Communication through Story:
Story-Making with a Child Diagnosed with Selective Mutism

Margaret Owen

A Research Paper

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements
For the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada

March 2008

Your file Votre référence
ISBN: 978-0-494-40972-5
Our file Notre référence
ISBN: 978-0-494-40972-5

Abstract

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This qualitative research study views the therapeutic use of story-making with a six-year-old girl diagnosed with selective mutism. The information gathered is presented as a descriptive case study and the therapeutic process is viewed through Renee Emunah's Integrative Five Phase Model. Mooli Lahad's Six-Piece Story-Making technique informed the story-making process, which was used in combination with other projective and psychodramatic techniques. Since verbal and emotional communication is usually the goal for children diagnosed with selective mutism, the primary research question investigated is: How does communication between a child with selective mutism and a therapist develop through story-making in a drama therapy setting? The study follows the detailed change in communication between the child and me as we move through several communication milestones prior to and during story-making.

Acknowledgements

I thank my supervisor, Alison Aylward, who consistently challenged me and supported my efforts throughout this process.

I am grateful to all of my classmates. Among them I thank Gav for her support and compassion, Louise for her enthusiasm and spirit, Kat for her generosity, Johanne for her wisdom, Chriszine for her kindness, Melanie for her gusto, Jenn for her humour and Calli for her honesty and drive. You are all extraordinary women.

I also thank Yehudit Silverman, Stephen Snow, and Bonnie Harnden. You each gave me confidence and space to grow into my role as a therapist, thank you.

I am grateful to my family and my partner, your unwavering support means the world to me. I love you Mom, Dad, Joe, Brendan, Sam, Lisa and Simon.

Finally, I thank Shannon, who showed me her view of the world through the stories she created.

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COMMUNICATION THROUGH STORY: STORY-MAKING WITH CHILD A DIAGNOSED WITH SELECTIVE MUTISM

Chapter 1: Introduction

As a child, I frequently turned to a book depicting a small, brown, stuffed teddy bear called Corduroy. The large rectangular-shaped pages lay on my 6-year-old hands, making the images contained appear larger than I. I immersed myself in Corduroy's home, a department store filled with life-size toys, titillating adventures, and unexpected dangers. In my 6-year-old mind, I accompanied Corduroy on his journey through the dark hallways and up the steep escalator in the closing hours of the mall. This brave, little teddy bear was on a mission to seek the button lost from his green vest, which hugged his fur-covered body. He was relentless in his search, moving through the vast shopping areas on his little teddy bear legs. He made friends in neighbouring departments and braved near-encounters with the security guard's flashlight beam. As the night ended and daylight appeared, Corduroy returned to his shelf without his button. Although his mission ended in failure, and he remained one button short, a young girl bought him that morning and brought him home with her. She cared for him dearly and replaced his missing button.

Almost 18 years later, as the book of Corduroy's journey lay buried in a long-forgotten box within my parents' attic, I recalled the story as I was sitting in my drama therapy class during the second semester of my studies. The class discussed the use of stories as an assessment tool with children and our instructor encouraged us to recall those that had had a significant impact on our own childhoods. I slowly mumbled the first

syllables of the name "Cordu . . .", when one of my classmates cut me off and repeated the title enthusiastically, "Corduroy!" Apparently, many other little girls had immersed themselves in the dark world of the department store, accompanying Corduroy on the search for his button. However, it was not the dark corridors of the store, nor the unconditional love the girl provided, that now drew me to the story. My personal journey had changed from that of a child exploring fear and love, to that of a 25-year-old graduate student searching for experience. My attention now focused on Corduroy's mission and journey. He searched for a missing piece of himself and had to embark on an adventure to find it. The theme of searching mirrored my experience as a therapist in training, forming my ideas and hopes for my future career. I had begun my journey and was searching for experience to develop my role as a drama therapist.

This experience drew me to the use of story in therapy. I witnessed how members of the drama therapy class welcomed memories and experiences awakened by childhood stories and the new relationships that they began developing with them in their older years. The process of making, reading or telling stories appeared both engaging and inspiring for the group. I left the class still pondering the plot of that particular story, and others that had left lasting impressions on me. As I became more comfortable in my therapist role, I began implementing story-making techniques and story-telling within my therapy groups. I discovered the process inspired curiosity and commitment among participants in the groups I co-facilitated.

In my second year as a graduate student, I faced new challenges when I began one-on-one drama therapy sessions with children and adolescents. I had the pleasure of working with Shannon, a brave 6-year-old girl diagnosed with *selective mutism*. Shannon

was brought to the clinic where I held my internship position because she was completely mute in her classroom, relying on gestures and writing to communicate. The clinic team suggested drama therapy as treatment.

This paper describes Shannon's journey through 28 drama therapy sessions during which she created expressive roles and elaborate stories that revealed some of her feelings regarding her life-struggles, as well as her hopes for speaking. Her forms of communication shifted from using slight gestures to using elaborate movements, facial expressions, pictures, writing, and eventually words. In-depth stories concerning Shannon's struggles at school and her difficulty dealing with lengthy separations from her mother preceded the shift towards verbal communication.

Before delving further into Shannon's process and her created stories, this chapter will proceed with an overview of story as a therapeutic tool. Chapter 2 describes the history of selective mutism, current views of the disorder and treatment approaches. Chapters 3 and 4 depict the use of story within drama therapy practice as well as related drama therapy theory. It is followed by the applied methodology in chapter 5 and case description in chapters 6 through 8.

In order to make the text easier to read, the gender of the terms *individual*, *client*, *participant*, *person*, *infant*, and *child* will be female in odd numbered chapters and male in even numbered chapters. However, the term *child* at times may refer to a specific person and will reflect that child's gender.

Story

The term *story* refers to a description of a reality or fictitiously-based happening, narrated through a causally-linked series of events (Denning, 2000). It is a container that

holds thoughts, feelings, opinions, morals, values, and memories through the setting, characters, and themes it contains. The safe containment of delicate emotional material, as well as the communication of this material, makes story a helpful tool in a therapeutic environment. White and Epston (1990) were early pioneers of narrative approaches in therapy, viewing story as a form that described an individual's path through life. This underlines the basic premise of *narrative therapy*, which states that the events in life expressed through life-stories sculpt an individual's identity (Gergen & Gergen, 2006).

White and Epston (1990) used narrative ideas with families and individuals to identify life-story problems and guide clients to transform them through alternate plots and endings. This provided the possibility of healthier endings to client's life-stories. The theory behind this approach was that by exploring new outcomes and consequences, a healthier resolution to daily troubles could be found, granting clients control over difficult decisions.

While narrative therapy primarily uses clients' real-life stories, a drama therapy session, such as those I will describe in chapters 6 through 9, may utilize a fictional story and remain in metaphor, without interpreting the content. The focus remains on the process through which an individual or group creates and reflects on characters, plots, and settings within the story. The metaphor aims to foster insight into the client's situation as she provides layers of possible meanings and keeps the process of therapeutic exploration in motion (Powell, Newgent, & Lee, 2006). Many therapists have used myths, fairytales, and legends, as well as client-created stories, to foster therapeutic change. The Anglo-Dutch drama therapist, Gersie (1991, 1997; Gersie & King, 1990) utilized myths, cross-cultural stories and story-making in her therapeutic groups and

individual therapy sessions. Gersie (1997) created a Therapeutic Storymaking model which guides individuals through a series of steps in creating their own story. However, her work is not limited to this model, but utilizes created stories as well.

Gersie (1990) applied specific stories to help identify problem areas and struggles within an individual's life, and suggested that, through the story structure or story-making process, the plots, characters, and setting an individual creates reveals the client's inner world (Gersie, 1997). Silverman (2004) also developed an approach with stories, using the metaphor contained in original versions of myths or fairytales as a safeguard with which to explore life problems. Silverman's approach focuses on the relationship individuals develop with a carefully selected myth or fairytale character. The course of selecting and employing a chosen story, character, and one dramatic moment within the story is emphasized and carefully guided by the therapist. Through this process, the client's real-life problems emerge in relation to the character's struggles within the story, but remain within the safe confines of metaphor provided by its structure.

Like Silverman, Gabel's (1984) approach requires intense therapist involvement in the creation of a story improvised through a series of connected pictures. While Silverman's approach describes the therapist as guide and witness, Gabel's therapist becomes an active participant in the process of story-making. Gabel's approach implements drawing and story in a collaborative process between a therapist and a child in order to build trust and communication. Through the series of connected pictures, a story emerges through which the client experiments with various endings and themes that connect to her own life. The process demonstrates the use of story as a tool to help an

individual regulate emotions, experiment with life-problems and work through difficult behaviours.

Similar to this approach is Lahad's (1992) Six-Piece Story-Making (6-PSM) technique. Lahad created a story-making technique using pictures in six frames. The technique assesses how individuals cope with stress, but many drama therapists apply these six frames in sessions as a therapeutic intervention as well (Dent-Brown & Wang, 2004b). The 6-PSM has been utilized and discussed in drama therapy literature and research in order to promote assessment in drama therapy (Pendzik, 2003), detect indicators of borderline personality disorder (Dent-Brown & Wang, 2004b), develop rating scales for projected stories (Dent-Brown & Wang, 2004a) and compare assessment methods (Landy, Luck, Conner, & McMullian, 2003). Lahad (1992) aimed to find the client's emotional language revealed by the 6-PSM technique. In chapter 4, his technique will be further discussed as it was applied within this case study.

All of these approaches use careful steps, which result in a process and story specific to each client. As the case study in chapters 6 through 8 depicts, Shannon's stories are usually embodied, not told, and her form of communicating difficult feelings is through the roles she plays in her stories. The roles in each story have taken on similar attributes in that there is one oppressor and one oppressed role. This process and the content of stories are unique to Shannon, as she remains silent in the session relying on her gestures and drawings to convey her plot line. Particularly relevant to this style of interaction is that stories open channels of communication between listener and teller, and offer a safe space for personal exploration (Cattanach, 1997; Gersie, 1997; Lahad, 1992). This is

significant for children, as they often have difficulty articulating their fears and anxieties with words (Gabel, 1984).

As a child reads, writes, draws or tells a story, the process of unfolding it accentuates where and when she feels most emotionally connected to characters and moments in the plot (Gersie, 1997). The story then becomes the lens through which the therapist monitors the therapeutic relationship, communication, and the client's progress. The child has the freedom to convey complex feelings through a progression that encourages creativity and promotes a natural mode of playful expression (Irwin, 1977). This process is particularly helpful with children who do not wish to speak in therapy, as they can use pictures, puppets, embodiment, and masks to share their story. Shannon utilized such dramatic tools to communicate her thoughts in our drama therapy sessions.

Since Shannon was diagnosed with selective mutism, I anticipated the need for several dramatic tools to promote non-threatening forms of communication between us. Many children with this disorder often will not speak in therapy sessions and have difficulty expressing their thoughts and feelings clearly. The therapeutic process with this population must not begin with pressure to speak, as this approach is often met with severe resistance (Landreth, 2002). The non-spoken story that is used within the therapy session may then become the mutually-agreed-upon framework for communication and may act as a catalyst for deeper emotional exploration (Hoey, 2005; Irwin, 1977).

Although story is a frequently used tool in therapy, few studies I reviewed have applied it with this population. Research with the selective mutism population is still young and many theories regarding etiology, epidemiology, and treatment are still

developing. The following chapter will explore some of the history of selective mutism as well as various features associated with the disorder.

Chapter 2: History of Selective Mutism

Selective mutism, initially labelled *aphasia voluntaria,* was first discovered in 1877 by German physician Adolf Kussmaul (Cohan, Chavira, & Stein, 2006a). The term described children who volunteered not to speak despite possessing full capacities to communicate verbally (Krysanski, 2003). The term *elective mutism*, designated by Swiss child psychiatrist Moritz Tramer in 1934 (Dummit, Klein, Tancer, & Asche, 1997), emerged with the understanding that individuals displaying this behaviour were doing so by choice (Cohan, Price & Stein, 2006b). The term was changed to *selective mutism* with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) (American Psychiatric Association [APA], 1980), but the original remains in the tenth edition of the *International Classification of Diseases* (*ICD-10*) (World Health Organization [WHO], 2007) This transformation is indicative of the specific situation in which mutism occurs, rather than the refusal of verbal communication (APA; Cohan et al., 2006a; Manassis et al., 2003). The change also reflects the notion that selective mutism is not necessarily an act of defiance, nor a representation of oppositional behaviour (Cohan et al., 2006a).

Etiology

The underlying causes of selective mutism are still not understood, although its etiology suggests that trauma, anxiety or family dynamics play a part in the disorder's manifestation (Anstendig, 1999; Black & Uhde, 1992; 1995; Cohan et al., 2006a; Cohan et al. 2006b; Cunningham, McHolm, Boyle, & Patel, 2004; Elizur & Perednik, 2003; Standart & Le Couteur, 2003; Vecchio & Kearny, 2005). Current studies also postulate that the death of a loved one, a family history of depression and anxiety, an

overprotective mother, and a strict, remote father are significant factors in the development of selective mutism (Cohan et al., 2006b; Dow, Sonies, Scheib & Moss, 1995; Vecchio & Kearny).

The long-term effects of selective mutism may include communication disorders, obsessive-compulsive disorder, and oppositional defiant disorder in late childhood, as well as social phobia in adulthood (Black & Uhde, 1995). These possible associated disorders describe an extreme range of behaviours, making classifications of the various types of mutism central in determining treatment needs.

Attempts to Classify

Hayden (1980) studied a sample of 68 children with selective mutism over a 7-year period and discerned four types of mutism. The subtypes he observed included *symbiotic mutism*, *speech phobic mutism*, *reactive mutism*, and *passive-aggressive mutism*. Symbiotic mutism refers to a mother-child relationship wherein the mother or dominant caretaker meets all of the child's needs. Despite the child's shy and sensitive exterior, he displays oppositional behaviour towards other adults and appears to use silence as a way of controlling his environment. Almost half of the sample size was observed as having this type of mutism. Speech phobic mutism describes the fear of one's own voice, which is associated with high levels of anxiety. Reactive mutism is a sudden response to a specific or multiple traumatic events. Hayden observed that the majority of children in this category had moderate to severe depression. Passive-aggressive mutism is the withholding of speech as an act of defiance. Children in this category displayed violent and antisocial behaviour. Hayden stated that this kind of child may have been the scapegoat in the family, and used the restriction of speech in order to gain some form of

control. Each subtype of selective mutism was viewed as having a distinct etiology and difficulties.

Lesser-Katz (1986) narrowed these categories to two subtypes, describing one group as more reserved, shy, and insecure, and the other as more oppositional, avoidant, and passive-aggressive. However Hayden (1980) and Lesser-Katz did not evaluate a control group in their investigations, leaving no comparative measures. Kristensen (2001) continued to develop categories of internalizing (shy, timid, and withdrawn) and externalizing (disobedient, controlling, and demanding) behaviours to describe subtypes of selective mutism. He used a control group of non-referred 4-to 16-year-old children to determine behavioural variations. The results indicated that children with selective mutism differed substantially in internalizing problems and were more withdrawn than those in the control group. However, the wide age range among participants made results difficult to generalize. Although these categories are useful when treating various children, researchers have agreed that the way to obtain the best overview of the disorder is through family background and history (Krysanski, 2003).

Family and Selective Mutism

Parents of children with selective mutism report a family history of shyness, anxiety, selective mutism, and related disorders (Cunningham et al., 2004; Jainer, Quasim, & Davis, 2002; Schwartz, Freedy, & Sheridan 2006; Standart & Le Couteur, 2003). Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen, and Gutenbrunner (2001) found a high incidence of language and speech problems within families of children with selective mutism. In 78% of their sample, families exhibited mutistic reactions,

impoverished language production, speech and language disorders, thick dialects, and extreme shyness.

Kaplan and Sadock (1985) observed that the bond between mother and child affected the child's mutism in situations where the mother had a discordant relationship with the father. Coiffman-Yohros (2002) also noted a symbiotic relationship between the child with selective mutism and the primary caregiver. Hayden (1980) stated that mothers were either overprotective or covetous of relationships the child formed outside the home, while fathers often played a more distant role in the family.

In one of the few long-term follow-up studies of 45 individuals with selective mutism, Remshmidt et al. (2001) also observed that maternal overprotection appeared to contribute to selective mutism. The study revealed that 60% of mothers of these patients had some form of psychopathology. From the sample, 18 mothers suffered frequent mood changes and disturbances from social contact, 9 showed signs of chronic depression, and 4 presented symptoms of chronic neurotic disorders, personality disorders, and brain damage. Only 4 fathers had no obvious psychopathology. The rest of the sample included 12 fathers with minor psychopathological symptoms, 16 with psychopathological disorders, 3 with alcoholism, 2 with severe personality disorders, and 1, who had lived with chronic depression, who committed suicide. The remaining 13 fathers presented with withdrawal, irritability, aggressiveness, and shyness.

In total, 42 out of 45 individuals in this study revealed that their disorders were serious problems for them. They associated their mutism with anxiety, feelings of shame and insufficiency, and mistrust of people. The majority of patients associated their diagnoses with conflict in and out of the home. They perceived themselves as dependent

on others, less motivated for work or academics, as well as less healthy and mature than their contemporaries. Although this study's findings were based on retrospective interviews, they reveal the significant role family history (Ainsworth, Blehar, Waters & Wall, 1978) plays when assessing the disorder. The attachment patterns observed by Remschmidt et al. (2001) were observed in other studies (Coiffman-Yohros, 2002; Hayden, 1980; Kristensen, 2000; Lesser-Katz, 1986). These investigations indicated that certain attachment patterns within families of children diagnosed with selective mutism were associated with the disorder. However, these studies only suggested a link, as attachment was not the focus of the investigations. Bowlby (1952), an English psychoanalyst, studied mother-infant attachment patterns extensively, and determined that too much or too little maternal attachment severely affects emotional and personality development in infants. The following will give a brief overview of attachment theory only as it relates to this study, since the wealth of attachment literature is beyond the scope of this paper.

Attachment

Attachment theory states that every infant develops an attachment to his primary caregiver within the first year (Bowlby, 1952). The distinct qualities of attachment have been observed through the caregiver's receptivity and availability to the infant (Ainsworth et al., 1978). Ainsworth (1973), initially an assistant to Bowlby, devised "The Strange Situation" in determining a measure for attachment. The study suggested that an infant-parent relationship is considered *secure* when the parent provides a balance of protection and security on one hand and on the other, encouragement for the infant to explore the outside environment. An *insecure* relationship results when these two

parental provisions are unbalanced, or when one is absent (Ainsworth et al., 1978). Children perceived as secure adapt to surrounding stimuli with little distress. They regulate their need for parental closeness by exploring their surrounding environment and occasionally checking in with the parent. They do this by returning to the parent for a brief period or making eye contact. Children described as insecure react in developmentally-inappropriate ways, unable to balance their needs for parental proximity with the demands of their external environment (Spangler & Grossman, 1993).

Ainsworth et al. (1978) developed three categories for the patterns of attachments they observed, including secure, *insecure-ambivalent*, and *insecure-avoidant. Insecure disorganized/disoriented* attachment was identified in later observations (Main & Solomon, 1986). These categories were fashioned after observing mother-infant separation, which focused on the mother's return to the infant. In "The Strange Situation" (1978), a stranger entered the room prior to the mother's departure and remained with the child during the mother's absence. The secure infant was distressed during the mother's absence, but quickly soothed when the mother returned. Infants described as secure actively sought the mother's closeness, comfort, and interaction.

The insecure-avoidant infant displayed neither distress nor joy during separation and reunion with the mother (Ainsworth et al., 1978). The infant often ignored the mother upon her return or gave a slight acknowledgement. The typical behaviours associated with this category were avoiding eye contact, turning away, and preoccupation with objects in the room. When the mother picked the infant up, he neither resisted nor clung to her. The infant displayed similar responses towards the stranger in the room. An infant described as insecure—ambivalent displayed a strong need for contact, while

simultaneously resisting the caregiver once contact was established. The infant appeared consistently disconcerted and unable to be soothed. The category described as insecure disorganized/disoriented displayed an incoherent pattern of attachment as the caregiver served as both a basis of reassurance and fear, leading to the inconsistent behaviour in the infant (Shamir-Essakow, Ungerer, Rapee, 2005).

Although attachment theory has not, to my knowledge, been applied directly in research regarding selective mutism, the results of past studies demonstrate links between intense child-caregiver attachment and a child's selective mutism (Anstendig, 1998; Kristensen, 2000; Steinhausen & Juzi, 1996).

Current Views of Selective Mutism

Literature regarding this population is still scarce and long-term studies are needed. Large studies lacked long-term follow-up reports, making it difficult to determine which treatment approaches were most effective. Most information explaining the disorder's features has surfaced from descriptive case studies, making it difficult to generalize about the disorder's development. The current diagnostic criteria taken from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*) compile the most common found features of the disorder (APA, 2000).

Diagnostic Criteria

Individuals with selective mutism have the cognitive and physical abilities to speak, but remain mute in certain environments (APA, 2000; Black & Uhde, 1995; Cunningham et al., 2004; Steinhausen & Juzi, 1996). It is diagnosed in less than 1% of individuals in mental health settings. The diagnostic criteria are found under "Other Disorders of Childhood and Adolescents" in the *DSM-IV-TR* (APA, 2000). The disorder has an onset

before age 5. Therefore, research has mainly focused on selective mutism in childhood (APA, 2000; Black & Uhde, 1995; Cunningham et al., 2004; Schwartz et al., 2006; Steinhausen & Juzi, 1996).

In order for children to meet the diagnostic criteria, the mutism must last longer than 1 month after they begin school (APA, 2000). The criteria may not apply if the child has limited knowledge of the language of the country he is in or if he is diagnosed with a communication disorder (APA, 2000; Cohan et al., 2006). Toppelberg, Tabors, Coggins, Lum and Burger (2005) suggest that a diagnosis for bilingual children should be ruled out until the mutism remains in both languages for more than 6 months. The problem must also be accompanied with difficulties in academics, socialization or occupational achievement (APA, 2000; WHO, 2007).

Studies with smaller sample sizes have indicated no gender differences (Elizur & Perednik, 2003; Kopp & Gillberg, 1997). However, Steinhausen and Juzi (1996) discovered a ratio of 1 to 1.6 among their analysis of 100 cases of elective mutism, finding the disorder to be more prevalent among girls in their sample. The *DSM-IV-TR* (APA, 2000) asserts that it is more prevalent in girls as well.

Time of Onset

Selective mutism occurs before school entry, but becomes most conspicuous during school attendance (Schwartz et al., 2006; Standart & Le Couteur, 2003). The lack of verbal communication causes significant socialization and educational problems that do not abate over time without treatment (Schwartz et al., 2006). Extreme shyness, compulsive behaviour, somatic complaints, social isolation, withdrawal, fear of social embarrassment, clinging, temper tantrums and controlling or oppositional behaviour are

features associated with selective mutism (APA, 2000; Black & Uhde, 1995; Cunningham et al., 2004; Zelenko & Shaw, 2000). Black & Uhde discovered that the most common personality trait, in their sample of 100 children with selective mutism, was shyness. One-third of their sample was rated as depressed and two-thirds as anxious.

Language and Communication

Children with selective mutism generally have normal nonverbal language skills (APA, 2000). However, communication disorders or articulation problems related to medical conditions are possible (APA, 2000; Manassis et al., 2003). Communication usually occurs through gestures, head movements, pulling, tapping or pushing as well as utterances in one-word form, monotone or whispering (APA, 2000; Cunningham et al., 2004). Although the academic performance of children with selective mutism is similar to that of their peers, teachers report that they are more anxious and less socially assertive than other children of their age (Cunningham et al., 2004; Schwartz et al., 2006). They are also less likely to engage in social and recreational activities, indicating that these children may be avoidant and withdrawn (Vecchio & Kearney, 2005; Kristensen, 2001). Elizur and Perednik (2003) conducted a study of 10 immigrant children and 9 native children and discovered that the additional stress of a second language may be a possible clue towards the development of selective mutism. However, many have argued that it is not the additional language, but rather the anxiety associated with failure and ridicule that causes the silence (Anstendig, 1999; Black & Uhde, 1992, 1995).

Selective Mutism and Anxiety

Selective mutism is often accompanied by anxious symptoms (Anstendig, 1999; Bergman, Piacentini, & McCracken, 2002; Black & Uhde, 1992, 1995; Cunningham et

al., 2004; Dummit et al., 1997; Elizur & Perednik, 2003; Kristensen, 2000; Steinhausen & Juzi, 1996; Vecchio & Kearney, 2005; Yeganeh, Beidel, Turner, Pina, & Silverman, 2003). Such symptoms mirror those seen in children with separation anxiety (Standart & Le Couteur, 2003). Separation anxiety is not uncommon, as prevalence rates are estimated in 4% of children and young adolescents, most of whom present with a significant fear of separation from home or the attached individual (APA, 2000). The parent-child dyad is enmeshed and the child encounters severe anxiety and feelings of inadequacy when separated (Standart & Le Couteur, 2003).

Selective mutism has also been considered a symptom of social phobia (Black & Uhde 1995) and social anxiety disorder (Anstendig, 1999; APA, 2000; Steinhausen, Wachter, Laimbock, & Metzke, 2006; Vecchio & Kearney, 2005). Coexisting autism spectrum disorders have also been found, but are rare (Kopp & Gillberg, 1997). Vecchio and Kearney discovered that children with selective mutism and those with anxiety disorders both displayed internalizing behaviour problems (isolation, withdrawal) and a comparable degree of comorbid disorders. All children with selective mutism had comorbid diagnoses of social anxiety disorder and 53% had another anxiety diagnosis. Black and Uhde (1995) contended, after conducting a study with 131 children, that the disorder appears more as a symptom rather than a separate diagnosis. They proposed that the fear of public speaking suggests selective mutism is a symptom of social phobia and is attributable to a change in environment, family or interpersonal difficulties and speech phobia.

Other studies examining social phobia discovered social anxiety and avoidance in their samples, which is also found in children with selective mutism (APA, 2000; Black

& Uhde, 1995; Manassis et al., 2003). Therefore, conclusions cannot be drawn about which disorder is the primary cause of the symptoms. Frequently a comorbid diagnosis results, as symptoms from each criteria are present. However, since social phobia is a much more overt and studied disorder compared to selective mutism, treatment for selective mutism often follows techniques used for social phobia and other anxiety disorders (Standart & Le Couteur, 2003; Schwartz et al., 2006).

Treatment

There are few long-term studies presenting the overall course of selective mutism. Kolvin and Fundudis (1982) conducted a long-term study with 5 to 10 year follow-up interviews, showing that mutistic behaviour was still present. They observed that early therapeutic interventions were essential for improvement. Remschmidt et al. (2001) discovered that 16 out of 41 patients showed complete remission over a 12 year span. While 12 participants presented a remarkable improvement, all other patients continued having trouble with communication, unknown situations, talking to strangers, and using the telephone. Severity of these symptoms indicate a serious need for improved interventions and treatment plans for young children with selective mutism.

Psychotherapy and family therapy are currently the most common treatment approaches applied with this population (Black & Uhde, 1995; Cohan, Chavira & Stein, 2006a; Dummit et al., 1997; Kumpulainen, Rasanen, Raaska, & Somppi, 1998; Steinhausen & Juzi, 1996). Behavioural approaches also proved effective during short-term treatment (Anstendig, 1999; Cohan et al., 2006a; Fisak, Oliveros, & Ehrenreich, 2006; Masten, Stacks, Caldwell-Colbert, & Jackson, 1996). Many of these studies consist of case descriptions that do not credit one single method in treating selective mutism (i.e.

behavioural and cognitive-behavioural interventions, art therapy, play therapy etc.). Therefore, it is challenging to determine which intervention was the most successful.

Behavioural therapy.

Techniques that revealed short-term success included *contingency management* and *shaping*. Contingency management involves matching a desirable activity with an undesirable one and promoting progress through positive reinforcement. Shaping is employed by breaking the long-term goal down into smaller goals, progressing from easy tasks to more difficult ones. Although these approaches proved effective for a short period, there were no long-term follow-up studies conducted (Krohn, Weckstein, Wright 1992; Masten et al., 1996). Watson and Kramer (1992) discovered that contingency management and shaping did not maintain long-term benefits after treating an 8-year-old boy with selective mutism in both the home and the school environment.

Cognitive-behavioural therapy.

Cognitive-behavioural therapy (CBT) has also generated favourable results and focuses on reducing anxiety. Interventions applied to anxiety disorders are frequently used for selective mutism (Dow et al., 1995; Steinhausen et al.., 2006). Although Fung, Manassis, Kenny, and Fiksenbaum (2002) discovered less anxiety and decreased mutistic behaviour in participants, it remained difficult to determine which technique had helped reach therapeutic goals. They used relaxation techniques and exposure to fear stimuli, but the procedure did not reveal the primary intervention in detail (Dow et al., 1995).

Psychodynamic treatment.

Psychodynamic interventions with selective mutism mainly occur through individual psychotherapy and play therapy (Cohan et al., 2006; Hesse, 1981; Irwin, 1977; Landreth,

2002; Zelenko & Shaw, 2000). Since the onset of selective mutism occurs at a young age, play therapy is a common intervention. It involves the use of play with various materials (toys, art, games etc.) to explore and identify the child's feelings. The goal of such treatment is to use play as a form of expression and as a way to elicit verbal communication through the playful interaction of child and therapist. Success is measured by the commitment and ability to engage in *symbolic play* during sessions. Symbolic play is the connection of real experiences with abstract thoughts, which often occurs through the act of playing (Piaget, 1962). During play, objects used by children become symbols for their experiences and thoughts. Children then organize their personal experiences and thoughts represented by these objects, through the act of playing (Landreth, 2002).

Play is also used in drama therapy with individuals who have communication difficulties and limited verbal capacities (Crimmens, 2006; Hoey, 2005; Nissan, 2005; Snow, D'Amico, & Tanguay, 2003). Drama therapy involves reaching therapeutic goals through creative drama and stresses the process rather than the products created through the dramatic medium (Emunah, 1994; Johnson, 1982). Creativity and spontaneity are fostered through specific and deliberate dramatic techniques to promote well-being and personal growth (Jones, 1996). This treatment approach will be discussed in detail in chapter 3.

Multimodal treatment.

Moldan (2005) employed play therapy, parent training, stimulus fading, and a socialization group in a study of selective mutism. Self-regulation of emotions and behaviours, as well as speech development, were the goals of the study. Powell and

Dalley (1995) also applied play therapy in their study of a 6-year-old girl with selective mutism. They combined shaping, self-modeling, stimulus fading, and contingency management to the treatment. The girl was still speaking in school when the follow-up interview was recorded. Other research supports multimodal approaches, having found that art and play are important tools in connecting with individuals at the beginning of therapy (Cohan et al., 2006; Moldan, 2005; Remschmidt et al., 2001; Spasaro, Platt, & Schaefer, 1999; Yanof, 1996).

Art and play are used within drama therapy and are particularly prominent in the story-making technique used in this study. The following chapters will provide an overview of drama therapy, story, and Lahad's (1992) Six-Piece Story-Making technique. These are then followed by the case presentation.

Chapter 3: Drama Therapy, Story, and Selective Mutism

Drama therapy stresses the development and use of imagination, creativity, spontaneity and play as forms of self-expression. These elements are encouraged through the intentional application of specific dramatic tools including stories, roles, characters, puppets, scenework, and role-play (Johnson, 1982). The tools are designed to help contain, explore, and develop a client's therapeutic process as she engages in *as if* behaviour and make-believe play to explore various themes and life situations (Emunah, 2000). The space in which this occurs is representative of real life, yet transitional between reality and fantasy, and is termed *dramatic reality*. The playspace becomes the client's personal playground, where she can develop trust and confidence, enact significant situations and experiment with new forms of coping.

This environment is particularly appealing to children, as play is their natural language and mode of expression (Dunne, 2000; Emunah, 1994; Irwin, 1977; Jennings 1999; Jones, 1996; Lahad, 1992; Landreth, 2002; Walker, 1998; Winnicott, 1971). Through play, children experiment with outside experiences and explore inner thoughts while developing self-regulation, social competence, and confidence in coping with peer-related situations (Cohan et al., 2006; Landreth, 1992; Golinkoff, Hirsh-Pasek, & Singer, 2006; Moldan, 2005). The child's play process and action provide both verbal and non-verbal traces of her inner world, making it a vital element of therapy for children who do not speak (Irwin, 1977).

Three studies, one conducted by drama therapist Nissan (2005) and two conducted by drama therapist Hoey (2005), initiated spontaneous play and story-making techniques with silent children. These studies explored the use of art, story, role-play, puppetry,

embodiment, and sounds in order to improve emotional and verbal expression. In each case, the direct or indirect involvement of the drama therapist was an important factor in the building of trust and strengthening of the therapeutic alliance. Nissan (2005) worked with a young girl who was diagnosed with selective mutism. He utilized spontaneous play and simple activities (throwing a ball, jumping over objects in the room) to help build her self-confidence and develop trust between them. He remained an active participant in the session and was completely engaged in the play with his client. During this time the girl used gesturing, groaning and grunting to communicate with Nissan. He noted the lack of self-confidence the child displayed and credits the gradual building of the therapeutic alliance as an important step in reaching mutual verbal communication.

Hoey (2005) depicted the therapeutic process in working with a traumatized 4-year-old who witnessed a car accident and as a result would not speak. In contrast to Nissan's (2005) position in the therapy sessions, Hoey was a witness for this child, watching the play process. She provided objects, drawings and dolls and encouraged the child to create stories from these. After several sessions, the child began to communicate emotions in more detail through the characters within the story. Hoey asked questions during the process to clarify events within the plot, but did not participate. In this case, not participating fully with the child appeared to help the child find her own voice. This is a contrast to the process Hoey used in her second case study, in which she described an inarticulate 8-year-old girl.

Hoey (2005) was an active member during this girl's process, guiding the child through her stories and assisting in plot progression. The child developed improved emotional expression and verbal communication by articulating feelings with characters

in her stories and communicating the plotline to Hoey. Hoey took a collaborative position, consistently asking questions, making suggestions and supporting the child's actions. The collaborative process appeared to build trust and confidence in the girl, as she started speaking and clearly articulating her thoughts by the end of her therapy. The processes of these three studies appear to highlight the need for a strong therapeutic alliance in order to further the therapeutic process. The positions of the therapists in the sessions were contributing factors, as the distance or closeness provided appeared to help build trust between therapist and child.

Unfortunately, Nissan's (2005) case does not clearly outline the detailed progression into verbal communication, since it was presented as heuristic research and not in the form of a descriptive case study. Hoey (2005) outlined the process through the developing stories in both studies. These stories created tangible containers for the children to pour their thoughts into, while still allowing them to have the control to shape or change them however they wanted. The term that describes this process in drama therapy is called *dramatic projection.*

Dramatic Projection

Dramatic projection involves an individual taking internal issues and pouring them into dramatic containers, such as roles, masks, puppets, and stories, thereby allowing the newly externalized conflict to grow through interaction with these materials (Jones, 1996). It serves to help the client see the issue from another perspective, as the internal conflict is placed into a dramatic mould which then may be viewed or embodied. By exploring the conflict from this different view, a dramatic dialogue emerges through the previously internally held problem and the external expression of it (Jones, 1996). A new

relationship between these may then be developed. This can encourage insight for the client as she explores her projected material through dramatic processes and reflects on her own process and behaviour after enactments.

Projective tests emerged in the early to mid-twentieth century. Some of these tests include the Rorschach inkblots (Rorschach, 1942), the Draw-A-Person Test (Machover, 1949), and the Thematic Apperception Test (Murray, 1943). Each test displays an ambiguous and unstructured stimulus, so individuals are forced to rely on their inner workings to facilitate an answer (Johnson, 1988).

Similar to these tests is the use of a story as an ambiguous structure. Created stories act as a projective devices in drama therapy, since individuals take frameworks with little or no content and project their inner worlds onto narratives that they construct. In enacted stories, clients may project their inner worlds onto the roles contained therein (Landy, 1993) and in story-telling, they may identify and hone in on particular sections to which they are most drawn (Cattanach, 1997). Story, as well as other projective techniques, is employed in drama therapy assessment and treatment to help identify a client's needs (Lahad, 1992; Gersie, 1991).

Projective Techniques

Projective techniques utilized in drama therapy and other creative arts therapies include story-telling, masks, puppets, enactment, video, and photography, along with many others. Assessments have been created around projective techniques such as puppet interviews (Irwin & Malloy, 1975), story-telling and sandplay (Russo, Vernam, & Wolbert, 2006) as well as Rorschach inkblot story-telling (Sakaki, Ji, & Ramirez, 2007). These assessments include processes that utilize projective techniques to externalize an

individual's inner conflict, shaping it into a solid structure, thereby concretizing it. This enables a metaphorical and concrete separation to develop between individuals and their difficult material. This provides distance for them to view the structure (White & Epston, 1990). Examples of such structures include paintings, roles, masks, puppets, and stories.

Three criteria help determine which projective technique is most suitable for a particular client. These include the client's needs, the therapeutic goals and the *distance* the technique provides in relation to her (Landy, 1983). The third criterion is a key component in the drama therapy process, as the drama therapist chooses a projective technique to compliment the amount of distance a client may need.

Distance

Landy (1983, 1993, 1994) is a major pioneer in drama therapy and one of the developers of distance theory. In his work, he remarks that a person's level of emotional commitment to or detachment from sensitive information emerging in a therapy session can be seen on a scale. The scale represents a spectrum of separateness, closeness, and balance in relation to expression and withholding of emotion. A person's place along this scale depends on the degree of emotional intensity she has in relation to material she is exploring. On opposite ends of the scale are the areas of *underdistance* and *overdistance.* According to Landy, an underdistanced client becomes rapidly overwhelmed or flooded with emotions when dealing with certain personal information. This flooding of emotions does not bring relief or insight when expressed, as the client is too wrapped up in the intense emotional experience and thus unable to think through the problem (Landy). An overdistanced client, on the other hand, is further removed from intense emotion and

responds to painful or difficult personal material in an analytical or rational fashion. In this state, as Landy describes it, "one tends to remove oneself from feeling" (p. 367).

A balanced state on this scale, situated midway between underdistance and overdistance is called *aesthetic distance*. When positioned in this area of the scale and enacting an issue or problem, the client experiences emotion without becoming flooded by it. The expression of emotion provides a sense of relief rather than confinement and the client is able to reflect and possibly gain insight from the process of exploring her material. The balance enables the client to better grasp the nature of her problem. In order to help a client reach this point in her therapeutic process, the drama therapist uses a variety of projective and *psychodramatic* techniques (discussed in chapter 4).

In the case study I present in this paper, the concept of distance may be observed through the use of roles Shannon played in her stories. She began by casting me in the role of *silent student*, a role she was familiar with, as she went to school five days a week and did not speak in her classroom. She took on the role of *teacher* in one of her stories and we enacted a classroom scene. Throughout this process Shannon learned to role-reverse (a process in which two people playing roles switch roles) and to take on the role of silent student. As she took on the role, she expressed feelings of anger towards the role of teacher for making her speak. In order to gain distance from the silent student role, Shannon initially assigned the role to me and then gradually took it on herself. By initially exploring the role outside of herself, Shannon communicated her feelings about the silent student by attributing specific qualities to the role as I played it. Eventually she took on the role herself and played out how the role of teacher affected the silent student. This process also occurred in her other stories, in which she initially cast me in specific

roles and then later played them herself. The gradual move towards a less distanced stance allowed Shannon to communicate feelings and express emotions regarding certain issues in her life.

The role-reversal process also provided distance for Shannon, as she learned to step in and out of roles with greater ease and fluidity, which is a component of aesthetic distance. *Role* is an important concept in drama therapy, because like story, it is a gateway into a person's inner world. Before delving into the use of story, this term must be addressed.

Role

Landy (1994) referred to story and role as "primary media" (p. 101), since other expressive media (i.e. video, puppets, masks etc.) could develop through these two sources. Role theory describes role as "personae rather than person, character rather than full-blown human being, part rather than whole" (Landy, 1993, p. 12). In *Personae and Performance: The Meaning of Role in Drama Therapy*, Landy (1993) described his theory that the individual's personality is a system composed of various roles, each holding specific notions of oneself and others. The roles within this system are either *primary* (an individual is born with them), *secondary* (roles that are obtained) or *tertiary* (roles that are played out). Some of these roles are familiar or uncomfortable, while others remain undiscovered.

The term role is not to be confused with a *character,* as the former refers to "a structure, a container that is connected to an archetypal stratum- like mother, guide and trickster" (Pendzik, 2003 p. 95) whereas the latter is the "the particular way in which an individual personifies or incarnates a given role" (p. 95). For example, a client may

explore the role of warrior through characters such as Hercules, a soldier, a karate black belt or Achilles; while a client playing the character of Ophelia may invoke multiple roles such as daughter, lover, sister, victim, and suicide. Therefore, a character within a story may reveal multiple roles through her actions and relationships to other elements in the story. This becomes particularly evident during a created story, since the client must rely on her inner workings to produce the content. The process of creating a story has been outlined by many drama therapists, particularly Lahad (1992). He emphasizes the important steps of the process as they guide the client through her personal journey. Chapter 4 reviews the recommended steps in creating a six-piece story with Lahad's guidelines.

Chapter 4: Story in Drama Therapy

Story Process

Lahad (1992) is an Israeli psychologist and drama therapist as well as the founder of the Community Stress Prevention Center in Kiryat Shmona, Israel. Lahad's work consisted of assessing individual coping styles and resilience while experiencing stress (Lahad, 1992; Lahad & Ayalon, 1993). Lahad (1992) assessed these coping abilities with the Six-Piece Story-Making (6-PSM) technique. The technique stems from *bibliotherapy*, which promotes story-telling to help clients communicate in their own emotional languages (Lahad, 1992). Lahad stated in his work that clients often begin speaking the therapist's emotional language rather than their own. The goal, therefore, is to help the client find his own voice and emotional language using the story. Lahad's technique is well suited for children, as they often do not yet have the cognitive tools to express their understanding of their surroundings clearly through words (Gabel, 1984; Landreth, 2002).

The story-creation process begins with six squares that are filled out with specific instructions. The instructions guide the participant in creating a main character, a mission or task for the main character, a helper, obstacles, coping strategies (how to overcome the obstacle), and a resolution. Its application is popular among drama therapists as the steps are easy to follow and suitable for a variety of populations.

Six-Piece Story-Making Technique

The story-making process occurs by drawing the story on a piece of paper. It requires a writing utensil and a piece of paper. Each square contains a specific part of the story. Clients are instructed and questioned as follows.

1. Make six squares however you want on the paper (folding, drawing etc.) without cutting it.
2. Draw a main character, *the protagonist,* of the story in the first square. She, he or it can be imaginary, real, from a film or show, a legend or made up. Where does the character live? (The participant moves to the second square after this step.)
3. What is the mission or task the character must complete? (The participant moves to the third square after this step.)
4. What or who can help your character, if there is someone? (The participant moves to the fourth square after this step.)
5. What obstacle (or person) stands in your character's way of completing their task or mission? (The participant moves to the fifth square after this step.)
6. How will the main character cope with this obstacle? (The participant moves to the sixth square after this step.)
7. What happens? Does the story have an ending, or does it continue? (The sixth square should be complete after this step) (Lahad, 1992).

After the last square has been completed, the participant may draw any lines or shapes he needs to connect the story. The therapist notes the tone, context, message (themes), and prominent coping modes, while the story is told (Lahad, 1992). The method through which Lahad then measures the coping styles is called the BASIC Ph theory.

BASIC Ph

BASIC Ph is an acronym for coping through the reliance on *beliefs* and values, expression of *affect*, the *social* mode, the *imaginative* way, the *cognitive* response and the

physical and active coping strategy. The purpose is to discover a common language between therapist and client. This was the case for Shannon and I, as her stories provided a common point of reference and a seemingly comfortable medium for her to express herself with. The BASIC Ph categories provide the therapist with an understanding of behaviours the client may need assistance with, his strengths, and his emotional language.

When a client chooses not to tell his story verbally, it can be enacted with gestures and movements. This is particularly useful with children who have selective mutism, as they are less likely to verbally tell their stories, but can have the chance to communicate them through embodiment. In order to clarify what the child is conveying without sabotaging the created story, this researcher utilized the *double*, a psychodramatic technique.

Psychodrama's Double

Psychodrama is a therapist-guided process in which an individual explores a personal problem, in a group setting, through dramatic action (Blatner, 1996). The group acts out various scenes that illustrate the protagonist's problem, while the protagonist remains the focus of these enactments. Psychodramatic techniques are used by the therapist and group to vocalize or embody the protagonist's attitudes and feelings while he is acting out various scenes associated with his problem. Among these techniques is that of the *double*, also referred to as the *alter ego* (Blatner). The specific services the double provides are stimulation interaction, support, effective suggestions, amplification of specific statements, dramatization of feelings and embodiment of words and interpretations (Blatner; Kellerman, 1992). The double also encourages empathy towards the protagonist by identifying the emotion underlying his actions (Blatner). In a

traditional psychodrama, an individual from the group approaches the protagonist and stands behind him. This individual may then say something that he feels the protagonist is not saying aloud, or is indirectly communicating with his behaviour (fidgeting, avoiding eye contact, hesitating etc.), thereby 'doubling' him.

In order to present this material effectively, a double pays close attention to the protagonist's nonverbal communication, roles played, and the way in which the protagonist uses words (Blatner, 1996). The first cues are taken from nonverbal communication (i.e. body language, facial expression, and proxemics) and the double then reveals verbally what he believes the nonverbal communication of the protagonist means (Blatner; Kellerman, 1992).

Combining the double with the 6-PSM (Lahad, 1992) technique creates consistent interaction between the child and the therapist, sparking communication and reflection from both ends through story. Shannon and I engage in such a process in the case study described in this paper. I often doubled her as she enacted her stories, and I took on roles she assigned to me. I did not stand behind her; instead we stood face to face. In the developing stages of scenes and roles, I would use the doubling technique as Shannon enacted or drew her stories. Before describing this process further, I will provide an overview of the methodology, including the theoretical framework, of Emunah's (1994) Five Phase Integrative Model.

Chapter 5: Methodology

This research describes the development of communication between a child diagnosed with selective mutism and me, through the application of story in a series of drama therapy sessions. My findings are presented as a descriptive case study. The use of story was framed using Mooli Lahad's (1992) Six-Piece Story-Making (6-PSM) technique, and the therapeutic process is presented with Emunah's (1994) Five Phase Integrative Model. Although Lahad's process of creating a six-piece story served as a valuable starting point for our therapeutic interaction, the use of psychodramatic techniques described by Blatner (1996) and other projective techniques as proposed by Emunah (1994) and Landy (1994) also contributed to further communication between us.

The primary research question investigated in this study is: How does communication between a child with selective mutism and a therapist develop through story-making in a drama therapy setting? Within sessions, I responded to the content of the child's created stories verbally and through roles, puppets, and masks. The child, in turn, makes use of other projective techniques (masks, art, and puppets) to further communication. Thus, the following subsidiary questions emerge: How does this process of story-making affect the therapeutic alliance? What other projective techniques are effective throughout this process?

Collected Data

Data from the first 4 months of therapy was collected from client records, personal observation, pre and post - session notes, artwork, and meetings with the client's parent. The data collected from the subsequent 4 months , used for the primary description of this case, included the previously mentioned materials, along with video recordings of

sessions, audio recordings of the client's speech, parent meetings, six-piece stories (Lahad, 1992), embodied stories, a parent interview, and a teacher interview. I interviewed the parent after the final therapy session, in the clinic's playroom. I interviewed Shannon's primary teacher at her school, the week before the last therapy session. The teacher's primary language was French, and an English translation of the interview was made (see Appendix E), with her consent (see Appendix F). The interview was recorded and the recording then given to a translator, who transcribed the content into English. This study also includes my personal reflections, as I was an active participant in the sessions.

Setting

The therapeutic work described in this research took place in an outpatient clinic for children under the age of 12. The clinic specialized in treating children with anxiety disorders. Clients were referred by their paediatricians or were brought in by their parents. The treatment team, which consisted of a family therapist, a social worker, a psychiatrist, medical students, and drama therapy interns, decided on appropriate treatment. The proposed treatment varied from Cognitive-Behavioural Therapy (CBT), Eye Movement Desensitization Reprocessing (EMDR), mother-child observation and family therapy, to drama therapy, depending on the client's needs. Children diagnosed with selective mutism were regularly referred to the drama therapy interns, as this modality does not exclusively rely on speech for communication to occur between therapist and client.

Participant

In selecting the participant for this research, I sought a client between 6 and 9-years-old,with a diagnosis of selective mutism. The young girl presented in this study was chosen for a number of reasons. First, the mother's commitment to bringing her every week allowed for a continuous flow in the therapy and an opportunity for a good alliance to develop between the parent and me, as well as between Shannon and me. Second, there was a plethora of background information available, and the parent was willing to give weekly updates on Shannon's progress. Third, the girl took well to drama therapy and the study appeared to be a valuable addition to her overall therapeutic process. Finally, although I worked with several children diagnosed with selective mutism, this young girl was of the age I was seeking, was completely mute in front of others, and had no prior experience of drama therapy.

It is important to note that not all sessions contained one full story, but that the stories included in this study occurred throughout the therapeutic process. Some stopped for weeks and then resumed, while others did not have a clear beginning or ending. The child's mother has also offered valuable insights into some of the stories described in this study.

Structure of the Treatment Process

The therapy process consisted of 28 one-on-one sessions involving the participant and me, over an 8-month period. The first 13 sessions are summarized prior to the in-depth case description. Each session was 45 to 55 minutes in length and occurred in two separate playrooms in the clinic. Playroom 1 was used for sessions 1 to 13 and playroom 2 was used for the remaining sessions. The first playroom was no longer available after

the first four months, so we began sessions in playroom 2. The first playroom contained two microphones hanging from the ceiling, two two-way mirrors covered with roller shades, and a large chalkboard. An emergency phone was in a corner of the room, and a camera was set up in the rear. The second room included an adjoining bathroom, one large mirror and a chalkboard. I provided several objects during the sessions, including a dollhouse and a black suitcase containing a ball, hats, dolls, and masks. Writing utensils, paper, and various craft materials (glue, feathers, popsicle sticks, pipe cleaners, scissors etc.) were also made available. After greeting the participant in the waiting room along with her mother, we would proceed into the playroom, which already was set up.

Theoretical Focus

The theoretical lens through which the series of sessions is viewed follows Emunah's (1994) Five Phase Integrative Model. Emunah's model incorporates some concepts and beliefs underlying psychoanalysis, behaviourism, and humanism and integrates activities and views rooted in dramatic play, theatre, role-play, psychodrama, and dramatic ritual. The model offers a clear framework for the drama therapy process through a progression of five phases. It does not supply specific prescriptions, but rather tailors itself to the insights and perspectives that emerge in the therapeutic process in relation to the individual's situation (Emunah). Therefore, the goal is not to squeeze the individual into the five phases, but to use the phases flexibly to monitor the individual's progress or make appropriate interventions. The overall goals the model strives towards include expressing and containing emotion, developing the observing self, expanding one's role repertoire, and facilitating social interaction and interpersonal skills.

Emunah's Goals

Expression and containment of emotion refer to the release of various emotions with different degrees of intensity in a safe and contained environment. As children with selective mutism are often more withdrawn and unwilling to communicate than other children, this model's goal fits the population's therapeutic needs well. Since the expression in the drama therapy session is free of real-world consequences, children can learn to simultaneously release, yet control, their emotions without initial pressure to speak. This dance between release and containment is created through the distance between the Self and that which is enacted (Emunah). This goal reflects the importance of distance in the therapeutic process, as expression and containment of emotion work well when balanced, but can be therapeutically limiting when clients overly identify with either expression or containment of their emotions. This echoes Landy's (1983) continuum of distance, which highlights the level of release and containment a client may be able to tolerate regarding specific personal material. Emunah's model (1994) mirrors Landy's distance scale by guiding clients through a sequence of phases that carefully frame their need for distance through specific kinds of activities.

Emunah (1994) also emphasizes the need for balance between overdistance and underdistance. The model's first two phases contain suggested activities to provide a more distanced perspective. The next two phases are designed to explore much deeper emotional issues and therefore provide a structure which encourages less distance. In the fifth and final stage, the model intends to bring the client back to a more distanced perspective to help initiate a reflection process on the previous four phases.

A goal associated with expression and containment, and heavily related to the concept of aesthetic distance, is the development of the *observing-self.* This is the part of the individual that is capable of both witnessing and reflecting on the Self in relationship to things, individuals and experiences outside of it (Emunah, 1994). Developing the observing-self is a key component of a balanced therapeutic process, as this part is removed enough from emotion to see various choices, as well as to respond in a reflective stance while in emotional distress. Emunah (1994) calls this part the "director within us" (p. 32). The perspective provides a hopeful outlook, as the client can see how things *could be*, either in her outside life or in her internal world (Emunah).

The third goal Emunah (1994) lists is *role repertoire* expansion, which refers to the practice and elaboration of roles that one plays in everyday life. In the imaginal realm, provided by the dramatic process, a client can experiment with various roles and act out those which are dormant, overused, or undiscovered. This permits the client to practice new ways of relating to others and to play individual roles with more commitment, confidence, and flexibility (Emunah). Broadening the repertoire may help a client explore multiple life circumstances and a variety of outcomes. By responding to old circumstances in a new way, stronger coping abilities may also develop. In this case study, Shannon developed several roles through the stories she created. The gradual process of taking on these roles, experimenting with them, and then stepping out of them, signalled her commitment and confidence in telling her stories.

The expansion of role repertoire may also alter the way in which a client perceives herself. Emunah (1994) remarks that "there is a dynamic, interactive relationship between role and self-image: Our self-image determines our repertoire of roles, and our repertoire

of roles determines our self-image" (p. 33). A therapist can see how a client views herself through the roles she plays and the particular ways in which she plays them. Exploring various ways of playing one particular role or discovering others may then aid in promoting a healthier self-image in the client. In Shannon's case, she appeared to become more spontaneous and confident in her story plot progression as her role-repertoire expanded.

The final goals Emunah (1994) describes are the facilitation of social interaction and the development of interpersonal skills. Drama's collaborative structure addresses social interaction and interpersonal skill by increasing confidence in how individuals relate to one another, both verbally and nonverbally. These goals highlight the important nature of relationships in therapy and how building connections can result in what Emunah terms, "the deepest possible level of examination and understanding" (p. 33). When working on an individual basis, this may be observed through the therapeutic alliance, as it was in this case study.

The way in which these goals are reached is clearly outlined in Emunah's (1994) Five Phase Integrative Model described in *Acting For Real: Drama Therapy Process, Technique, and Performance.* The following section will guide the reader through these phases.

Emunah's Five Phases

During Phase One, *dramatic play*, the goal is to develop trust in a non-threatening, playful environment. Emunah (1994) remarks that children may benefit most from this phase as play is "the child's method of symbolically expressing and resolving internal conflict; assimilating reality; achieving a sense of mastery and control" (p. 4). The

process involves highlighting the strengths and healthy aspects of the client in order to build ego-strength and to encourage interpersonal relationships. Such strength will enable the client to tolerate subject matter that is more challenging in later phases. The activities used to explore themes or specific topics are engaged in from a distanced perspective. Since the therapeutic process described in this report focuses on a child's journey, this phase was one of the most frequently explored, as the playful atmosphere is one children are often drawn to most (Landreth, 2002; Golinkoff et al., 2006). The trust, cohesion, and confidence gained within this phase become the foundation for later work.

Phase Two, *scenework*, moves from the spontaneous play encouraged in Phase One, to improvised scenes containing fictional roles and characters (Emunah, 1994). These dramatic scenes are worked through without much verbal processing, but rather through the freedom of expressing emotions and thoughts by developing characters and roles within scenes. This provides a more distanced perspective, as clients are not forced to make connections between fictional roles or characters they play and their real life. Individuals begin to comment on their own enactments and, toward the end of the phase, start making connections between themselves and the roles they are playing (Emunah). For young children, such as Shannon, these connections are unlikely to occur, as they perhaps do not yet possess the cognitive tools to garner such insight. However, her tolerance for hearing and answering questions about her enactments became more noticeable in this stage. The roles that Shannon began to develop over the course of Phase Two took the shape of actual life roles, as some of her stories became similar to situations in her real life. In Emunah's model, the phase in which real-life roles are further explored is phase three, *role play.*

The life-drama connection becomes most apparent in Phase Three, in which individuals explore scenes that border on real-life stories. There is less distance between the role, character, or story, and the client, as the environment shifts from fictional material to actual material. Although the enactments are still contained by the drama, the exploration of real-life issues in this phase creates less distance then the previously explored fictional content. In order to promote this personal experience, yet prevent the flooding of emotions, the therapist may choose to pause in the middle or at the end of a story or scene to examine or interpret roles and the client's behaviour (Emunah, 1994). This provides the client with both the emotional experience during the enactment, and with a cognitive stance when pausing and reflecting on the content.

Phase Four, *culminating enactment*, reveals the core issues the client faces, making it the least distanced phase. In the previous phase, the client has gained insight into her role repertoire and life patterns, shifting the focus from concrete, everyday concerns to a more in-depth exploration of the unconscious (Emunah). The issues discussed in this phase often shed light on experiences that are distressing the individual. The culminating scenes may contain the reliving and enacting of past events or the releasing of suppressed emotions. The primary basis of this phase is psychodrama and psychodramatic techniques, such as the previously discussed use of doubling (Emunah, 1994).

Phase Five, *dramatic ritual*, marks transitions and closures in the sessions, providing a frame, a form of evaluation and feedback. It is a key developmental step in the therapeutic journey, as the progress from preceding phases results in acknowledged and integrated insights. The function of dramatic rituals is to prepare for the closing of the session by reflecting on what has transpired and acknowledging achievements. This

phase provides a frame for the session and helps the client transition into the outside world.

These phases often overlap and unfold in a variety of sequences. Aspects of several phases can be present in a single session or occur over a longer span of time. In Shannon's case, Phase One remained a consistent component of the session. She slowly progressed through the remainder of the phases, with the exception of culminating enactments, over the 8 months we worked together.

Chapter 6: Shannon

Presentation and Family Background

Shannon presented as an energetic yet somewhat shy 6-year-old girl. Her brown bangs hid her big, dark eyes and her mouth often remained closed, except for the occasional smile. Her first language was Romanian, which she spoke at home with her parents and her 3-year-old brother. She attended first grade at a French school and spoke English fluently as well. Her mother described at-home-Shannon as sometimes speaking *non-stop* when she returned from school, but silent most other times, particularly when outside of their residence. Shannon's selective silence was not a new phenomenon, but one she had carried with her since she was 18-months-old. She would speak at home in a quiet voice, yet only when thoroughly encouraged. By the time she was 3-years-old and beginning daycare, she would not speak to anyone outside of the home.

Shannon's mother described herself as having been similar to Shannon when she was younger. The mother, henceforth referred to as Mrs. S, likewise did not speak outside of the home. Unlike Shannon, Mrs. S eventually began to speak outside of the residence and in front of non-family members at age four. Shannon's father, Mr. S, had been a quiet child and remained so as an adult. Shannon's younger brother, David, also displayed signs of extreme shyness, speaking only in the home and displaying fear of strangers. He had a language delay and was seeing an audiologist and a speech and language pathologist.

Shannon's silence had become even more problematic since she began attending first grade and the demands for speech increased. Her mother sought a psychiatric evaluation

for Shannon before coming to the clinic, because she had become increasingly concerned about Shannon's silence in school.

Prior Evaluations

Shannon was evaluated 2.5 months before beginning treatment at the clinic. From this evaluation it was decided that Shannon's therapeutic objectives were to improve emotional and verbal communication. During the summer, a few family sessions were held and mother-daughter play times were also set into place outside of the therapy sessions. The results of these interactions were not provided in Shannon's file and were unknown to the therapy team. Shannon was then referred to the clinic, where drama therapy was chosen as the primary intervention. The senior psychiatrist coached Mrs. S, during the assessment and in bi-weekly meetings, on how to model emotional expression with her daughter in order to help Shannon build a better base of communication. However, having recently begun an intensive training program, Mrs. S was unable to continue some of these after-school activities midway through Shannon's treatment. Her mother's main concern remained that Shannon was not speaking in the school setting. Mrs. S described several key moments that she believed played a part in Shannon's silence.

Key Incidents

Shannon was a sensitive child, making it difficult to determine how affected she was by certain events. Mrs. S stated that Shannon often hid her feelings from others, including her. It was in moments of stress that Shannon's sensitivity became evident. For example, Shannon was singing Christmas songs with other children at school, but she immediately stopped once she observed an adult looking at her. A second incident also occured at

school, while Shannon and her friends were playing in the snow. Shannon stumbled, and the other girls piled on top of her. She cried silently, but no one noticed. She would not ask them to get off her, and her mother had to remove the girls so she could get up. Mrs. S frequently volunteered during lunch hour at Shannon's school, which is why she was present for the incident. She believed that this incident may have perpetuated her daughter's silence.

A third incident involved a game at school, in which children described the shirts they were wearing. They sat in a circle and spoke one after the other. When it was Shannon's turn to speak, she broke down on the floor and wept. Yet another incident involved a game of tag with her classmates. Shannon was unaware of the instructions given and therefore was immediately tagged "out" and unable to continue the game. She walked towards her mother, crying, and remained upset for the rest of the week.

These events exemplify Shannon's sensitivity and anxiety about speaking, and her desire to connect with others. She became upset when forced to speak, stopped vocalizing when she noticed others watching, and cried when unable to express herself. Her mother conveyed concern for Shannon's safety, because she believed Shannon would also not cry aloud when in potential danger.

Team Goals

The goals proposed by the assessment team in deciding to implement drama therapy, were to help Shannon express and regulate her emotions, communicate clearly both verbally and nonverbally (through gestures, facial expression etc.), and eventually begin communicating verbally on a regular basis. Therefore, her long-term goals focused on developing verbal communication and emotional expression, while her short-term goals

consisted of promoting and elaborating upon her nonverbal communication skills. Shannon exhibited some avoidant behaviours in the waiting room and during sessions, which made it difficult to work on emotional expression. Thus, my first task in our sessions together consisted of raising her self-esteem in order to foster trust and cohesion.

Drama Therapy Goals

During the early sessions, Shannon often turned away from me or abruptly ended activities. This behaviour interrupted the flow of the session and appeared to hinder movement towards her therapeutic goals. She turned away most often when I joined in the activity or asked her a question. Because her goals called for communication development and emotional expression, the avoidant behaviour was slowing progress. Therefore, I proposed an additional goal to Shannon within the session. It was specified in a hand-drawn contract created by the two of us. The contract consisted of pictures that represented the goal of learning to *play together*. This would entail continued interaction through play until the end of each session.

My goals within sessions were the following: to use story in order to engage Shannon in interactive play, to maintain her interest, to observe her involvement, to facilitate communication, to discern which elements in stories appeared important to her, and to observe how and if she connected her stories to her real life. Maintaining interest and involvement goals developed over the first few sessions. During each session, I observed her tolerance and commitment to activities, and gradually attempted to draw them out longer every week through encouragement and questioning.

Shannon's ability to tolerate questions and interact with me grew every few sessions, until she began leading the activities herself and directing me in her scenes. The goal

remained to play together and to help Shannon speak. In session 19, she began recording her voice onto a tape recorder after each session. The goal had progressed from saying a word, to a phrase, to a sentence, and eventually to many sentences.

Session Structure

Sessions typically consisted of a beginning ritual, a warm-up, a core segment, and closure. The ritual, which we created together, involved taking off our shoes and uttering the phrase "Let's get comfortable.". During this time, I would inquire about Shannon's day and how she was feeling. The opening segment usually consisted of an art activity or a game. The middle segment consisted of a scene or role-play between us. The final segment consisted of a 5-minute notification of session closure, which was followed by putting our shoes back on and exiting the play area. After the first 4 months of therapy, the roles, scenes and stories Shannon created from sessions 13 through 28 filled the majority of the sessions.

Activities and Tools

I placed several toys and art supplies in the room and observed which tools Shannon most frequently used and appeared to most enjoy. She engaged in art, played with a ball, and used a clown nose, finger puppets, and a dollhouse. The activities I facilitated with her using these tools were as follows: 6-PSM technique (Lahad, 1992); Draw Your Family, wherein Shannon drew a picture of her nuclear family; My House, in which Shannon used the dollhouse to show me what her home environment looked like; and Who is Who, in which Shannon used finger puppets to describe what various family members were doing in the house. Among the other activities and tools I used were little plastic figures, masks, the Find Me game, and mirroring.

The Find Me Game

This activity required two people, one a follower and the other a leader. Shannon usually pointed at me to be the follower. I used a hat to cover my eyes and turned around in a circle three times. I then moved towards the sounds Shannon made in an attempt to find her. The sounds were whistles, clicks, taps, stomps, laughs, snorting, and claps. The activity built cohesion, relaxed Shannon, and prepared her for the next activity.

Mirroring

There are many types of mirroring exercises in drama therapy (Emunah, 1994) and one of the most frequently applied in this case was *Partner Mirror.* Shannon and I faced one another with a large distance between us. One of us was the designated leader and the other a follower. The leader began slow and simple movements and the follower imitated her. The activity required concentration and commitment, as Shannon and I had to maintain eye contact for an extended period of time in order to mirror one another. The purpose of this activity was to promote interaction between us without putting pressure on her to communicate. The activity provided distance, as it was simple and usually kept Shannon's attention for a while. The activity granted her full control and gave her the opportunity to take on the follower position whenever she felt ready, which occurred in the later half of her therapeutic process.

Chapter 7: Therapeutic Process

Synopsis of the First 4 Months

The first time Shannon and I met, she hid behind her mother's legs and hesitated to follow me into the therapy room. Her mother, a very encouraging, supportive woman, gently nudged her towards me, which appeared to help. Shannon slowly followed me into the playroom and scanned the area. She was initially shy about interacting with me, so I took a directive stance during the first three sessions, suggesting activities we could do and asking specific questions. In order to build our alliance, I began with a variety of activities aimed at assessing what toys and activities Shannon would be comfortable with. As Shannon became more confident over the first three sessions, I increasingly switched to a less directive approach and let her creativity and spontaneity lead the session. She then began to laugh aloud and make frequent eye contact before continuing an activity.

The Beginning

The first 12 sessions developed Shannon's ability to play collaboratively, sustain a small scene, and take on a role. She progressed from avoidance to interaction within the first four sessions. Sessions 1 through 3 involved Shannon playing alone and turning her back towards me. She avoided eye contact and rarely answered questions or initiated any form of collaborative play. She would often walk around the room and pick up toys or draw a picture in the corner of the room with her back towards me.

In session 4 this changed when Shannon approached the dollhouse and allowed me to sit next to her. I asked her to show me, using the little furniture and the finger puppets, what her house and her family looked like. She assigned the penguin finger puppet to herself by pointing to first it and then herself. (Mrs. S later told me that Shannon was

reading a book about a penguin that lived at the North Pole, but gave no details.) She transitioned through the dollhouse rooms, using gestures and drawn pictures to describe each one. After the last room, Shannon stood up and moved to another activity without explanation. In response to this, I initiated the first six-piece story (Lahad, 1992) technique to re-engage Shannon in a collaborative activity.

The first story.

Shannon drew her brother, David, as the main character; but the next square shifted to her standing in front of her house. She stamped her feet when I began looking away, and I asked if she would like me to watch her as she drew. She nodded and continued with the third square, which depicted her mother driving her to school. Shannon then drew herself standing in front of the school building and finished the story with all of her family members in a car travelling along a road. The shifts between squares made it difficult to follow the thread of the story, but they gave a glimpse of Shannon's life. I told the story back to Shannon and asked her to correct me at any point. The following story resulted from this interaction.

Once upon a time, there was a little boy named David. He had a sister named Shannon who was standing in front of her house. Then Shannon's mother drove her to school, and afterwards the whole family drove somewhere. The end.

Showing me something familiar during this session appeared to put Shannon at ease. Her home and her family were subjects about which she could communicate clearly, and the activity appeared to foster more interaction and communication between us. Shannon seemed more confident when drawing and receptive to my questions during the story-making process.

A sad face.

During session 6, Shannon communicated her sadness through a drawing. Mrs. S informed me that Shannon had broken down crying in front of her class because the in-class activity required her to speak. Shannon was initially reluctant to communicate in any form during this session, but agreed to draw on the blackboard. She turned away and began drawing on toys and throwing them across the room. I asked her to stop, but she struggled with the newly-set boundary, continuing to mark several toys and throwing them onto the floor. I asked her to draw me a face on the blackboard that reflected her feelings about the afternoon event at school. Shannon stopped and approached the board, drawing a face with a frown and tears coming out of the eyes. She nodded to my questions, confirming she was upset because she did not want to speak in front of the class.

Shannon was unsure how to help herself feel better until I offered my help. I initiated a mirroring game to promote focus and cohesion. The experience of breaking down appeared to have made Shannon upset, and her silence at school did not allow her to share this sadness with anyone until her mother came to pick her up. The inability to articulate her sadness appeared to contribute to her frustration and avoidance during the session. In order for Shannon to feel heard and validated without experiencing more pressure to speak, the activity needed to be simple, fun, and collaborative. Shannon stopped throwing toys after the activity and appeared calm. During the closure of the session, I asked her to draw another face on the board depicting how she was feeling. She drew a face with a straight mouth. She confirmed through head movements and gestures that she felt better but was still upset.

When she turned to leave with her mother, Shannon turned around, made eye contact, and waved goodbye. Mrs. S turned to me in surprise and informed me that this was unusual. This interaction demonstrated Shannon's willingness to initiate the closing of our meeting by directly acknowledging my presence with a wave. The following weeks would challenge Shannon in other ways, as she successfully spoke in front of her teacher and struggled with being acknowledged and praised by her mother and me.

Mirroring emotions.

During session 8, Shannon hid behind the curtain in the waiting room while Mrs. S informed me that she had read aloud to her teacher that day. When I praised Shannon for her success in the playroom, she hid under the table, covering her face and shaking her head. Although Shannon was satisfied with the transition into speaking, she could not cope with the attention she received after the act. I believed the transition was too soon for Shannon and therefore refrained from speech goals, continuing instead to focus on emotional expression for that week. I initiated mirroring again by lying on the floor and hiding my face. Shannon responded by taking the leadership position and making bigger movements, until she crawled out from under the table and we stood across from one another. She began to laugh aloud and we experimented with volume and quality of laughter by mirroring each other.

In session 9, we used mirroring again when Shannon became upset with me because some toys were missing from the playroom. She began throwing objects and looking around the room for the other toys. When I asked if she was displeased with me, she nodded and made a grimace. I mirrored the grimace and said, "I'm so mad! Where are the toys?" Shannon laughed and we continued to mirror one another by sticking our tongues

out and stamping our feet. We then slowly moved towards one another, and she quickly shied away. I asked if this was too close for her and she nodded. We played the Distance game, wherein I would move towards her and she would raise her hand when I was too close. I asked if she felt nervous and she nodded, indicating that she did not like people that close to her. Shannon's ability to communicate her feelings had improved tremendously since the first session. The next session signalled a temporary transition out of dramatic play and into role development, as Shannon created a clown role that reflected shyness and embarrassment. Although no gender was assigned to the role, the male gender will be used to avoid confusion.

The clown.

The role of the clown emerged in session 10, when I placed a clown nose on my face. Shannon reacted by pointing her finger at me and laughing in an unusual way. The laughter sounded forced, as she took a deep breath and pushed out the sound. It appeared as though she was not laughing at *me*, but rather at whatever I had become by placing the clown nose on my face. I responded by asking, "Am I embarrassed? Scared? Sad?" She answered these questions affirmatively by nodding and taking all of the objects in the room and lining them up in front of me in the role of the clown. She indicated that they were looking at the clown by pointing at the toys and the clown. When the clown attempted to escape, Shannon moved a toy in front of him. In the role of the clown I played that he did not like all the toys looking at him. As the little scene ceased to move forward, I requested a role-reversal, and Shannon put on the clown nose. As the clown, Shannon looked at the objects and walked through them, knocking them over and signalling her freedom by celebrating and throwing her hands up. During session 11,

Shannon created an alternate ending to this scene, by having the clown sneak away from the staring objects without being noticed. She celebrated silently, as she hopped up and down waving her hands.

The role of the clown captured many of Shannon's feelings that arose from upsetting events she had experienced. These included the stares she received from her classmates when she had cried and refused to speak, the closeness that had made her nervous within the session, and the need to be seen without the pressure to speak. Shannon's ability to take on this new role opened up new opportunities for coping with these feelings as she tried out different approaches of dealing with the stares she received. However, she continued to struggle. When she returned the following week, she hid under the table and covered her face.

A long way to go.

In session 12, the last session before vacation, Shannon brought in a little chocolate heart. As she handed me the heart, she once again hid under the table and put her head in her hands. I thanked her and began to mirror her movements. Shannon mirrored me back and emerged from under the table, as she had in previous sessions. We transitioned into the Find Me game, in which she tapped, stomped, and laughed to enable me to find her. For the closure, we returned to mirroring, and I assumed the leadership position. When I opened my mouth widely, Shannon ceased to mirror me. She shied away slightly and I gave her control of the mirroring game.

Shannon was not ready to give me complete control over the mirroring game, as indicated when she withdrew after I opened my mouth. Returning control back to her helped her regain confidence to continue the game at her own pace, without the potential

threat of having to open her mouth or communicate verbally. Shannon and I still needed to build further trust and cohesion before she would be ready to experiment with speaking.

Stages of Emunah's Five-Phase Model

Dramatic play consistently remained Shannon's safety zone, as she could engage in activities that were distanced and in which she was not pressured to speak. Overall, the 12 sessions described followed Emunah's (1994) first stage closely, with occasional transitions to Phases Two and Three. Dramatic play was a phase inherent in all sessions. It was Shannon's home base and she returned to it when dealing with stressful topics such as school and speaking. She could not cope with these issues effectively in the session and required activities that built ego-strength in order to progress towards her therapeutic goals. Mirroring acted as one of the key activities that gave Shannon strength and motivation to work through these moments. It promoted spontaneity and interaction, another ingredient in Emunah's First Phase. The spontaneity fostered by mirroring, helped Shannon sustain activities for prolonged periods, as she learned to cope with transitions and began reacting to similar situations in new ways. This change presented itself in session 10 when Shannon set up a little scene with the role of the clown.

The clown scene permitted Shannon to act in a manner that she would usually avoid. The newly developed spontaneity enabled her to act within the present moment. She changed her usual pattern of avoiding and hiding, replacing it with a new action with the help of the clown. As Emunah (1994) stated, this was the strong point of scenework, as the "diverse scenes and roles afford clients the opportunity to experience and exhibit new sides of themselves" (p. 37). Shannon was often stuck in the role of silent child in the

outside world, rarely having the opportunity to break free from this role unless in the safety of her own home. Landy (1994) remarked that "one projects qualities of oneself outward in order to play and to test reality from a safe distance" (p. 108). Shannon's shyness found a tangible form in the clown, concretizing a potential aspect of her semi-silent life.

Although the direct meaning of the clown was not overtly discussed, it is the playing out of the scene that is important in Phase Two, as this helps uncover the underlying meaning of the enactment (Emunah, 1994). As Shannon and I repeated the scene several times over the course of two sessions, the themes incorporated shyness, anxiety, fear of being seen, and nervousness. Shannon's initiative in changing her ending to the scene highlighted her growing confidence and trust in our therapeutic alliance. It prepared her for the next 13 sessions, during which she created multiple roles and stories.

Chapter 8: Communication and Story

Creating Stories

Return from Vacation

In the waiting area, before session 13, Mrs. S told me that Shannon had agreed to read aloud with her in the library every week. Shannon's new enthusiasm for reading aloud was significant, since she had been unwilling to participate in such activities before. She smiled at her mother's comment, then ran quickly ahead into the playroom, hiding under the table and covering her face. She appeared embarrassed about this new ambition. I entered the room behind her and began the mirroring game to help her feel confident and ready to restart the therapy after her winter break. She slowly moved from under the table into the center of the room and we mirrored each other until she dropped the movements and sat in a chair. I asked her if she would like to make a story and she agreed, so we began a six-piece story (Lahad, 1992).

Shannon's hands moved quickly as she drew. She sketched a sunny environment as a setting and a penguin as her main character. She drew a bowl of food for the penguin in the second square and a dog as the helping character in the third square. These were reappearing characters, which Shannon had used for the Who is Who activity in session 4. The activity involved Shannon choosing various finger puppets to portray her family. She had used the penguin to represent herself and the dog to represent her mother. I believe that Shannon was using familiar things because she was returning from vacation and perhaps needed this familiarity to get comfortable in the session.

Before I could ask the fourth square question (What thing or person is in the penguin's way of getting its food?), Shannon got up and wandered around the room. She

expressed no interest in continuing the story. Appearing energized, she indicated with gestures that I mirror her, thus continuing the mirror game we had played earlier. Since the purpose of this session was to re-engage Shannon in her therapeutic process after having been on vacation, I followed her lead. After mirroring, Shannon passed me the hat and we played the Find Me game without returning to the story she had created. It appeared we would remain in Emunah's (1994) first phase, dramatic play, for the remainder of the session, participating in familiar activities from earlier sessions.

Shannon was restless during this session, possibly because it was the last day of her vacation; school was to begin again on Monday. Mrs. S had also told me, before the session, that Shannon was excited to be back, which became apparent in her quick transitions between activities. Her excitement and enthusiasm were signs that she was willing to work, but they were also elements that had to be contained within a dramatic form to help her reach her goals. Although the activities served to focus her for a short period, her excitement had exceeded the containment of each activity, making it difficult for her to communicate clear thoughts.

Going for a ride.

In session 14, Shannon and I began with the mirroring game, which helped her focus. She also brought the book "Jingle Bells" with her and signalled, by pointing her finger at me and then at the book, that she would like me to read to her. The book depicted characters riding through the sky on a sleigh. After I finished reading it, she spontaneously initiated a scene, creating a gradual entry into Phase Two, scenework. Shannon began by setting the scene. She got up and placed three chairs in front of the door. She set a stuffed animal in the last seat, pointed for me to sit in the middle and

climbed into the front seat herself, using the door handle as a steering wheel. She began moving left and right and I followed her movements as we 'went for a ride'. She laughed loudly, and began to jump up and down in the seat to simulate the vehicle picking up speed. We continued the scene for several minutes, switching seats as I drove and she followed my movements. I encouraged her to play out the scene, during which she made a small shrieking noise when the vehicle stopped.

It is possible that the "Jingle Bells" story had inspired the scene. Although she was still experimenting with spontaneous material, she had progressed into scenework, making the process easier for me to follow as the scene began to shape her material into a small storyline. Inviting me into the vehicle and letting me take the wheel further indicated that she was learning how to play together and share the playspace. The following sessions further demonstrated Shannon's willingness to initiate interaction as she began communicating with me by writing words on paper.

The telephone.

During session 16, Shannon initiated a short role-play when she picked up a toy telephone, indicating that she wanted to call a friend. She laughed into the receiver but did not say anything. I asked her if she would like to call someone. She gathered a piece of paper and wrote the name "Trudy" on it. I inquired if this was a friend at school, to which she nodded. I asked, "Would you like to practice what that might be like, to speak with Trudy?" Shannon smiled, nodding, and I put on a mask to play Trudy. She pretended to call Trudy and laughed into the phone, but then indicated that something was wrong by frowning and pointing at the phone. I asked if she would like to speak with someone on the other line, to which she nodded. She wanted to call someone on a real

phone. This role-play was significant, since Shannon was expressing a desire to communicate verbally, something she had not done yet within the session.

Mrs. S and I discussed Shannon's role-play following the session. Mrs. S asked her daughter if she would like to try calling a friend that week, but Shannon shook her head. It appeared that rehearsing within dramatic reality was a more manageable task for her at that time. She practiced laughing into the phone again in session 17, but then put it on the table and initiated a scene which included the role of a student and the role of a teacher. This scene developed into a story that spanned three sessions. Four additional enacted stories followed, trailed by a drawn six-piece story (Lahad, 1992) in the final session.

Six Stories

Before describing Shannon's process further, it is important to note that she did not select the titles for the following stories on her own. The titles are provided as reference points for the reader in order to follow Shannon's process more easily. Neither did she name all the roles in the stories herself, since she did not speak in the session. During the process, I suggested names, based on the description Shannon provided for each role. We kept the names she liked and discarded the others. Additionally, although the details of story development are discussed within each section, some are not explained because they are included in the actual story. The following will describe this process over the course of 11 sessions, which involved the creation of five stories. Shannon orally recited the sixth story, one she learned in school.

The Student and the Teacher

In session 17, Shannon approached the blackboard and picked up a piece of chalk. I asked if she would like to write on the board. She stamped her feet and pointed at me

with a frown. She repeated the gesture and then wrote an arithmetic problem on the board. I reacted in the role of the *student* and sat in front of the chalkboard, raising my hand. The environment transformed from a therapy room into a classroom, where a student had to answer a math question. She put several more arithmetic problems on the board and stamped her feet, indicating that I had to answer them immediately. As the setting and my role slowly became clear to me, I wondered what role Shannon was acting out. I asked her if she was a bossy *teacher*, to which she responded by laughing and nodding. This was the first time a topic regarding school appeared within the therapy. It was an important developing scene, because school was the setting in which her silence had been most prevalent.

Shannon placed a finger over her lips and looked at me while I was in the role of the student, indicating that she wished the student to be silent. She played the role of *silent student* in her real life, a role she needed distance from, as it was causing serious problems and prompting concerns from her mother and her teachers. Within this scene, Shannon appeared to view the classroom as hostile, as the teacher demanded answers from the student. The teacher role provided her with the opportunity to gain distance from the silent student and to express her own feelings of frustration towards the role.

After the teacher had continuously forced the student to solve math problems without speaking, Shannon stepped out of role by approaching me and sitting in my place, wanting to play the student. In the student role, she began to defy the teacher by laughing aloud, throwing objects, and moving around the classroom. Interestingly, the more the teacher requested silence in the classroom, the louder the student laughed. The opposite was true in Shannon's outside life, as the more her mother, teacher, and other adults

asked her to speak aloud, the more she refused and remained silent. Her oppositional behaviour left me wondering about my own involvement as the teacher in the scene. Shannon displayed a lot of anger each time she played one of the roles. The transference that resulted led her to act out towards me even when we were out of role, a phenomenon that occurred in later sessions as well.

After Shannon and I ended the scene and began closing the session, she continued to come towards me, stamping her feet and pointing at the board. I informed her that we were no longer in role and that we must end the session for the day. She continued her gestures, stuck her tongue out at me and raised her hand as through she was going to hit me. I immediately set a boundary, stating that no hitting was aloud, unless it was 'pretend,' and then only within a scene or story. She agreed and slowly helped pick up some of the chalk she had dropped earlier in the scene.

Since I was another adult in Shannon's life who was attempting to help her speak, I anticipated that she would react in the same way to me as she did to other adults in her life - with silence. Shannon's seemingly aggressive reaction as both teacher and student surprised me and led me to consider that these roles may be closely related to her real life. I believed that we were entering Emunah's (1994) third phase, role-play; but I was not sure if Shannon was prepared for this phase, as her aggression could break the frame of the story and keep her from exploring both roles effectively. To help Shannon remain within the scene, we used a little yellow plastic bird she brought with her to session 18 to represent the teacher role. Using this object, Shannon could express her emotions fully, yet have enough distance to keep the story going.

In session 18, Shannon and I reviewed the story, signalling one of the first transitions she had made into a reflective stance. In response to my questions about the teacher role, Shannon made one of the biggest transitions in communication up to that point and wrote the words 'yes' and 'no' on a piece of paper. I believe the questions I asked became too difficult to answer without words, compelling her to seek a clearer way of expressing herself. This demonstrated Shannon's commitment to the conversation and her willingness to make her thoughts clear to me. She indicated through her gestures and her written answers to my questions that the teacher was male and very mean.

It appeared that Shannon was referring to a real teacher, as she communicated through head movement that not all her teachers at school were mean. Mrs. S had also informed me, before the session began, that Shannon had had a difficult time at school over the previous week, when a teacher had tried to make her speak in class. Shannon specified through her yes/no paper that she had felt nervous and scared in his class because she had had to approach the board in front of all her classmates. She became visibly upset, signified by her tightening lips and clinching eyebrows. I asked her, "Do you get mad just thinking about it?" She nodded, grabbing a crayon box off the table and throwing it onto the floor. I continued, "He makes you talk in class?" Shannon picked up the little, plastic bird that represented the teacher, stuck out her tongue at him, then pretended to sit on him.

These reflections on the teacher role were a large step in Shannon's therapeutic process, as she clearly communicated emotions and thoughts to me with gestures. She continued to explore the role of teacher in session 19 by drawing him on a piece of paper, which she showed me. I began reviewing the information she had given me the previous

week about the teacher, but she shook her head when I said the teacher she depicted in her story was mean. I attempted to clarify her answers and continued to ask if the teacher was nice. Shannon nodded, but then quickly shook her head. I asked her if the teacher was mean in the story and she nodded. During this session, she appeared less upset when reflecting on the teacher role, occasionally admitting that he was not *always* mean, yet he remained so in this particular scene. *The Student and the Teacher* scene then developed into a story through another connected scene in session 19.

In session 19, I took on the role of the student again, in order to offer interaction between both roles and to move the story forward. Shannon took on the role of teacher, standing next to the board and writing arithmetic problems on it. When the student gave an incorrect answer to the problem, the teacher raised his arm and bolted towards her as though he were going to strike her. The teacher then stopped abruptly, lowered his arm, grabbed a long piece of string, and tied it around the student's arms. He raised his arm again and made quick little slashing motions. I stepped out of role and asked Shannon if the teacher was cutting the student. She nodded and continued the motion. I then asked for a role-reversal, using a tapping motion. Shannon became the student and quickly pretended to tackle the teacher to the ground. Throwing her head back, she indicated that the teacher was dead. The student celebrated victory by jumping up and down and opening her mouth, but no sound emerged.

As the story ended with the death of the teacher, Shannon reached out her hand for a tape recorder in the room. Mrs. S and I had set up a rewards system for Shannon the previous week.. As it appeared she was still resistant to the idea of speaking in the sessions, her mother was willing to reward her outside of the session if she began to

speak every week. When Shannon pushed the record button, she looked at me and pointed at the door with her finger. I asked if she would like me to wait outside while she spoke and she nodded. I exited the room and she recorded, "cookie, cookie, cookie," giving the tape recorder to me when I re-entered. She indicated by plugging her ears and shaking her head that she did not want to hear the recording. She then pointed at me and the recorder, implying she would like me to listen to it while she waited outside.

Shannon also gave the recording to her mother, who entered the room after the session was over. Mrs. S explained that Shannon had wanted cookies on the way to the clinic, but that she had decided to wait until after the session to buy them for her daughter. Shannon made eye contact and nodded. The message on the tape recorder had made her wish clear, and she would now receive a cookie on the way home. Shannon had not only broken her silence but had completed a story as well. Her goal for emotional expression was being met by her willingness to clearly describe through signs, written words, and actions her character's feelings, characteristics, and actions in the story. I noticed that she appeared frustrated with the teacher in her story, perhaps because he had made her feel powerless, anxious, and forced to speak in class. However, she also demonstrated her frustration with the vulnerability as the student, since her silence made her appear incompetent and foolish in front of the class. Through these two roles, she was able to explore, fight, and metaphorically kill some of those fears, frustrations, and feelings of anger within the session.

The completed story also highlighted Shannon's ability to play together and to sustain interaction with me for longer periods. In the story process, we engaged in a nonverbal dialogue through the characters, reacting to one another in role and reflecting

through drawings and written words. This was a big shift from her previous interactions. Instead of turning away without explanation, she was taking initiative to search for a mode by which to communicate. A new level of trust was achieved, in which Shannon shared anger, frustrations, and hurt feelings with me as we both reflected on her story. In combination with the rewards system and her mother's participation in the process, she appeared comfortable enough to use her voice. However, she still demonstrated a need for distance from me, and perhaps from her own speaking role, shown by her need to leave the room before I played her tape.

The following is the summarized created story that led up to this part of her process over sessions 17, 18, and 19.

Once there was a bossy teacher and a silent student. The teacher wrote many math problems on the board and the student tried to solve the problems. However, no matter how hard the student tried to get the answers right, the teacher always laughed and pointed at the student, telling her she was wrong. The teacher was mean and demanded that the student get up in front of the class to solve the problems. This made the student feel scared and nervous and her heart began to beat fast. The teacher also tried to make the silent student speak in class, which made the student very angry. One day the teacher took a long piece of string and tied the student up. The student was powerless and no one could help her. She had no friends in class and was all alone. When the student asked what the teacher wanted from her, the teacher began to cut the student with scissors, wanting to hurt her.

The student managed to free herself from the string and jumped up in front of the teacher. She beat the teacher down to the floor, tied him up and killed him with the

scissors. She celebrated by laughing, clapping her hands and opening her mouth to rejoice, but no sound emerged. The end.

The Student and the Teacher story revealed that Shannon's silence may have been a result of anxiety she felt about speaking in front of other people, a theme we had explored with the clown role. It also demonstrated her view of the teacher, as she believed he was actively attempting to harm the student. The theme of being harmed and feeling threatened trickled into successive stories and remained a solid theme for the remainder of her therapy. *The Student and the Teacher* story opened up avenues by which Shannon would begin new stories that involved her fear of monsters, her helplessness, her need for survival, and her anger towards me.

The Poo-monster

During session 20, Shannon brought a little green frog with her and used it to portray a poo-monster in her new story. She conveyed through gestures that she had received the little rubber figurine as a reward from her mother for having spoken in the session the previous week. She approached the center of the room with her frog and sat in front of the blackboard. She pointed at the board and signalled for me to write something on it. I took a piece of chalk and wrote an arithmetic problem on the board. While my back was turned, I heard a *pfft* noise behind me. As I turned, Shannon shook her head and pointed at the little frog. I took on the role of teacher, as it appeared we had set up a classroom environment similar to that of the previous week. The teacher scolded the little frog for making noises in the classroom.

When the teacher turned and wrote on the board again, the little frog made another *pfft* sound, louder than before. As the teacher turned, Shannon once again shook her head

and blamed the little frog for the disturbance in the classroom. A new plot unfolded and *The Student and the Teacher* scene faded out. The little green frog became the main character, guided by Shannon's hands.

The scene began with a calm little frog that became increasingly disruptive and aggressive towards both Shannon and me. The setting changed and Shannon got up from the floor and spontaneously began hand-washing and tooth-brushing movements, indicating that we were now in a bathroom. She and I engaged in continuous cleansing rituals (i.e. washing hands, brushing teeth, and showering) because the little green frog continuously peed and pooped on us. Shannon demonstrated the green frog's actions by acting them out. She made *shh* and *huu* sounds to describe washing hands, showering, and brushing her teeth. Loud groans came from the poo-monster as Shannon frantically moved throughout the bathroom.

It was a different process compared to Shannon's story of *The Student and the Teacher.* In this story I became a mirror to her rather than one of the other roles or characters. I mirrored all of her movements and expressions, as though we were one person. I saw the story through her eyes and she through mine, as we feared the poo-monster together. The only questions I asked during this time were those that guide Lahad's (1992) 6-PSM technique. Shannon acted out the entire story, using the questions as a guide. The following describes this story, which occurred in session 20 and did not reappear thereafter.

There once was a little green frog that continuously peed and pooped. If people got in its way, it became angry and peed and pooped on them. It found its way to a bathroom where a girl, Shannon, was brushing her teeth and washing her hands. It peed and

pooped on the girl, who then returned to brushing her teeth and washing the pee and poop off. However, the green frog became so furious that it peed and pooped more than before until washing hands and brushing teeth was not enough for Shannon to get clean. She had to take showers to rinse the pee and poop off. She was very afraid of the green frog, which was relentless and continued to pee and poop on her. She had to repeat the same sequence of brushing her teeth, washing her hands, and taking a shower in order rinse off the pee and poop.

Shannon then had to use the toilet. The cleansing sequence began from the beginning as the little green frog peed and pooped again. She feared it and decided to flush it down the toilet. However, the frog hopped out of the toilet and repeated its pooping rampage. Then Shannon made a little place for the frog to live so it would stop coming into her bathroom. She surrounded the frog with blocks and built a little city for it. She decorated the little blocks with paper and placed the frog in the center of it. It peed and pooped within the walls she had built. She stepped back and looked at the little home she made. The frog pooped and peed in peace in its new home. The end.

This story highlighted Shannon's vulnerability as the victim of the story, a role she had tested briefly during our reflections on *The Student and the Teacher* story, but had not fully explored and taken on in her therapeutic journey. As the victim, Shannon would pant, sigh, and look at me with her eyes and mouth wide open and her eyebrows raised. The pace of the story was very fast, and Shannon showed a sense of urgency in each transition, through her quick movements from sink, to shower, to toilet. As she conveyed these strong feelings of fear, she was not overcome by them; she could move swiftly without hesitation from playing the poo-monster character to playing her own role

throughout the story. The smooth transitions through the 6-PSM (Lahad, 1992) questions, her ability to move in and out of roles with ease, and the new noises that she made (noises accompanying washing and the role of the poo-monster) indicated that this fictional setting elicited a more balanced expression of emotion than had the previous setting.

This contrasted with the transitions between roles during *The Student and the Teacher* story as well as with Shannon's position as the victim. Although Shannon, playing the student, appeared to be a victim in the previous story, in moments when the role was being victimized (tied up, forced to approach blackboard) I was playing the student and Shannon was playing the teacher. When the teacher became the victim towards the end of the story, Shannon role-reversed and played the Student, consistently placing herself in the oppressive role. In *The Poo-monster* story, the plastic object and the bathroom setting appeared to provide Shannon with enough distance from the previously life-mirroring classroom story. *The Poo-monster* gave her the chance to explore her feelings of vulnerability and fear in a more distanced and fictional setting.

The smooth transitions into, during, and after the story, appeared to have left Shannon smiling and in what appeared to me to be a happy mood. She walked through the room and scanned the table top and the floor. She appeared to be looking for something. Shannon found the tape recorder and pointed towards the door, indicating she wanted me to exit. While I was outside the room, she recorded, "I love you," and then reopened the door. She indicated by pointing her finger at the device that she would like me to listen to the tape while she waited outside. Shannon was still not ready to hear her own voice. After I heard the recording, she pointed towards the waiting room, indicating

that she wanted to play the "I love you" for her mother. We brought her mother to the playroom and played the message. As the recording played, Shannon plugged her ears. She could not explain why she did this. Her mother and I did not push the subject, as she appeared already nervous about us playing the taped message with her present.

A two-week break followed this session. Shannon had a one-week vacation and was attending camp. The following week, she returned to school. During that time, her mother also began classes. Mrs. S reported that, during this week, Shannon had become increasingly aggressive at home with her brother and had even claimed that she was ill at school, requesting her mother to pick her up. When Shannon returned to the clinic for another session, she appeared agitated and frustrated, throwing objects and avoiding eye contact with me. I recalled session 13 as having begun in a similar, but more playful manner, compared to Shannon's behaviour this time. It appeared that when Shannon was separated from the therapeutic process for longer than one week, she returned needing more structure and support than usual. It took nearly half of session 21 to engage her, until she created a story with figurines that shed light on her current frustration.

The Intruder

Shannon approached the dollhouse in the playroom, picked up four figures (a little bird, a zebra, a leopard and a little kitten) and placed them in the dollhouse. She set the figures up and began to show me a story with the animals. At this point, I remained an observer, only asking questions about the characters she was manoeuvring with her hands. She placed the little bird inside the house and stuck out her bottom lip. I asked her if the bird was sad. She initially shook her head, then changed her mind and nodded. She picked up the giraffe and showed it walking towards the house. I continued, "What would

the Giraffe like in the house?" Shannon pointed at the bird and the kitten. The giraffe kicked the little bird out of the house. Shannon then threw the giraffe onto the floor and frowned.

I was unsure at this point where this story was leading, but the manner in which Shannon was telling it indicated that she was frustrated with something. I inquired: "Who do you think can help the bird?" She grabbed the zebra and the leopard and placed them in the home. The Leopard fed the little kitten, which sat next to the bird and then all the animals fell asleep. Shannon looked at the house and smiled, indicating that everything was all right in the home. The animal family seemed to mirror Shannon's family structure, the detailed actions indicating that she was telling a story very close to her real life.

Shannon grabbed the giraffe, which then jumped towards the house in a sudden movement, catching the sleeping animals off guard. I asked, "What do you want to do to the giraffe?" She placed the giraffe in the trash and laughed. I queried, "Do you think he'll come back to hurt the bird?" She nodded, put all the figures in the home to sleep, took the giraffe out of the trash and made him creep quietly towards the house. The leopard woke up and attacked the giraffe as it tried to enter the house. Meanwhile, Shannon gasped, indicating that the other figures were frightened. I asked, "What does the giraffe want?" to which Shannon pointed at the kitten and the bird. As she made the giraffe enter, the leopard and zebra fought the giraffe to keep it out of the house. I inquired, "Why does the giraffe want the little one?" Shannon shrugged her shoulders and the giraffe battled the zebra, killing it. The giraffe attempted to enter the home, but the leopard kicked it out and remained with the kitten and the bird. Shannon knocked the

giraffe over and implied it was dead by tilting her head to the side. She then picked the zebra up and placed it back in the home.

At this point, the story ended and I asked her if the animals were a family, to which she nodded. I inquired as to which one was the father and she pointed to the zebra. She indicated that the leopard was the mother, the kitten the baby and the bird the older sibling. I suspected that this story was related to Shannon's frustration surrounding her mother's absence, as this was a large issue in her life at the time. I was unsure whom the giraffe figure may have been meant to represent, but she appeared open to reflecting on the story, so I continued to question her.

I asked Shannon if everything was now safe in the home and she nodded. I questioned, "Are you angry at the giraffe?" She nodded. I asked, "Is it a woman or man giraffe?" She walked up to the board and drew a female stick figure with long hair, a triangle dress, and a smiling face. I replied, "Woman." Shannon nodded and wiped it away. I asked, "Is she young or old?" Shannon wrote the word *yung* [*sic*] on the board. The person Shannon drew on the board looked similar to me, but the end of the session was drawing near, so I waited until the following week to mention the giraffe again. Shannon walked over to the table and picked up the tape recorder. As in session 20, she signalled for me to leave the room while she taped a message. She pointed at the adjacent bathroom, which I entered and where I remained until she had recorded her message. Once she had completed recording her phrase, I asked her to add an additional phrase about her experience at camp the previous week. Shannon agreed and followed the first message, "I love you, Mommy," with, "I love my professor."

Shannon then handed me the tape recorder, pointed at it and then at me. She closed the bathroom door behind her and I remained, listening to the messages while she waited in the bathroom. After hearing the messages, we fetched Mrs. S and played them for her. Mrs. S was puzzled by the meaning of the second message and asked Shannon what she meant by it. Shannon approached her and whispered in her ear that she was referring to her camp director. This was a significant moment for Shannon, as she had never spoken with me in the room before. She appeared relaxed while doing so, continuing to play with masking tape in the room while her mother and I talked. Another significant part of this interaction was the cooperation Shannon showed by adding a second phrase onto the tape recorder. It appeared that she was becoming more relaxed and receptive towards my request for her to speak. She showed this by simply following my request without hesitation.

The next week Mrs. S told me that Shannon had been unusually talkative and sociable at her brother's birthday party, interacting with guests and speaking to them aloud. Since Mrs. S did not offer details about this event, it is difficult to draw clear connections between Shannon's speaking in public and her therapeutic process. Regardless, Shannon's verbal communication indicated some form of change in her behaviour, as she had refused to interact in such a manner previously. Mrs. S said she was happy about her daughter's progress. Shannon returned to session 22, smiling and appearing in a good mood. We revisited *The Intruder* story and I asked her questions about the giraffe figure. She drew the young woman on the board again and laughed. I asked her if I was the giraffe woman and she laughed aloud and nodded.

I recalled the content of the previous week's story and wondered if Shannon believed I was interfering in her family life. I asked her if she believed I was trying to take her away from her mother, to which she nodded. I also asked if she was angry with me because her mother was no longer at home and she nodded again. It appeared Shannon and I had reached a new level of trust in our therapeutic relationship, as she now felt comfortable enough to signal that she was angry with me. I believe Shannon may have felt that I was taking her away from her home, because I was encouraging her to speak aloud in the session. This is something she usually did only at home, particularly with her mother. Now that her mother was not home as often, and she was beginning to speak more frequently outside of the home, Shannon had to cope with being more independent and with voicing her needs.

Shannon did however, clearly indicate through hand and head gestures in response to my questions, that she was sad her mother was not around as much, and that she felt alone. Since she was still silent, it was difficult to understand at times what she needed during the session. However, this story suggested that she was struggling with the separation from her mother and she felt she was being taken away from her. I asked her if we could get her mother and tell her the giraffe story. She agreed and we brought her mother into the playroom.

Shannon wanted me to tell her mother the story. Mrs. S listened then asked her daughter why she was angry with me, to which Shannon shrugged. I continued to explain the story and its connection with Mrs. S's absence. Mrs. S smiled at her daughter and comforted her, assuring Shannon that no one was going to take her away. I asked Shannon again at the end of the session if she was still angry and she shook her head.

Mrs. S informed me later, during our interview, that Shannon often kept things from her, particularly feelings like this. It appeared that the story had strengthened communication between Shannon and her mother as well as between Shannon and me.

The following is a synopsis of this story, which describes Shannon's feelings of separation and loneliness.

Once there was a little kitten that was very sad. It lived in a home with its bird brother, its leopard mother and its zebra father. One day a big giraffe came into the house and tried to kick the little kitten out. It did not work, and the giraffe had to leave the house. The kitten was still sad. To make it feel better, the leopard fed it and put it to sleep. All the animals then fell asleep and everything appeared to be alright. Suddenly, the giraffe emerged again and tried to enter the home. The leopard fought the giraffe and the other animals were very scared. The giraffe was trying to take the kitten and the bird away. The zebra joined the giraffe in the fight and died. The leopard then killed the giraffe and returned home to the two other animals. The zebra came back to life and joined them there. The end.

During the second half of session 22, after Shannon had finished her enactment of *The Intruder*, another story began to emerge. She and I strayed from the subject of the giraffe and she spontaneously turned off the lights in the room. This became the opening ritual for *The Good Guy and the Bad Guy,* a story that spanned over the last six sessions of Shannon's therapy.

The Good Guy and the Bad Guy

During session 22, Shannon laid a blue mat on the floor, which became the playspace for a new story. She shut off the lights and turned to me, making a gesture that

implied I was to 'play dead.' I followed her instruction and laid on the mat. She took masking tape and pretended to tie my legs and arms together. She then took a wooden block from the toy box and pretended to tap me with it. I asked her, "Am I scared?" She first nodded, and then shook her head. I continued, "Am I angry?" Shannon nodded again. I inquired, "Should I scream for help?" She nodded. I asked, "Who can help me?" She tapped the mat to signal a role-reversal.

I suggested we use a mask to distinguish who was playing which role in the scene. Shannon agreed. I placed a mask on my face and took the wooden block. She immediately fought back. She appeared very excited, breathing loudly and moving her legs and arms rapidly to protect herself from the masked role I was playing. I asked if I was playing a *bad guy* and she nodded, her eyes wide open and eyebrows raised. I inquired whether she was playing a *good guy,* and she nodded again. These were the only options I provided for names, as Shannon clearly agreed to the titles I suggested.

Shannon continued to wave her arms and legs, fighting the bad guy, until she collapsed next to me minutes later. I took the mask off and asked her what else she would like to do with the story, as the session was nearly over. She placed the mask in the centre of the room, grabbed the club and hid behind the bathroom door. She then ran out from behind the door and smashed the mask to pieces.

Although smashing the mask appeared to be cathartic for Shannon (she was groaning, clenching her teeth, and grumbling), she signalled that she did not feel better after doing so. One apparent theme continuously arising during this scene, as well as during other stories, was Shannon's need to fight or save herself. She had been going through many real-life transitions since session 1. She had also been getting older, and

more expectations were being placed on her by school, her parents, and me. The theme reflected her need to survive and to prevent outside influences from getting to her. Her stories depicted how she was continuing to grow and to take on bigger obstacles, from teachers to poo-monsters, to me in the giraffe role.

In session 23, Shannon included me in an additional story when she decorated a new mask and wrote the name *Meggie* [*sic*] on the forehead. Shannon placed it in the centre of the room and began to smash it, as she had done to the previous mask. She then laughed and handed it to me. During this I thought back to the story about the giraffe. I was uncertain as to why she had placed my name on the mask and wondered if she was angry about something I had done. Shannon turned off the lights after labelling the new mask with my name, placing herself in the position of the good guy. I put on the Meggie mask and pretended to tap her with the wooden block. Suddenly, she ran behind the bathroom door and I pretended not to know where she was. I faced away from the door, sitting on the blue mat and pondering aloud, "I wonder where you could be?" She bolted out from behind the bathroom door, giggling, and quickly climbed onto my back. I responded by asking her if she would like to go on a trip. Shannon nodded and I began asking her where we should go. She shrugged as we wondered around the room with me carrying her on my back. Shannon then stopped me by shaking her foot. I let her down.

She stopped in front of the blue mat and jumped onto it as though it was a swimming pool. She pretended to swim, then got up to take a bow. I applauded her and she smiled. She dove back into the 'pool', this time dancing in the water. She stood up once more and took a bow, and I applauded her again. I was unsure why she was engaging in this scene, but I encouraged her to play it out until she bowed one last time. As the session was

ending, I asked Shannon to hop onto my back so we could return to the *normal world.* Since this was the first story that required Shannon and me to travel to another world, returning to the normal world had become our closing ritual before putting our shoes back on.

Shannon frowned and reluctantly climbed onto my back. We circled the room one last time. She grabbed the tape recorder and recorded a message while I waited in the bathroom. Upon returning, she handed me the tape recorder and hid under her jacket, giggling, while I played it. The recording said, "I love you, Maggie". The message was encouraging, as it indicated that Shannon was continuing to communicate feelings through the tape recorder. Her mother joined us for a few minutes and listened to the message. She said that Shannon had wanted to say that phrase for the past two weeks, but had not had the courage. Shannon's message was interesting, considering she had initially smashed the mask with my name on it, then told me (via the tape recorder) that she loved me. Hiding under her jacket and being willing to share her anger in the session signalled to me that she not only had begun trusting me, but also wanted to tell me how she felt about our relationship. It appeared that Shannon was able to show her anger and frustration with less embarrassment than her feelings of love.

During session 25, Shannon took on the role of the good guy and I become the bad guy again, placing the Meggie mask on my face. Shannon indicated that she wanted to travel, as we had in the previous session. We rode around the room. Suddenly, she removed the mask from my face. I asked, "We don't need that anymore?" She nodded and we continued with the story until we arrived in a land called *Ha-ha.* Shannon called it this because she made the sound of laughter when we arrived. Once again, the theme of

survival emerged, as the good guy had to kill all of the creatures in Ha-ha because they were threatening him. I took on the role of the bad guy - without the mask - in this story and Shannon handed me the wooden block. Chairs spread throughout the room represented the animals in Ha-ha.

Shannon approached each chair. Through her responses to my questions, it became clear that each animal was hostile and wanted to hurt the good guy. Shannon therefore enacted killing all of the animals she met. I asked her who else lived in Ha-ha, and she pointed at me (meaning the bad guy). As the good guy, Shannon then enacted killing the bad guy, and I left the wooden block behind and shed the role. The good guy and I then left the land and travelled back to the normal world.

This story was similar to *The Student and the Teacher,* wherein one role destroyed the other. The ending did not appear until session 28, wherein the good guy killed all of the inhabitants of Ha-ha. Shannon's mother said that, from this session to session 28, Shannon was more aggressive at home with her brother, pushing him and taking toys away. She believed that Shannon was having trouble with termination, as well as with separating from her during the day. Mrs. S explained that Shannon had revealed that she was sad about terminating therapy in four sessions and was disappointed that she and I would not see each other thereafter.

Mrs. S agreed that her daughter was struggling with various difficult feelings. Her mother and I believed that was why Shannon was becoming excited and acting out in various ways. Shannon, her mother, and I sat down and discussed the fact that my time at the clinic would be over and that the time we had had in sessions had been very important. I praised Shannon's progress and she was able to tolerate it, smiling and

making eye contact, in strong contrast to her previous reactions of crawling under the table and hiding.

The following narrative was cumulatively created over the course of 6 sessions during which the roles of the bad guy and the good guy appeared. Although two masks were used during this process, one of which was the 'Meggie' mask, they were applied to the same role. The masks did not directly factor into this story, but were rather used to provide distance and to distinguish the players. The names of the other characters mentioned in the story were my suggestions, approved [through gestures] by Shannon. The gender of each role was undetermined, but the masculine is used here to avoid confusion.

Once there was a bad guy, who used a wooden block to hit others. The bad guy lived in Ha-ha, a scary land. He had three evil friends - George the monster, Fred the caterpillar, and Violet the cockroach. The bad guy was the leader and he was mean because he hit little children. One day, a good guy came to Ha-ha. The good guy saw how mean all of the creatures were in Ha-ha. He did not like it there, because the inhabitants beat him. They hit his belly. He did not feel safe and decided to kill all of the people in Ha-ha land. After he killed the others, he clapped and celebrated, opening his mouth to rejoice, but no sound emerged. The end.

When this story was over, I asked Shannon how she felt about terminating. She pointed her thumbs down and stuck out her bottom lip. This was the first acknowledgement she had made about her feelings and termination to me directly, without her mother in the room. Her ability to clearly communicate feelings, without the aid of role, a tape recorder, or her mother's comfort, was a sign of significant progress

towards her therapeutic goal of emotional expression. The story she created may also have served as a metaphor for the feelings of anger, fear, and anxiety she had been battling in our playspace, a world she would have to leave behind as termination drew near.

During session 24, in the midst of the development of *The Good Guy and the Bad Guy*, Shannon acted out a story about a bad dream she had had. The story took a course similar to that of *The Poo-monster*, as Shannon conveyed to me her feelings of vulnerability and fear during the dream.

The Nightmare

In *The Nightmare*, a story containing prominent themes of fear and helplessness, Shannon revealed her vulnerable side through the embodiment of a figure that visited her in her dreams. It began when Shannon turned the lights off and unfolded the blue mat. At this point, we had already explored the beginning of *The Good Guy and the Bad Guy*, and I was assuming this moment would be a continuation of that story. However, Shannon acted out something different this time. She was the sole participant in this new story, while I acted as a witness to her actions.

Shannon laid on the blue mat and pretended she was sleeping. Suddenly, she began kicking her legs and waving her arms, her eyes remaining shut. I asked if she was showing me a dream. She nodded and I inquired whether this dream was a nice dream. She shook her head and continued to move her body, then nodded when I asked if the dream was scary. I requested that she draw on the board what she had seen in her dream. Shannon drew a big, blob-like figure with very large hands and horns. I inquired whether the figure came during the day or at night, using two gestures. Shannon chose the second

gesture, which represented night. I asked how scared she was of it, on a scale from one to ten, and she spread her hands apart widely, indicating that she was very scared. She turned towards her figure drawing and pointed her rear towards it. She made *sss* and *pfft* sounds, showing me that she wanted to poop and pee on the figure. I asked her what the monster wanted to do to her and she made a hitting motion. She kicked the air, demonstrating that she was fighting back. I asked if the figure had many friends. Shannon nodded with two palms up, indicating that there were many monsters. I asked, "You want it to go away?" She nodded. I inquired, "He comes to you and gives you nightmares?" Shannon nodded again.

Shannon once again laid down on the blue mat, acting out her nightmare from beginning to end. As she embodied her story, I attempted to narrate aloud what was happening. She nodded or shook her head to show whether she agreed or disagreed with the narration. The following is the story produced from this exchange.

Once there was a little girl named Shannon, who was sleeping. In her dream, a mean figure with horns, stubby feet and gigantic hands, attacked her. The girl was very afraid of the monster. She was afraid he would get her with his big hands. The girl believed the monster would never go away and would be there forever. The girl tried to pee and poop on the monster to make him go away. The monster hit the girl and the girl fought back by kicking and punching him. The girl then noticed that the monster had ten monster friends. The girl peed and pooped on the monsters; she just wanted them to go away. There was no one who could help her. The end.

Shannon agreed to share this narrative with Mrs. S when she entered the playroom after we finished the story. She showed her mother the drawing and I recounted the story

for Mrs. S, who had been previously unaware of this bad dream. The following week, Mrs. S said that Shannon had told her that she sometimes saw this creature and that it scared her. Mrs. S believed the creature had become more apparent now that she was home less and Shannon was becoming anxious about her absence. The creature was not brought up again, either within the session or at home, following this conversation. The creature's disappearance may have come about as a result of the communication the story had sparked amongst Shannon, Mrs. S and me, since we had been able to reassure her that this figure would not get her and that it was just a bad dream.

Shannon's ability to reflect on and discuss the story with her mother showed her progress in articulating her thoughts and opinions. She had difficulty voicing her fears, particularly to people outside the family, so this process gave her the opportunity to face her fears within the safe confines of the story and session. This was true for all of her stories, which revolved around themes of fear of failure, embarrassment, being taken away, anger, cleansing, helplessness, and triumph. In regards to her verbal communication, she made progress speaking both within sessions and at school as this story developed. At the end of session 25, Mrs. S entered the room and encouraged Shannon to say something while I remained in the room. Shannon agreed, but wanted me to face the wall while she spoke. I turned around and she said, "I love you, Mommy." Her mother encouraged her further by suggesting she tell me a story about a cat, which she had learned in school.

Shannon Tells a Story

Previously, Shannon had spoken in short phrases, left the room to tape or avoid hearing her own recorded messages, and whispered into her mother's ear with me

present. It appeared she was becoming more confident in expressing her feelings directly, through nonverbal gestures as well as by using her voice while I was in the room. Shannon's trust in me appeared to have developed to the point that she was willing to take on the challenge of speaking without the tape recorder. I believe that without Mrs. S present in the session, Shannon would not have told the story aloud. Although Shannon was willing to use the tape recorder independently, it was her mother's encouragement that led her to tell me the story. Her willingness and cooperation were a change from her previous demand that I leave the room, as well as her having had to plug her ears to avoid hearing her own voice. It appeared she was now working with her mother and me, and that she was actively trying to meet her verbal communication goals. In terms of my study, this is a significant landmark. Shannon was not only uttering words and phrases, but was also improving her verbal communication by applying the same tool we had been using to help with her nonverbal communication.

The following is a story she had learned in school and then agreed to tell me about in session 25.

The cat opened its eyes. The sun entered. The cat closed its eyes. The sun stayed. This was why at night, when the cat woke, I saw in the darkness, two pieces of sun.

As Shannon told the story, she breathed only once and spoke quickly. Her voice remained low and monotonic. She buried her head in her jacket when she was finished. I believed her shyness and perhaps embarrassment were showing, so the response to this courageous act had to be confidence-boosting as well as delicate. I thanked her for the story and told her what a gifted storyteller she was. She shook her head and kept her face buried in the jacket: it appeared that she was still coping with the fact that she had spoken

aloud, and needed a little time to regain her confidence in order to face me. Shannon's reaction gave me a better idea of how these situations could be handled in future sessions. Although the achievement had to be acknowledged, I also had to be cautious not to make a 'big deal' out of the actual act of speaking.

Shannon's difficulty tolerating praise and compliments was a theme we had explored in previous sessions. Although she was becoming more comfortable, we had reached a new point in her process. She was willing to let go of her silence and leave herself vulnerable and defenseless in front of her mother and me. During this point in her treatment, it was extremely important that Shannon felt encouraged, but not forced, to speak. Doing otherwise could have resulted in her resisting further speaking. More talking was encouraged in a playful manner, either through more stories or games, in order to help Shannon cope with her achievement, without placing too much weight on the moment of speech.

In session 26, Shannon played a game with her mother and me after she and I developed her story (*The Good Guy and the Bad Guy*) for 40 minutes in the playroom. The last 10 minutes were used to bring her mother into the room so we could all play together. Her mother's presence appeared to relax her, since she was aware that this time was meant for her to speak aloud. We began with a small warm-up by tossing a ball between the three of us. After we had thrown the ball around three times, I began to say the person's name to whom I was tossing the ball, which became the rule of the game.

When it was Shannon's turn to throw the ball to me, she shook her head, indicating that she did not want to speak. I asked her to throw the ball to her mother instead, and Mrs. S encouraged her, saying, "Come on, say it." Shannon appeared nervous, moving

around in her seat and looking at her mother before speaking. She threw the ball and said, "Mommy." Her mother responded by saying, "See? That wasn't so bad." I asked Mrs. S to continue the game. When it was Shannon's turn to throw me the ball again, she hesitated and looked at her mother. Her mother pointed at me and asked her to throw it, but she shook her head. I offered to close my eyes while she threw the ball and Shannon laughed, nodded, threw it and said, "Maggie," while I struggled to catch the ball with my eyes closed.

Shannon appeared pleased by my willingness to compromise with her and attempt to catch the ball with my eyes closed. It seemed to turn the rule of saying my name into a fun activity, rather than an anxiety-provoking task. She began to smile understood and continued the game, saying phrases such as, "Throw the ball" and, "Thank you." She spoke quietly, softly, and with subtle intonation. Throughout this session, she did not hide behind anything and faced both her mother and me during the game. After we had finished the game, Shannon was smiling but somewhat avoiding eye contact.

This behaviour was significant because Shannon, Mrs. S, and I were having a spoken conversation throughout the ball game. It was also significant because it appeared to be a positive experience for Shannon, signified by her smiling and laughing in the middle of the game. It also indicated that she was becoming more confident, signalled by her initial refusal and then compliance with regards to speaking. Her facial expression, in my opinion, was one of shyness and fear, rather then of opposition. Overcoming this shyness and fear in the session was a sign that she was coping well with the transition into verbal communication.

The progress in the sessions also manifested outside of the clinic. In school, Shannon's teacher began witnessing her speaking to a few of her friends on the playground and using a few words within the classroom. Unfortunately, the last session was coming up and she was only in the middle of discovering her voice in her therapeutic process. During the final session, Shannon created one six-piece story (Lahad, 1992) on a piece of paper with six squares. She had gone from completing three squares of a story to creating full-length stories that spanned multiple sessions, with intricate plots and emotionally laden content. The following is the last story Shannon created in session 28 through the 6-PSM technique (Lahad).

The Last Story

During the second half of session 28, Shannon and I celebrated the last day of her therapeutic process with some cookies. As a form of closure, I suggested she draw one last story before we ended the final session. She pointed at me, indicating that she wanted me to draw the story for her. I asked her what the story should be about. She pointed at the little penguin finger puppet once again, returning to something familiar. She then approached most of the toys that were stacked in her little drawer and gave them a hug. She answered questions that confirmed she was sad and would miss the toys she had played with in our sessions. I continued to ask her the guiding questions for each story square. Although I was drawing this story, Shannon dictated through her gestures what was happening within the plot. The following story resulted from this process. The penguin's gender was undetermined in the session, but it will be presented as female in order to avoid confusion.

Once there was a penguin that lived at the North Pole. She wanted a chocolate and a vanilla cookie. However, a giant white whale was guarding the cookies. The penguin's friend Meggie [*sic*] *was there to help her get the cookies. The Penguin picked up a green stick and hit the whale with it. This hurt the whale, and the Penguin and Meggie got their cookies. The end.*

Overall, Shannon's stories mirrored the development of trust and cooperation between us. She had cast me as the bossy teacher, the mirror, the intruder, the bad guy, the witness, the listener, and eventually the helper in her stories. Her stories reflected the growth of our therapeutic alliance, as she had come to accept my help within the therapeutic process and had learned to fight her own fears and anxieties through our work together.

Chapter 9: Discussion

Looking back on Shannon's process, I was struck by the commitment and enthusiasm she displayed during story-making. Since creating these stories required concentration and collaboration, the gradual development of listening, focus, following, leading and improvisation skills was important in allowing her to gain confidence and trust in her own abilities. The sessions prior to story-making were vital, as they prepared her for the dramatic skills the process would later require. In gaining these dramatic skills, it appears Shannon took further steps towards communicating with me and developing her emotional and verbal expression.

I will discuss three significant periods in Shannon's process that introduced noticeable changes in communication and new ways of relating to me. The first period occurred from sessions 8 to 13, during which I encouraged regular partner mirror exercises that helped Shannon relinquish some control and begin to reciprocate my movements. This activity would later become essential to building stories. This group of sessions, which mostly remained in Phase One (Emunah, 1994), dramatic play, will be referred to as the *mirroring period.* The second period occurred from sessions 10 to 16. Here, dramatic play became less pronounced, while scenework and role-play became more common. Shannon began listening and reacting more frequently in character and building more detailed scenes. This period, which prepared her for making longer, more detailed stories in later sessions, will be referred to as the *transition period.* The sessions thereafter contained all of Shannon's stories and marked a time when activities flowed smoothly and in-depth emotions were explored. This period, sessions 16 to 28, will be referred to as the *story-making period.*

Although this paper looks at how communication developed through the use of story, it is undeniable that the mirroring and transition periods were essential building blocks in our learning to communicate with one another. These categories are presented sequentially, but overlapped at times. The periods do therefore not denote rigid segments of the process, but rather act as guidelines to help follow the development of communication between Shannon and me.

The Mirroring Period

Mirroring developed into a prominent psychodramatic tool in session 8, during which Mrs. S informed me that her daughter had read aloud to her teacher at school for the first time. I congratulated Shannon on her accomplishment, in response to which she hid behind a curtain in the waiting area, then ran into the playroom and crawled under the table. I reflected on my reaction to her achievement and determined that perhaps I should have put less weight on the event. It appeared she was unable to tolerate that amount of praise, as she admitted to feeling shy and embarrassed in the session. This new development, hiding, offered an opportunity to build stronger coping skills for Shannon through the partner mirror exercise.

The mirroring exercise provided Shannon with distance from the flood of feelings she appeared to be experiencing, as she could metaphorically view herself from a distance through my mirroring her. It seemed that by joining her in her world of shyness, by making myself appear as vulnerable as she, I allowed Shannon to gain some confidence in leading and eventually following in the activity. The magnification of feelings expressed through the mirroring also made the process less cognitive and encouraged Shannon to use her body to express herself. As I followed her movements, I

was acknowledging this new form of self-expression and joining her way of communicating.

Mirroring was particularly helpful in allowing a wide variety of emotions to be explored. For example, in session 9 Shannon became angry with me about missing toys. Mirroring her anger and frustration appeared to diffuse the intensity of her emotions, provide distance, and contain her outbursts. Since I reacted to her anger and frustration in the same way I had reacted to her feelings of shyness and embarrassment in previous sessions, I encouraged the notion that all emotions would be mirrored and accepted. She then began expressing herself with more gestures and facial expression, making communication between us clearer than in previous sessions.

Overall, the skills Shannon developed from mirroring included being able to sustain eye contact, be patient, commit to a longer activity, follow my lead and focus. It also appeared that she had begun coping with her shyness and anger in a new way, since she stopped hiding under the table and throwing objects by the middle of the transition period.

The Transition Period

The transition period marked the beginning of extended participation, as Shannon began to take on a role and to play out scenes that were contained by clear beginnings and ends. We rarely used mirroring during this period, moving instead towards scenework and role-play. A significant improvement in this period was Shannon's willingness to listen. An example of this occurred in session 10, when I played the role of clown. While asking her how I should play the role, our way of relaying information to one another began to follow the structure of a conversation. I noticed the degree of

freedom she gave me to speak as she would stop, look at me, and await the next action or question, after answering. This kind of communication made the scene run smoothly, as she provided clear answers and added to the story through actions. Perhaps as a result of this communication, the sessions during this period contained less abrupt endings than previous sessions.

Other contributors to our new style of communication were Shannon's abilities to lead and follow in a scene. This was most noticeable in session 14, during which she initiated the 'going for a ride' scene. The scene marked a significant transition in her development into scenework. The enactment was more developed than the previous clown scene, as Shannon set the stage prior to beginning it, assigned both of us a specific role, and added verbal sounds that fit the context of the enactment. Her gestures made it clear who we were in the scene (passenger and driver) and what we were doing (driving somewhere).

Two key moments in this process were Shannon's invitation to me to enter the scene and her willingness to role-reverse. I believe that the previous use of mirroring largely contributed to the development of this enactment. We had practiced being leaders and followers in the mirroring period, and Shannon was becoming more willing to share the responsibility of leader with me. The two roles Shannon created in this scene also appeared to mirror our relationship at that point in the therapeutic process. Shannon was the driver not only in that scene, but also in the session, taking most of the control over which activities were completed and which were not. As the scene portrayed, Shannon was beginning to let me 'take the wheel' on occasion. This was an important step in her

process, because it demonstrated that we were working together and developing the plot through listening and reacting to one another.

The new development of granting me control in activities continued in the telephone role-play in session 16. Considering Shannon's resistance to speaking, making other sounds, or dealing with spoken questions, I was surprised when she began to play with a telephone and indicated her desire to speak to a friend. This role-play was extremely important, because it addressed the previously-taboo topic of *speaking*. What was interesting was that Shannon initiated the topic herself and elaborated on it by writing her responses to questions on a piece of paper. This role-play was a clear indication that we had built a stronger foundation of trust, as Shannon was beginning to volunteer new ways of communicating with me.

Overall, I believe the most important tools Shannon developed during this period were taking on a role, role-reversing, leading, building an improvisational scene and sustaining prolonged dramatic activities. It appeared that we had moved from activities that required a leader and a follower (mirroring, the Find Me game, the Distance game) to collaborative scenework, which demanded that both of us communicate through actions, react to each other in character and help promote the plot in the scene. These tools were invaluable for story-making in the next period.

The Story-making Period

The story-making period was marked by several significant moments that highlighted Shannon's progression into verbal communication. The content of stories, and the way in which she expressed them, revealed several clues about how she preferred to communicate specific emotional material. I took note of the particular roles in which

Shannon chose to cast each of us, and in the manner in which she told the stories. When she was unable to contain her aggression, breaking the dramatic frame, we used objects in the stories.

Stories Through Objects

I observed that once an object was introduced into a story, Shannon began expressing more feelings of helplessness, fear and sadness. The control and distance the objects provided for her seemed to allow for deeper exploration of her struggles. In *The Student and the Teacher* we used a little yellow bird to portray the teacher role. She began to direct her anger towards the bird, rather than at me playing the role of teacher, and was able to express how nervous and upset she became in the classroom setting. It appeared that she would often become angry before revealing that she was sad or upset about something particular. I continued to notice this pattern of behaviour in later stories with objects including *The Poo-monster* and *The Intruder.*

Each of these stories were developed with the 6-PSM (Lahad, 1992) questions and flowed without interruption, as I remained a witness to Shannon, who led the action using objects. She could communicate with the object, through the safe container of the story, the fear she felt towards the Poo-monster, the embarrassment and ridicule she felt in the classroom and the loneliness and helplessness she felt being away from her mother. While objects appeared to help in the expression of such feelings, emotions such as anger and frustration were ones she seemed more comfortable expressing through embodiment.

Embodied Stories

Shannon's embodied stories included the *The Student and the Teacher* and *The Good Guy and the Bad Guy.* I noticed several differences in the process of creating these two

stories as opposed to the others. First, while *The Poo-monster*, *The Intruder*, *The Nightmare* and the last six-piece story had been structured around the 6-PSM questions, the embodied stories were much less structured and developed mainly through improvisation. Second, the use of our bodies as vehicles to drive the story forward provided less distance, as only the story and the roles were the containers that held the dramatic enactment. Third, they required both of us to take on roles and interact directly with one another. Since they contained longer periods of role-playing between us, more direct communication was necessary in order for a story to be completed. This may have been difficult for Shannon to tolerate, as a result of which she began to break the dramatic frame before objects were introduced. The collaboration the embodied stories provided was helpful towards reaching our goal of playing together. I also noted Shannon's casting choices, as she would place me in roles that she appeared to perceive as hostile.

Casting

There appeared to be a pattern to Shannon's casting method. I noticed that she cast me as an active player in stories containing themes of anger, frustration, killing, and celebration and as a witness or mirror in stories containing themes of fear and helplessness. In *The Poo-monster*, I played a part similar to that which I had enacted when we were still in the mirroring period. Because Shannon appeared to be less confident in expressing emotions of fear and helplessness, I mirrored her throughout this story, which seemed to encourage her. I took on a more distant role in *The Intruder,* as she excluded me from the story and I remained a witness. In this situation, it appeared Shannon needed me to listen, rather then to reassure or encourage her. As the witness I

did not take part in the story, but could ask questions on the plot. *The Nightmare* followed a similar process, as I remained in the role of witness to Shannon's bad dream.

In stories that contained themes of anger and frustration, I was cast in roles Shannon perceived as hostile towards the role she was playing. I often wondered why she continuously cast me in these threatening roles and concluded that she had few relationships with adults other than those in her family and at school. I represented 'the intruder', an outsider who stepped into her world and promoted a change in her way of being. Such an act could be seen as threatening by a 6-year-old unwilling to communicate as expected by the outside world. Another motivation for Shannon's casting choice may have been the fact that I was also a female and, as a therapist, someone attempting to guide and help her with difficult issues. Because her mother was leaving for school and had provided similar guidance to Shannon in the past, I believe she was under the impression that I was somehow replacing her mother. As we explored her inner world more deeply with every story we encountered, Shannon appeared to feel more separated from her mother. The decision to include Mrs. S in the final segments of our sessions during the story-making period proved helpful, because it encouraged us to reflect on her stories before sharing them with her.

Reflection

The process of reflecting on the things Shannon had done in the session became a new development in session 18. Reflection occurred mainly through my re-telling of Shannon's story close to the end of the session. We would look at a role or part of a story and I would ask her how she felt about it. This occurred after an enactment, once a story was completed, at the beginning of the session or with her mother present. Reflection was

usually encouraged by my asking Shannon specific questions and seeing whether she would be willing to engage in this kind of conversation. For instance, she demonstrated in her expression regarding *The Student and The Teacher* that the teacher was not *always* mean, that I was not trying to take her away from her mother, and that the monster in her nightmare would not return, although her mother was gone during the day.

This conversation, along with others held in the story-making period, demonstrated Shannon's ability to cope with long periods of expressing her needs and thoughts, answering and posing questions and speaking aloud with me present. Other skills she appears to have developed in this period were communicating clear actions and thoughts, using her dramatic skills to explore sensitive material, using story to contain her outbursts, reflecting on stories and speaking aloud. It seemed that with each period, Shannon developed new skills and mastered old ones, giving her confidence in her own abilities and trust in her actions both as a storyteller and as a player.

Therapeutic Alliance

The therapeutic alliance went through several transitions, which were significantly influenced by transference and countertransference. Both affected the therapeutic frame, boundaries, and agreement of playing together. As previously mentioned, Shannon was initially resistant to playing together, often turning away. The process of finding a common way of communicating through mirroring, scenework, role-play, and story-making revealed her preferences in emotional expression, as well as her desire to begin speaking in school and during sessions. As Shannon learned more dramatic skills, the range of her emotional expression expanded, as well as the manner in which she expressed herself. As sessions became more structured through the story-making process,

Shannon's communication became clearer and more specific. This also made transference more readily apparent.

Transference within the Therapeutic Alliance

As Landy (1996) remarked, "Dramatic transference becomes most pronounced when the client (or the therapist, in the sense of countertransference) chronically casts the other in the same role" (p. 91). Transference in creative arts therapies can refer to an aesthetic process in which "the therapist enacts a client's transferential drama or contains a client's hurt and anger within his or her body" (Landy, 1992, p. 313). The clown's shame, the bad guy's anger, and the teacher's expectation of speech and cooperation all appeared to represent facets of Shannon's anxiety and frustration with herself and those around her. There were two specific moments in which transference became notably apparent. The first moment occurred the session after she had created *The Intruder*.

At this time Shannon appeared to believe I was attempting to take her away from her home and showed this when she revealed the giraffe's identity through her drawings on the blackboard. She was physically distant during this time, remaining at the other end of the room while I asked further questions. At this point Shannon did not appear angry, but seemed a little uncomfortable, yet satisfied that I understood what she was feeling. She showed this by avoiding eye contact until I answered a question to her liking, at which point she looked at me, nodded and smiled. I believe two factors contributed to Shannon's feelings about me during that moment. One was that her family was the only group of people with whom she was speaking consistently. *The Intruder* story took place in session 21, two sessions after Shannon had begun to speak into the tape recorder. It may have appeared to her that I was intruding into her family, as I was becoming another

person she was speaking to. In addition, she expressed that she felt upset and sad about her mother's absence after we discussed my part in her story. Although Mrs. S knew the separation was hard for her daughter, she mentioned that Shannon had not communicated with her about these feelings until this session. This moment was significant, as her act of confession demonstrated that her belief that her needs and feelings would be met with respect and comfort.

The second moment in which transference became apparent was in session 22, when Shannon smashed the mask. A possible contributing factor to her anger was our impending termination. She was aware that our time together would be ending, which meant that I would be leaving her. By this point in our process, Shannon had learned to trust me and share sensitive material in sessions. It may have been that, at this juncture, she was feeling abandoned, as she seemed to have shown by smashing the Meggie [*sic*] mask in the next session. As I slowly appeared to become the bad guy, both in playing the role and wearing the mask with my name on it, Shannon appeared to express her frustration and anger in the story. As in previous sessions, feelings of sadness and love emerged once the story containing themes of anger and rage were played out.

Countertransference within the Therapeutic Alliance

Landy (1992) stated that "transference and countertransference define a relationship between two persons in symbolic terms, implying that each brings to that relationship an experiential world populated with previous affiliations" (p. 313). Being aware of my own contributions was imperative during this process, as they influenced the movement of the stories. Consistent reflection on my own actions was an important step in remaining a helpful player and witness, as I was more aware of my own assumptions during sessions.

Weekly supervisions with the staff psychiatrist and my academic supervisor, were crucial in helping me to explore how my own opinions and thoughts related to the sessions.

I noted that my curiosity and need for clarification sometimes led me to ask too many questions, which distracted from the act of playing. Shannon's reluctant reaction to my questions immediately set an unspoken boundary, indicating that too many questions would be met with resistance. In looking back at the data, I also found that I had unknowingly established a pattern. I noticed that if Shannon's actions were unclear to me I would consistently ask questions until I gained more understanding of her behaviour. Overall, we were able to strengthen our alliance regardless of these differences because we developed the common goal of playing, which allowed us to develop our dramatic skills and eventually to communicate through roles within the story frame.

The roles I played included those of listener, witness, narrator and translator, and I needed to pay close attention to which attributes Shannon assigned and which I added to these. One particular role I struggled with was that of witness during *The Intruder*. I had been cast in the role of witness and thus no longer had a voice through a role or character. In previous stories I had been an active player, but this time Shannon kept me on the outside looking in on the plot. Like the giraffe, I was intruding into her previously-mother-filled, silent world. I believe casting me in the role of witness for this story was a form of silencing and a demand for attention. During sessions like these, my process notes were helpful in processing and reflecting on Shannon's behaviour and her choice in casting.

My session notes also acted as a form of closure, as I remained in the playroom after each session, writing down notes and reflecting on my own contributions. This weekly

ritual helped me de-role from the threatening roles in which I was frequently cast and allowed for distance from the hostility I was expected to display in those roles. Looking back on these notes, I noticed how valuable role-reversals had been for helping me to avoid becoming trapped in oppressive roles.

According to Landy (1996), countertransference can be "handled within the movements from one role to another, from in and out of the therapist and player roles" (p. 94). Role-reversal became an important tool for me when attempting to gain distance from repeated role placements and to avoid becoming trapped in one particular role. It also gave me insight into Shannon's way of handling certain situations with the roles she played. The occasional confusion I experienced during sessions regarding Shannon's actions, was something I needed to accept at times, since she was still discovering our common mode of communication. Role-reversing was extremely encouraging for us in these moments, as Shannon could *show* me details rather than have to hear me ask questions.

Therapeutic Goals

In looking back over the process it appears that Shannon's ability to express emotion preceded her ability to verbalize and built the trust, cohesion, and dramatic skills necessary to enable her to take on roles and enact scenes. As I learned to find activities that highlighted her natural form of communication through movement, Shannon began to express a wider range of emotions, which included shyness, fear, sadness, anger, frustration, and helplessness. I noticed that the increase in her confidence and trust during the mirroring period promoted collaboration during the transition period. During this phase, Shannon used the position of follower to listen to the 6-PSM questions for her

stories. In the story-making period she appeared comfortable expressing emotions towards me and regarding events in her outside life. Her first words appeared after *The Student and the Teacher* story in session 19 and progressed to telling a full story in session 25. She also demonstrated growth in emotional expression through the stories she created. While she began experimenting with words and phrases in *ordinary reality* as of session 18, she had continuously worked on her emotional expression in *dramatic reality*.

Therapeutic Goals within Dramatic Reality

Shannon's emotional expression developed through the various modes in which she expressed her stories. As she initially showed difficulty expressing feelings of helplessness, embarrassment, and sadness (i.e. without hiding), it became apparent that she would require more distance in order to explore and express these feelings more fully. Thus, stories in which such emotions were prevalent, (*The Poo-monster, The Intruder, and The Nightmare*) involved either objects or art as part of the story-making process. The distance provided by the objects and masks appeared to help Shannon in both enacting and expressing her fears and helplessness. The fact that Shannon, towards the end of therapy, was increasingly capable of revealing these feelings, showed how much her range of emotional expression had grown.

In exploring emotions with which Shannon appeared to feel comfortable, including anger and frustration, we used less distanced tools such as embodiment and roles. Such stories became more difficult to contain at certain moments, as illustrated when her anger appeared to escalate quickly in roles of the student and the good guy. These incidents were regulated by the use of an object or mask, which helped to restore balance to the activity and allowed us to re-engage in the story. Shannon's feelings of anger and

frustration appeared to become less prevalent outside of stories towards the end of her therapy.

Therapeutic Goals in Ordinary Reality

Shannon began speaking single words beginning at the end of session 19, and progressed to longer phrases thereafter. Her initial reaction to me hearing her recording was to leave the room, which she grew to better tolerate. After a few sessions, she would remain in the room and plug her ears while I listened. She then proceeded to speak without recording, during which I would remain in the room, first, while facing the wall, then while facing her with my eyes closed. Eventually Shannon was able to speak to me while my eyes were open with her mother present. Reuniting Shannon with her mother and making Mrs. S part of the session seemed to help Shannon feel secure and ready to speak aloud. Mrs. S appeared to provide a significant amount of support for her daughter, as her encouragement was an important part of Shannon eventually speaking aloud to me. Mrs S. also provided support and encouragement *after* Shannon spoke aloud, a time equally significant to the actual act of speaking as Shannon often appeared extremely vulnerable. Her mother's presence appeared to help her regain her confidence to finish the session and to leave the playroom.

Looking Back

Although the use of story appeared to have a significant impact on Shannon's willingness to communicate, there were several limitations in my study. First, as this is a case study and I had specifically selected Shannon as a participant, the findings cannot be generalized to apply to the larger population of children with selective mutism. Second, this study cannot be replicated in order to verify the findings, because it reflects only the

findings of one individual. The stories were client-specific, the material was often created through improvisation, and I was an active participant in the study, adding a subjective perspective to a portion of the research. Since Shannon was silent in the sessions, I had to rely on some outside information and my own assumptions at times.

This research study was also not designed to determine cause and effect with regards to the use of story, but rather to follow the development of communication between Shannon and I. Although I used the 6-PSM technique (Lahad, 1992) in the sessions, the manner in which it was applied was flexible and did not follow a standardized procedure. The stories, drawn, embodied or acted out with objects, were sometimes created with no particular order or predetermined method of communicating. Time was also a significant limitation, given that the therapeutic process was terminated at the end of the academic term.

During the final six sessions, Shannon made significant progress. However, the process of verbal communication was only achieved within therapy and did not fully translate into the outside environments with the exceptions of a few incidents (see Appendix E). Although the interviews with Mrs. S and Shannon's teacher revealed useful information about her outside life, they were held at the end of the therapy process, before session 27, and following session 28. Had there been two sets of pre-therapy interviews with which to compare these, more information could have been gathered about Shannon's progress. I established Shannon's baseline behaviour through conversations with her mother, and from information from files concerning such aspects as her family history. Weekly conversations with Mrs. S served to inform me about Shannon's progress and behaviour outside of therapy. This included Shannon's thoughts

on speaking and incidents regarding her silence at school. Unfortunately, her father did not partake in the therapeutic process. His point of view would have been a valuable contribution to the research.

Another limitation concerns my dual role as both researcher and therapist. Although use of the video recording served to allow data collection from a somewhat more objective perspective, my notes and interactions within the sessions derived primarily from my role as therapist.

I discovered only one other study that has examined this specific population and drama therapy (Nissan, 2005). I believe, therefore, that this report contributes to a narrow research pool of drama therapy with children diagnosed with selective mutism. The detailed description of stories, roles and mirroring explored herein shed light on possible future applications of psychodramatic and projective techniques as potential treatment tools for the selective mutism population.

In future applications of drama therapy with this population, a method that may prove to yield favourable results would be combining story with *shaping*. The short introduction of this concept in session 18 appeared to motivate Shannon to speak into the tape recorder. During session 18, Mrs. S and I discussed a rewards system for Shannon designed to motivate her to speak. The goal underlying this system was to encourage her to progress from uttering a single word to eventually verbalizing complete stories. However, it is difficult to determine its significance in this study, since Mrs. S chose the rewards outside of the therapy and I was unable to observe this process. However, the initial success engendered by the rewards system in sessions 19 and 20 suggests that shaping could contribute to a client's transition into verbal communication. Shaping may

add greatly to verbal communication goals, while the use of story could serve to meet those concerning emotional expression. To my knowledge, the combination of both has not yet been applied.

Additionally, I would advocate including a parent at an earlier point in the therapy. Having Shannon's mother join us in the last 10 minutes from session 18 and onwards appeared to encourage her to speak with me in the room. This was particularly evident when Mrs. S encouraged Shannon to tell me a story from school and when we played the ball game together. I believe that she could tolerate her mother's strong push towards speech due to the strength and closeness of their relationship. Had I pressured her to speak as her mother did, I believe she would have refused because we did not have that same degree of closeness and trust. Also, having Mrs. S present in the therapy session appeared to acknowledge that we were moving forward with speech goals, validated and supported the therapy and encouraged Shannon to speak when her mother became actively involved in playing with us.

Translation into the Outside World

Shannon's teacher and her mother offered valuable insights into her progress outside of therapy. The following observations occurred towards the end of her therapy, around sessions 22 through 25, and were discussed in an interview with Shannon's teacher. According to this teacher, Shannon had been an active member of her classroom, completing projects and participating in group activities through gestures. At the beginning of the school year, her peers had had to accommodate her silence with a hand language and specifically phrased questions (see Appendix E). Her teacher had had to limit her questions to Shannon to the *yes-or-no* form, making it easier for her to

communicate without speaking. She stated that Shannon had remained mostly silent in the classroom, during the period of our therapeutic process. However, towards the end of the school year, she observed Shannon speaking to a few children and negotiating playing strategies on the playground (see Appendix E).

Mrs. S. also remarked that Shannon took an oral exam during which she was required to read aloud to her teacher. This occurred while we were in the transition period. Although she was initially reluctant, she completed the exercise with her teacher present. Mrs S. witnessed similar progress when she saw Shannon speaking to people at her brother's birthday party and when they read aloud together in the library.

It appears Shannon was in the formative stages of speaking aloud, unsure of herself and her own voice. The therapy terminated at the point at which her verbal communication was just becoming tangible. As her journey through emotional expression had spanned 19 sessions before she spoke, one can assume that verbal communication needed more time to develop. I speculate that, had the therapy continued, verbal communication would have increased, as Shannon's emotional expression increased. However, because she had only nine sessions in which to experiment with various phrases, it is not surprising that verbal communication could not more fully develop.

Final Thoughts

The 28 sessions in which Shannon and I played together were filled with struggles, elaborate adventures and triumph. Shannon's journey towards speaking was long and challenging, but rewarded with confidence and encouragement. She moved from fearing a teacher, monsters and a bad guy to celebrating her success, gaining trust in me and

ultimately, to breaking her silence. It was clear that her quest to find her voice was far from over, as she continued to struggle in other environments.

Looking back over this process, I cannot help but reflect upon my own journey as a therapist as well as remember that little teddy bear of my childhood, Corduroy. In my mind, he is still roaming the dark corridor of that vast department store searching for his little button. Like that favourite character from long ago, Shannon and I both continue searching. Perhaps the best part of our respective journeys will prove to be this process of discovering and learning along the way.

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Appendix A: Consent Form

I agree to allow my child to participate in the research inquiry conducted by Margaret Owen, entitled *Communication through Story: Exploring Story Creation with a Selectively Mute Child,* as part of her Master's studies in the Department of Creative Arts Therapies at Concordia University.

I have carefully read and understand the consent information about the above study. Its purpose and nature have been explained to me, I have had the opportunity to ask questions about it, and I am satisfied with the answers I have received.

I understand that my child will be participating in drama therapy sessions during which my child will have the opportunity to create, read and/or enact stories. These stories may be video or audio recorded in order to document accurate information. My child and I will be given an opportunity to respond to the researcher's summary of my child's created stories.

I understand that my child's identity will be kept confidential, though the student's advisor may read transcripts of sessions with participants identified through pseudonyms. I understand that my child's sessions will be audio and video taped. The tapes and the stories will be stored separately under lock and key without my child's name attached to them. The final research report will include narrative accounts of the sessions, describing aspects of my child's and possibly my experience, with identities kept confidential. Stories used to describe my child's experience will be used but my child's name will not be disclosed in the research paper, or in any future presentations or publication of the research. No written stories or artwork will be photographed without my written permission. I understand that at the end of the project, my child's artwork and stories will be returned to me and my child.

I understand that I have the right to withdraw my consent at any time. I understand the purpose of this study and that there is no hidden motive of which I have not been informed.

I understand that copies of the research paper will be bound and kept in the Program's Resource Room and in the Concordia University Library

I freely consent and voluntarily agree to let my child participate in this study.

_____ In addition, I authorize Margaret Owen to photograph my child's stories and artwork under the conditions of confidentiality outlined above.

_____ I reserve the right to make any decision regarding consent to having my child's artwork and stories photographed until after my child has participated in a number of sessions.

_____ I authorize Margaret Owen to speak with my child's teachers, but am aware that no confidential information about my child's sessions, artwork, stories or any other session information will be disclosed in this setting.

Signature: _____

Date: _____

Witness: _____

Date: _____

Appendix B: Consent Information

Drama Therapy Student: Margaret Owen
Concordia University
Supervisor: Alison Aylward
Part-time Concordia Faculty

Background Information
In order for drama therapy students to improve their understanding of drama therapy they write a research paper that includes case material and art work by clients they have worked with during their practicum. The purpose of this research paper, as well as other students and drama therapists, who read the research paper, is to increase their knowledge and skill in giving drama therapy services to a variety of persons with different kinds of problems. The long-term goal of this research is to aid future individuals with developed drama therapy skills and to enable new drama therapy students to read about these experiences.

Permission
As a student in the Master's program in The Department of Creative Arts Therapies at Concordia University, I am asking you for permission to photograph your child's artwork, written stories and transcribed audio and video recordings in my research paper. I am also asking you for permission to consult your child's file (medical or other) for a period of one year (or until I have completed my research paper). I am also asking for consent to interview you and you child's teacher at school. A copy of the research paper will be bound and kept in the Concordia University Library, and another in the Department's Resource Room. This paper may also be presented in educational settings or published for educational purposes in the future.

Confidentiality
Because this information is of personal nature, it is understood that your child's confidentiality will be respected in every way possible. Your child's name, the same of the setting where your drama therapy took place, nor will any other identifying information appear in the research paper or on your art work.

Your Consent
Whether or not you give your consent will have no effect on your child's involvement in drama therapy or any other aspect of your treatment. You may consent to all or just some of the requests on the accompanying consent form. As well, you may withdraw your consent at any time before the research paper is completed with no consequences, and without giving any explanation. To do this, or if you have any questions about this research study, you may contact my supervisor (Alison Aylward (514) 848 2424)
If at any time you have questions regarding your rights as a research participant, you may call Adela Reid, Compliance Officer, in the Office of Research.
Adela Reid, Compliance Officer
Office of Research, GM-1000, Concordia University, Montreal, Quebec H3G 1M8
Phone: 514-848-7481
Email: adela.reid@concordia.ca

Appendix C: Interview with Parent

Interviewer (I): So, if I followed your child through a regular day at home, what would I see her doing?

Mrs. S: At home. Like on a weekend?

I: Uhm hum

Mrs. S: Ok so uh . . . she will draw, she with play with . . . dolls. She will fight with her brother, hehe, most of the time *(raises eyebrows)*. Ermmm . . . she will ask for, uh, .some snacks *(pause)* she will ask to go to some . . . I dunno, shopping . . . or just seeing things outside the house. And sometimes she will ask to go some . . . to be with some friends. That's all . . . she watch the TV. I guess everything that a child would do *(scratches head and smiles)* . . .regular stuff, hehe.

I: When your child talks about his or her day well I meant her day, what does she tell you about?

Mrs. S: Uhh . . when she comes from school she will talk about . . uh . . . some different projects she did . . . like for example . . . for the class of . . uhm . . pottery she was very excited when she was doing some . .uhm rabbit *(makes hand gesture that describes the shape of the rabbit)* . . . or I don't know some statue there. Or she tell me about the books she choose from the library Yeah, mostly, (*nods*) more excited things, not the regular stuff . . ."what we are doing today" . . or no, she not start with this. If I am asking, yes, she will tell me, otherwise she will tell me about the new things she is doing.

I: Uhm hum. How does your child tell you what she wants or needs at home?

Mrs. S: Regular . . I need this . . . I want that hehe *(very short answer, as though it were obvious)*. Normal questions ask, asked.

I: Ok . . . How does your child tell you what they want or need in public?
Mrs. S: Uh . . . the same way only in a slower voice . . . in a lower voice yeah, especially if someone is next to us.

I: Slower or . . .

Mrs. S.: uh lower . . *(nods)*

I: . . . lower.
Mrs. S.: yeah yeah. But she will ask *(nods).*

I: Ok. How does your child communicate with visitors in the home?

Mrs. S: Uhm . . . *(pause)* . . .that depends (pause). If . . uh she is very tired . . . she may chose . . . not to communicate. Just smiling . . . and . . . uh gestures only. If not uhm . . . . once in a while she will say something. Not much, but yeah . . . . she will say something.

I: Ok. How does your child communicate when visiting friends or relatives outside of the home?

Mrs. S: Same way . . . *(nods)* . . . if she knows the f family . . . she will say maybe something but not too much *(Nods).*

I: Does your child communicate equally with all family members in the home?

Mrs. S: yes, *(nods)*

I: Who does he or . . . sorry

Mrs. S: she . . .

I: . . . she communicate with most?

Mrs. S: Hmm . . . right now I guess with her brother . . . because they are . . . inter- . . . interfere? Uh No . . .they are playing together . . . so it's most of the time their part.

I: Hm . . . Who does she communicate with least *(cough)*?

Mrs. S.: School . . at school . . . (nods).

I: Uhm but in the home . . .
Mrs. S.: From the family? No. I don't think there is a preference. No.

I: What common gestures or words does your child use most often?

Mrs. S: *(pause).* Hm . . gestures? I dunno . . . .not something to pop up now in my mind . . . for . . no. Nothing special.

I: So just regular?

Mrs. S.: Regular yeah.

I: Is there anything else you would like to add?

Mrs. S.: *(Shakes her head.)* No, nope I have no idea, I was waiting for the questions. No, no, I don't know what to add.

I: Ok, well thank you.

Mrs. S.: Yeah that's it? You're welcome.

Appendix D: Informed Consent

Drama Therapy Student: Margaret Owen
Concordia University
Supervisor: Alison Aylward
Part-time Concordia Faculty

Background Information

In order for drama therapy students to improve their understanding of drama therapy they write a research paper that includes case material and art work by clients they have worked with during their practicum. The purpose of this research paper, as well as other students and drama therapists, who read the research paper, is to increase their knowledge and skill in giving drama therapy services to a variety of persons with different kinds of problems. The long-term goal of this research is to aid future individuals with developed drama therapy skills and to enable new drama therapy students to read about these experiences.

Interview

I understand that this interview is for research purposes only. The information will be used for Maggie Owen's research project for her Master's in Drama Therapy at Concordia University.

I agree to be video and audio recorded and am comfortable with the questions presented to me. I understand that all of the information discussed will be kept confidential. I have read the consent form and agree to the current conditions.

Signature_____ Date_____

If at any time you have questions regarding your rights as a research participant, you may call Adela Reid, Compliance Officer, in the Office of Research.
Adela Reid, Compliance Officer
Office of Research, GM-1000, Concordia University, Montreal, Quebec H3G 1M8
Phone: 514-848-7481

Appendix E: Translated Teacher Questionnaire

1. If I followed your student through regular class time what would she be doing?

My student manages very well in class and is very good at following instructions. She's very, very good student. The only problem we have is that she doesn't speak.

2. How does your student tell you what she wants or needs in class?

Normally, she organizes herself. If she needs anything corrected she comes to me. She really takes pleasure in showing me what she's done but she never speaks.

3. When your student communicates with you, what does she tell or show you?

She doesn't ever speak to me – she never has. She replies using head gestures but she never ever speaks to me.

4. Does your student wait for you to come to her for any concerns, or does she approach

you?

On one occasion she was unwell and started crying. I asked her questions about what was wrong and, again, she replied using signs and head gestures and indicated that her stomach hurt.

5. If the student approaches you, how does she express the problem or concern?

As I have just mentioned, she does so using signs and head gestures and that's how I get answers from her.

6. How does your student communicate with other students in the class?

In class she doesn't speak but, if the children ask her questions, she responds with head gestures. But I have been told that in the playground – and with certain children – she will, in fact, speak. It's all very recent. At the beginning of the year it didn't happen but,

more recently, she has started talking a little with certain students. Outside *(inaudible)*... She attends music classes and there she has sung a bit. That's about it.

7. Does she communicate with many other students? Is she an active student? If so, how is she active in class?

It is pretty much as I described earlier: it's only outside that she has spoken to, maybe, three students.

8. How does your student react during presentations or other projects requiring public speaking or a lot of attention from the class (i.e. answering questions, going up to the board)?

As for oral presentations where she has to stand in front of the class, it's very difficult for her. Occasionally, she comes forward and starts crying. I have suggested that she can go into the corridor and record onto cassette what she wants to say but she has never ever wanted to do it. When it's a question of answering questions on the blackboard, she will come up and write her replies. She'll do that – but she will never speak.

9. Are there any students that try to speak for this child in class?

There are some who tried to speak for her but, right at the beginning of the year, I was quick to explain to them that, if they did that, she would never learn and that she had to be the one to speak. From time to time, one sees that the children are kind of tempted but they don't do anything to help because they know that I don't like them doing it. I'm not saying it never happens: when they split into groups to work, I get the impression that it probably does happen because the level of supervision is different. When they talk in pairs they probably answer on her behalf or put questions to her to which she can reply

by means of head gestures, perhaps. They've learned from how I work with her so maybe they're doing the same things.

10. If so, how often does this child or do these children play the interpreter for your student?

Not often because they know that I don't want them to do it. So it happens rarely. It's funny because I sometimes hear them… it's like they give her choices: """"If it's this one, do this, if it's the other answer you want, do that"""". *(Laughing)* That way they give her choices so that she can reply. They've really worked out a way of managing.

11. If there is one or more interpreters, in what situations does this happen?

(Laughing) One never knows what's going to happen! They'll use other tactics. Once, when I was outside, she was nearby and I was watching them playing. """"If you really don't want to, do this; if you do want to, do that,"""" and they were working out signs so that the child could play with them. She is by no means a shunned child – not at all. The others play with her a lot. They could perhaps have been put off (by her problem) but it's not been the case at all. She is very well liked by the class . . . they have their own language, with hands . . . yes.

12. Anything else to add?

No, that's about it. She's been thoroughly integrated into the group. She's occasionally managed to speak here – not when in large groups but in very small ones. It's certainly happened. She went into speech therapy and, with her mother, she did some reading. But, when her mother started working, she couldn't come anymore.

Appendix F: Teacher Consent Form

Drama Therapy Student: Margaret Owen
Concordia University
Supervisor: Alison Aylward
Part-time Concordia Faculty

Background Information

In order for drama therapy students to improve their understanding of drama therapy they write a research paper that includes case material and art work by clients they have worked with during their practicum. The purpose of this research paper, as well as other students and drama therapists, who read the research paper, is to increase their knowledge and skill in giving drama therapy services to a variety of persons with different kinds of problems. The long-term goal of this research is to aid future individuals with developed drama therapy skills and to enable new drama therapy students to read about these experiences.

Interview

I understand that this interview is for research purposes only. The information will be used for Maggie Owen's research project for her Master's in Drama Therapy at Concordia University.

I understand that all of the information discussed will be kept confidential. I also understand that an interpreter will be viewing this tape and translating the French into English. This interpreter will sign a document stating that this information remains confidential and all names and identifying information will remain anonymous.

I have read the consent form and agree to the current conditions.

Signature_____ Date_____

If at any time you have questions regarding your rights as a research participant, you may call Adela Reid, Compliance Officer, in the Office of Research.

Adela Reid, Compliance Officer
Office of Research, GM-1000, Concordia University, Montreal, Quebec H3G 1M8
Phone: 514-848-7481

Appendix G: Consent from Parent to Translate

I _____ hereby allow an interpreter to view and translate the recording of an interview held with the teacher of my child. I understand that this information will be kept confidential and that the purpose of the translation is to aid in Maggie Owen's research project towards her Master's in Drama Therapy.

I also understand that denying this request or accepting will in no way affect the quality of treatment my child receives.

Signature_____ Date_____