ETC, when “optimal functioning” is met. Alternatively, it may be reached when all six

components are integrated effectively. Thus, experiences at this level may be complex or simple. (Hinz, 2020).

The ETC provides therapists with a deeper understanding of the unique properties of art materials and modalities, a framework for their uses in therapy, and a tool to assess their clients using the arts (Hinz, 2020). Its use in therapy has been supported by research. Ziff et al. (2014) found that the ETC “is a valuable framework for supporting groups of children in kinesthetic, affective, and cognitive ways” (p.107). The ETC was also found to be an effective assessment tool in the treatment of a child with SM (Fernandez, et al., 2014).

### ***Expressive Therapies and Selective Mutism***

Expressive therapies could be a valuable treatment method for selective mutism as it offers multiple modes of nonverbal expression. Some research has been done on this topic however it is limited to small-scale case studies, thus preventing the findings from being applicable to the broader population of individuals with SM. Even so, recent case studies have shown promising results and should inspire further research on this application.

Oon (2010) used drama therapy (DT) as a mechanism to enhance the evidence-based behavioral interventions commonly used to treat SM. The case study, which featured a five-year-old girl with SM, attempted to determine if the use of three drama therapy elements — play space, role-playing, and dramatic projection — would evoke therapeutic changes, such as lessened anxiety and increased vocalization and speech, in the client. The researcher saw the client for 18 sessions over the course of five months.

The first element of DT used in this study was the play space, a metaphorical space to which the client was invited, "where everything is play. This is an area set apart from the everyday world. In this space, a client adopts a playful and experimental attitude towards himself

or his life experiences” (Oon, 2010, p. 218). The next element, role-playing, is both a tool for exploring inner issues through projection and for exploring new sides of oneself. Dramatic projection is the act of externalizing inner conflicts through projection onto materials or into enactments, “protecting the client from feelings of shame or guilt that may arise from immediate self-disclosure” (Oon, 2010, p. 218). These artistic processes were combined with the evidence-based SM intervention of behavioral skill shaping, “breaking down the target behaviour... into a series of steps, and then reinforcing the child to attain each step of the series” (Oon, 2010, p. 219).

The data was based on the observations made by the therapist over the course of the 18 sessions, along with observations made by the client’s schoolteacher over the five months that the research was being conducted, as well as one-year post-study observations. The client’s vocalization and speech in the sessions increased over the five months, with spontaneous conversations between client and therapist by the end of the 18 sessions. The teacher reported increased speech in front of peers in class by session 12, and by the one-year follow-up, the client was described as a talkative student (Oon, 2010). This study is limited by its single participant; however, it demonstrated drama therapy’s potential with working with children with SM.

In another case study, Hunt (2020) explored the use of music therapy with a child with selective mutism. In this study of a 10-year-old girl with SM, Hunt used music therapy with peer inclusion to support goals of participation, listening, and decision-making. The study took place in a “mainstream” school in New Zealand where the child was in a class with 26 other students. The treatment model consisted of 24 music therapy sessions. These sessions began as individual therapy, with the music therapist and the child. The child’s school aid attended the first ten

sessions for support. To encourage the development of peer relationships and decrease dependence on the school aid, peers were included in the music therapy, beginning with the sixth session. One peer joined per session, but peers rotated, some returning for several sessions.

The music therapy sessions were designed with structure, familiarity, and repetition to increase the child's comfortability. Although the study was not described to be intermodal, the researcher did use dance and movement, synchronously with music, to engage the child. Musical games were also used in session as they supported peer interaction and social engagement. Additionally, there was a focus on "creating a safe space, developing a strong therapeutic relationship and use of a no-pressure approach [which] echo findings in previous music therapy studies on SM" (Hunt, 2020, p.155).

Progress was tracked through observations of the child, both in the music therapy sessions and in the classroom. At the end of the 24 sessions, a reduction of the child's anxiety in the classroom was found, along with an increased sense of belonging and the development of positive peer relationships. Peer inclusion in the music therapy sessions was paramount to these outcomes: "Peers formed a bridge between the music therapy room and the classroom, allowing improvements in one to generalise to the other" (Hunt, 2020, p.141). The author noted their own professional development as a limitation because they were in their final year of training for a master's in music therapy at the time the research was conducted.

Only one case study was found to examine an intermodal, expressive arts therapy approach with a child with SM. Fernandez et al. (2014) used the expressive therapies continuum (ETC) as an assessment tool for ExAT interventions in the treatment of SM in a 10-year-old boy. The authors discuss the different creative modalities and arts processes used in the intervention with the client, using the ETC to understand the client's comfort level and ability to engage

(Fernandez et al., 2014). The authors did not report the length of treatment and number of sessions conducted with the client.

The researchers assessed that the client was uncomfortable in the higher levels of the ETC when they found him to be overwhelmed and uninterested in the art materials presented to him. They shifted their method to begin on the lower end of the ETC, using structured games that tap into the kinesthetic/sensory level (Fernandez et al., 2014). This entry made the client comfortable enough to engage with internal stimuli and emotions on the perceptual/affective level, through the sculpting of clay. In later sessions, the client's creative process reached the cognitive/symbolic level, as he began creating characters and stories with clay and toys (Fernandez et al., 2014). Researchers found "it was evident that the use of art and expressive therapies enabled Marco to break down his defenses, establish rapport with the therapist, reduce his anxiety in the therapeutic setting, and expand the communication process," and the client became more verbal with each session. Increased speech was found outside the sessions, as well, and the parents terminated treatment once the child began inviting classmates over to his house (Fernandez et al., 2014, p.29).

The research in these three studies is limited by the single-client case study method, making it difficult to transfer findings to the general SM population. As explained by Oon, "the rarity of this condition explains the challenge in conducting a large-scale study to understand its etiology and determine evidence-based treatment approaches" (2010, p.216). Nonetheless, each study provides promising results and should encourage further research on the topic.

### **The Therapeutic Relationship**

The therapeutic relationship is universally valuable to the outcomes of any therapeutic treatment. Also referred to as the therapeutic alliance, it can be defined as the alliance co-created

between the therapist and client. The therapeutic relationship has been argued to be one of the greatest predictors of positive treatment outcome, regardless of the therapists' orientation, approach, or intervention used (Fernandes, 2022; Hartley et al., 2022; Norcross, 2010). There is substantial research to support this claim (Ardito & Rabellino, 2011; Fernandes, 2022; Karver et al., 2006).

One meta-analysis reviewed 49 youth treatment studies to examine the therapeutic relationship and how, if at all, it influences treatment outcome (Karver et al., 2006). The meta-analysis confirmed that the therapeutic relationship did have a positive effect on treatment outcomes, and more specifically which constructs related to the therapeutic relationship were the most influential. Results showed that certain traits of the therapist were stronger predictors of positive outcomes than others: the therapist's direct influence skills and interpersonal skills were found to have the strongest relationship to treatment outcome. The client's role in the therapeutic relationship was also found to be influential in the treatment outcomes in the meta-analysis, as both the youth client and parents' willingness to participate in treatment were determined to be treatment outcome predictors (Karver et al., 2006). This large meta-analysis shows promising results that support the idea that the therapeutic relationship is one of the strongest predictors of treatment outcomes for youth.

Experts have distinguished three constructs necessary in the foundation of the therapeutic relationship: collaboration, bond or attachment formation, and common goals (Ardito & Rabellino, 2011; Bordin, 1979; Johnson & Wright, 2002). Collaboration refers to the idea that client and therapist must work together in the pacing of and engagement in activities used in therapy. The bond or attachment formed between client and therapist includes qualities of trust, caring, and respect in a positive therapeutic relationship. Lastly, common goals for treatment

should be decided by therapist and client together, and there must be a shared investment in the achievement of these goals (Bordin, 1979; Johnson & Wright, 2002). These three constructs typically require speech by both the therapist and client. The current literature does not address how this foundation can be achieved when working with clients with SM.

## **Summary**

Selective mutism is a rare disorder that remains somewhat mysterious. There are ongoing debates around the cause, classification, comorbidities, and treatment of SM. Although, there has been a consensus in the field that CBT is the recommended treatment for SM, this may be because CBT is the treatment that has been most researched with this disorder (Oerbeck et al., 2018). There are some valuable critiques about this treatment method for SM (Fernandes, 2022; Kuntz, 2017) and there is a need for research on alternative treatments. The therapeutic relationship should be considered a critical aspect in the treatment of SM as it has been argued to be one of the greatest predictors of positive treatment outcome, regardless of the diagnosis or the therapists' orientation, approach, or intervention used (Fernandes, 2022; Hartley et al., 2022; Norcross, 2010). The expressive therapies are a potential treatment option that could be used in addition to or as an alternative to CBT treatment for SM. The numerous nonverbal modes of expression offered by expressive arts therapy may be beneficial to clients with SM. With ExAT, the therapeutic relationship is formed "by engaging creative resources through spontaneity, heightened sensitivity to inner states (and outer observations), deep connectivity to self and other, and awareness of energetic and embodied shifts in consciousness" (Kossak, 2021, p.47). This unique approach to the development of the therapeutic relationship, which can easily adapt to a client's failure to speak, may be particularly advantageous for this population.

## **Methods**

### **Setting**

The method was carried out in a therapeutic elementary school in a suburb of a major Northeastern city in the United States. The school served children ages 3 to 12 years old, primarily Caucasian and middle to upper-middle class, with a variety of emotional and neurological difficulties. One student was selected to participate in this research. The participant was the only student enrolled in the school with a selective mutism diagnosis, highlighting the rarity of the condition and limiting the number of qualified participants.

### **Participant**

Isabella (pseudonym) was an 11-year-old girl in the fifth grade. She was Caucasian and Hispanic, with a father who immigrated to the United States from Mexico in adulthood, and a mother who was born and raised in the United States. Isabella was bilingual and spoke both English and Spanish fluently. The family was in the middle class and resided in a single-family home in a neighboring suburb. The research was conducted during Isabella's first year at the therapeutic school. She arrived at the school with the diagnoses of selective mutism, autism spectrum disorder (ASD), and generalized anxiety disorder. Her current treatment team was determining if ASD was an appropriate diagnosis at the time of this research.

Isabella did not speak to anyone outside of her family circle— her immediate family and a few select extended family members. Isabella did not speak in the presence of anyone outside of that circle, in or outside of the home; however, when alone with her family circle, she spoke freely at an age-appropriate level. In addition to her selective mutism, it was observed that Isabella had clinically significant anxiety and cognitive rigidity.

Isabella and I had an existing relationship prior to the start of this research. I was part of the therapeutic teaching team in Isabella's classroom, both before and during research, as a clinical intern at the school. Prior to the development of this method, I had only seen Isabella in group settings. This research was the beginning of our individualized, therapeutic relationship.

## **Procedure**

The method used was a series of expressive arts therapy experientials designed to develop a therapeutic relationship between the client and myself. The interventions were conducted in weekly, 30-minute sessions, over 6 weeks. Each session occurred at the therapeutic school during school hours.

The Expressive Therapies Continuum (ETC) provided structure for designing expressive arts therapy interventions for this client. The developmental hierarchy of the ETC created the framework for the method and the first three levels of the continuum were used. The kinesthetic/sensory level, the earliest developmental stage of the ETC, was a natural starting place for the client. From there, the method progressed through the ETC following the developmental hierarchy, with two sessions dedicated to each level.

Isabella, in our relationship and at school, was nonverbal. The kinesthetic/sensory level does not require any verbal language, which made it a suitable place for our therapeutic relationship to begin. Since language was not an available tool, working at this level allowed us to connect and attune with one another through our senses and movements. The intervention used at this level was mirroring, a dance/movement therapy technique where the client and therapist face one another, one acting as a mirror to the other as they copy and reflect their movements, postures, and expressions. This process builds embodied empathy and emotional understanding of one another, creating space for the formation of a safe relationship (Baron-

Cohen & Wheelwright, 2004; Engelhard & Vulcan, 2021). Scarves were used as a prop during this activity to expand and inspire movement. With the goal of deepening this connection and engaging more of the senses, musical mirroring was also used, where the client and therapist mirrored each other's musical improvisations using hand percussion instruments.

Two interventions were implemented at the perceptual/affective level in the following two sessions, where form and emotion were explored. The internal weather report, a visual art directive, invited the participant to choose a type of weather (i.e., sunny, thunderstorm, tornado, etc.) that fit how she was feeling, and draw a visual representation of that. The drawing acted as an entry to discuss her emotions with the therapist. The second intervention used was a drum conversation, where the therapist and client had a conversation using drumming rhythms instead of words. Different from musical mirroring where the client and therapist attempt to copy one another, the drum conversation asked the participant to express how she felt through musical improvisation and to perceive emotions from the musical improvisation of the therapist.

The last two sessions focused on the cognitive/symbolic level of the ETC. The intervention used was storytelling through imaginative play: the therapist narrated a story based on the enactments of the client. This was a collaborative storytelling technique that required the client to think of symbolic movements to portray her ideas nonverbally. It required attunement between client and therapist so that both were in agreement on the narrative of the story.

### **Data Collection**

Progress notes, including my observations of the client, myself, and our relationship were kept as data. I observed the client for changes, or lack thereof, in affect, mood, ability to engage, and behavior. Additionally, I observed the emotions and thoughts evoked in myself during a session, as well as the progression of our therapeutic relationship. Progress notes were completed

within 24 hours of each session and reviewed for connections to the three essential constructions of a therapeutic relationship— collaboration, attachment/bond, and common goals— at the end of the six weeks.

## **Results**

The data collected over six sessions showed evidence that expressive arts therapy techniques may have benefitted the development of therapeutic relationship with this child with selective mutism. The results describe the observations from each level of the ETC accessed in the method and connections are made to the three essential constructs for a positive therapeutic relationship: collaboration, attachment/bond, and common goals.

### **Kinesthetic/Sensory Level (Sessions 1-2)**

Isabella entered the first session with a flat affect. Her body movements were rigid, and her eye contact was inconsistent, fluctuating between normal and avoidant. She appeared anxious with an extremely slumped, tense posture and hands in fists. Her behavior was cooperative and withdrawn; she complied with all directions and invitations but did not initiate any interpersonal interactions. The activity of mirroring was introduced, and I invited Isabella to move how she would like, explaining that I would mirror her movements. She began with slow, restricted movements while her affect remained flat. In a matter of a couple of minutes, her posture relaxed some, though still tense, her affect brightened some, though still constricted, and the pace and complexity of her movements increased. I felt as though she was trying to make the movements hard for me to follow and I did struggle to mirror accurately. I did not feel a strong sense of connection or attunement with the client.

Isabella arrived at the second session with a flat affect that brightened when she saw and grabbed the scarves. Her anxiety was again visible in her tense posture. Isabella began as the

mirror while I led the movement, reversing roles from the previous session. She was able to follow big movements and facial expressions well, however, she missed smaller details such as foot placements. Musical mirroring was introduced during this session and Isabella successfully tried both roles. I felt greater attunement in both our movement and musical improvisations. Isabella allowed me to follow more easily and strived to follow my improvisations with greater accuracy. I recorded that I felt the improved attunement was the beginning of a bond formation. Isabella's behavior was cooperative until the end of the session when she showed resistance towards putting the instruments away and returning to the classroom. Though less cooperative, this resistance suggested to me that she may feel greater comfort in our sessions than in the larger classroom.

#### **Perceptual/Affective Level (Sessions 3-4)**

In session three, Isabella's affect remained constricted, and behavior withdrawn and cooperative. Her anxiety remained evident in her tense posture, though she was less hunched than in previous sessions. She completed the internal weather report directive, taking her time with attention to detail. She drew a blue sky with the sun shining over green grass. She included a smiling girl with a dog beside her. When I asked her what feeling this weather represented, she said "happy" using her text-to-speech app, though her affect remained constricted. Her dialogue around the image was limited but was well engaged in the art process. Her cooperative behavior and positive engagement in the activity displayed her participation in our common goals.

In the following session, Isabella appeared less tense and hunched, though some tightness was still apparent. Her affect was not full but was less constricted; she appeared more relaxed. With our drum conversation, Isabella experimented with different surfaces to drum on. She started with a chair, the floor, and the table. She then experimented with drumming on my body,

first on my shoes, then my legs and my head. She was gentle, caring, and playful. The reduction of tension in Isabella's body and constriction in her affect suggested that she felt more comfortable with me. The initiation of physical touch and closeness by Isabella gave me confidence that our therapeutic relationship was building, making me feel more connected and attuned with the client. I recorded "It feels like our bond/attachment is growing- initiation of touch/closeness, increased playfulness, reduced tension".

### **Cognitive/Symbolic Level (Sessions 5-6)**

In the fifth session, we co-created a story about a butterfly who makes a new friend. Isabella mimed and I created narrations based on her movements. She was cooperative and collaborative, creating large, dramatic movements that were easily interpreted. Isabella played the butterfly and used a pillow from the room to represent the friend. The butterfly tried to teach the pillow how to fly, unsuccessfully, and in the end brought the pillow for a ride on her wings. Isabella presented with a full affect throughout the session and her behavior was less withdrawn. She was animated as she acted with a great reduction in the visible tension in her body.

In the sixth and final session, Isabella continued to present with full affect, a less anxious posture, and less withdrawn behaviors. We co-created a story about a girl exploring a mysterious noise in her safe space. She discovered it was a robot and told it not to disturb her peace. In both sessions, Isabella was spontaneous with her dramatic play, with less rigidity observed than in previous interactions. Isabella's increased playfulness, spontaneity, and relaxation assured me of her comfort in our growing bond. In both sessions, her investment in the story was shown through her engagement; we worked collaboratively towards the common goal of creating a story.

## Discussion

The results detailed above are based on my experience and observations as the researcher-therapist implementing expressive arts therapy activities designed to develop a therapeutic relationship with an eleven-year-old female student with selective mutism (SM). The developmental hierarchy of the expressive therapies continuum (ETC) served as a framework for the creation and implementation of therapeutic interventions. The current literature has shown positive treatment outcomes predicted by positive therapeutic relationships (Hartley et al., 2022; Norcross, 2010); however, the development of therapeutic relationships with children with SM has not been addressed in the literature, despite the role that speech plays in the creation of such an alliance. This study was designed to address this gap in the research and its results show promising signs that expressive arts therapy may benefit the development of the therapeutic relationship with children with SM.

Three essential constructs for a positive therapeutic alliance have been identified: bond/attachment, collaboration, and common goals (Ardito & Rabellino, 2011; Bordin, 1979; Johnson & Wright, 2002). The bond/attachment creates qualities of trust, caring, and respect in a positive therapeutic relationship (Bordin, 1979; Johnson & Wright, 2002). I found these qualities developing in my relationship with Isabella. This was highlighted in session four, working at the perceptual/affective level. During the drum conversation, Isabella initiated physical touch by drumming on my body. As she did so, she was caring, respectful, and gentle. The initiation of physical closeness was interpreted as a reflection of increased trust in the relationship. Increased trust was also shown in Isabella's expansion of affect and behavior over the course of the six sessions, as well as the apparent reduction of tension and anxiety.

Another essential construct in the therapeutic relationship, collaboration, refers to the idea that client and therapist must work together in the engagement of activities used in therapy (Bordin, 1979; Johnson & Wright, 2002). There was collaboration in sessions at each level of the ETC as Isabella and I worked together. The collaboration produced reciprocal engagement with each intervention, showing some evidence of alliance. There was a shared investment in the achievement of goals, which is the third necessary construct in a therapeutic relationship (Bordin, 1979; Johnson & Wright, 2002). With the use of ExAT, the client was able to participate in collaboration and common goals nonverbally. For example, the collaborative storytelling at the cognitive/symbolic level allowed Isabella to contribute to the narrative by dramatic movements and miming, and work towards the common goal of co-creating a story.

There are several limitations of this study that should be mentioned. As the researcher-therapist, the results are subject to my own bias. The single-participant sample size prevents the generalization of results. Additionally, the short-term nature of this research could have limited the potential of the method. This study could be looked at as a pilot study because a larger sample-size and extended research period could expand upon the preliminary results of this study. The existing relationship between myself and the client could be another limitation; working with an unfamiliar therapist may have yielded different results.

The findings of this study suggest that expressive arts therapy may benefit the development of the therapeutic relationship with a child with selective mutism. Further exploration of this topic is strongly substantiated by the results found. Future studies should expand the age and number of participants, to better understand the generalizability of results. Greater clarity on the effects of ExAT on the development of therapeutic relationships with children with SM could improve treatment outcomes for this population.

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