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Breaking the Silence: An Inside Look of the Experiences of Music Therapists Working With Children Who Have Selective Mutism

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BREAKING THE SILENCE: AN INSIDE LOOK OF THE EXPERIENCES OF MUSIC THERAPISTS WORKING WITH CHILDREN WHO HAVE SELECTIVE MUTISM

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BREAKING THE SILENCE: AN INSIDE LOOK OF THE EXPERIENCES OF MUSIC THERAPISTS WORKING WITH CHILDREN WHO HAVE SELECTIVE MUTISM

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ABSTRACT

Selective Mutism is a complex childhood anxiety disorder characterized by a consistent difficulty to speak in specific social situations, despite being able to speak in other settings. While existing literature has highlighted the efficacy of music therapy as a promising intervention for children with Selective Mutism, there remains a need to explore the experiences of music therapists working with this population. This interpretative phenomenological study aims to explore the experiences of music therapists working with children diagnosed with Selective Mutism. Two board-certified music therapists, selected for their extensive experience in treating children with Selective Mutism, were recruited through social media groups. Semi-structured interviews were conducted via a virtual interface, "Zoom". Thematic analysis of the data revealed five key themes, including initial encounters and preparations, clinical techniques, progress monitoring and challenges, emotions and feelings, and collaboration and support. The findings underscore the significance of anxiety reduction techniques, social integration strategies, and humanistic treatment approaches in creating a comfortable and supportive environment for children with Selective Mutism. Interdisciplinary collaboration is highlighted as crucial for providing comprehensive care for these children. This study contributes to the growing body of literature on music therapy for Selective Mutism, offering insights for clinical implication and future research endeavors.

Keywords: music therapy, Selective Mutism, childhood anxiety disorder, therapeutic process, experiences of therapists, interdisciplinary collaboration, supportive environment, anxiety reduction.

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CHAPTER 1: INTRODUCTION

This interpretive phenomenological study aims to explore the experiences of music therapists who work with children diagnosed with Selective Mutism. The research question guiding this study is: "What are the experiences of music therapists who work with children diagnosed with Selective Mutism?" Given the exploratory nature of the research question, an interpretive research method was employed to gain insights into the music therapists' experiences. The researcher used a phenomenological approach to analyze the phenomenon and understand its significance in this study.

My interest in this topic stems from a profound resonance with communication challenges in social circumstances. While I did not personally experience Selective Mutism, I can empathize with the challenges through my struggles with social anxiety starting from childhood. The difficulty in expressing myself and connecting with others caused feelings of anxiety, isolation, and even instances of bullying. Upon relocating to the United States at the age of 15, the expectation to fluently speak English in various unfamiliar settings has heightened my social anxiety. As a result, I remained mostly quiet throughout high school. My experience with social anxiety profoundly influenced my worldview, instilling a sense of admiration for individuals with strong communication skills and leading me to internalize self-blame for my fear of speaking up.

To cope with the pain and anxiety, I sought solace in playing the piano, finding in music an escape from social interactions. During this journey, I discovered the music therapy field, which resonated deeply with me. I also found significant meaning in using music to assist others suffering from anxiety to speak. My childhood experiences with social anxiety have motivated me to find ways to help other children with similar experiences. Communication and socialization are essential for children, and I am passionate about assisting them to reach their

social goals. In particular, children with Selective Mutism face unique challenges in expressing themselves, and I hope to learn from other music therapists who work with this particular population to assist them to maximize their potential.

During my clinical experience, I worked with several non-speaking clients and witnessed how music therapy can enhance communication. I observed that clients unwilling to communicate verbally could establish relationships and build intimacy with the music therapist through music, such as playing in a "call and response" manner or sharing the same instrument. Outside of my professional student career, I am currently teaching piano to a young girl with Selective Mutism who has been unwilling to communicate verbally in class for over five months. Her mother expressed concern about her daughter's performance in school and ability to make friends, which further motivated me to explore how music therapy can be an effective tool in helping children with Selective Mutism communicate and express themselves.

Given the limited research on exploring the experiences of music therapists working with children diagnosed with Selective Mutism, conducting a study in this area holds significant importance within the music therapy field. This study aims to raise awareness of innovative treatment approaches for children with Selective Mutism. By exploring music therapists' subjective experiences and practices, this study may expand the existing knowledge base on using music therapy as a treatment for Selective Mutism. The insights gained from this study may contribute to developing effective music therapy interventions for children with Selective Mutism while also providing a deeper understanding of the potential benefits of music therapy in promoting social communication and emotional expression for this population. The findings of this study may also offer valuable guidance and inspiration to music therapists, teachers, and parents, enabling them to better support and assist children with Selective Mutism.

Music Therapy

Music therapy is a well-established intervention defined as "a systematic process wherein the therapist helps the client to promote health, using music experiences and relationships that develop through them as dynamic forces of change" (Bruscia, 1998, p. 20). It involves utilizing music to address individuals' physical, emotional, cognitive, and social needs. For children with Selective Mutism, music therapy could offer a creative outlet for ideas, thoughts, and feelings that are challenging to express verbally. Bruscia identified four main music therapy methods: receptive, composition, improvisation, and re-creative techniques. Receptive music therapy refers to listening to pre-recorded music; Compositional music therapy encourages clients to create original music; Improvisational music therapy involves creating music spontaneously with the therapist; and Re-creative music therapy requires clients to play pre-existing music on an instrument or sing a pre-existing song (Bruscia, 1998).

Selective Mutism

Selective Mutism is a rare childhood anxiety disorder that affects a child's ability to speak in specific social situations where they feel insecure or uncomfortable (American Psychiatric Associations, 2013). While able to communicate in familiar environments, such as at home, children with Selective Mutism experience an intense fear of social interaction that can be debilitating and painful. The disorder manifests differently in each child, with some being utterly mute while others may whisper or speak to a select few individuals. Children with Selective Mutism tend to be timider and shyer than their peers, with the disorder representing an extreme end of the spectrum of social anxiety (Shipon-Blum, n.d.)

In 1877, Kussmaul identified elective or Selective Mutism as "aphasia voluntaria" (voluntary inability to speak), but it did not receive much attention afterward. In 1983,

Hesselman proposed that the term "Selective Mutism" was more descriptive, and this term replaced "Elective Mutism" in the transition from DSM-III-R to DSM-IV (Hoeve, 2022).

In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Selective Mutism is categorized as an anxiety disorder, which replaced the category of "disorders first identified in infancy, childhood, or adolescence" in DSM-IV. (American Psychiatric Association, 2013). The DSM-V criteria specify that persistent failure to speak in specific contexts should not be due to "organic inability rooted in language ability, another communication disorder such as stuttering, or concurrent diagnosis of pervasive developmental disorder, schizophrenia, or other psychotic disorder" (Wong, 2010, p. 24). The disorder must persist for at least one month, excluding the first school month. Selective Mutism is linked to various comorbid disorders that complicate the clinical presentation, including enuresis, obsessive-compulsive disorder, depression, and developmental delay, with 63% of affected children showing comorbidity with autism spectrum disorder (Steffenburg et al., 2018).

Additionally, Selective Mutism often coincides with speech and sound disorders, particularly Childhood Apraxia of Speech (CAS), a motor speech disorder that significantly impacts a child's intelligibility (Velleman et al., 2023). A recent research study found that within a total sample of 146 children with Selective Mutism, 59% displayed some form of language deficits (Klein & Armstrong, 2021). In the United States, Selective Mutism affects less than one percent of children, appearing slightly more common in girls than boys (National Organization for Rare Disorders, 2011).

There is conflicting evidence regarding the etiology of Selective Mutism. However, researchers widely acknowledge that this disorder does not fall under the categories of speech/language disorders, communication disorders, defiant disorders, or shyness. Instead, it is commonly associated with anxiety, specifically social phobia. Findings from a study indicated

that 80% of children with Selective Mutism were diagnosed with an additional anxiety disorder, notably social phobia (69%) (Driessen et al., 2020). Furthermore, studies indicated that a family history of anxiety plays a significant role in developing this disorder (Camposano, 2011). Selective Mutism treatment includes behavioral therapy, play therapy, cognitive behavioral therapy (CBT), medications, speech-language therapy, family therapy, and other innovative therapies (Shipon-Blum, n.d.).

Interpretive Phenomenological Study

Interpretive research is a qualitative research approach that aims to understand social phenomena from the perspective of the individuals involved. It acknowledges the subjective nature of reality and emphasizes the importance of personal experiences, beliefs, and values in shaping social phenomena. Interpretive research seeks to uncover people's meanings and interpretations of their experiences rather than imposing predetermined categories or concepts on them (Wheeler, 2016).

Phenomenology is a standard method used in interpretive research that focuses on exploring the nature of a phenomenon through the analysis of first-person experiences. Phenomenologists seek to understand the subjective experience of individuals and how they make sense of their world. Interpretive phenomenological research can provide a deep understanding of complex social phenomena that cannot be easily quantified or measured, allowing researchers to explore the complexities of lived experiences (Jackson, 2016).

Thematic Analysis

Thematic analysis is a qualitative research approach that focuses on the exploration of the experiences of participants and seeks to uncover the subjective meanings and interpretations that they attach to particular experiences. The thematic analysis uses semi-structured interviews to gather rich and in-depth information from participants, which is then analyzed to identify and

describe underlying themes and patterns. This analysis involves a detailed examination of the participant's verbal and nonverbal expressions to gain a deep understanding of their experience. Thematic analysis is beneficial in exploring complex, subjective experiences that cannot be easily measured or quantified, such as emotions, attitudes, and beliefs (Dawadi, 2020). This research study used thematic analysis to analyze the music therapists' experiences and insights gathered from the interview and create an organized and logical written transcript.

In conclusion, this interpretive phenomenological study aims to explore the subjective experiences of music therapists working with children diagnosed with Selective Mutism. The research was conducted through semi-structured interviews with two board-certified music therapists and analyzed using thematic analysis. This research study may contribute to the music therapy literature by raising awareness of innovative treatment approaches and expanding the knowledge base on using music therapy for Selective Mutism. These insights may potentially spark inspiration for the child's therapeutic team to assist them in overcoming anxiety and improving their overall quality of life.

CHAPTER 2: REVIEW OF LITERATURE

The primary focus of this study is to explore the experiences of music therapists who work with children diagnosed with Selective Mutism. *Selective Mutism* is a rare multidimensional anxiety disorder that can impede a child's ability to communicate effectively in certain situations, such as school or social settings (Shipon-Blum, n.d.). While various interventions have been proposed to address Selective Mutism, such as medication, behavioral therapy, and psychotherapy, music therapy has gained increasing attention as another innovative treatment option (Hoeve, 2022). Despite this growing interest in music therapy as an intervention for Selective Mutism, limited research has been conducted to explore the experiences and perspectives of music therapists working with this population. Thus, this literature review aims to examine existing research, critically evaluate the current knowledge on this topic, and identify areas for future research.

The Needs of Children with Selective Mutism

Given that Selective Mutism is classified as an anxiety disorder in the DSM-V, the primary need for children with Selective Mutism would be to ease anxiety levels. Morris and March (2004) provided a comprehensive overview of anxiety disorders in their book "Anxiety Disorders in Children and Adolescents." They identified 13 categories of anxiety disorders, including generalized anxiety disorder, social phobia, separation anxiety disorder, panic disorder, obsessive-compulsive disorder, posttraumatic stress disorder, specific phobia, and Selective Mutism. Morris and March proposed that anxiety disorders in children stem from "distorted beliefs about the dangerousness of certain stimuli or situations" (Morris & March, 2004, p. 12). Children with anxiety tend to have a bias towards threatening stimuli, which leads to behavioral inhibition, a tendency to exhibit fearfulness, restraint, and withdrawal in situations involving unfamiliar rooms, toys, peers, and adults.

Another study conducted by Cartwright-Hatton and colleagues (2005) confirmed the existence of distorted beliefs and biases in children with anxiety disorders. The study examined whether children with social anxiety suffer from social deficits or cognitive distortions. Two groups of children aged 10 to 11, one with high social anxiety and the other with low social anxiety, participated in a conversation with an unfamiliar adult. The results showed that the adult observers could not differentiate between the two groups, though the high socially anxious group rated themselves as less skilled and more nervous-looking compared to the low anxious group. The authors suggested that clinicians should focus on addressing these distorted beliefs about appearing nervous during social encounters rather than solely focusing on social skill training.

Camposano (2011) systematically reviewed Selective Mutism, exploring its current issues, etiology, and treatment trends. The author emphasized the need to shift focus away from the absence of verbal communication at the initial stage of treatment. Instead, the immediate goal should be establishing rapport and building a trusting relationship with the child. Once rapport is established, anxiety reduction should be a vital component of any treatment method. Followed by anxiety reduction, the treatment team should collaborate to enhance the child's self-esteem and confidence, especially in social settings. Once anxiety levels decrease, verbal communication interventions would likely follow.

Many research studies support that adequate socialization and communication skills are crucial in children's developmental stages. It is essential to assist children in feeling confident when interacting with others. Socializing allows children to communicate with individuals beyond their immediate family, enabling them to understand social cues, take risks, and develop listening skills. Through social interactions, children can learn to share, become less self-centered, develop empathy, and build friendships, all of which are crucial skills for a fulfilling life (Child's Play Early Learning Center, n.d.).

In their study, Nowakowski and colleagues (2009) examined the receptive language and academic abilities of children diagnosed with Selective Mutism and other mixed anxiety disorders. The researchers included a control group and administered standardized tests within a laboratory environment to evaluate receptive language skills and academic performance. The findings revealed that both the Selective Mutism group and the mixed anxiety group exhibited significantly lower scores in receptive vocabulary and mathematics compared to the control group. These results highlighted the significance of addressing communication and academic needs in children with Selective Mutism.

Treatment Approaches for Children with Selective Mutism

Children with Selective Mutism are positioned at the end of the social anxiety spectrum and require individualized, specialized, and long-term care to address their social needs and build their confidence in speaking in unfamiliar environments. Over the years, researchers have explored various treatment methods for children with Selective Mutism. Wong (2010) conducted a systematic review of the etiology, comorbidities, and treatment for Selective Mutism and noted that treatment can be divided into two primary domains: non-pharmacological and pharmacological-based interventions. Among the non-pharmacological-based options, behavioral therapy and family therapy are the most common, whereas, among the pharmacological-based interventions, selective serotonin reuptake inhibitors (SSRIs) have been shown to be most effective. Behavioral therapy is typically a multimethod approach that involves techniques such as positive reinforcement, stimulus fading, token procedures, shaping or prompting, contingency management, and self-modeling. Family therapy is another treatment option in which family members play an essential role in the treatment of Selective Mutism.

In addition, Morris and March (2004) added that besides pharmacological-based interventions and psychodynamic therapy, psychosocial interventions are another essential

component of the treatment plan for children with Selective Mutism. The authors stated that successful efforts to treat Selective Mutism focus on involving the child in peer-group activities, such as arranging playdates with several friends who can be regular playmates. The child should also be encouraged to participate in nonverbal relationships with adults, answer questions that require only a one-word response and engage in non-threatening activities with strangers. Additionally, selectively mute children should remain in a regular classroom and play in a regular environment, if possible.

In recent years, newer and unconventional treatment methods that show promise in treating Selective Mutism have merged. Klein and colleagues (2016) conducted a pilot study to examine the feasibility of implementing Social Communication Anxiety Treatment (S-CAT) developed by Dr. Elisa Shipon-Blum in treating Selective Mutism. The sample consisted of 40 children between the ages of 5 and 12 with Selective Mutism who underwent a 9-week treatment program. The treatment approach involved a stepwise progression, starting with the therapist mirroring the child and then assisting them in producing voiceless phonemes, followed by voiced phonemes and consonant-vowel combinations. The results revealed significant improvements in speaking frequency and decreased levels of anxiety among the children. The Ritual Sound Approach (RSA), a cognitive and behaviorally based treatment approach, is part of the S-CAT that many speech-language pathologists have used to help children with Selective Mutism reduce anxiety when speaking. It involves *shaping* from a behavioral therapy approach to reinforce the child's oral movements, which starts with voiceless speech sounds, such as breathing and blowing in and out of the child's mouth, followed by less audible sounds, such as /h/, /t/, and /p/ (Selective Mutism Association, n.d.).

In a systematic review, Hoeve (2022) discussed three innovative approaches for treating Selective Mutism: mobile applications (Apps), virtual reality, and music therapy. According to

Hoeve, children are typically less anxious while using mobile apps, and one game called "Lift-Off!" was developed to encourage children to record their own voices and share the recording with others. This app effectively treated Selective Mutism in a case study involving a 17-year-old girl who has had Selective Mutism for years. Virtual reality is another effective treatment method, as it was used successfully with a group of 24 children diagnosed with Selective Mutism. Over the course of 10 weeks, these children successfully interacted with a virtual classroom simulation. Hoeve (2022) identified music therapy as another form of expressive therapy that is helpful in treating Selective Mutism, and this will be discussed in more detail in the following sections of the paper.

Sociocultural Considerations and Interdisciplinary Collaboration in Treatment

As clinicians navigate various treatment approaches for Selective Mutism in children, it is imperative to consider individual differences and the socio-cultural impact on each child. Hungerford (2017) highlighted the multifaceted nature of Selective Mutism, emphasizing the various contributing variables, including "a reticent or withdrawn temperament, second-language learning, environmental stressors, and underlying articulation or language disorders". A study has shown that the prevalence of Selective Mutism is three times higher in immigrant language minority children. A migrating child could be erroneously diagnosed with Selective Mutism if unaware of the complexity of learning a second language, as true selective mute children exhibit mutism in both their primary and secondary languages in several settings (Toppelberg et al., 2005).

Furthermore, Slobolin (2023) conducted a systematic review of eight studies that included culturally and linguistically diverse children with Selective Mutism and concluded that bilingualism and minority status are associated with Selective Mutism. The researcher suggested

the potential direction for future research in examining the “cultural and psychological meanings of silence and talk, socialization goals, gender inequality, and parental acculturation strategies”.

Due to the complex nature of Selective Mutism, a multidisciplinary approach involving collaboration among clinicians, parents, teachers, and professionals from various disciplines would provide the highest quality of care. Hungerford (2017) discussed that children with Selective Mutism often are not diagnosed until they enter school or even later. Pediatricians and teachers might think the child is shy, and the parents might not be aware of the mutism in school. The researcher recommended early treatment to avoid the social and emotional distress carrying over to adulthood. In another study, two hundred and one speech-language pathologists and counselors participated and responded to a survey about parent involvement in treating Selective Mutism in children. Most respondents agree that parental inclusion has powerful potential since they are often the only people their children would talk to. However, some raised the concern that certain parental traits and parenting styles might contribute to the presence of Selective Mutism (Frazier & Howard, 2020).

Music Therapy for Easing Anxiety and Enhancing Social and Communication Skills

Among all treatment approaches for anxiety reduction, pharmacological approaches, and Cognitive Behavioral Therapy (CBT) are recognized as the primary treatment methods. However, many medications have numerous side effects, and up to 36% of anxiety patients do not respond well to CBT. To address this issue, therapists have explored other supportive psychological interventions, such as music therapy. Multiple studies have found that music therapy can significantly reduce anxiety and address the social and communication needs of children (Lu et al., 2021).

In a recent meta-analysis, Lu and colleagues (2021) examined the impact of music therapy on anxiety levels by analyzing data from 32 randomized controlled trials published in

multiple electronic databases from 2003 to 2021. The studies involved a total of 1,924 participants. The results showed that music therapy was associated with a significant reduction in anxiety levels compared to the control group. The authors suggested that music may act as a distractor, diverting the patient's attention from negative stimuli to something pleasant and encouraging. The continuous attunement created by the music therapist to the patient's individual needs may have played a role in the effectiveness of music therapy in treating social anxieties.

Furthermore, Goodings (2011) conducted a quantitative study that included three studies testing the effectiveness of a music therapy program in improving social competence in children with social skills deficits. The studies involved 45 children who participated in five group music sessions that used active interventions, such as music performance, movement to music, and improvisation, along with cognitive-behavioral techniques, such as modeling, feedback, and transfer training. This study demonstrated music therapy's efficacy in improving children's social and communication skills.

Music Therapy as a Treatment for Children with Selective Mutism

Music therapy is a form of expressive therapy that utilizes music to address various emotional and psychological issues. Numerous case studies have demonstrated the effectiveness of music therapy in treating Selective Mutism, as it offers a nonverbal form of communication that helps children feel comfortable expressing themselves. While music therapists may have different approaches and techniques, a review of the literature reveals that the four primary methods (receptive, compositional, improvisational, and re-creative) have all been implemented by therapists in their practice.

In a heuristic case study conducted by Jones (2012), the author aimed to establish a theoretical understanding of the application of music therapy in the treatment of foundation-stage children with Selective Mutism. Eleven sessions of music therapy with a four-year-old boy with

Selective Mutism were videotaped and analyzed. Through this process, a theoretical framework emerged, highlighting the following stages in the therapeutic process: creating a safe and nurturing environment, addressing, and working through anxiety, fostering trust through a no-pressure approach, promoting meaningful communication, and supporting the child's healthy and confident separation.

In recent years, Jones and Odell-Miller (2022) conducted a comprehensive multiple case study to develop an enhanced theoretical framework that provides a detailed description of the music therapy process for six young children with Selective Mutism. During the therapy sessions, the therapist utilized oral instruments such as kazoos, whistles, recorders, and echo/parrot toys to encourage and amplify the children's voices. This approach facilitated a reduction in anxiety levels and fostered self-expression through increased physical movements, humor, and laughter. Remarkable improvements were observed in the children's ability to express themselves more dramatically and loudly.

Another qualitative study by Hunt (2020) explored an additional approach to treating Selective Mutism. The study focused on the inclusion of peers in individual therapy sessions to foster a sense of belonging and the development of friendships for a girl named Isobel, who had Selective Mutism. A trusted teaching assistant (TA) was initially present in the therapy sessions. As the therapy progressed, the therapist gradually introduced different peers to the sessions, aiming to reduce Isobel's reliance on her TA. The inclusion of peers significantly increased Isobel's participation, as the peer support provided opportunities for interaction. Isobel gradually began to verbalize throughout 24 music therapy sessions of improvisation and games. The involvement of peers in music activities allowed Isobel to engage with her peers in a fun and pressure-free manner.

Moreover, in their book "Introduction to Music Therapy Practice," Heidersheit and Jackson (2018) presented a case study of a 14-year-old boy named Sean with Selective Mutism. The music therapy sessions initially focused on creating a pressure-free environment for Sean, in which the therapist avoided asking Sean questions. Instead, the therapist observed and reflected on Sean's body affect and movement through music. As Sean became comfortable, the therapist introduced challenges, such as leaving longer pauses for him to showcase his musical ideas. The sessions eventually centered around songwriting, providing Sean with a safe space to develop relationships and explore his musical and lyrical expressive abilities.

The music therapy literature is replete with case studies highlighting the positive impact of music therapy on children with Selective Mutism. Wakamatsu (2022) conducted a case study on a 16-year-old girl named Teressa, who had Autism Spectrum Disorder and Selective Mutism. Teressa had not spoken to anyone besides her brother and mother in Vietnamese since age six. The study reported significant improvements in her communication skills after receiving 60 music therapy sessions over four years. The music therapist held sessions at Teressa's home to increase her comfort level. After discovering Teressa's love for singing, the therapist encouraged Teressa to sing her favorite Vietnamese songs on karaoke; then, the therapist helped her gradually transfer her singing to English and learn many more songs. As a result, Teressa began speaking to more people outside of therapy over time.

Similarly, in a case study by Amir (2012), a six-year-old girl named Shiran, with Selective Mutism, discovered her voice through music therapy. Initially, the therapist used the gentle sounds of the autoharp to establish a connection with Shiran. As Shiran grew comfortable, the therapist introduced small instruments for her to play. In the 40th session, while passionately playing the big drum, Shiran suddenly let out a scream followed by tears, marking a significant turning point in her treatment journey. Through singing and improvising on various instruments,

Shiran gradually increased her verbal communication and eventually overcame her Selective Mutism.

Furthermore, Kos (2022) conducted a systematic review of Selective Mutism in children, focusing on the unique features of the disorder and techniques for improvisational music therapy. The review highlights the potential of music therapy in lowering anxiety, promoting non-verbal communication, and building a positive therapeutic bond with the child. The study concludes that music therapy has psychological, medical, and educational benefits in tackling communication difficulties and fostering spontaneous speech formation in young children with Selective Mutism.

Music Therapists' Experiences in Working with Children with Selective Mutism

The experiences of music therapists working with children with Selective Mutism can vary depending on the child's individual needs and treatment goals. Many music therapists start by creating a safe and welcoming environment for the child and then gradually introduce musical activities that encourage communication, such as singing, playing instruments, improvising music, using vocal equipment, and imaginative play. These activities can help build the child's confidence and comfort with communicating while providing a non-threatening and enjoyable way to recognize and express their emotions and needs (Jones & Odell-Miller, 2022).

As a researcher and a music therapist, Amir (2012) described her approach to music therapy for children with Selective Mutism as music psychotherapy. The author highlighted that music therapy sessions can serve as a microcosm of the client's life, where emotional, psychological, and creative expressions can be fully expressed in the present moment through musical improvisation. To create a supportive atmosphere and alleviate the child's anxiety, the therapist adopts a gentle and musically active approach, honoring the child's pace and respecting their silence.

While Selective Mutism in children has gained attention in recent years, it remains an under-researched area, particularly from the perspective of music therapists. Few first-person case studies exist where researchers share their experiences as music therapists working with children with Selective Mutism. Consequently, there is a lack of available resources regarding the therapist's insights and experiences in this current literature. Further research in this field is crucial to comprehensively grasp the experience of working with children with Selective Mutism. Understanding the music therapist's experiences working with children with Selective Mutism could potentially spark inspiration for other music therapists working in the same field, thus enhancing the quality of care for children with Selective Mutism.

CHAPTER 3: METHODOLOGY

Research Topic, Design, and Type of Data

The purpose of this interpretivist research study was to obtain a thorough understanding of the experiences of music therapists who work with children diagnosed with Selective Mutism. The research question guiding this proposed study was: “What are the experiences of music therapists who work with children diagnosed with Selective Mutism?" By employing an interpretive phenomenological design, this study seeked to delve into the subjective experiences of music therapists from a first-person perspective. The researcher conducted semi-structured interviews with the music therapists and gathered and transcribed data using thematic analysis.

Participants and Inclusion Criteria

For this study, two board-certified music therapists who have experience working with children diagnosed with Selective Mutism were recruited. The music therapists who participated in this study met the following inclusion criteria:

1. The music therapist must possess a Master’s degree in Music Therapy, be currently Board-Certified, and have worked in the field for at least five years.
2. The music therapist must have worked with at least one child diagnosed with Selective Mutism for is currently working with one.
3. The total duration of music therapy with the child with Selective Mutism must be at least two years or a minimum of 80 sessions in total.
4. The child whom the music therapist worked with or is currently working with must be between the age of 6 to 12.

The inclusion criteria are crucial in guaranteeing that the experiences and insights of the music therapists are pertinent to the research question and are grounded in a substantial period of working with children diagnosed with Selective Mutism. This criterion ensured that the music

therapists have extensively engaged with this population, increasing the likelihood of valuable and informative contributions to this study. For confidentiality purposes of this study, the two participants recruited are now referred to as Emily and Kaitlyn.

Participant 1: Emily

Emily began her journey in music therapy by earning her bachelor's degree in music therapy from Elizabethtown College in 2013. Following this, she pursued an internship in pediatric and psychiatric music therapy in Pittsburgh, where she gained valuable experience at the Western Psychiatric Institute and Clinic and the Children's Hospital of Pittsburgh. After completing her internship and obtaining certification, Emily transitioned to private practice, joining a business in rural Pennsylvania. She currently primarily works in school-based settings under contracts with local public schools. Her caseload encompasses a wide range of populations, from nonverbal children diagnosed with Autism Spectrum Disorder to adolescents recovering from traumatic brain injuries using music as a therapeutic tool.

Emily's expertise spans nine years at her current company, where she continues to make impactful strides in the field. Alongside her music therapy career, Emily is pursuing a master's degree in family therapy, aiming to integrate her knowledge from both disciplines for a more comprehensive approach to therapy. Despite her extensive experience, Emily has only worked with one child with Selective Mutism, an eight-year-old second-grade student she has been supporting since April 2023.

Participant 2: Kaitlyn

The participant, Kaitlyn, has an extensive background spanning 26 years in the field of music therapy. She was trained at the Roe Hampton Institute in London and adopted a psychodynamic approach to music therapy. Her professional journey has been diverse, including roles at the Roe Hospital for neuro-disability in London and working with adults in residential

care with learning disabilities. For the past two decades, she has primarily focused on providing music therapy in the borough of Lambeth through her set up in a music therapy charity. Kaitlyn's academic pursuits have been equally remarkable. Following an MA in music therapy and a postgraduate diploma, Kaitlyn obtained a PhD in 2019. Additionally, she contributes as a researcher at the Guildhall School of Music and Drama.

Over her career, Kaitlyn has worked with a substantial number of children with Selective Mutism, estimating between 50 to 70 individuals, spanning ages from two to around 14. Her experience with these children encompasses various settings, from nursery settings to special schools, often involving complex cases where Selective Mutism intersects with other conditions such as autism. Though not throughout her entire career, her focus on working with children with Selective Mutism intensified significantly upon starting her career in Lambeth.

Recruitment Procedures

Following the approval granted by the Molloy University Institutional Review Board (IRB), the researcher used a multi-faceted recruitment strategy to identify potential participants for this study. The first step involved identifying and joining social media groups associated with music therapy and Selective Mutism. The researcher posted announcements in three Facebook groups associated with music therapy and Selective Mutism, outlining the purpose and procedures of the study and detailing the inclusion criteria for recruitment.

Moreover, a snowball sampling method was employed to propagate information about the study to music therapists within the researcher's existing network, seeking collaboration to extend the reach of the recruitment effort. This procedure involved requesting assistance from these music therapists to establish connections with their professional counterparts, thereby enhancing the likelihood of identifying potential study participants. Upon receiving responses

from potential participants on the Facebook group, “Music Therapy and Selective Mutism”, the researcher communicated to verify their alignment with the inclusion criteria.

After verifying that the potential participants met the established inclusion criteria, the researcher sent recruitment emails to invite them to participate in the study and provided detailed information about the study procedures and requirements. In this process, the researcher gave potential participants sufficient time for consideration and provided opportunities for clarifying potential inquiries. Upon expressing interest in participation, the potential participants received a consent form outlining the purpose and procedures of the study and detailing the participants' rights and responsibilities. Both participants agreed to participate in the study, and they signed the informed consent form and were scheduled for an interview with the researcher at a mutually agreed time and date.

Data Collection Procedures

To gather data for this study, the researcher conducted semi-structured interviews with the participants using the video conferencing interface "Zoom." The interviews were audio recorded through both "Zoom" and the "Voice Memos" app on an iPhone to ensure data accuracy and security in case of technical issues. The approximate duration for the interview was planned to be in between 30 to 45 minutes to allow for a comprehensive exploration of the participants' experiences and perspectives while respecting their time. The first interview lasted for 36 minutes, and the second interview lasted for 31 minutes. During the interview, the researcher asked open-ended questions to explore the music therapists' experiences working with children diagnosed with Selective Mutism. The interview questions encompassed a range of topics, delving into aspects such as the music therapist's professional background, their overall experience in treating Selective Mutism in children, insights on establishing rapport and delivering personalized treatment, approaches employed in music therapy sessions, challenges

and gratifications encountered while working with children with Selective Mutism, collaborative efforts with other professionals, and guidance for peers, parents, and the child's treatment team. See appendix C for specific questions asked during the interviews.

Upon completion of each interview, the researcher transcribed the recordings into written transcripts and sent them to the participants for member checks to ensure the accuracy of the content. The transcripts were designed to be easily readable, and participants should be able to complete their review within an hour. The researcher has received some feedback for corrections from Emily and made minor changes to the transcript according to her suggestions. The researcher has not received responses from Kaitlyn. The member checking process enhanced the validity and reliability of the data, as participants had the opportunity to review and verify their statements.

Materials, Setting, and Time Involved

The virtual conference application "Zoom" was utilized for the interviews. Additionally, to mitigate potential technical issues, the interviews were also recorded on an iPhone's "Voice Memos" app as backups. The virtual interviews were conducted in a quiet room to ensure minimal interruptions. The anticipated duration for each interview was approximately 30 to 45 minutes.

Data Protection Procedures

The data collected from participants was stored securely on an external hard drive located in the researcher's home office, which was locked and only accessible by the researcher and their direct supervisor. The data was retained for the duration of the research and has been securely destroyed upon completion. To protect participants' identities, their real names were not used in the research paper, and any identifying information shared from the interview, such as the child's

name, address, school, parent's name, teacher's name, and classmate's names were kept confidential and anonymized.

Data Analysis Procedures

The data analysis for this study utilized the thematic analysis approach to gain an in-depth understanding of the participant's subjective experiences and perspectives working with children diagnosed with Selective Mutism. The researcher first transcribed the interviews from audio recordings using an online software program known as “Notta”. Thematic analysis was used to analyze the transcripts line-by-line, identifying codes, patterns, and meanings within the data. These codes were then clustered into larger themes to develop a coherent narrative of the participants' experiences. The researcher interpreted the data by discussing the themes in the context of existing literature and theories, ultimately presenting the data clearly and concisely (Dawadi, 2020). This analysis provided insights into the lived experiences of music therapists working with children with Selective Mutism and the potential impact of music therapy on their practice.

CHAPTER 4: RESULTS

This chapter presents the findings derived from interviews conducted with two board-certified music therapists who shared their experiences and insights in working with children with Selective Mutism. For confidentiality purposes, the participants are pseudonymously referred to as Emily and Kaitlyn.

Participants

Participant descriptions herein are intentionally kept minimal to maintain anonymity. A breakdown of participant demographics can be seen in Table 1 below:

Table 1

Participant Demographics

Participants	Background	Education	Years of Experience in Music Therapy	Number of Children with Selective Mutism Participants Worked with	Age Range of Children with Selective Mutism Participants Worked with
Participant 1: Emily	Adult female. Resides in the United States	Bachelor's degree in Music Therapy. Master's degree in Family Therapy.	9 years	1 child	8 years old
Participant 2: Kaitlyn	Adult female. Resides in the United Kingdom	Master's degree in Music Therapy. Doctoral degree in Music Therapy.	26 years	50-70 children	From 2 to 14 years old

Through in-depth data analysis, several key themes emerged, shedding light on various aspects of the therapeutic process. The themes identified include:

- Theme 1: Initial Encounters and Preparations
  - Sub-theme 1: Referral and Assessment
  - Sub-theme 2: First Encounter and Rapport-building
  - Sub-theme 3: Clinical Goals
- Theme 2: Clinical Techniques
  - Sub-theme 1: Therapeutic Approaches
  - Sub-theme 2: Therapeutic Methods
- Theme 3: Progress Monitoring and Challenges
  - Sub-theme 1: Progress Monitoring
  - Sub-theme 2: Challenges Encountered
- Theme 4: Emotions and Feelings
- Theme 5: Collaboration and Support
  - Sub-theme 1: Interdisciplinary Collaboration
  - Sub-theme 2: Support and Resources

These themes encapsulate the multifaceted nature of music therapy interventions for children with Selective Mutism, encompassing aspects such as referral and assessment, rapport-building, treatment approaches and methodologies, challenges encountered, collaborative efforts, and emotional dynamics within therapeutic settings. By examining these themes, we gained valuable insights into the experiences of music therapists and the complexities inherent in addressing Selective Mutism through therapeutic interventions.

Theme 1: Initial Encounters and Preparation:

When reflecting on their initial encounters with the first child diagnosed with Selective Mutism, participants in this study discussed several key aspects. These encompassed the referral and assessment process, participants' existing knowledge regarding Selective Mutism, and the steps taken to establish rapport with the child and formulate targeted therapeutic goals. Understanding these initial interactions is essential as they lay the groundwork for effective music therapy interventions tailored to the unique needs of children with Selective Mutism.

Sub-theme 1: Referral and Assessment:

Emily shared her experience with the referral process when she first began working with a child with Selective Mutism. Drawing from her academic background in her current Master's study in family therapy, she explained that during her study, she independently researched and presented the topic of Selective Mutism. When she received a referral for a child with Selective Mutism from the school district that she is working at, Emily expressed her readiness to engage with the referred child. She elaborated:

> *"Prior to getting this child referred to my caseload, I was in a class for my Master's in family therapy on diagnosis… I had to select a DSM diagnosis from a specific category to basically do a presentation on. Totally independent of my music therapy work, I had selected Selective Mutism as the thing to focus on. I had done a deep dive into what are the diagnostic criteria and what are the exclusions… Totally independent. Then a couple months later, I got the new referral from the school district like, 'Hey, we have a child who we think would benefit from music therapy. Can you do an assessment to see if this would help them?' I read that their primary diagnosis was Selective Mutism. And I went, 'I know about that.'"*

While Emily approached the referral process with confidence drawn from her academic background in family therapy, Kaitlyn's experience with the first child with Selective Mutism was quite different. Kaitlyn recalled the experience of receiving referred to these children described as "quiet." She was unfamiliar with the concept of Selective Mutism. Teachers and staff expressed uncertainty about these children's behavior, prompting referral for assessment during music therapy sessions. Through assessment, Kaitlyn discovered the transformative effect of music therapy on children with Selective Mutism. She elaborated,

> *"I was just being referred to children who were described as quiet. Um, and I didn't know what Selective Mutism was. So, um, teachers and staff who were referring to children saying, Oh, there's something about this child. We can't figure out, they're very quiet. We're not sure what's going on. Please, can you assess them in a music therapy session?' Um, and so I would assess them and then they would start playing. Um, and then they would start interacting and talking in music therapy and then sort of go back to their classroom and talk in the classroom, and the teachers would become surprised and sort of say, 'Oh,' you know, 'Wow, What have you done?'... I was curious then as to what was going on, because they clearly didn't, in a lot of cases, didn't seem to have particular learning difficulties or language difficulties. Some of them are more complex… And then of course, they discovered that there was this condition called Selective Mutism."*

Sub-theme 2: First Encounter and Rapport-Building

During her initial interactions with the child, Emily encountered unique challenges related to rapport-building due to the child's teasing and sarcastic demeanor. Emily stated that initially, she modeled how other professionals interact with this child, and she reflected:

"Rapport-building with this child has been interesting, not because of her diagnosis, but because of her personality. She is a little bit like, teasing and sarcastic, almost like to the point where I'm kind of like, 'should we be concerned'... like so, she is highly withdrawn when she's anxious, but then when she's feeling comfortable, she's very much like, 'No, not you, I'm gonna do the thing!'... like I followed what I saw other people doing where it was like, 'Oh, do you want me to just play the drums then?' Because then she'll be like, 'No, I'm playing the drums.' And so building that sort of like, teasing, but slightly adversarial relationship is how I kind of started because I was following what other people had modeled."

Unlike Emily, who initially found the rapport-building process challenging, Kaitlyn expressed a contrasting experience, noting that it was comfortable for her. She briefly described her approach to building rapport, stating, *"just using play and sort of follow their lead as well. So just being interested in whatever they are interested in."* Additionally, due to a lack of prior knowledge of Selective Mutism, Kaitlyn began researching and learning more about this condition to improve the therapeutic relationship with the children and better assist them under her care. She elaborated on her journey to becoming a researcher in this field:

"So then I had to really go and research it myself and find out more about it. And in the UK, a man called Dr Tony Klein has written a book called 'Selective Mutism in Children.' And I went to a research conference up in the center of London, where they were presenting the consensus-based research, international research on care pathways for children with Selective Mutism. And Tony Klein, the man that had written that book, was in the audience, in fact he was sat in front of me. And so I was watching this presentation of the research, and at the end of it I was just really excited. So I tapped him

on the shoulder, and I was sort of, "Oh, Dr Klein, Dr Klein, music therapy works for children with Selective Mutism." And so, yes, so he said, "Yes, I totally believe you, but you need to go do some research." So that's my whole, yeah, that's sort of my story, my into investigating it and becoming a researcher."

Sub-theme 3: Clinical Goals

When outlining the clinical goals for this child, Emily emphasized a "*two-branched approach*" to music therapy, targeting both verbal communication development and non-verbal social and relational skills. She described her structured treatment plan, consisting of three individual sessions per month focusing on "*honing communication and social skills*," complemented by a small peer group session during the last week of the month, which aimed for real-world application with peers.

In contrast, Kaitlyn provided valuable insights in the multifaceted nature of therapeutic goals, encompassing anxiety reduction, psychoeducation, communication development, and social integration. During the interview, she stated,

"I'd say that often the goals would be around anxiety reduction, um, trying to create, sort of an anxiety-free environment for them in their school settings. Um, and providing sort of psychoeducation around the child, educating family and staff. That would be another goal. Um, I mean, ultimately communication, um, and verbal communication, but really building that through this sort of musical relationship. Um, and also I think it's really, yeah, really important for some children to develop social communication with, with peers as well. So I've had some children who've requested to have friends in, in the sessions and to really sort of, um, support that development. So that can be a really important aspect of it as well."

Theme 2: Clinical Techniques:

Both participants discussed their clinical techniques, encompassing therapeutic approaches and methods. They expressed a shared inclination towards employing a humanistic approach, in which they followed the child's lead during musical interactions and maintained flexibility throughout sessions. Emily further elaborated on the significance of maintaining consistency and predictability, as well as the strategy for planning and adapting engagement levels to anticipate varied responses from the children. Regarding therapeutic methods, both participants outlined specific music therapy techniques, such as song recreation, improvisation, and receptive listening, while briefly mentioning their selection of instruments and materials. Furthermore, they emphasized the importance of fostering a playful and creative atmosphere, providing clinical examples of engaging musical experiences tailored to the children's preferences and developmental needs.

Sub-Theme 1: Therapeutic Approaches

Emily's therapeutic approach for working with children with Selective Mutism is deeply rooted in a humanistic framework, emphasizing individualized support, and matching with the child's needs at the moment. She prioritizes creating a safe and supportive environment, allowing the child to express themselves at their own pace and manner. Emily emphasized the importance of flexibility and adaptability in her approach, ensuring that accommodations are in place if the child does not feel comfortable verbalizing, allowing them to engage with music therapy without the pressure to speak. Emily described her approach as "*working to support them as a human in whatever ways they need, and just taking it day by day and moment by moment.*" She demonstrated her flexibility and patience with a child with Selective Mutism during a session, as she described below:

"I have a practicum student with me who was observing this girl's session… She was having a more anxious day because there was somebody new in the room, the practicum student and I had scarves out because we had enjoyed dancing with scarves earlier, but she really just wanted to hide underneath the scarves. And so I was like, of course that's what we're doing, we're going to hide underneath the scarves. And so 'Where is so and so (student's name)? Where did she go? Where did she go?' And allowing that last phrase to really like hold on so that you know that you're safe in this place and you're supported. And whenever you're ready, you can lift that scarf up and go, 'Here I am!' That was a really an interesting moment because like, it was allowing her to use that impulse to hide and withdraw in a playful way, in a functional way… it allowed her to really take the time and emerge from her hiding place when she was ready and on her time."

Following Emily's insightful approach, Kaitlyn also underscored the importance of flexibility and a child-led approach in working with children with Selective Mutism. Kaitlyn emphasized the significance of maintaining a light approach and adapting to each child's individual interests and preferences. By adopting a humanistic approach, Kaitlyn aimed to create a supportive and engaging environment where children feel empowered to express themselves freely. Reflecting on her experiences, Kaitlyn noted,

"I think that it's really important to have quite a light approach with young children with Selective Mutism and have, um… I think that particularly in the UK, we would have a very sort of child-led approach, so we would sort of work with whatever the child was interested in and really be very flexible about what we're offering each child, so working to their own sort of tastes and interests and offering a wide range of instruments, but just focusing on whatever they are interested in and as well as offering musical instruments."

Having explored Kaitlyn's humanistic approach, which prioritizes flexibility and meeting the child's interests and needs, we now refocus on Emily's valuable insights regarding the intricacies of planning multiple levels of engagement and ensuring consistency and predictability in therapeutic sessions. To maintain flexibility and accommodate the child's state of being in the moment, Emily emphasized the importance of pre-planning multiple levels of engagement before each session. She elaborated,

> *"Plan even like three or four levels of engagement. So they like, where the top might be like, they are singing and they are improvising with their singing and they are generating independent verbalization. The middle one being like, they are making non-verbal choices about instruments by picking up the one they want or selecting picture cards, with the bottom one just being like they might just need to sit and listen to music today. They might not be able to even articulate a choice because that feels overwhelming."*

Furthermore, Emily highlighted the importance of consistency and predictability in her therapeutic approach. By maintaining a consistent and supportive presence, she aimed to establish a sense of safety and security for the child. Emily explained that:

> *"It's been a whole lot of just maintaining consistency in how I show up every single session and making sure that she knows that there are always going to be levels of scaffolding and support in place… So like, if you're ready to sing, we're gonna sing. If you're not ready to sing, we have picture cards. There are still ways for you to participate and like just really being super consistent and predictable with showing up with those supports in place so that she can rely on them and rely on the fact that I'm a person that's going to be accepting of you're not talking today… Consistency and predictability and just really like allowing the music to be a part of the session as well."*

Sub-Theme 2: Therapeutic Methods

Emily stated that the music therapy methods she commonly used with the child with Selective Mutism include song recreation, improvisation, and movement to music. She discussed the use of a pre-composed song, "Down by the Bay," where the child fills in the blanks with their ideas, allowing for creativity within a familiar framework. When discussing improvisational work, Emily provided examples of experimenting on the xylophone or drums back and forth, providing opportunities for the child to make choices and assert agency by asking whether they wanted to play fast or slow. Emily mentioned that she avoids compositional experiences due to the potential overwhelming effects on the child with Selective Mutism.

Kaitlyn described free improvisation as a central component of her therapeutic methods. However, recognizing that free improvisation can sometimes be anxiety-provoking for children with Selective Mutism, she also incorporated known structures and songs, such as nursery rhymes. For instance, Kaitlyn described a technique used in the song "Old MacDonald Had a Farm," where she left gaps for the child to fill by making sounds and pointing to objects, thus encouraging interaction and communication. She stated that if the child appeared very anxious, she would usually offer sounds for them to respond. Kaitlyn mentioned that she had not done compositional methods but sometimes collaborated with the child to develop songs or pieces together in free improvisation. She elaborated,

> *"I do use a lot of free improvisation, but also because that can be quite, can be quite anxiety-provoking for some children with Selective Mutism, we also use sort of known-structures and songs such as nursery rhymes. So some of the techniques that I might use as well are using a known song, like a nursery rhyme such as "Old Mac Donald Had a Farm," where you leave gaps, And you can then either pick up a model of*

a cow or point to a cow or make a "moo" sound or actually name a cow… Yeah, I mean sometimes because I'm working with younger children, they tend to want to interact. So not so much receptive, but if children are very anxious, then I will offer them sounds to sort of come into, you know, to sort of respond to and to try and lower anxiety as well. So not exactly receptive techniques, but yeah, you might sort of offer something to them… I haven't done compositional methods, but within, except within sort of free improvisation where I guess you might sort of work with whatever the child is offering you and develop a song or yeah, a piece of music around that. But yeah."

Regarding instrumentation, Emily briefly described her practice of providing a diverse array of instruments and strategically placing them around the room to allow the child to select their preferred instrument freely. Additionally, Emily utilized picture cards to facilitate "fill in the blank" songs, offering the child additional avenues for expression. Similarly, Kaitlyn emphasized the importance of offering a wide range of instruments and materials within the therapy room to enhance accessibility and engagement. Alongside instruments, Kaitlyn incorporated puppets, drawing materials, and other interactive elements to provide a diverse range of mediums for expression. Furthermore, Kaitlyn provided examples of using oral instruments in sessions, such as the kazoo and didgeridoo. She elaborated,

"What I think is very helpful for children with Selective Mutism is to… give one particular example, of children really appreciating the use of what I say, oral instruments, so instruments that you can blow or sing down like a kazoo. So sometimes children are so happy to play, say a recorder, and there was one child that I'm thinking of in particular, so he not only blew the recorder, he also sang down it, so starting to vocalize through it and from there moved into speech. So I think the use of oral

instruments is really useful for a lot of children with Selective Mutism. Another child that I was working with, we used didgeridoo, And because it's quite a fun instrument and you can obviously, you can look through it. You can try and play it, and actually children are quite surprising and then they can quite often play a didgeridoo… it's a really long tube that Indigenous Australians would use. But I've used those in sessions as well. And because you can sort of do lots of different things with them, you can look down them, you can sort of play the note on them, but you can also talk through them."

In addition to providing a variety of instruments and other materials to engage with children with Selective Mutism, both participants expressed a shared perspective on the significance of employing playful and creative approaches. Emily and Kaitlyn both emphasized the transformative impact of fostering a playful atmosphere during sessions, recognizing it as conducive to establishing rapport and encouraging communication. Emily further elaborated on the importance of playfulness by recounting a specific fun experience from one of her sessions:

"*I think the one that she (the student) had the most fun with recently is… I have a set of resonator bells, which are like a xylophone, but they're not as tinny, and they're color-coordinated and each note comes apart from the set. And I also had created a laminated set of cards with the capital letter that matches each note, C through G, in the same color as the tone trimes bar instrument. And I was working on, I was hoping that she would spell out B-E-D, that spells "bed", and we would play B -E -D… that would be descending on the chimes… but she really got into like, "Miss Emily, what is this word?" And it was a nonsense word. And I could have chosen to be like, "so and so (student's name), that's not a real word. Can we try again?" But what I did was, I sounded out her nonsense word, and she laughed and laughed and laughed. And I was*

like, "You try sounding out your nonsense word." And she tried it and we laughed. And then we played the nonsense word on the xylophone… It was accessing that like verbal decoding, because she was also saying them, she was sounding out the silly nonsense words, she was saying them back to me. Um, but also like playing them on the xylophone getting all that stuff going, it was again, meeting a functional goal but using play."

Alongside Emily, Kaitlyn also offered valuable insights into the integration of playful and creative experiences into her sessions, especially when considering the anxiety commonly experienced by children with Selective Mutism. She noted that maintaining a light-hearted atmosphere can be beneficial in alleviating tension. She believed such playful interactions create opportunities for communication and expression, allowing children to engage in various ways. Kaitlyn further illustrated her approach with examples from her music therapy sessions. She elaborated,

"Also being quite playful in the sessions because quite often, you know, they're quite anxious and so actually, yeah, just keeping things quite light-hearted sometimes can be useful. And I've just seen in various sort of case studies a lot of other music therapists doing similar things, having a very sort of playful, play-based approach, sometimes using puppets and not necessarily always focusing on the music too much as well, you know, to sort of, yeah, look at other things in the room. I've done things like playing musical football and just inventing games, sort of throwing shaky eggs onto a drum and sort of bouncing them on the drum and making goals and just being quite playful really, I think has been a sort of, yeah, good way to develop rapport… So you're sort of leaving spaces for communication with that child, but in a sort of very fun and sort of, sort of finely, sort

of tuned way so they can do anything from just pointing to speaking. So yeah, so lots of little games that we've borrowed as well like that from speech and language therapy."

Theme 3: Progress Monitoring and Challenges

Both participants provided evidence of the efficacy of music therapy as a treatment for Selective Mutism by discussing the progress made with the children under their care. They shared significant session moments, demonstrating how music therapy facilitated communication and emotional expression. Participants also discussed the diverse challenges in their therapeutic work alongside these progress and breakthrough moments. These varied challenges shed light on the complexities of treating Selective Mutism in children.

Sub-theme 1: Progress Monitoring

In monitoring the child's progress with Selective Mutism, Emily highlighted the non-linear nature of their development and progress. She emphasized the importance of understanding the child's learning trend, which may encompass peaks and valleys rather than a straightforward trajectory of improvement. Emily elaborated,

"When I was first starting to work with her, they really made sure that I was aware that progress with this particular child really looks like this. She can be hitting those goals and objectives out of the park for weeks and weeks, but then really revert back to 'I'm just not going to talk at all today.' And that's part of the diagnosis. And that's part of her learning trend. Her progress trend is not going to be linear. It's going to be lots of peaks and valleys."

During the interview, Emily shared a significant breakthrough during the child's first group session with peers. This transformative moment underscored the profound impact of social interactions on the child's progress and emotional well-being, demonstrating the importance of

therapeutic interventions in facilitating positive experiences. The child's laughter during the session symbolized a significant milestone in their therapeutic journey, indicating increased comfort and engagement within the group setting. Emily described,

> *"I don't know what to expect. Is it going to totally backfire and she'll shut down? But she chose who she wanted to do music with, and I gather that this person is a good friend to her and the person that she chose was just super outgoing and the three of us were laying on our stomachs on the carpet, kicking our feet up in the air, singing back and forth and giggling. I heard this child laugh for the first time when her peer was there. It was just like. childhood joy just erupted in that room, in that moment. And I was just, I felt really privileged to like, be there with the two of them. Like it had like "sleepover vibes." I don't know how else to describe it. There was just like, such, like giggling, silly, early fun happening."*

Kaitlyn also shared examples of the progress observed in children she worked with during music therapy sessions. One notable case featured a child who initially communicated through singing using a toy karaoke machine, subsequently progressing to spoken language. As the therapeutic journey unfolded, this child expressed a desire for friendship, resulting in increased social interaction with peers. Kaitlyn elaborated,

> *"One child that springs to mind, she was already talking to me… She made a huge amount of progress using a toy karaoke machine that I took into the session, and it had a really lovely harmony setting on the karaoke machine. And so she started speaking first by singing for whole sessions through this karaoke machine because it made such a beautiful harmony sound. And then the following session she spoke. So that was really wonderful progress. But then later on in her sort of therapeutic journey, she said to me*

that she wanted to have friends, because she didn't really have any friends. And so then she chose other children to come into the session, and we introduced them one at a time. And then she sort of spoke to them in the sessions. And then, yes, eventually, we have to recruit sort of more support from staff actually to help her, then generalize their speech out into the, into the school. But that was good. And we actually did a more intensive process with her and had more than once a week, we sort of ended up… she was having three or four sessions a week that were provided by other staff within the school. So sort of created a more intensive approach for her which worked really well."

Additionally, Kaitlyn recounted a transformative moment involving another child with Selective Mutism who, previously reserved, boldly broke into speech by striking a cymbal loudly and vocalizing. This event demonstrated the newfound confidence in verbal expression nurtured through music therapy. Kaitlyn further elaborated,

"I really remember there was one child actually who, she'd been quite quiet. And I think she was desperate to sort of burst into speech. And she… sometimes children seem to go into speech by hiding under some of the noise, and she'd been playing the cymbal a little bit in the session. But then all of a sudden, she sort of hit the cymbal really loudly. And she just went shout "China!" because she associated cymbals with China. She hit it really loudly and shouted. And it was really lovely and then, and then after that she just went on to talk non-stop about her family and sort of all these sort of secrets and things you know about her family came out, but that was lovely, so she sort of burst through into, into speech and that was good…"

Sub-theme 2: Challenges Encountered

When discussing challenges in working with this child with Selective Mutism, Emily acknowledged that the primary challenge was the unpredictability of the child's presence during the day, and she emphasized the importance of recognizing and responding to the child's emotional fluctuations with adaptability and support. She explained that,

> *"The biggest challenge is just the unpredictability, um, you know, like I could have a plan in place for interventions where I'm like… 'We're gonna say these things today,' um, but maybe she's just… had a really bad moment with a teacher right before I came to the session and her anxiety is spiking and she's not in a place where she's ready to use her words… and I just have to adapt, as we all do with all of our clients… but I think just the uncertainty of like, which kid am I gonna see today? Am I gonna see silly, we're making up words and we're rolling on the floor together, giggling kid, or am I gonna see totally withdrawn, hunched over, not making eye contact, not moving kid?"*

In contrast, Kailyn experienced distinct challenges in her work. She shared challenges she faced in transitioning speech gained within music therapy sessions back into the classroom or wider environment, stressing the indispensable need for support and resources. Notably, Kaitlyn emphasized the complexities of collaborating with school staff and establishing an environment conducive to the child's progress. These challenges underscored the intricate dynamics involved in bridging therapeutic gains to real-world settings. Kaitlyn stated,

> *"I guess there can be challenges sometimes when you're trying to move any speech that you've gained within the music therapy sessions back into the classroom or into the wider world, because you do need some support sometimes or resources to do that. So I think that quite often the challenges in working with it in this clinical area is in working with staff and the environment around the child. And it's quite, I think those are maybe new*

> *techniques for some music therapists as well, so doing something called psychoeducation, which is basically teaching the people in the school about Selective Mutism. And then getting the support to help generalize the speech from the sessions into the classroom environment and around the school. So those can be some of the most challenging aspects, I think."*

Furthermore, Kaitlyn highlighted the potential setbacks children might experience during breaks in therapy, particularly during long summer holidays. She acknowledged that such breaks could lead to a regression in progress, as she explained,

> *"Children can have setbacks for different reasons. So having breaks in therapy… So I work in school environments, so quite often then we might have a break for the long summer holidays in the UK. And so children may sometimes lose progress in that time. And so you have to sort of think about those gaps."*

Theme 4: Feelings and emotions

Within the realm of assisting children diagnosed with Selective Mutism, both participants expressed a range of emotions and feelings. Their firsthand experiences unveiled the intricate emotional journey inherent in this specialized work. From initial uncertainties and unfamiliarities to eventual rewards and fulfillments, they provided profound insights into the diverse array of sentiments experienced while supporting these children. This section delved into their personal reflections, offering an exploration of the complex emotional dynamics while assisting children with Selective Mutism.

Emily initially felt intimidated when she began working with a child diagnosed with Selective Mutism, as it was her first encounter with this condition. However, as she gained

experience, she became more intuitive and realized that the approach was no different than working with other clients, adopting a humanistic approach. She stated,

> *"Initially, I think I was a little bit intimidated, you know, like it was my first experience working with somebody with this diagnosis. And I was a little bit like, "I don't know how to approach this!" That was kind of intimidating to me because I was like, "what do I do?" But now like,,, after having worked with her and having known her, it feels very intuitive… To me on the clinical side coming from like a humanistic background, it doesn't feel any different than meeting any other client with any other diagnosis where they are that day."*

In discussing the challenges posed by the uncertainties of working with a child with Selective Mutism, Emily openly acknowledged feeling scared due to the unpredictable nature of the work and the uncertainty about how the student would present each session. However, as she gradually built rapport with the student, Emily noted a sense of growing comfort. She explained,

> *"And like… What is your level of comfort today? Are you feeling super withdrawn, and we just need to engage in nonverbal music so we're maintaining our relationship, and we're still developing social skills without the kind of prerequisite of verbal speech? Or are you feeling like singing "Down by the bay" and calling out all kinds of different animals to rhyme with, and you are giggling and having fun and singing a lot? Like it can really vary. And that was really scary. But I think now that I know her and I know the work that we can do, it's just like, oh yeah…"*

Regarding the child's personality, Emily expressed concerns about the teasing and sarcastic behavior, which sometimes bordered on bullying towards classmates. She noted that some adults in the child's life seemed overly enthusiastic about the child's verbal communication,

disregarding the problematic behavior. Emily found that the adversarial approach modeled by others did not align with her way of building relationships. She elaborated,

> *"She is a little bit like, teasing and sarcastic, almost like to the point where I'm kind of like, "should we be concerned"… And I do sometimes worry about that with her, because I think many of the adults in her life are so like, "She said words, she's interacting!"... that they're not curbing that rude behavior, the way that they would do with a typically developing child, because they're just so thrilled that she's saying something. But it is a concern that I have, because some of her behaviors and comments towards her peers, they could be construed as bullying a little bit. And it is just, it's an area of concern for me... And so building that sort of like, teasing, but slightly adversarial relationship is how I kind of started because I was following what other people had modeled. But I was like, this isn't working for me. I don't… I'm not an adversarial person. This is not how I relate to clients."*

When discussing the child's first group session, Emily expressed the feeling of nervousness due to the uncertain nature of the work, as she stated, *"I was so nervous for her first group session with her peers because I was really… I wasn't sure what to expect."* However, as the session progressed, the child was able to connect with their peers and seemed to enjoy the social interaction, Emily shifted to a feeling of relief and joy. She elaborated,

> *"It did feel like a huge weight off my shoulders. Like, this is fine. And we're having fun. We're interacting. My client is talking. They're singing. They are playing back and forth with rhythm sticks and copying each other's movements, which is what I asked them to do. All kinds of like it was just, it was so joyful. And I just felt very like, to me... Yeah, because I wasn't sure how it would go."*

While Emily experienced a range of emotions, from intimidation and nervousness to feeling more intuitive, Kaitlyn expressed a different perspective on working with children with Selective Mutism. During the interview, Kaitlyn acknowledged that she felt comfortable working with children with Selective Mutism, as she stated,

> *"Yeah, I feel very comfortable working with, with children with Selective Mutism, because it, you know, generally we've had quite sort of a high success rate really. And it seems to be such a positive intervention for children with Selective Mutism."*

As Kaitlyn reflected on her personal experience working with children with Selective Mutism, she revealed a deep sense of excitement and passion. She recounted her journey of transitioning into a researcher in this field, recalling the first time she watched a presentation on research in the intersection of music therapy and Selective Mutism, stating, *"And so I was watching this presentation of the research, and at the end of it I was just really excited."* Kaitlyn expressed enthusiasm and passion for advancing research and spreading awareness of Selective Mutism. Furthermore, her eagerness to support and collaborate with others in the field was evident in her proactive outreach efforts. She expressed her readiness to assist music therapists in the United States and advocated for collaboration to enhance support and resources for affected children. Kaitlyn's passionate advocacy and dedication to the field reflect a profound commitment to improving outcomes for children with Selective Mutism. She elaborated,

> *"I'm just I'm very pleased that you're doing this research, and I've reached out because I want more people and more music therapists to be interested in this topic and do more work in this area so… if there's any other ways that I can I can help support music therapists in the US in their work, or you know there's other ways of collaborating, that would be, that would be amazing."*

Theme 5: Collaboration and Support

During the interviews, participants shared insights into the collaborative efforts essential for effectively addressing Selective Mutism in children. They underscored both the significance and the challenges inherent in interdisciplinary teamwork, spotlighting collaborations with psychologists, speech therapists, educators, and other professionals to ensure comprehensive care. Moreover, participants extended their support beyond clinical contexts, providing valuable advice and resources to teachers, parents, and new music therapists embarking on this field. Their experiences highlighted the pivotal role of collaboration and support in empowering the child's support network to navigate the intricacies of Selective Mutism intervention, thereby enhancing the therapeutic journey for children with Selective Mutism.

Sub-theme 1: Interdisciplinary Collaboration

Emily highlighted the challenges of collaborating with other professionals due to logistical constraints in scheduling and shared workspace. She noted that each professional, including herself, was itinerant, leading to limited face-to-face interaction. Despite this, Emily emphasized the importance of communication through email updates and annual team meetings. She frequently shared updates and sought input from colleagues asynchronously, acknowledging the benefits of collaborative communication despite the challenges of co-treating in person. Emily expressed a desire for more direct collaboration but acknowledged the limitations imposed by the school's scheduling practices. She explained,

> *"It's challenging to collaborate with the other professionals… because all of us are kind of itinerant, and we all have to share one room. We deliberately schedule our services on different days. So like, if Mondays, I'm at the elementary school, and Wednesdays, I'm at the high school, maybe the speech therapist is at the high school on Mondays, and the*

middle school on Wednesday. So like, so logistically, so that we each have a designated space and time to work with the kids… it's more spread out for them. And that's a great practice for those reasons for logistics and for not burning out the kiddos, but it does mean that. face-to-face time with my colleagues and other professionals is really limited. I don't, I'm not often in the same building on the same day as them, because that's how we designed it. But I do keep in touch with like email updates with the whole team pretty regularly. And we do have our annual team meeting where we all sit around a table, but like I will occasionally just send out a quick email. Like 'You'll never believe what so-and-so did in his session today. He isolated his finger to push down on the key. I thought you'd want to know, occupational therapist.' Or 'Hey, PT, I've noticed so-and-so moving her arm more. Is that something that you're working on that I can support?' So we do collaborate, but it's often asynchronously via email rather than like co -treating collaboration, which I would love to do more of. It's just not really always feasible with the way that the school has, kind of said that we need to set up our sessions. But maybe I can change that."

Building on Emily's insights into collaboration, Kaitlyn further underscored the significance of collaborative efforts in addressing Selective Mutism intervention. She emphasized the value of direct collaboration, specifically with speech and language therapists, whom Kaitlyn identified as key figures in this field within the UK. Kaitlyn stressed the necessity of forming a cohesive team around the child, involving parents, teachers, and other relevant staff, to create a supportive environment conducive to the child's progress. She elaborated,

"Yes, a lot of collaboration. I think it's really important in this field. So in the UK, speech and language therapists are the main professionals who work with children with Selective

Mutism, but also psychologists, but mainly, mainly speech and language therapists. So we would always communicate with the speech and language therapy team, and to let them know what we're doing, and also to think about creating a team around the child, in any case, so including parents and the children's teacher and any sort of other important staff, speech and language therapy, ourselves, and creating a little team around the child. And that part of the work is really important. So that everybody knows what Selective Mutism is, everyone is trying to create a sort of pressure-off environment around that child. So yeah, I'd say it's a huge part of the work."

Sub-theme 2: Support and Resources

Emily stressed the importance of acknowledging children with Selective Mutism beyond their speech capabilities. She advised caregivers against solely concentrating on speech development, urging them to embrace the child's individuality instead. Emily encouraged caregivers to alleviate the pressure surrounding speech milestones and to allow the child to express themselves authentically. She emphasized the need to appreciate the child's intrinsic worth and beauty rather than fixating on speech milestones. She stated,

"*I would just advise every like… if it's a parent coming to the like… 'Oh, we just got this brand-new diagnosis, what do we do?' Or like somebody who's new to working with it, I would say that your kids are still your kids regardless of whether or not they can speak to you. There are plenty of children and adults who are non-verbal for various reasons. Maybe they were born deaf and they use sign language; maybe they have a neuromuscular disorder where they can't get their tongue to talk to their brain correctly, and they're not... Their personalities are still there, their likes and dislikes are still there, their sense of humor is still there. So I would, again, it's not like a tangible resource, but*

like take the burden of like, oh, we got to get their speech out of the kid and just let them be the kid that they are. The speech will come when they're comfortable, or it may not, and that's fine too. But don't… don't focus so much on this one quote unquote, deficit area, that you forget to see the beautiful child that you have in front of you."

Building upon Emily's advice to caregivers, Kaitlyn delved deeper into the discussion of support and resources regarding music therapy for Selective Mutism. She emphasized the importance of acquiring comprehensive knowledge before engaging in therapeutic work with children with Selective Mutism. Kaitlyn's advice underscored the necessity for thorough training beforehand, pointing out the *Selective Mutism Resource Manual* as a valuable tool for music therapists. She also highlighted the availability of free training resources in both the UK and the US, including websites and organizations such as the *Child Mind Institute* and the *Selective Mutism Association*. Kaitlyn stated,

"Before you start working in this area, try to get as much information as you can about Selective Mutism. So one of the big things that came out of my PhD was that music therapists felt in the UK, they felt unprepared to work in this area. Although we've got lots of strong skills and intuition about working with children with Selective Mutism, I think that we're lacking some knowledge about what it is. And so my advice to any music therapist is to get as much training as you can before you start. In the UK we have something called the 'Selective Mutism Resource Manual,' which I advise all music therapists to buy and use. Yeah, to borrow as much as possible really from speech and language therapists because they kind of lead the way. And yes, I would advise there's free trainings in the UK as well that I could share as well. So we have sort of websites with free trainings on. And I think in the US you have some free information on the 'Child

Mind Institute' website about Selective Mutism. So yeah, just to get as much information about Selective Mutism as possible…I would encourage all parents to… sort of signpost them to their national charity about Selective Mutism in the UK. It's the organization called SMIRR. So that would be the first thing I do for parents. But also we have these manuals, we would be printing off pages from the manual and giving people, you know, examples of information about what Selective Mutism is, and supporting teachers to sort of know how to approach things within the classroom environment. But yeah, so you could try and access as much training as possible. In the UK, I'm also developing a training myself as well, I've already offered a pilot one, but I'm sort of developing a training as well at the Guildhall. So yeah, and encourage networking really with other music therapists in the field you're working in this area."

In conclusion, this chapter has presented the rich findings derived from interviews with two Board-Certified music therapists, Emily and Kaitlyn, who shared their invaluable experiences and insights in working with children diagnosed with Selective Mutism. Through rigorous data analysis, several key themes emerged, illuminating various facets of the therapeutic process. These themes offer a comprehensive understanding of the multifaceted nature of music therapy interventions for children with Selective Mutism. By exploring themes such as referral and assessment, rapport-building, treatment approaches, challenges encountered, interdisciplinary collaboration, and emotional dynamics within therapeutic settings, we have gained invaluable insights into the experiences of music therapists and the intricate landscape of addressing Selective Mutism through therapeutic interventions. These findings serve as a foundation for further exploration and advancement in the field of music therapy for Selective

Mutism, contributing to improved clinical practices and enhanced support for children with Selective Mutism.

CHAPTER 5: DISCUSSION

This study aimed to explore the experiences of music therapists working with children diagnosed with Selective Mutism. Guided by the research question, "What are the experiences of music therapists working with children diagnosed with Selective Mutism?", the study delved into the subjective first-hand experiences of two board-certified music therapists who have directly engaged with such children. By shedding light on the therapists' perspectives, this research contributed to bridging the gap in the literature on music therapy and Selective Mutism, offering unique insights into the therapeutic process. Through thematic analysis, five key themes emerged, encompassing various dimensions of the therapists' experiences: Initial Encounters and Preparations, Clinical Techniques, Progress Monitoring and Challenges, Emotions and Feelings, and Collaboration and Support. This exploration provides a comprehensive understanding of the complexities inherent in therapy sessions with children diagnosed with Selective Mutism, paving the way for improved clinical practice and inspiring future research endeavors.

Summary of General Findings and Interpretations

Participants in the study demonstrated varying degrees of prior knowledge and preparation upon receiving referrals to work with children diagnosed with Selective Mutism. Emily had a pre-existing familiarity with the topic, having encountered it through a case presentation during her graduate studies. However, she faced challenges in establishing rapport with the child due to their teasing and sarcastic demeanor. Nevertheless, Emily found the process gradually becoming more intuitive over time. In contrast, Kaitlyn entered the field with limited knowledge about Selective Mutism, but she showed proactive engagement by experimenting with a humanistic approach focused on following the child’s interests. This initial lack of

familiarity motivated her to explore deeper into the subject, ultimately leading her to become a researcher in this field.

In terms of clinical objectives, both participants emphasized the importance of integrating communication development and social integration into their treatment approaches. Emily outlined her therapeutic strategy, consisting of three individual sessions per month focused on refining communication skills, supplemented by a small peer group session during the final week of the month to facilitate social integration among peers. Kaitlyn also shared a significant moment from one of her sessions when the child expressed a desire to form friendships and sought to invite classmates to participate in music therapy sessions. Drawing from the literature, Morris and March (2004) highlighted the significance of psychosocial interventions as a crucial element of treatment plans for children with Selective Mutism, emphasizing successful interventions involving the child in peer-group activities such as arranging playdates with multiple friends who can serve as regular playmates. In alignment with this, Hunt (2020) discussed the efficacy of including peers in individual therapy sessions to cultivate a sense of belonging and foster the development of friendships.

Both participants emphasized the vital role of anxiety reduction in music therapy sessions for children with Selective Mutism. They stressed the necessity of shifting the focus away from solely striving for verbal speech productions and instead, prioritizing the expression of the client's desires and needs through their chosen communicative modality. Camposano (2011) further supports this viewpoint by highlighting the importance of redirecting attention from the absence of verbal communication in the initial stages of treatment. Emily and Kaitlyn both advocated for integrating anxiety reduction techniques as essential components of therapeutic interventions, highlighting the importance of prioritizing rapport-building and creating a safe

environment for the children as immediate goals. By embracing this approach and incorporating it into their practices, both participants prioritized the emotional well-being and comfort of their clients over mere communication objectives.

In discussing their therapeutic approaches, both participants embraced a humanistic approach, emphasizing the importance of following the child's lead and maintaining flexibility to accommodate individual needs. Central to this approach is the creation of a safe and supportive environment, allowing children with Selective Mutism to express themselves at their own pace and in their preferred modalities. Both therapists employed playful and light-hearted techniques to alleviate anxiety and nurture a sense of safety and comfort during therapy sessions. Their use of a diverse range of instruments, including puppets, picture cards, and oral instruments such as the didgeridoo, highlighted their adaptability and creativity in engaging children with Selective Mutism in music therapy. Moreover, the variety of instrument choices granted children autonomy, empowering them to make decisions and express their ideas freely.

Emily and Kaitlyn both discussed their utilization of improvisation and song recreation as primary music therapy methods when working with children diagnosed with Selective Mutism. Emily elaborated on her use of a pre-composed song, "Down by the Bay," wherein the child fills in the blanks with their ideas, fostering creativity within a familiar structure while providing opportunities for the child to make choices and assert agency. Similarly, Kaitlyn described a technique employed during the recreation of the song, "Old MacDonald Had a Farm," where she intentionally left gaps for the child to fill with sounds or point to objects, thereby encouraging interaction and communication. Occasionally, she offered sounds as prompts for the child to respond when they felt too anxious to speak. Both participants acknowledged their avoidance of

using compositional methods due to the potential risk of increasing anxiety for children with Selective Mutism.

Both participants shared instances of progress observed in therapy sessions, illustrating the efficacy of music therapy in working with children diagnosed with Selective Mutism. Some progress unfolded gradually over an extended period, with children slowly beginning to make sounds little by little, while others experienced sudden breakthroughs in speech. Moreover, participants discussed openly about individual struggles and challenges encountered while working with children diagnosed with Selective Mutism. Emily highlighted unpredictability as the most challenging aspect, emphasizing the dynamic nature of therapy with children with Selective Mutism. She noted the non-linear nature of progress, with peaks and valleys where progress might seem slow at times. Emily also highlighted the challenge of anticipating the child's energy level for each session, and she proposed the preparation of three to four different levels of musical activities beforehand. In contrast, Kaitlyn identified the transfer of progress from music therapy to real-life situations as a significant challenge. She observed that some children may feel comfortable speaking only within the confines of music therapy sessions but struggle to do so outside of them. Additionally, Kaitlyn discussed the setbacks resulting from breaks as noteworthy challenges. These findings indicate the complexity of therapy outcomes and emphasize the importance of addressing individual needs and circumstances.

Participants expressed a spectrum of emotions in their work with children diagnosed with Selective Mutism, ranging from initial fear and apprehension to eventual pride and fulfillment as they observed progress during therapy sessions. Emily admitted to feeling intimidated initially, unsure of how to approach children with this diagnosis, but later found the process to be intuitive and rewarding. On the other hand, Kaitlyn conveyed her comfort in working with such children

and expressed her passion for the field as she shared her journey of becoming a researcher and advocating for awareness of Selective Mutism. These emotional experiences highlight the intricate and gratifying nature of working with children with Selective Mutism, emphasizing the importance of self-awareness and support for therapists in this field.

Both therapists emphasized the significance of collaborating with other interdisciplinary team members to support children diagnosed with Selective Mutism. However, they encountered challenges in establishing face-to-face connections with other professionals due to logistical constraints. Despite these obstacles, Emily and Kaitlyn offered valuable advice and resources for caregivers and treatment teams, emphasizing the importance of ongoing education and training in Selective Mutism. Emily advised caregivers against pressuring the child to speak, advocating for patience and allowing the child time to reach the speech milestones at their own pace. She emphasized the importance of celebrating the child's talents and individuality, rather than solely focusing on communication goals. Kaitlyn shared a wealth of resources during the interview, including the *Selective Mutism Resource Manual,* and websites and organizations such as the *Child Mind Institute* and the *Selective Mutism Association*.

Overall, the themes identified in this study provide a multifaceted understanding of the experiences of music therapists working with children with Selective Mutism. These findings have implications for clinical practice, education, and research, highlighting the importance of individualized approaches, collaboration, and ongoing professional development in supporting children with Selective Mutism in music therapy settings.

Clinical Implications and Future Research

This study offers practical strategies derived from the experiences of music therapists that can significantly benefit individuals involved in the care and support of children with Selective

Mutism. Teachers, parents, and other therapists can gain insights from the therapeutic strategies discussed in this study, enabling them to better support children with Selective Mutism as a cohesive team. By learning about music therapy approaches specifically tailored for children with Selective Mutism, teachers, therapists, and parents can enhance their understanding of effective interventions and approaches. This study provides valuable guidance on anxiety reduction techniques, respecting the pace of the child, and fostering a supportive environment where children feel safe and comfortable to express themselves. By implementing these strategies, therapists, teachers, and parents can create collaborative and supportive environments that promote the well-being and development of children with Selective Mutism.

Additionally, aspiring music therapists entering this field can benefit from the insights provided in this study, learning to approach children with Selective Mutism in a playful and supportive manner. By following the child's lead, providing autonomy, and celebrating their talents, therapists can establish meaningful therapeutic relationships that facilitate progress and growth. Overall, this study aims to serve as a valuable resource for educators, therapists, and parents, offering practical strategies and insights to better support children with Selective Mutism in educational and therapeutic settings.

The lack of studies in this domain underscores the need for further research to expand our understanding of Selective Mutism and improve care for affected children. This study represents one of the few investigations into the exploration of music therapists' experience working with children diagnosed for Selective Mutism, highlighting the importance of continued research in this field. Future research endeavors should aim to raise awareness of Selective Mutism, explore novel and effective approaches to supporting children with Selective Mutism, and address the gap in knowledge and training among therapists, teachers, and parents. Increasing the number of

participants in future studies will enhance the robustness and generalizability of findings, ultimately contributing to the advancement of clinical practice and the provision of quality care for children with Selective Mutism. Future research in this field may also involve quantitative research studies with a more extensive and diverse participant pool to yield a broader understanding of the topic.

Furthermore, research that incorporates cultural considerations and addresses diverse populations is crucial for ensuring culturally sensitive and inclusive interventions. By understanding how cultural factors influence the presentation and management of Selective Mutism, researchers can develop more tailored and effective interventions that meet the needs of children in diverse communities. In future research, researchers could investigate deeper into exploring the cultural backgrounds of children with Selective Mutism, as literature suggests that cultural factors play a significant role in Selective Mutism.

Lastly, the development and evaluation of innovative music therapy interventions specifically designed for children with Selective Mutism should be prioritized. By leveraging the creativity and expertise of researchers and clinicians, effective approaches can be developed to address the unique challenges faced by children with Selective Mutism, ultimately enhancing the quality of care and support provided to this population.

Limitations

The study participants originate from distinct cultural and professional backgrounds, with one practicing in the United States and the other in the United Kingdom. This divergence in contexts may influence their perspectives, approaches, and experiences with Selective Mutism therapy, thus warranting acknowledgment of potential impacts on the study's findings and interpretations.

Another limitation arises from variability in the participants' years of practice and levels of experience in working with children with Selective Mutism. While one therapist may possess extensive expertise in this area, the other may have less experience or employ different approaches. Such discrepancies could affect the depth and richness of the collected data, necessitating consideration when interpreting the findings. In addition, during the member checking phase, only one participant provided feedback on the completed audio transcription, thereby limiting the validation of the data. The absence of feedback from the other participant diminishes the validity of the findings.

Furthermore, ambiguity arose when discussing the four music therapy methods (receptive, recreative, improvisational, and compositional), as participants were not entirely clear on the terminology. This discrepancy may stem from variations in how these concepts are taught across different schools. Clarification was required to ensure alignment between the researcher and participants, potentially impacting immediate interpretations of the methods. Differences in training experiences among participants, with some individuals lacking familiarity with certain terminologies, necessitated additional explanation and clarification during data collection. These variations in training may have influenced participants' interpretations and responses, introducing potential differentiation in data interpretation.

CHAPTER 6: CONCLUSION

In recent years, music therapy has emerged as a promising and innovative treatment for children with Selective Mutism. Although previous studies have highlighted its effectiveness, this research uniquely contributes to the literature by exploring the lived experiences of music therapists who work directly with these children. By examining their firsthand experiences, challenges, and clinical methods, this study provides valuable insights into the therapeutic process that have been largely unexplored. These findings not only deepen our understanding of music therapy's impact but also identify areas for further research and clinical development.

Two board-certified music therapists participated in this study, sharing their insights, perspectives, and strategies for working with children with Selective Mutism. Through semi-structured interviews and thematic analysis, five overarching themes emerged: Initial Encounters and Preparations, Clinical Techniques, Progress Monitoring and Challenges, Emotions and Feelings, and Collaboration and Support. Participants exhibited varying levels of prior knowledge and preparation when receiving referrals to work with children with Selective Mutism. However, both therapists adopted a humanistic approach that followed the child's lead, maintained flexibility, and prioritized creating a safe and supportive therapeutic environment.

Anxiety reduction and rapport-building were highlighted as primary goals for working with children with Selective Mutism. The therapists emphasized the importance of using a variety of musical instruments and materials to foster autonomy and encourage initiations and interactions. They highlighted the importance of respecting children’s growth pace and allowing ample time for them to progress. Furthermore, participants advised against solely focusing on speech goals, advocating for appreciating the child's unique identity without undue pressure.

Participants in the study shared rewarding moments witnessing the growth and progress of children with Selective Mutism, highlighting the potential for positive change. Yet, they also

acknowledged distinct challenges. One therapist highlighted unpredictability as the most challenging aspect, while the other emphasized the difficulty of transferring progress made in therapy sessions to real-world settings. Collaboration with other professionals, teachers, and parents was underscored as essential for supporting children with Selective Mutism comprehensively.

The findings of this study have significant clinical implications for professionals involved in the care and support of children with Selective Mutism. Implementing the strategies and insights shared by the participants, therapists, teachers, and parents can enhance their understanding and approach to working with these children. The humanistic approach emphasized by the participants, focusing on adaptability, flexibility, patience, and collaboration, can serve as a guiding framework for effective interventions. Furthermore, the study underscores the critical importance of ongoing research in this area to expand understanding, improve interventions, and address knowledge gaps. Future research endeavors should explore novel and effective approaches to supporting children with Selective Mutism, incorporating the diverse needs and contexts of affected children with cultural consideration.

In conclusion, this study contributes valuable insights to the literature, offering guidance and resources for treating and supporting children with Selective Mutism. The findings highlight the importance of a humanistic approach in therapeutic practice and urge the need for ongoing research to advance our understanding and improve outcomes for individuals with Selective Mutism.

REFERENCES

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

Amir, D. (2012). Re-finding the voice: Music therapy with a girl who has Selective Mutism. *Nordic Journal of Music Therapy, 21*(2), 154-174. https://doi.org/10.1080/08098131.2011.611311

Bruscia, K. (1998). *Defining Music Therapy* (2nd ed.). Gilsum, NH: Barcelona.

Camposano, L. (2011). Silent suffering: Children with Selective Mutism. *The Professional Counselor, 1*(1), 46–56. https://doi.org/10.15241/lc.1.1.46

Cartwright-Hatton, H., Tschernitz, N., & Gomersall, H. (2005). Social anxiety in children: Social skills deficit, or cognitive distortion? *Behaviour Research and Therapy, 43*(1), 131–141. https://doi.org/10.1016/j.brat.2003.12.003

Child's Play Early Learning Center. (n.d.). *The importance of socializing for kids.* https://www.childsplayelc.com.au/the-importance-of-socialising-for-kids/#:~:text=Socialising%20allows%20kids%20to%20build,new%20social%20interactions%20less%20scary

Dawadi, S. (2020). Thematic analysis approach: A step by step guide for ELT research practitioners. *Journal of NELTA*, *25*(1–2), 62–71. https://doi.org/10.3126/nelta.v25i1-2.49731

Driessen, J., Blom, J. D., Muris, P., Blashfield, R. K., & Molendijk, M. L. (2020). Anxiety in children with Selective Mutism: A meta-analysis. *Child Psychiatry and Human Development*, *51*(2), 330–341. https://doi.org/10.1007/s10578-019-00933-1

Frazier, K. F., & Howard, K. (2020). Perspectives of speech-language pathologists and school counselors on the nature and treatment of selective mutism. *Perspectives of the ASHA*

Special Interest Groups, *5*(4), 1045–1056. https://doi.org/10.1044/2020_PERSP-19-00162

Gooding, L. F. (2011). The effect of a music therapy social skills training program on improving social competence in children and adolescents with social skills deficits. *Journal of Music Therapy, 48*(4), 440-462. https://doi.org/10.1093/jmt/48.4.440

Heidersheit, A. & Jackson, N. (2018). Case D2 – Nordoff-Robbins music therapy and Selective Mutism. In *Introduction to Music Therapy Practice.* (pp.214-216). Barcelona Publishers.

Hoeve, J. V. (2022). Innovative approaches to treating Selective Mutism in children. *Intersect: The Stanford Journal of Science, Technology, and Society, 16*(1), 1-10. https://ojs.stanford.edu/ojs/index.php/intersect/article/view/2393

Hungerford, S. (2017). Conquering challenges of interprofessional treatment for Selective Mutism. *The ASHA Leader. 22*(8). https://doi.org/10.1044/leader.SCM.22082017.34

Hunt, E. L. (2020). Developing a sense of belonging: A case study on the use of peer inclusion to support a child with Selective Mutism. *The New Zealand Journal of Music Therapy*, *18*, 141-158.

Jackson, N. A. (2016). Chapter 40, Phenomenological Inquiry. In Wheeler, B. & Murphy, K. (Eds.), *Music Therapy Research (3nd ed.)* (pp. 885-906). University Park, IL: Barcelona.

Jones, K. (2012). How intense is this silence? Developing a theoretical framework for the use of psychodynamic music therapy in the treatment of Selective Mutism in children with English as an additional language: A heuristic case study. *British Journal of Music Therapy, 26*(2), 15–28. https://doi.org/10.1177/135945751202600204

Jones, K., & Odell-Miller, H. (2022). A theoretical framework for the use of music therapy in the treatment of Selective Mutism in young children: Multiple case study research. *Journal of Music Therapy, 59*(1), 4-28. https://doi.org/10.1093/jmt/thac002

Klein, E. R., & Armstrong, S. L. (2021, October 8). *Speech language therapy and selective mutism*. Selective Mutism Association. https://www.selectivemutism.org/resources/archive/online-library/speech-language-and-selective-mutism/

Klein, E. R., Armstrong, S. L., Skira, K., & Gordon, J. (2016). Social Communication Anxiety Treatment (S-CAT) for children and families with Selective Mutism: A pilot study. *Clinical Child Psychology and Psychiatry, 22*(1), 90–108. https://doi.org/10.1177/1359104516633497

Kos, E. (2022). Music therapy and music-based intervention as a form of therapeutic and educational work with preschool and early school-aged children with Selective Mutism. *Psychiatria i Psychologia Kliniczna, 22*(3), 186–192. https://doi.org/10.15557/PiPK.2022.0025

Lu, G., Jia, R., Liang, D., Yu, J., Wu, Z., & Chen, C. (2021). Effects of music therapy on anxiety: A meta-analysis of randomized controlled trials. *Psychiatry Research*, 304, 114137. https://doi.org/10.1016/j.psychres.2021.114137

National Organization for Rare Disorders. (2011, March 10). *Mutism, Selective.* https://rarediseases.org/rare-diseases/mutism-selective/#affected

Nowakowski, M. E., Cunningham, C. E., McHolm, A. E., Evans, M. A., Edison, S., Pierre, J. St., Boyle, M. H., & Schmidt, L. A. (2009). Language and academic abilities in children with

Selective Mutism. *Infant and Child Development, 18*(3), 271–290. https://doi.org/10.1002/icd.624

Morris, T. L., & March, J. S. (2004). *Anxiety disorders in children and adolescents* (2nd ed.). Guilford Press.

Selective Mutism Association. (n.d.). *Speech Language Therapy and Selective Mutism.* https://www.selectivemutism.org/resources/archive/online-library/speech-language-and-selective-mutism/

Shipon-Blum, E. (n.d.). *What is Selective Mutism? Selective Mutism: A Comprehensive Overview.* Selective Mutism Center. *https://selectivemutismcenter.org/whatisselectivemutism/*

Slobodin, O. (2023). Beyond the language barrier: A systematic review of Selective Mutism in culturally and linguistically diverse children. *Transcultural Psychiatry, 60*(2), 313-331. doi:10.1177/13634615221146435

Steffenburg, H., Steffenburg, S., Gillberg, C., & Billstedt, E. (2018). Children with autism spectrum disorders and Selective Mutism. *Neuropsychiatric Disease and Treatment, 14,* 1163–1169. https://doi.org/10.2147/NDT.S154966

Toppelberg, C. O., Tabors, P., Coggins, A., Lum, K., & Burger, C. (2005). Differential diagnosis of Selective Mutism in bilingual children. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(6), 592–595. https://doi.org/10.1097/01.chi.0000157549.87078.f8

Velleman, S. L., Guimaraes, V. N., Klein-Tasman, B. P., Huffman, M. J., Becerra, A. M., & Mervis, C. B. (2023). Relations between selective mutism and speech sound disorder in children with 7q11.23 duplication syndrome. *Journal of Speech, Language, and Hearing*

Research : JSLHR, 1–11. Advance online publication. https://doi.org/10.1044/2023_JSLHR-22-00721

Wakamatsu, Y. (2022). Finding Teresa's voice: Following the journey of a young woman with Selective Mutism over four years. *Australian Journal of Music Therapy, 33*(2), 66–71. https://search.informit.org/doi/10.3316/informit.829534212385720

Wheeler, B. L. (2016). Chapter 13, Principles of Interpretivist Research. In Wheeler, B. & Murphy, K. (Eds.), *Music Therapy Research (3nd ed.)* (pp. 294-314). University Park, IL: Barcelona.

Wong, P. (2010). Selective Mutism: A review of etiology, comorbidities, and treatment. *Current Psychiatry Reports, 7*(3), 23-31. https://doi.org/10.1007/s11920-021-01263-z

APPENDIX A: Molloy University IRB APPROVAL

MOLLOY UNIVERSITY

1000 Hempstead Ave., PO Box 5002, Rockville Center, NY 11571-5002
www.molloy.edu

Patricia A. Eckardt, PhD, RN, FAAN
Chair, Molloy University Institutional Review Board
Professor, Barbara H. Hagan School of Nursing and Health Sciences
E: peckardt@molloy.edu
T: 516.323.3711

DATE:	December 18, 2023
TO:	Elaine Chen
FROM:	Molloy University IRB
PROJECT TITLE:	[2136395-2] Breaking the Silence: The Experiences of Music Therapists Working with Children who have Selective Mutism
REFERENCE #:	
SUBMISSION TYPE:	Amendment/Modification
ACTION:	APPROVED
APPROVAL DATE:	December 18, 2023
EXPIRATION DATE:	December 17, 2024
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # 7

Thank you for your submission of Amendment/Modification materials for this project. The Molloy University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval(45days) before the expiration date of December 17, 2024.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Patricia Eckardt at 516-323-3711 or peckardt@molloy.edu. Please include your project title and reference number in all correspondence with this committee.

Sincerely,

Patricia Eckardt, Ph.D., RN, FAAN
Chair, Molloy University Institutional Review Board

This letter has been issued in accordance with all applicable regulations, and a copy is retained within Molloy University IRB's records.

APPENDIX B: LETTER OF INFORMED CONSENT

Music Therapy Department

1000 Hempstead Avenue, Public Square 220

Rockville Centre, NY 11570

516-323-3320

Title of the Study:

Breaking the Silence: An Inside Look of the Experiences of Music Therapists Working with Children Who Have Selective Mutism

Principal Investigator: Elaine Chen, Graduate Student, Molloy University

Thesis Advisor: Vienna Sa, MT-BC, NMT

Thesis Committee Member: Yuchuan (Kathleen) Tai, Speech Language Pathologist

Key Information About this Study:

This consent form is designed to inform you about the study you are being asked to participate in. The purpose of this interpretive phenomenological study is to explore the experiences of music therapists who work with children diagnosed with Selective Mutism.

You are invited to participate in this study because you have been identified as a Board-Certified music therapist who meets the following inclusion criteria:

1. The music therapist must have worked with at least one child diagnosed with Selective Mutism, or currently working with one.
2. The total duration of music therapy must be at least two years or a minimum of 80 sessions in total.
3. The child that the music therapist worked with or is currently working with must be between the ages of 3 to 15.

Procedures of the Study:

If you agree to participate in this study, you will be asked to participate in a semi-structured interview lasting approximately 30 to 45 minutes. The interviews will be conducted via Zoom video. During the interviews, you will be asked about your experiences working with children diagnosed with Selective Mutism.

Confidentiality:

Your identity and individual responses will be kept confidential. The audio recordings of the interviews and transcribed data will be securely stored on an external hard drive, accessible only to the primary investigator and the thesis advisor. After the study, all data will be destroyed to ensure confidentiality.

Risks and Discomforts:

There are no anticipated risks or discomforts associated with participating in this study. You can choose to skip the questions that make you uncomfortable or withdraw from the study at any time.

Expected Benefits:

Results from this study will contribute to the existing literature, offering valuable insights for music therapists working with children who have Selective Mutism. Additionally, the findings may provide valuable insights for parents, teachers, and caregivers.

Voluntary Participation:

Your participation in this study is voluntary. You may refuse to participate or withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled.

Questions and Contact Information:

If you have any questions about the study or your participation, please feel free to contact me at dchen1@lions.molloy.edu. If you have concerns about the research and wish to contact someone not involved in the study, you may reach out to Vienna Sa at vsa@pacific.edu.

Signing this form means that:

1. You have read and understood this consent form;
2. You have had all your questions answered;
3. You have been provided sufficient time to decide, you have chosen to participate in this study.

The participant will be given a copy of the signed consent form.

_____

Participant's Printed Name

_____

Participant's Signature

_____

Date

_____

Principal Investigator's Printed Name

_____

Principal Investigator's Signature

_____

Date

APPENDIX C: INTERVIEW QUESTIONS

Introduction and Background:

1. Can you share your background and journey as a music therapist?
2. How many children with Selective Mutism have you worked with before? What are their ages? How long have you worked with them?
3. What sparked your interest in working with children with Selective Mutism?

Experience with Selective Mutism:

4. Overall, how do you feel about working with children with Selective Mutism? What is your comfort level?
5. Can you identify the general needs and goal areas you focus on with children with Selective Mutism?

Building Rapport and Trust:

6. Can you share insights into how you establish rapport and build trust with a child who has Selective Mutism?

Individualized Treatment:

7. How do you personalize your music therapy interventions to meet each child's specific needs and preferences? Can you share an example?

Music Therapy Approaches:

8. What music therapy methods have you used in the past for children with Selective Mutism?
9. Can you share an experience where a particular musical intervention positively impacted a child with Selective Mutism?

Challenges and Rewards:

10. Reflecting on your experiences, are there specific challenges you've encountered working with children with Selective Mutism?

11. Are there any rewarding moments? Can you share an example of a child's improvement or progress?

Collaboration with Other Professionals:

12. Do you collaborate with other professionals to enhance the overall care of children with Selective Mutism? If so, how?

Advice for Peers, parents, and other professionals:

13. For fellow music therapists, what advice would you offer to those new to working with children with Selective Mutism?
14. What resources or insights would you offer to parents, teachers, and other professionals on the child's treatment team to better support the child together?

APPENDIX D: INTERVIEW TRANSCRIPTION

Interview 1: Emily

Interviewer:

Can you share your background and journey as a music therapist?

Emily:

Yes! So I got my bachelor's degree in music therapy in 2013 from Elizabethtown College in Elizabethtown, Pennsylvania, and from there I went on to do my internship in pediatric children's music therapy and psychiatric music therapy in Pittsburgh. I was doing psychiatric through the Western Psychiatric Institute and Clinic in Pittsburgh and my pediatric music therapy through the Children's Hospital of Pittsburgh.

Following my internship and passing of the CBMT exam, I went into work in private practice underneath somebody who had started their own business and had previously been like, doing it like, as a one woman operation in rural Pennsylvania. We have a couple different populations that we work with, but my caseload is primarily school-based. And, so, our company has contracts with local public schools. And so I'm itinerant. I go to the schools, haul my gear with me, and do IEP-based music therapy, which can range from children who are nonverbal and are diagnosed with autism, to middle schoolers who are non-ambulatory and nonverbal, and have like, Rett syndrome and XXY syndrome and seizure disorders, to a high schooler who was in a car accident and was recovering from a TBI and was using learning piano to like help support rehabilitation for her left hand, which had been the neural connection, had been damaged in the brain injury. So like a whole gamut of things. Very, very wide population. And I just started my ninth year at that company, which is kind of weird to reflect back on, that I've been doing this for almost a decade, but yeah…

I'm also currently pursuing a master's degree in family therapy, specializing in child and adolescent family therapy through an online institution. I'm gonna have to take a step back from doing music therapy in September so that I can do my internship in family therapy, but hopefully come back and kind of meld those two together and be just a better clinician overall from everything that I learned.

Interviewer:

That's nice! Is this your second master’s degree? Do you have one in music therapy?

Emily:

Nope, this is my first. I only have the bachelor's degree in music therapy. That was part of the impetus behind choosing to pursue a master's degree in something. It was a little bit of a discernment process, you know, Do I really want to, like, go for additional training in music therapy that will really give me a deep but narrow knowledge? Or do I want to pursue a master's in something that would complement the knowledge that I already have and give me a little bit of a wider scope of stuff? I went with that direction.

Interviewer:

Yeah that makes sense. Great! How many children with Selective Mutism have you worked with before? What are their ages? And how long have you been working with them?

Emily:

So just one. And, oh gosh, she is a second grader. When I'm working in the schools, I focus on their grade level more than their chronological age just because, like, often they can go up to 21, 22 now. And so, like, when they're adults who are still in school, you know, you're just a super senior. I don't… you know, she's a second grader, which would put her around age seven or eight. I could look it up if you really would like me to. I can follow up with email if that's useful.

Interviewer:

Sure. Thank you!

Emily:

I'll make a note to get her actual date of birth and follow up with email for that. And I have been working with her since April of 2023. So coming up on a year of having worked together.

Interviewer:

All right. Thank you. And what sparked your interest in working with children with Selective Mutism? Is there something about this population that you enjoy working with?

Emily:

That's an interesting question. So prior to getting this child referred to my caseload, I was in a class for my Master's in family therapy on diagnosis because unlike music therapists, family therapists can diagnose… and I had to select a DSM diagnosis from a specific category to basically do a presentation on. Totally independent of my music therapy work, I had selected Selective Mutism as the thing to focus on. I had done a deep dive into what are the diagnostic criteria and what are the exclusions? What is the differential diagnosis process? You cannot say a

Selective Mutism if this, this, this, this, and also some of the recommended treatments for that. Totally independent. Then a couple months later, I got the new referral from the school district like, “Hey, we have a child who we think would benefit from music therapy. Can you do an assessment to see if this would help them?” I read that their primary diagnosis was Selective Mutism. And I went, “I know about that.” So I don't know that it's so much so, an interest in working with children with Selective Mutism, so much as it was like, I have a contract to provide music therapy in the schools. And this is a student who was referred for assessment. Does that make sense?

Interviewer:

Yeah, totally. That’s great. And my next question is, overall, how do you feel about working with this child with Selective Mutism? What is your comfort level?

Emily:

Initially, I think I was a little bit intimidated, you know, like it was my first experience working with somebody with this diagnosis. And I was a little bit like, “I don't know how to approach this!” And in consultation with the speech therapist from the school and her teachers, I like, when I was first starting to work with her, they really made sure that I was aware that progress with this particular child really looks like this. She can be hitting those goals and objectives out of the park for weeks and weeks, but then really revert back to ‘I'm just not going to talk at all today.’ And that's part of the diagnosis. And that's part of her learning trend. Her progress trend is not going to be linear. It's going to be lots of peaks and valleys, and that was kind of intimidating to me because I was like, “what do I do?” But now like,,, after having worked with her and having known her, it feels very intuitive. It doesn't… to me on the clinical side coming from like a humanistic background, it doesn't feel any different than meeting any other client with any other diagnosis where they are that day and working to support them as a human in whatever ways they need, and just taking it day by day and moment by moment. And like… What is your level of comfort today? Are you feeling super withdrawn and we just need to engage in nonverbal music so we're maintaining our relationship, and we're still developing social skills without the kind of prerequisite of verbal speech? Or are you feeling like singing “Down by the bay” and calling out all kinds of different animals to rhyme with, and you are giggling and having fun and singing a lot? Like it can really vary. And that was really scary. But I think now that I know her and I know the work that we can do, it's just like, oh yeah…

Interviewer:

OK, thank you. Can you identify the general needs and goal areas that you focus on with this child? Does she have any IEPs from the school?

Emily:

Yes, she does have IEP goals. So I really am looking at it as like a two branched approach. I am working to support her development of verbal speech as possible, but I'm also working to develop her social and relational skills non-verbally, right? So I see her individually three times a month, and then, the last week of the month I see her in a small peer group. So like… the first three are really to hone her communication and social skills, and then the last one is so that she can apply them in, like a real world setting with a peer from her classroom.

And so, I think I kind of touched on this before, but like, if she's in a place where she's like, "My words are flowing, I'm ready to talk," I'm providing as much opportunity for her to verbalize choice within a session as possible. So order of intervention… "What do you want to do next? Do you want to play this drum?... Great, we're going to do that… Stop, do you want to play loud or quiet? Great, we're going to do…" like fill in the blank songs like I mentioned with "Down By The Bay" or any sort of like song that has like, you can make this whatever you want. You can fill in all these choices. Can she articulate or verbalize what she's wanting that day? But I also always have accommodations in place so that if her voice is not flowing today, she can still engage with the music without having to speak. So all of the choices for instrumentation, I always have just like set around the room so she can look at them. And if I go, "what do you want to do next?" and she's not ready to tell me, she can either just walk over and pick up the instrument and start playing or she can point with those, like fill in the blank songs. I have picture cards that, if she's not in a place where she's ready to verbalize them, she can still engage with the music by pointing to or holding up the card that symbolizes what she wants to do in that day. And we do a lot of just like turn-based stuff. with music-making so that she can practice, really just being with a person in a supportive space and understand that she doesn't have to use words to be with another person so that she can start to feel safe because that will hopefully bring her anxiety down and help her feel more equipped to then really just take off and do all kinds of things.

Interviewer:

Yeah, thanks. Can you share insights into how you establish rapport and build trust with this child who has Selective Mutism?

Emily:

Rapport-building with this child has been interesting, not because of her diagnosis, but because of her personality. She is a little bit like, teasing and sarcastic, almost like to the point where I'm kind of like, "should we be concerned"… like so, she is highly withdrawn when she's anxious, but then when she's feeling comfortable, she's very much like, "No, not you, I'm gonna do the thing!" Or when I was doing her observation, I was observing her in her classroom working with peers, and I noticed that her peers were very like, "Hey, so -and -so, do you wanna come and play this with us?" But then when she did feel more comfortable, it'd be like she wanted to play the teacher, and boss the rest of the kids around, and the other kids would be like, "Can I take a turn to be the teacher?" And she'd be like, "No, just me!" And I do sometimes worry about that with her, because I think many of the adults in her life are so like, "She said words, she's interacting!"... that they're not curbing that rude behavior, the way that they would do with a typically developing child, because they're just so thrilled that she's saying something, even if what she's saying is like, "No, I'm not gonna do what you say." Like, "Oh, you spoke, that's amazing!"… But you also need to learn to get along with others. I don't know, I haven't brought it up to the team yet, because again, I think everyone else who works with her is just like, "And she's talking." But it is a concern that I have, because some of her behaviors and comments towards her peers, they could be construed as bullying a little bit. And it is just, it's an area of concern for me... I feel like I've gotten away from your question…

Yes, rapport. So like, because she is, like her natural inclination is to be a little bit like standoffish or like teasing or sarcastic, like I followed what I saw other people doing where it was like, "Oh, do you want me to just play the drums then?" Because then she'll be like, "No, I'm playing the drums." And so building that sort of like, teasing, but slightly adversarial relationship is how I kind of started because I was following what other people had modeled. But I was like, this isn't working for me. I don't… I'm not an adversarial person. This is not how I relate to clients. So really, it's been a whole lot of just maintaining consistency in how I show up every single session and making sure that she knows that there are always going to be levels of scaffolding and support in place. And it goes back to what I was talking about, right? So like, if you're ready to sing, we're gonna sing. If you're not ready to sing, we have picture cards. There

are still ways for you to participate and like just really being super consistent and predictable with showing up with those supports in place so that she can rely on them and rely on the fact that I'm a person that's going to be accepting of you're not talking today. Cool. We're still going to do something. Consistency and predictability and just really like allowing the music to be a part of the session as well.

I have a practicum student with me who was observing this girl's session and we did, she was having a more anxious day because there was somebody new in the room, the practicum student, and I had scarves out because we had enjoyed dancing with scarves earlier, but she really just wanted to hide underneath the scarves. And so I was like, of course that's what we're doing, we're going to hide underneath the scarves. And so where is… I'm not going to use her name… "where is so and so? Where did she go? Where did she go? Where is so and so? Where is so and so…" And allowing that last phrase to really like hold on so that you know that you're safe in this place and you're supported. And whenever you're ready, you can lift that scarf up and go, here I am. And so like that was a really an interesting moment because like, it was allowing her to use that impulse to hide and withdraw in a playful way, in a functional way. She could play out that impulse to be hidden, to hide and really allowing the music to be there throughout, and really be supportive of like, "Yes, we are! We are hiding and you can hide for as long as you want! But also that, like that five chord that…(singing the melody)… and sustain… There's an expectation that something else will happen, right? You're not going to sit here under your… but it allowed her to really take the time and emerge from her hiding place when she was ready and on her time. So incorporating the music as much as possible has been really important for establishing safety and just showing up consistently and proving yourself to be a safe person by your consistency.

Interviewer:

Okay. Thank you. My next question, I think it doesn't really apply to you, but here it is, how do you personalize your music therapy intervention to meet each child's specific needs and preferences? But since you only work with one child, so I guess we can skip this question… All right, and the next one, what music therapy methods have you used in the past with this child with Selective Mutism? So the four methods include song recreation, improvisation, receptive, or compositional.

Emily:

Yeah, so we do a lot of song recreation, like I mentioned, like the “Down By The Bay” song, where she's able to fill in some blanks with her own ideas. Is that improvisation though? Hold on…

Interviewer:

I think that might be song recreation.

Emily:

Yeah, it's still song recreation because it's a known song, it's a familiar song, but she's also like asserting her own ideas. We do a lot of improvisation as well. So just experimenting on the xylophone or playing drums back and forth, like I mentioned, like, “Do you want to play the drum fast or slow? Which one?” And that sort of thing, just providing as much opportunity for agency and choice in the session as possible. We also do a lot of movement to music, so that would be receptive?

Interviewer:

Yeah, I guess.

Emily:

We don't do a whole lot of composition because I think that would really just freak her out.

Interviewer:

I understand. Can you share an experience where a particular musical intervention possibly impacted this child? Like a specific example of a musical intervention?

Emily:

I would like to hope that all of my interventions positively impact this child. I am trying to think… she does enjoy that drumming improvisation where she gets to dictate how the music sounds. But I think the one that she's had the most fun with recently is, I have a set of resonator bells, which are like a xylophone, but they're not as tinny, and they're color-coordinated and each note comes apart from the set. And I also had created a laminated set of cards with the capital letter that matches each note, C through G, in the same color as the tone trimes bar instrument. And I was working on, I was hoping that she would spell out B -E -D, that spells “bed”, and we would play B -E -D… B -E -D, that would be descending on the chimes, and then we would make a sound, a new word, and we played it on the chimes, but she really got into like, “Miss Emily, what is this word?” And it was a nonsense word. And I could have chosen to be like, “so and so, that's not a real word. Can we try again?” But what I did was, I sounded out her nonsense

word, and she laughed and laughed and laughed. And I was like, “You try sounding out your nonsense word.” And she tried it and we laughed. And then we played the nonsense word on the xylophone. And then I was like, “How about we try cab? And she was like, “No, let's do this nonsense word.” And we spent about like eight minutes making absolute nonsense words out of the letters A through G. Like it would be like, xxx, that's the word for today. That it was, it was accessing that like verbal decoding, because she was also saying them she was sounding out the silly nonsense words, she was saying them back to me. Um, but also like playing them on the xylophone getting all that stuff going, it was again, meeting a functional goal but using play.. Um, and I think that that was really helpful because a lot of the time you know when she is having to like sound out words, it's like “You need to say it. Can you try? Can you say it for us? You know what sound this letter makes, can you say it?” And there's a right and a wrong which I think increases the anxiety, but these, these are not words. Nobody knows how they're pronounced, Maybe it's not xxx, maybe it's xxx… that was, that was helpful for her to kind of like, de-intensify anxiety around reading out loud specifically.

Interviewer:

Great! And reflecting on your experiences, are there specific challenges you've encountered working with this child?

Emily:

Yeah. I mean I think the, the biggest challenge is just the unpredictability, um, you know, like I could have a plan in place for interventions where I'm like I you know we're gonna, we're gonna say these things today, um, but maybe she's just… maybe she's just had a really bad moment with a teacher right before I came to the session and her anxiety is spiking and she's not in a place where she's ready to use her words, um, and I, and you just have to adapt, as we all do with all of our clients, we just have to adapt, um, but I think just the the uncertainty of like, which kid am I gonna see today? Am I gonna see silly, we're making up words and we're rolling on the floor together, giggling kid, or am I gonna see totally withdrawn, hunched over, not making eye contact, not moving kid?

Interviewer:

All right. Are there any rewarding moments? Can you share an example of an improvement or progress?

Emily:

Yes, I was so nervous for her first group session with her peers because I was really, I wasn't sure what to... again, that uncertainty… I wasn't sure what to expect. Is she going to access the skills that we've been working on and put them into practice, or is the added factor, the social factor of having a new person in the room, somebody's watching me, I don't know what to expect. Is it going to totally backfire and she'll shut down? But she chose who she wanted to do music with, and I gather that this person is a good friend to her and the person that she chose was just super outgoing and the three of us were laying on our stomachs on the carpet, kicking our feet up in the air, singing back and forth and giggling. I heard this child laugh for the first time when her peer was there. It was just like. childhood joy just erupted in that room, in that moment. And I was just, I felt really privileged to like, be there with the two of them. Like it had like "sleepover vibes." I don't know how else to describe it. There was just like, such, like giggling, silly, early fun happening. And I was just like, you don't need me, you guys can go. But it's just like, it was just so because I think partly because I wasn't sure how the group was going to go.
It did feel like a huge weight off my shoulders. Like, this is fine. And we're having fun. We're interacting. My client is talking. They're singing. They are playing back and forth with rhythm sticks and copying each other's movements, which is what I asked them to do. All kinds of like it was just, it was so joyful. And I just felt very like, to me... Yeah, because I wasn't sure how it would go.

Interviewer:

Nice. Do you collaborate with other professionals to enhance the overall care of this child? If so, how?

Emily:

Yeah, I do try to, as much as possible. One of the things that makes it challenging to collaborate with the other professionals is that because all of us are kind of itinerant, and we all have to share one room. We deliberately schedule our services on different days. So like, if Mondays, I'm at the elementary school, and Wednesdays, I'm at the high school, maybe the speech therapist is at the high school on Mondays, and the middle school on Wednesday. So like, so logistically, so that we each have a designated space and time to work with the kids and so that the kids aren't bombarded with like, okay, it's Wednesday, that means I have physical therapy, I have music therapy, I have speech therapy, boom, boom, boom, it's more spread out for them. And that's a great practice for those reasons for logistics and for not burning out the kiddos, but it does mean

that. face-to-face time with my colleagues and other professionals is really limited. I don't, I'm not often in the same building on the same day as them, because that's how we designed it. But I do keep in touch with like email updates with the whole team pretty regularly. And we do have our annual team meeting where we all sit around a table, but like I will occasionally just send out a quick email. Like"You'll never believe what so-and-so did in his session today. He isolated his finger to push down on the key. I thought you'd want to know, occupational therapist." Or "Hey, PT, I've noticed so-and-so moving her arm more. Is that something that you're working on that I can support?" So we do collaborate, but it's often asynchronously via email rather than like co -treating collaboration, which I would love to do more of. It's just not really always feasible with the way that the school has, kind of said that we need to set up our sessions. But maybe I can change that.

Interviewer:

You said you collaborate with PT and OT. Are there any other professionals?

Emily:

And speech. And not for the kiddo that we're talking about today, but the school does contract with an autism consultant who will just weigh in on,"Hey, have you tried this approach with the students who have autism?" But I don't collaborate with her for the student that we are discussing for this interview.

Interviewer:

Great. I have two more questions, so I think we'll be finishing it up on time actually. For fellow music therapists, what advice would you offer to those who are new to working with children with selective medicine?

Emily:

I mean, I've found that the two key components are: Be flexible, be patient. Those are the same thing. And think about accommodations ahead of time, right? If you are planning an intervention where they are doing a fill in the blank, have those picture cards there, have some way that if they would like to engage with the music, but their voice is not working today, or they're not accessing their verbalization skills today, they can still participate. Plan those ahead of time. Plan even like three or four levels of engagement. So they like, where the top might be like, they are singing and they are improvising with their singing and they are generating independent verbalization. The middle one being like, they are making non-verbal choices about instruments

by picking up the one they want or selecting picture cards with the bottom one just being like they might just need to sit and listen to music today. They might not be able to even articulate a choice because that feels overwhelming. Plan out like, multiple levels of engagement expectation and make sure that you're providing for all of them. That would be my advice.

Interviewer:

And the last question, what resources or insights would you offer to parents, teachers and other professionals on the child's treatment team to better support the child together?

Emily:

I don't know if I have any like tangible resources like, “Oh, here's a great book to read.” But I think like, I would just advise every like… if it's a parent coming to the like… “Oh, we just got this brand new diagnosis, what do we do?” Or like somebody who's new to working with it, I would say that your kids are still your kids regardless of whether or not they can speak to you. There are plenty of children and adults who are non-verbal for various reasons. Maybe they were born deaf and they use sign language; maybe they have a neuromuscular disorder where they can't get their tongue to talk to their brain correctly, and they're not... Their personalities are still there, their likes and dislikes are still there, their sense of humor is still there. So I would, again, it's not like a tangible resource, but like take the burden of like, oh, we got to get their speech out of the kid and just let them be the kid that they are. The speech will come when they're comfortable, or it may not, and that's fine too. But don't… don't focus so much on this one quote unquote, deficit area, that you forget to see the beautiful child that you have in front of you.

Interviewer:

Okay. Thank you. I think that's everything. Are there anything else that you would like to share or do you think you covered everything?

Emily:

I think I've covered everything. I will follow up with email with her exact age, because I didn't have that in front of me.

Interviewer:

Great. So I will… I'll listen back to this and then transcribe it into words. And I could send it back to you to check for member checking.

Emily:

Yeah, sure. Great. Yeah. Have a nice day.

Interviewer:

This is really helpful. Thank you so much.

Emily:

Take care. Bye.

Interviewer:

Bye.

Interview 2: Kaitlyn

Interviewer:

Can you share your background and journey as a music therapist?

Kaitlyn:

Yeah, sure. So I've been working as a music therapist for about 26 years now. And I… so I was trained 26 years ago at Roe Hampton Institute in London, which is kind of a psychodynamic approach to music therapy. And since then, I've sort of worked in a number of different places. I worked at the Roe Hospital for neuro-disability in London, and I've worked with adults in residential care with learning disabilities. And then.. but mainly, I've worked sort of for the last 20 years or so in Lambeth, my setup, a music therapy charity, to provide music therapy in this borough in London. So that's mainly what I've done. And then, I've also recently, I did in the UK… our training initially was just back in the day, was just a postgraduate diploma and then it turned into MA so I did a top-up MA quite late and did a case study on a child with Selective Mutism and then I did… After that I did a PhD, which I gained in 2019. And a couple of years ago, I started working at the Guildhall School of Music and Drama as a researcher, so I've got a day a week there just as a researcher, which is fantastic.

Interviewer:

That's nice, thanks for sharing. So how many children with Selective Mutism have you worked with before, and what are their ages? How long have you worked with them?

Kaitlyn:

Okay, so I was trying to think about this before, hang on. I don't, because I don't work full time. I haven't seen a vast amount, but I would probably say that now… I've probably seen… It's quite tricky to say… between, say, 50 to 70 children maybe, with Selective Mutism.

Interviewer:

Wow, that's a lot!

Kaitlyn:

Yeah. Yeah. Um, but that's sort of over my whole career. And so, and they range from young children in nursery settings, so ages two and three, up to slightly older children. I have seen, um, children around the age of sort of 13 or 14 that some of those had, um, were in special schools and had autism as well. Um, so a bit of a range.

Interviewer:

Okay. I see. So you've worked with them like, throughout your whole career?

Kaitlyn:

Yeah. Well, not quite my whole career, but it started more when I, um, first started working in Lambeth in a sort of, in a London borough.

Interviewer:

What sparked your interest in working with children with selective autism?

Kaitlyn:

Yeah. So, um, well, first of all, I was just being referred to children who were described as quiet. Um, and I didn't know what Selective Mutism was. So, um, teachers and staff who were referring to children saying, "Oh, there's something about this child. We can't figure out, they're very quiet. We're not sure what's going on. Please, can you assess them in a music therapy session?" Um, and so I would assess them and then they would start playing. Um, and then they would start interacting and talking in music therapy and then sort of go back to their classroom and talk in the classroom, and the teachers would become surprised and sort of say, oh, you know, "Wow, What have you done?" You know, and quite often then they'd be quite a noisy child. And so I was curious then as to what was going on, because they clearly didn't, in a lot of cases, didn't seem to have particular learning difficulties or language difficulties. Some of them are more complex, but yeah, I was trying to understand what was going on for them. And then of course, they discovered that there was this condition called Selective Mutism. So then I had to really go and research it myself and find out more about it. And in the UK, a man called Dr Tony Klein

has written a book called *Selective Mutism in Children*. And I went to a research conference up in the center of London, where they were presenting the consensus-based research, international research on care pathways for children with Selective Mutism. And Tony Klein, the man that had written that book, was in the audience, in fact he was sat in front of me. And so I was watching this presentation of the research, and at the end of it I was just really excited. So I tapped him on the shoulder, and I was sort of, "Oh, Dr Klein, Dr Klein, music therapy works for children with Selective Mutism." And so, yes, so he said, "Yes, I totally believe you, but you need to go do some research." So that's my whole, yeah, that's sort of my story, my into investigating it and becoming a researcher.

Interviewer:

That's an interesting story! So overall, how do you feel about working with children with Selective Mutism? What is your comfort level?

Kaitlyn:

Yeah, I feel very comfortable working with, with children with Selective Mutism, because it, you know, generally we've had quite sort of a high success rate really. And it seems to be such a positive intervention for children with Selective Mutism.

Interviewer:

All right. Can you identify the general needs and goal areas that you focus on with children with Selective Mutism? Like do they have IEPs in school? That is Individualized educational plan, and we use them here in the United States. Not sure about your area.

Kaitlyn:

Yeah. Yeah, so it's, it's a similar system in the UK, but they're called… at the moment… that we used to call them IEPs actually, but they're now called EHCP, so that's educational and healthcare plans, but the same thing essentially. So yes, if a child is not speaking or has Selective Mutism, they will, this would be sort of noted in their school records and a plan developed. But they wouldn't, if they've got just Selective Mutism, I'm not sure whether they would then have an IEP or an EHCP, there would be just some initial provision put in place around them. So because we don't diagnose Selective Mutism so much in the UK, we just identify it and then put systems in place around the child in school. There was another part of your question that I haven't answered, I think I can't remember what it was…

Interviewer:

Um, so how do you say the goal areas would be? Like, for example, like maybe communication goals or social goals?

Kaitlyn:

Yeah. I think really it's sort of, we work in a very sort of child-led way. So, um, but generally when we're working with children with Selective Mutism, I'd say that often the goals would be around anxiety reduction, um, trying to create, sort of an anxiety-free environment for them in their school settings. Um, and providing sort of psychoeducation around the child, educating family and staff. That would be another goal. Um, I mean, ultimately communication, um, and verbal communication, but really building that through this sort of musical relationship. Um, and also I think it's really, yeah, really important for some children to develop social communication with, with peers as well. So I've had some children who've requested to have friends in, in the sessions and to really sort of, um, support that development. So that can be a really important aspect of it as well.

Interviewer:

Nice. Um, okay. So my next question is, can you share insight into how you establish rapport and build trust with a child who has Selective Mutism?

Kaitlyn:

Hmm. That's a good question. I think that it's really important to have quite a light approach with young children with Selective Mutism and have, um, and sort of build up rapport with using play and sort of following their lead as well. So just being interested in whatever they are interested in, but also being quite playful. in the sessions because quite often, you know, they're quite anxious and so actually, yeah, just keeping things quite light-hearted sometimes can be useful. And I've just seen in various sort of case studies a lot of other music therapists doing similar things, having a very sort of playful, play-based approach, sometimes using puppets and not necessarily always focusing on the music too much as well, you know, to sort of, yeah, look at other things in the room. I've done things like playing musical football and just inventing games, sort of throwing shaky eggs onto a drum and sort of bouncing them on the drum and making goals and just being quite playful really, I think has been a sort of, yeah, good way to develop rapport.

Interviewer:

All right. Since you have worked with so many children in this area, how do you personalize the music therapy interventions to meet each child's specific needs and preferences?

Kaitlyn:

Yeah, so like I was saying before, I think that particularly in the UK we would have a very sort of child-led approach, so we would sort of work with whatever the child was interested in and really be very flexible about what we're offering each child, so working to their own sort of tastes and interests and offering a wide range of instruments, but just focusing on whatever they are interested in and as well as offering musical instruments, also having things like puppets and drawing materials and other things in the room so that children can access quite a wide range of mediums.

Interviewer:

What music therapy methods have you used in the past for children with Selective Mutism? So, these methods may include song recreation, improvisation, receptive listening and compositional.

Kaitlyn:

Yeah, okay, so we use a lot of… I do use a lot of free improvisation, but also because that can be quite, can be quite anxiety-provoking for some children with Selective Mutism, we also use sort of known-structures and songs such as nursery rhymes. So some of the techniques that I might use as well are using a known song, like a nursery rhyme such as “Old Mac Donald Had a Farm,” where you leave gaps, And you can then either pick up a model of a cow or point to a cow or make a “moo” sound or actually name a cow. So you're sort of leaving spaces for communication with that child, but in a sort of very fun and sort of, sort of finely, sort of tuned way so they can do anything from just pointing to speaking. So yeah, so lots of little games that we've borrowed as well like that from speech and language therapy. So yeah.

Interviewer:

All right, so that's song recreation and improv. What about the other two?

Kaitlyn:

What was the other ones that you mentioned again?

Interviewer:

So that's receptive, basically just listening to music. Have you done anything like that?

Kaitlyn:

Yeah, I mean sometimes because I'm working with younger children. they tend to want to interact. So not so much receptive, but if children are very anxious, then I will offer them sounds to sort of come into, you know, to sort of respond to and to try and lower anxiety as well. So not exactly receptive techniques, but yeah, you might sort of offer something to them.Yeah.

Interviewer:

I see. What about compositional methods?

Kaitlyn:

Yeah, I haven't done compositional methods, but within, except within sort of free improvisation where I guess you might sort of work with whatever the child is offering you and develop a song or yeah, a piece of music around that. But yeah.

Interviewer:

All right. Can you share an experience where a particular musical intervention positively impacted a child with Selective Mutism?

Kaitlyn:

Yes, I suppose I've got quite a few examples. What I think is very helpful for children with Selective Mutism is to give one particular example of children really appreciating the use of what I say, oral instruments, so instruments that you can blow or sing down like a kazoo. So sometimes children are so happy to play, say a recorder, and there was one child that I'm thinking of in particular, so he not only blew the recorder, he also sang down it, so starting to vocalize through it and from there moved into speech. So I think the use of oral instruments is really useful for a lot of children with Selective Mutism. Another child that I was working with, we used didgeridoo, And because it's quite a fun instrument and you can obviously, you can look through it. You can try and play it, and actually children are quite surprising and then they can quite often play a didgeridoo. Do you know which, what I mean by a didgeridoo? The sort of long Aboriginal, it's like a tube that Aboriginal people in Australia blow down. It's very long. And you just sort of...

Interviewer:

So it’s a type of oral instrument, right?

Kaitlyn:

Yes, it's a type of... Yeah, sorry. It's a type of musical instrument and essentially it's a really long tube that Indigenous Australians would use. But I've used those in sessions as well. And because

you can sort of do lots of different things with them, you can look down them, you can sort of play the note on them, but you can also talk through them.

Interviewer:

Wow, that sounds quite fun!

Kaitlyn:

So, yeah, that's quite good.

Interviewer:

Do you mind typing down the name of this instrument?

Kaitlyn:

Yeah. Do you want me to put it in the chat?

Interviewer:

Yeah, yeah, that'd be great. Thank you! It's just that I've just never heard of it before. It sounds so interesting… Okay, so reflecting on your experiences, are there specific challenges you encountered working with these children?

Kaityln:

Yeah, I guess there can be challenges sometimes when you're trying to move any speech that you've gained within the music therapy sessions back into the classroom or into the wider world, because you do need some support sometimes or resources to do that. So I think that quite often the challenges in working with it in this clinical area is in working with staff and the environment around the child. And it's quite, I think those are maybe new techniques for some music therapists as well, so doing something called psychoeducation, which is basically teaching the people in the school about Selective Mutism. And then getting the support to help generalize the speech from the sessions into the classroom environment and around the school. So those can be some of the most challenging aspects, I think.

Interviewer:

Okay! Is there anything else?

Kaitlyn:

Yes, I mean, I suppose it's sort of part of that as well as it is if children can have setbacks for different reasons. So having breaks in therapy… So I work in school environments, so quite often then we might have a break for the long summer holidays in the UK. And so children may sometimes lose progress in that time. And so you have to sort of think about those gaps.

Interviewer:

Yeah. True. Are there any rewarding moments? Can you share an example of a child's improvement or progress?

Kaitlyn:

Yes. I mean, there's lots of fantastic examples really of children when obviously, when they start talking in the sessions. But one child that springs to mind, she was already talking to me. I just talk about how she got into speech. She made a huge amount of progress using a toy karaoke machine that I took into the session and it had a really lovely harmony setting on the karaoke machine. And so she started speaking first by singing for whole sessions through this karaoke machine because it was made such a beautiful harmony sound. And then the following session she spoke. So that was really wonderful progress. But then later on in her sort of therapeutic journey, she said to me that she wanted to have friends, because she didn't really have any friends. And so then she chose other children to come into the session, and we introduced them one at a time. And then she sort of spoke to them in the sessions. And then, yes, eventually, we have to recruit sort of more support from staff actually to help her, then generalize their speech out into the, into the school. But that was good. And we actually did a more intensive process with her and had more than once a week, we sort of ended up… she was having three or four sessions a week that were provided by other staff within the school. So sort of created a more intensive approach for her which worked really well. So yeah…

Interviewer:

Thanks! You mentioned you have many examples, you can share one more if you want, because yeah, we still have some time...

Kaitlyn:

Yeah, okay. Thinking of a good one… I really remember there was one child actually who, she'd been quite quiet. And I think she was desperate to sort of burst into speech. And she… sometimes children seem to go into speech by hiding under some of the noise, and she'd been playing the cymbal a little bit in the session. But then all of a sudden she sort of hit the cymbal really loudly. And she just went shout “China!” because she associated cymbals with China. She hit it really loudly and shouted. And it was really lovely and then, and then after that she just went on to talk non-stop about her family and sort of all these sort of secrets and things you know about her family came out, but that was lovely, so she sort of burst through into, into

speech and that was good but then I remember after that session when we were walking back to her classroom on the journey back she was talking to me but as she was getting close to her classroom she was sort of verbalizing how she felt and she's saying “Oh I feel scared,” so she was scared about then going back into her classroom, so yeah.

Interviewer:

I'm just curious, like from the music therapy room to the classroom, is there a long distance? Is it in the same building?

Kaitlyn:

Yeah so it's, I mean it's something I think about a lot and I sort of worked in different environments, I remember in that case it was quite a reasonable walk. It was a… I think we had to go across a playground. So it was almost part of the therapy really, that transition from the therapy room back into the classroom. Because it was a space obviously where we were coming out of the physical therapy room, but we were still talking to each other across the playground, going back to the classroom. So I think that is quite an important part of, an important aspect of working with children with Selective Mutism.

Interviewer:

I see! So do you collaborate with other professionals to enhance the overall care of the children? If so, how do you collaborate?

Kaitlyn:

Yeah, okay. Yes, a lot of collaboration. I think it's really important in this field. So in the UK, speech and language therapists are the main professionals who work with children with Selective Mutism, but also psychologists, but mainly, mainly speech and language therapists. So we would always communicate with the speech and language therapy team, and to let them know what we're doing, and also to think about creating a team around the child, in any case, so including parents and the children's teacher and any sort of other important staff, speech and language therapy, ourselves, and creating a little team around the child. And that part of the work is really important. So that everybody knows what Selective Mutism is, everyone is trying to create a sort of pressure-off environment around that child. So yeah, I'd say it's a huge part of the, of the work.

Interviewer:

Alright, my next question is, for fellow music therapists, what advice would you offer to those who are new to working in this population?

Kaitlyn:

Yeah, I would say before you start working in this area, try to get as much information as you can about Selective Mutism. So one of the big things that came out of my PhD was that music therapists felt in the UK, they felt unprepared to work in this area. Although we've got lots of strong skills and intuition about working with children with Selective Mutism, I think that we're lacking some knowledge about what it is. And so my advice to any music therapist is to get as much training as you can before you start. In the UK we have something called the *Selective Mutism Resource Manual*, which I advise all music therapists to buy and use. Yeah, to borrow as much as possible really from speech and language therapists because they kind of lead the way. And yes, I would advise there's free trainings in the UK as well that I could share as well. So we have sort of websites with free trainings on. And I think in the US you have some free information on the *Child Mind Institute* website about Selective Mutism. So yeah, just to get as much information about Selective Mutism as possible.

Interviewer:

Great, thank you. And let's also connect my next question, which you already answered a part of. What resources or insights would you offer to parents, teachers and other professionals on the child's treatment team to better support the child together?

Kaitlyn:

Yeah, so I would encourage all sort of parents to, like in the States, I think it's called the *Selective Mutism Association*, to sort of signpost them to their national charity about Selective Mutism in the UK. It's the organization called SMIRR. So that would be the first thing I do for parents. But also we have these manuals, we would be printing off pages from the manual and giving people, you know, examples of information about what Selective Mutism is, and supporting teachers to sort of know how to approach things within the classroom environment. But yeah, so you could try and access as much training as possible. In the UK, I'm also developing a training myself as well, I've already offered a pilot one, but I'm sort of developing a training as well at the Guildhall. So yeah, and encourage networking really with other music therapists in the field you're working in this area.

Interviewer:

All right, thank you! So that's all my questions. Are there anything else that you would like to share before we end?

Kaitlyn:

Just trying to think. Yeah I mean if you would like… I'm just I'm very pleased that you're doing this research, and I've reached out because I want more people and more music therapists to be interested in this topic and do more work in this area so, you know, I wish, I wish you all the best with it, but if there's any other ways that I can I can help support music therapists in the US in their work, or you know there's other ways of collaborating, that would be, that would be amazing. So yeah…

Interviewer:

Thank you, thank you for your time!

Kaitlyn:

Oh, you're very welcome.

Interviewer:

So I will transcribe this and then send you back for member check after I complete. So that will take a few weeks, I think. But yeah, I'll get back to you via email.

Kaitlyn:

Yep. Have a good day. Thank you. Good luck with it all.

Interviewer:

All right, thank you! Bye.

Kaitlyn:

Take care. Bye.