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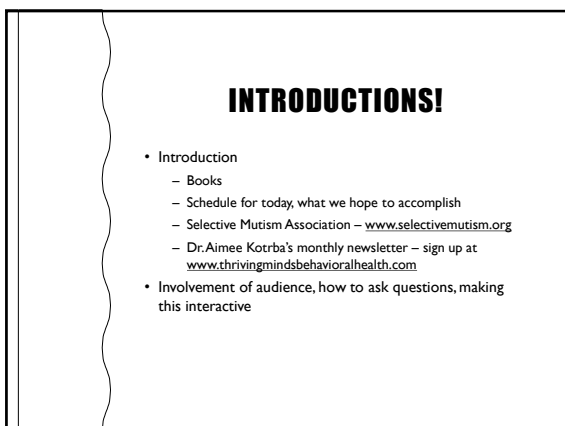
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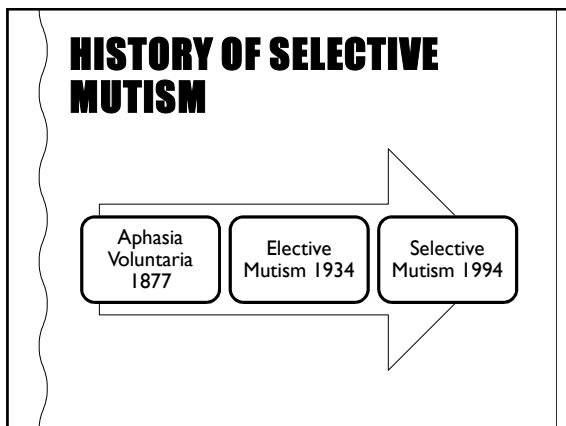
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## DEFINITION OF SM (DSM-5)

- Specific anxiety disorder
- Consistent, ongoing failure to speak in specific social situations, especially school
- Not due to a primary language disorder
- Other disorders (e.g., stuttering, autism) have been ruled out
- A relatively rare childhood disorder, affecting approximately 1% of children in elementary school settings
- Behavior is deliberate self-protection, not deliberate oppositionality

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## COMMON TRAITS

Mutism	Heightened sensitivity
Blank facial expression, freezing, poor eye contact	Excessive worries
Difficulty responding and/or initiating nonverbally	Oppositional/bossy/inflexible behavior at home
Slow to respond	Intelligent
	Bilingual

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Go to [www.menti.com](https://www.menti.com) and use the code 49 90 85

Most common misdiagnosis of SM?

0% Speech and language delay    0% Oppositionality    0% High Functioning Autism

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## SHYNESS VS. SELECTIVE MUTISM

### SHYNESS

- Slow warm up period
- Can often respond with a nod or small smile
- Same demeanor everywhere – quiet and reserved

### SELECTIVE MUTISM

- Warm-up time MUCH longer than expected
- Cannot respond at all -may appear frozen
- Dual personality – restrained at school and talkative at home



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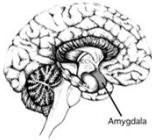
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## WHERE DOES SM ORIGINATE?

- NO evidence of causal relationship to abuse, neglect, or trauma
- Genetic predisposition model (genetic loading)
- Biological indicators
  - Decreased threshold of excitability in amygdala
  - Amygdala reacts more and takes longer to return to normal



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## PHYSIOLOGICAL CHARACTERISTICS

- Why don't children with SM look anxious???
- More chronically over-aroused than children with social phobia alone
  - Higher levels of arousal at baseline in studies, not just when asked to engage with others
- Children with SM appear to modulate their anxiety **better** than children with social anxiety, thereby not **appearing** as anxious outwardly.

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## PREVALENCE STATISTICS

- Most recent stats show approximately 1%....and growing?
- 1.5-2.6 / 1 female / male Garcia et al (2004)
- 90% comorbid with Social Anxiety
  - But different – higher rates of oppositionality, agoraphobia, and language problems

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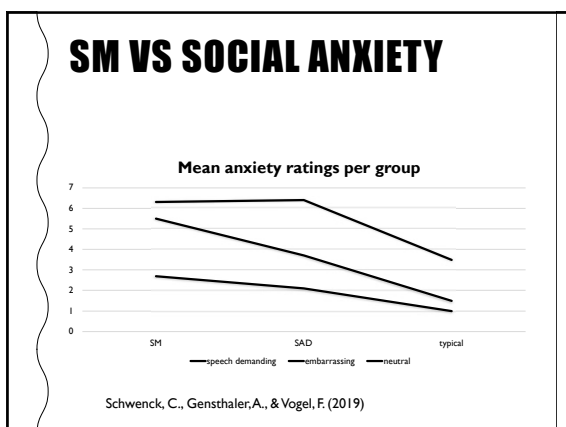
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**COEXISTING PROBLEMS**

- Generalized Anxiety Disorder
- Other Specific Phobias
- Obsessive Compulsive characteristics
- Speech problems (35-75%)
- Defiance/Oppositionality
- Enuresis
- Sensory Dysfunction
- Separation Anxiety
- Hearing issues (MEAR)

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**COEXISTING PROBLEMS CONT.**

Language Based Learning Disorder or communication deficits

- Including pragmatics, grammar, semantics, articulation, voice, and fluency
- produce shorter, linguistically simpler, and less detailed language than typically developing children (McInnes, Fung, Fiksenbaum, & Tannock, 2004)
- possibly weaker auditory-verbal memory span (Kristenson & Oerbeck, 2006)
- lower receptive language scores than age matched peers (Nowakowski et al., 2009)

May be:

- Independent of SM
- Precursor to SM
- Be exacerbating SM
- Arising from lack of experience communicating due to the social anxiety of SM

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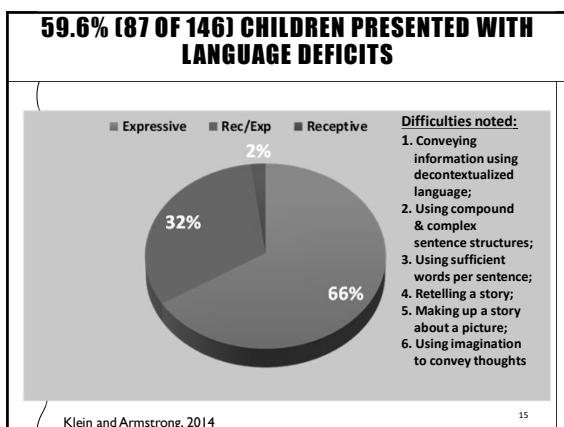
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**Anxious**

**Anxious-Oppositional**

**Anxious-Communication Delayed**

**TYPES OF SELECTIVE MUTISM**

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**PARENTING FACTORS**

Preventive Factors

- High expectations
- Lack of family accommodation
- Involved parent and school in intervention

Maintaining Factors

- Social isolation
- Denial of an issue
- Family accommodation
- Accidental reinforcement
- Speaking for the child

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**FAMILY RESCUING/ACCOMMODATING**

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graph TD
    FA([Family Accommodations]) --> PA((Parent Anxiety))
    FA --> CA((Child Anxiety))
    PA --> CA
    
```

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## SAFETY BEHAVIORS

- Anxious people often engage in a range of behaviors to make themselves feel safer when they cannot avoid anxious situations
- These behaviors are attempts to *neutralize* feelings of anxiety
- High rate of “coercive behaviors”
  - Child truly believes the only way to alleviate anxiety is parent rescuing



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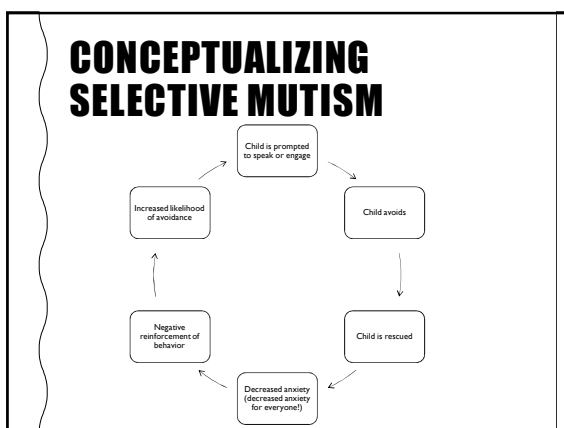
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
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
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
## AVOIDANCE – THE OXYGEN OF ANXIETY



KEEPS KIDS FROM LEARNING THAT FEAR IS A WARNING, NOT A PREDICTION.



DEFAULT WAY OF RESPONDING TO THE WORLD



TEACHES KIDS TO STEER THEMSELVES AWAY FROM UNPREDICTABLE OR UNCOMFORTABLE SITUATIONS

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## ACCIDENTAL REINFORCEMENT



- Behaviorism 101 = reinforce whatever you want to maintain or increase
- How do school personnel and therapists accidentally reinforce?
- How might this impact anxiety?

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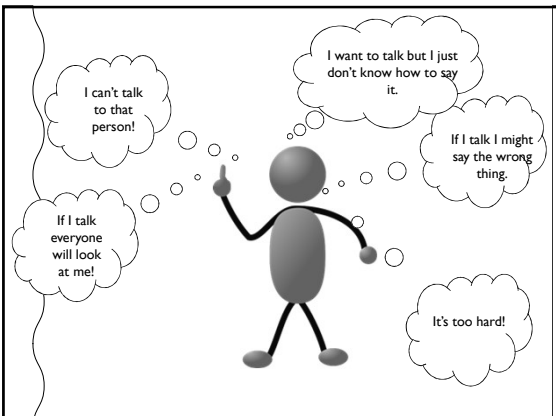
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## SCHOOL IMPLICATIONS

- Academic implications
  - Inability to assess skills (especially reading)
  - Possibly limited peer relationships
- Behavioral implications (participation)
- Social Implications (how peers see child)



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### IF LEFT UNTREATED....

- Worsening anxiety and depression
- Social isolation, impaired peer relationships
- Self-esteem issues
- School refusal, poor academic performance
- Self-medication
- Problems adjusting to work situations
- Everyday that a child continues with impairing symptoms:
  - Is not neutral
  - Strengthens the habit of avoidance
  - Strengthens perceptions that they are the child that doesn't talk
  - Decreases self-confidence

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### EVALUATION OF SELECTIVE MUTISM

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### DIAGNOSTIC INTERVIEW

#### Modes of Communication

- Who
- What
- Where
- How
- Speech issues?

#### Family

- Genetic history
- Home life description
- Recent stressors

#### Child

- Behavioral characteristics
- Medical history
- Repetitive or restricted interests, obsessive thoughts, etc.

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## EVALUATIVE TOOLS

- Selective Mutism Questionnaire
- SCARED (Screen for Childhood Anxiety Related Disorders)
- And....
  - Autism Diagnostic Observation Schedule (ADOS)
  - Speech/language evaluation
  - IQ (nonverbal)
  - Etc...

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### Scoring

1. Add totals in each section
2. Divide by number of items in section
3. For total score, add up totals in each section – DO NOT divide

Parent's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

**Selective Mutism Questionnaire (SMQ)**  
(Self-Report for Children)

Please describe your child's behavior and activities at the past month and indicate how frequently each statement is true for your child.

ALL SITUATIONS

	Always	Often	Sometimes	Never
1. My child usually speaks to people who are not family members.				X
2. My child usually speaks to people who are not family members.				X
3. My child usually speaks to people who are not family members.				X
4. My child usually speaks to people who are not family members.				X
5. My child usually speaks to people who are not family members.				X
6. My child usually speaks to people who are not family members.				X
7. My child usually speaks to people who are not family members.				X
8. My child usually speaks to people who are not family members.				X
9. My child usually speaks to people who are not family members.				X
10. My child usually speaks to people who are not family members.				X

Parent's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

**IN SOCIAL SITUATIONS (OUTSIDE OF HOME)**

	Always	Often	Sometimes	Never
11. My child usually speaks to people who are not family members.				X
12. My child usually speaks to people who are not family members.				X
13. My child usually speaks to people who are not family members.				X
14. My child usually speaks to people who are not family members.				X
15. My child usually speaks to people who are not family members.				X
16. My child usually speaks to people who are not family members.				X
17. My child usually speaks to people who are not family members.				X
18. My child usually speaks to people who are not family members.				X
19. My child usually speaks to people who are not family members.				X
20. My child usually speaks to people who are not family members.				X

Parent's Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

$$0+0+0+0+0=0$$

$$/6=\text{School}=0$$

$$3+2+2+3+2+2=$$

$$14/6=$$

$$\text{Family}=2.33$$

$$0+1+2+0+3=$$

$$5=\text{Other}=.6$$

$$\text{Total } 0+14+3=17$$

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The Selective Mutism Questionnaire (SMQ) assesses the degree of a child's speech inhibition in various situations. The SMQ includes 17 statements describing typical situations in which children are expected to speak: opening three domains: at school, with family, and in social situations. Parents rate the frequency of each item using a 4-point scale (1=always, 2=often, 3=sometimes, 4=never for speaking situations).

Lower scores represent less frequent speaking behavior (more severe selective mutism symptoms).

	Child's Score	Average Score For Children with SMQs in Age 3-5 years	Score For Children with SMQ	Score For Children without SMQ
School	1	1.0 (1.0-1.0)	20	20
Home/Family	2.33	1.62 (1.09-2.23)	17.33	20.00
Public/Social	6	2.5 (2.2-2.8)	34	20.00
Total	9.33	1.3 (1.14-1.49)	71.33	60

At school, child is more severe than most children with SM (average = .33)

	Child's Score	Average Score For Children with SMQs in Age 6-11 years	Score For Children with SMQ	Score For Children without SMQ
School	1	1.0 (1.0-1.0)	20	20
Home/Family	1.52	1.40 (1.13-1.70)	17.52	20.00
Public/Social	2	1.7 (1.5-1.9)	18	20.00
Total	4.52	1.37 (1.13-1.61)	55.52	60

At home, child is less severe than most children with SM (average = 1.62)

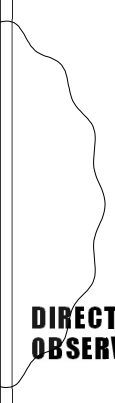
	Child's Score	Average Score For Children with SMQs in Age 12-17 years	Score For Children with SMQ	Score For Children without SMQ
School	1	1.0 (1.0-1.0)	20	20
Home/Family	1.52	1.40 (1.13-1.70)	17.52	20.00
Public/Social	2	1.7 (1.5-1.9)	18	20.00
Total	4.52	1.37 (1.13-1.61)	55.52	60

In public, child is less severe than most children with SM (average = .28)

Total shows the child is less severe than many children with SM

Wiggins, K. Lindsey, Kuffel, Mody, L., Pincus, A., and Bergman, J. (2000). The Development and Psychometric Properties of the Selective Mutism Questionnaire. *Journal of Clinical Child and Adolescent Psychology*, 29, 2, 476-484.

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• Observation and coding occurs:

- Speech in private with parent
- Speech in room with novel adult
- Response to yes/no questions
- Response to forced-choice questions
- Response to open ended questions
- Return to baseline in private with parent?

**DIRECT  
OBSERVATION**

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Speech Frequency (How?)	Communication Partners (Who?)	Setting Variable (Where?)	Intervention Recommended
Limited	Most people	Most environments	Contingency management
Typical	One or limited people	Most environments	Stimulus fading of new people in specific environments
Typical	Most people	One environment	Stimulus fading of environments
Limited	One or limited people	One environment	Stimulus fading of new people into comfortable environment AND stimulus fading of environments
No speech	No people	No environments	Shaping AND Stimulus fading of new people and environments

(Shriver, 2011)

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**LITERATURE/RESEARCH  
ON SELECTIVE MUTISM**



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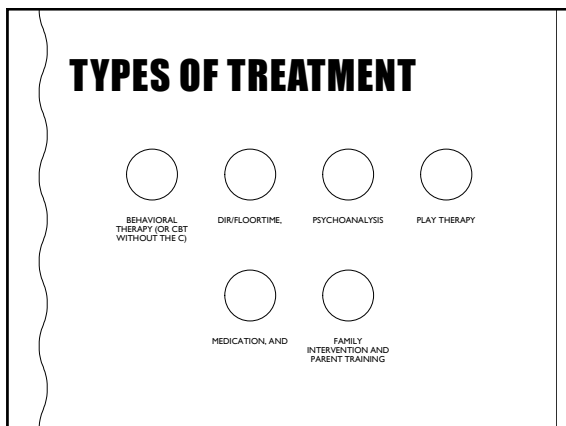
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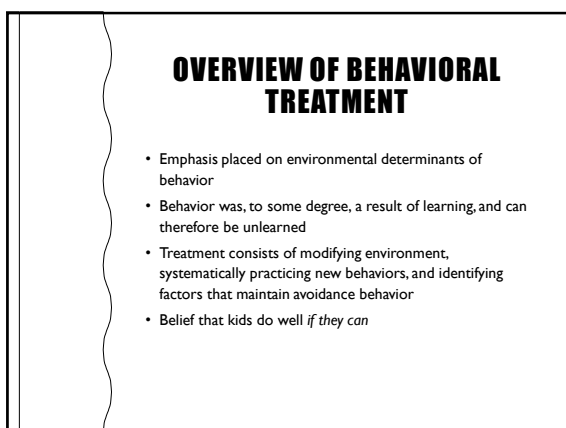
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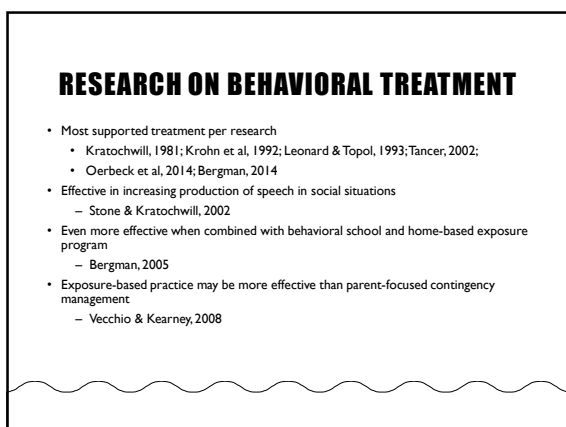
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### RESEARCH ON OTHER INTERVENTIONS

- Psychoanalysis, DIR/Floortime, play therapy
- No real experimental research published; some case studies.
- No evidence of effectiveness for treatment of Selective Mutism

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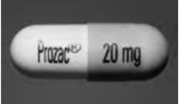
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### MEDICATION AS AN INTERVENTION?

- Addresses biological determinants
- Most common medication utilized and researched for SM is Prozac (Fluoxetine), a Selective Serotonin Reuptake Inhibitor
- NOT effective alone
- Goal is use as water wings
- Goal is usually to have the child take the medication for 9-12 months
- Concerns?



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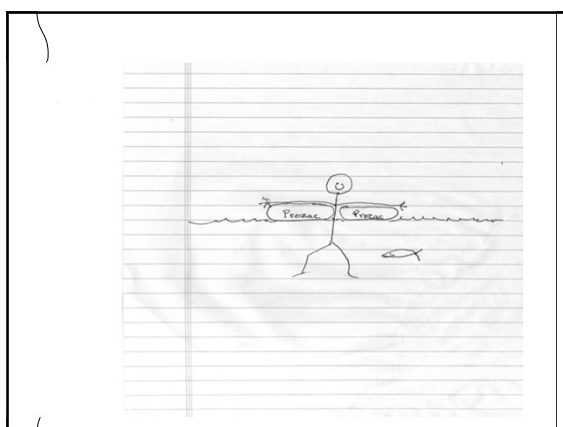
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## MEDICATION

### UNLIKELY TO MEDICATE

- Less severe impairment
- No CBT trial in the past
- Low comorbidities
- Family history not strong
- Meeting CBT benchmarks

### MORE LIKELY TO MEDICATE

- More severe impairment
- Poor prior CBT response
- High comorbidities
- Strong family history
- Not meeting CBT benchmarks

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## RESEARCH ON PSYCHOPHARMACOLOGICAL INTERVENTIONS

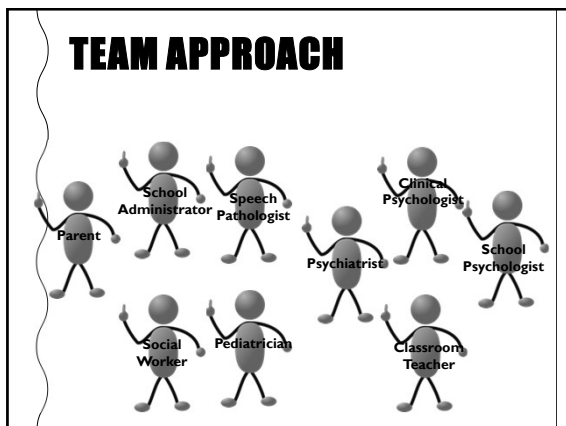
- Overall, research on Prozac suggests it is helpful in reducing anxiety and increasing social interactions. (Carlson, Mitchell, & Segool, 2008)
  - Differences in parent report and teacher/clinician report of child's mutism
- Minimal support for Zoloft (Sertraline) as a beneficial treatment
- Two research studies support other SSRIs as beneficial medications. (Lehman, 2002; Thomsen, Rasmussen, & Anderson, 1999)
- Currently, no medications have achieved FDA approval for the treatment of childhood social phobia or SM.

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## EVIDENCE-BASED INTERVENTION

### BEHAVIORAL TREATMENT

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## PSYCHO-EDUCATION FOR KIDS

- Explain in developmentally appropriate speech
  - Building brave muscles
  - Practicing to get better
  - Starts hard, gets easier
  - How our brains send the “emergency” signal even when it’s not necessary – we can learn to ignore or overpower the signal.
  - Warheads example

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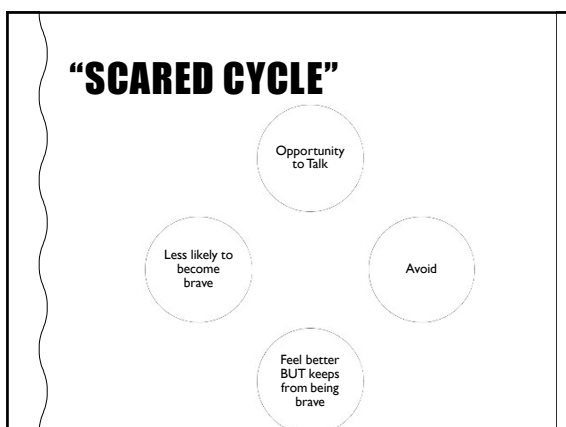
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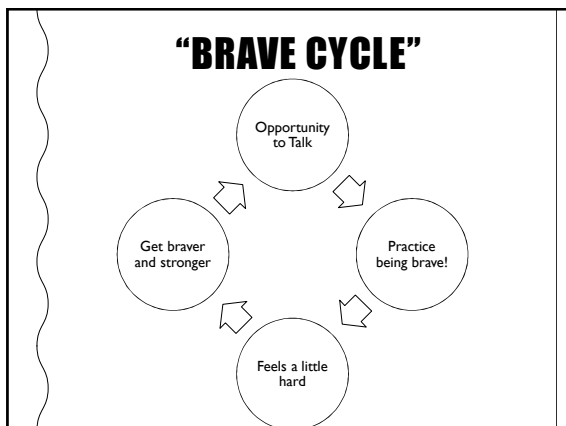
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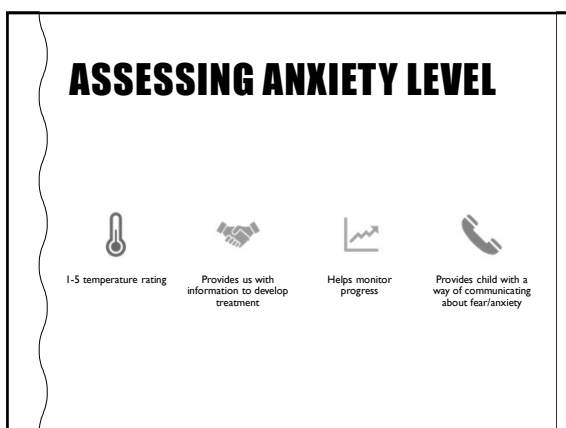
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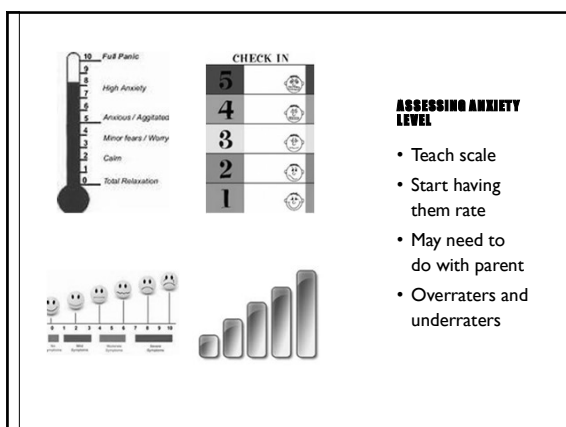
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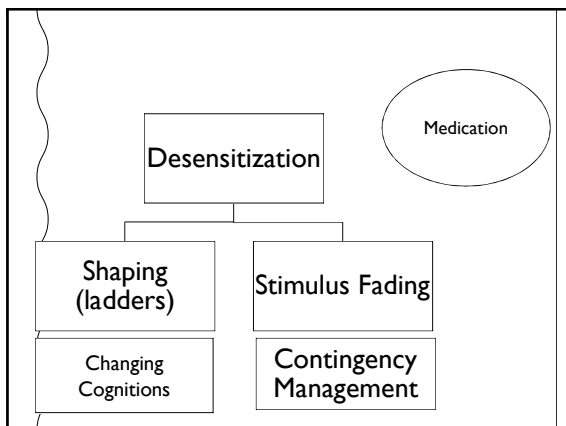
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## WHAT IS DESENSITIZATION?

- Increasing ability to communicate slowly through facing fears at a reasonable pace
- Stops pattern of reinforcement of avoidance
- Allows for slow decrease of anxiety
- Demonstrates successes, which increases motivation
- Practice, practice, practice!

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### Challenge Pathway Planning

Which Challenge Pathway are you ready to conquer?

*Responding to peers at a public playground*

Child is prompted to ask the peer a scripted question  
Example: "Why don't you ask our friend, how old are you?"

Parent continues to prompt the peer to ask questions  
Example: "Can you ask my daughter how old she is?"

Parent prompts the peer to ask the child a forced-choice question  
Example: "My daughter has a favorite slide too, can you ask her if she likes the big or the small slide?"

Parent engages the peer  
Example: "Do you like the big slide or the small slide?"

Adult prompts for speech within context of the peer  
Example: "Do you want to go on the big slide or the small slide?"

Adult speaks to another child (a peer) in order to bring them into the interaction  
Example: "Parent notices a peer playing by the slide and moves with child near the slide."

Adult encourages the child to be comfortable and verbal (with them) at the playground  
Example: "Parent plays with child on the swings and might ask the child how fast they want to swing."

**Which factors might influence progress?**

THE AUDIENCE	THE ENVIRONMENT	THE SPEECH DEMAND
<input type="checkbox"/> This interaction should be private with no other adults present (could make it harder) <input type="checkbox"/> It's best if the peer is a girl	<input type="checkbox"/> We should go to Liberty park because it tends to be quiet <input type="checkbox"/> It's best if it's not too cold when we do the challenge	<input type="checkbox"/> Start with forced-choice questions and then move on to basic questions with one word answers. <input type="checkbox"/> If the situation, that's ok. We can work on volume later.

**Notes:**

- I need to remember that every child progresses at a different pace. She may be able to move through all of these steps in one interaction, or she may be practicing a specific step over a longer period of time. Steps may need to be repeated or reinforced. I won't know until we try!
- If you ask why she doesn't talk or if the parent, I should say "She speaks when she is comfortable, and she is practicing speaking to new friends. Sometimes learning new things takes time!"

Kotrba, A & Saffer, S.

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## GOAL OF TREATMENT

- NOT making anxiety go away!
- Can't talk your amygdala out of a fear – it's not listening! (signals between the cortex and amygdala run mostly one way)
- Our amygdala has to be activated to learn something new – activate it, hang around and nothing terrible happens, amygdala learns.
- Learning to be "comfortable with discomfort!"
- To build distress tolerance (in adults AND the kids!) through facing fears.

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## KEY PLAYERS -

- Desensitization is done by:
  - Psychologist/mental health professional outside school (helping with family training and public practice, consulting with school)
  - Parent
  - Keyworker – school personnel who is primarily in charge of:
    - Desensitizing (exposing)
    - Generalizing to all school environments
    - Communicating with teacher, parent, psychologist



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## CHILD DIRECTED INTERACTION (CDI)

- **PRIDE** skills play (to build rapport)
  - P = labeled praise
  - R = reflection
  - I = imitation
  - D = behavioral description
  - E = excitement/enjoyment
- NO asking questions, giving commands, or teaching!!!

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## VERBAL DIRECTED INTERACTION (VDI)

### DOS

- Labeled praise for talking
- Reflecting verbalizations
- Play-by-play announcer
- Forced choice/open ended questions
- Direct prompts to talk
- Wait 5 seconds

### DON'TS

- Mind reading
- Yes/no questions
- Indirect commands
- Negative talk
- Enabling/rescuing

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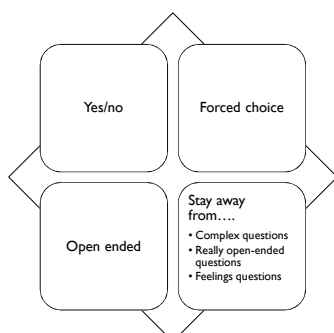
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## TYPES OF QUESTIONS



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## FORCED-CHOICE QUESTIONS

- Forced choice questions increase the likelihood of a verbal response!
  - Practice developing forced-choice questions.
    - What are you going to be for Halloween?
    - Do you want a brownie?
    - Do you have a sister?
    - What is your favorite school subject?
    - Do you remember where we are going on the field trip today?



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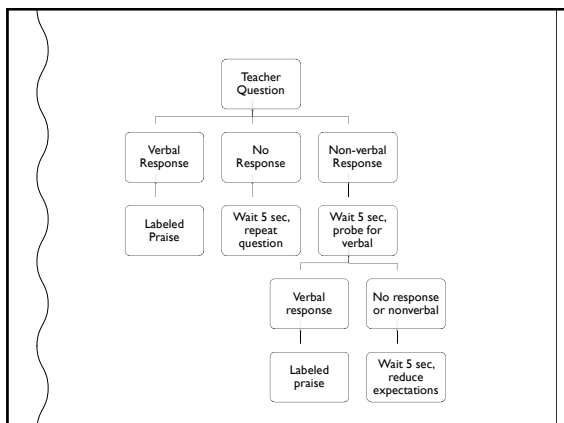
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## STIMULUS FADING

- Gradually increasing the number of different people the child speaks to and settings the child speaks in
  - Start where the child currently speaks
  - Gradually introducing new people into conversations
  - Speaking in new settings with the help of stimulus associated with speaking (e.g., communication ladders with speaking partner or keyworker)
  - [Stimulus fading video](#)

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## GENERALIZING SKILLS

- Pathway Hazards
  - People
  - Environment
  - Speech demands

\*\*Only change one at a time!

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## COMMUNICATION LADDER (SHAPING)

- Shaping
  - Reinforcing successive approximations of verbalizations
  - Initially reinforcing more frequently occurring behaviors (nonverbals, simple sounds, etc.)
  - Gradually reinforcing behaviors that approximate full speech (words, sentences, etc.)

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## COMMUNICATION LADDER

- ☐ Spontaneous Initiating
- ☐ Multiple word, longer utterances
- ☐ Single words
- ☐ Sounds to indicate meanings
- ☐ Voiced sounds
- ☐ Voiceless sounds
- ☐ Blowing air
- ☐ Nonverbal communication
- ☐ Following directions

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## SCAFFOLDING VS. ENABLING/RESCUING

### SCAFFOLDING

- Understanding a child's current ability and asking them to push themselves consistently outside of their comfort zone
- Knowing what is TOO far and assisting them in bridging the gap to still be successful/participate

### RESCUING

- Setting the bar at or below the child's current functioning
- Allowing avoidance to occur or **continue**
- Stepping in before the child has a chance to manage their own anxiety and make an effort

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## EXAMPLES

### SCAFFOLDING

- Answering to a parent 5 feet from counter at the ice cream store, then moving closer the next time to the parent
- Reading to small group with peer and teacher; then fading in more peers
- Systematic plan for show and tell- on video, then in front of small group, then class

### ENABLING

- Child orders to parent, 5 feet from counter; always
- Only reading in small group all year
- Use of iPad for Show and tell all year

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## TRACKING BRAVE PRACTICES

Date:	Location:	Communication Partner:	Content of Speech:	Notes:
10/22	SLP's Office	Speech Pathologist	Named colors in game with one-word responses to forced-choice questions	Quiet but audible speech. Responded well to rewards.
10/25	Hallway	Speech Pathologist	Did Favorite's Game in public location	Notable reduction in volume when others came by
10/31	SLP's Office	Speech Pathologist and Classroom Teacher	Played jenga game with questions while teacher faded in.	No reduction in volume; very brave!! :)

- When to Increase to a harder demand

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## TIPS FOR ENCOURAGING SPEECH

- REMAIN CALM!!!
- Use specific praise
- Judicious use of direct prompts to speak
- Brave talking is target behavior; not correctness
- Always wait 5 seconds for reply – child needs opportunity to respond
- Try to always ask forced-choice instead of yes/no questions (to avoid head-shaking)
- Use situations that are motivationally driven to encourage more speech
- Don't mind read


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## CONTINGENCY MANAGEMENT

- Child avoids talking = reduction of anxiety = negative reinforcement
  - Child is more likely to avoid speaking

GOAL – making nonverbal communication less reinforcing and verbal communication more reinforcing

- No longer accepting nonverbal gestures as a response
- Not answering for the child
- Stop avoiding asking the child questions
- Providing positive reinforcement following verbalizations (e.g., praise, stickers, points, toys)



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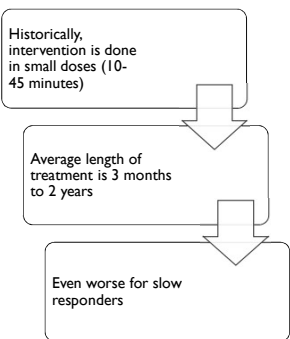
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## BENEFITS OF INTENSIVE INTERVENTION?



Historically, intervention is done in small doses (10-45 minutes)

Average length of treatment is 3 months to 2 years

Even worse for slow responders

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## INTENSIVE TREATMENT

- Perhaps intensive doses are better
  - Pros: Less warm-up time, likely quicker outcomes, avoiding negative outcomes of continuing behavior, return to appropriate developmental tasks, greater access to treatment, cost effectiveness
  - Cons: cost up front, not covered by insurance, exhausting, interrupts daily activities

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## INNOVATIVE INTERVENTIONS CONT...

In school intensives

In clinic intensives

In camp intensives (group treatment)



**CONFIDENT KIDS CAMP**

[www.confidentkidscamp.com](http://www.confidentkidscamp.com)  
July 27-31, 2020

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## DOS AND DON'TS OF INTERVENTION

**DO....**

- Work with school to create intervention plan
- Advocate for child
- Be creative with rewards, practices, goals, etc.
- Use stimulus associated **with** speech (you!) to elicit speech in school
- Identify avoidance and work toward *approach or scaffolding*

**DON'T....**

- Allow avoidance to continue unchecked
- Rescue
- Plateau
- Forget about both responding AND initiating
- Say "don't worry – no one will hear you!"
- Quit! ☺

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## COMMUNITY

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## CREATING A GAME PLAN

- Determine appropriate community practices: Child's anxiety level should always be the guide
- Fit practices into ordinary outings
- Use motivationally-driven situations whenever possible
- Preparing your child
  - Discuss why you're practicing
  - Quantifying anxiety (e.g., 1-5 scale, red/yellow/green light)
  - Consider environmental variables (e.g., time of day)
  - Discuss motivational factors
  - Rehearse several times
- Preparing the community person
  - Simple explanation of the purpose
  - Prompt the person with what you'd like to say (script it exactly!)
  - Don't be afraid to correct!



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## TRACKING COMMUNITY BRAVE PRACTICES

Date:	Location:	Communication Partner:	Content of Speech:	Notes:
10/22	Red Robin	Server	Responded drink and food choices in one word answers ("Cheeseburger")	Loud environment; speech was audible
10/25	Target	3 Employees	Mom said "Where can we find," and Lauren gave name of items	Speech became louder with each practice
10/31	Local	Neighbors	Said "Trick or Treat" with siblings at several homes	Visibly less anxious after each practice

- When to Increase to a harder demand

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## EXAMPLES OF SCAFFOLDING V. RESCUING IN COMMUNITY

### SCAFFOLDING

- Community person can't hear child, parent/employee asks child to speak up, the child speaks louder and parent amplifies speech
- Child says he isn't able to do the practice, parents help child find a Plan B that is somewhat easier
- Child nonverbally indicates ice cream choice, parents script a question for the employee to ask

### RESCUING

- Community person can't hear child so the parent takes over and answers all additional questions
- Child tells parents he isn't able to practice, parents allow child to avoid that practice
- Child nonverbally indicates ice cream choice and gets ice cream

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## DEALING WITH WELL-INTENTIONED (BUT UNHELPFUL) COMMUNITY PERSONS

- Community persons often make well-meaning mistakes:
  - Looking to the adult to speak for the child
  - Allow nonverbals
  - Encouraging nonverbals ("You can point to your choice")
  - Asking you what the child said
- Tips:
  - Prepare the person in advance (if possible)
  - Look at the child
  - Politely give them a script of what to say
  - Remember, you won't likely see this person again so if its uncomfortable, its okay



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## FAMILY MEMBERS

- Education
- Practice Partners
- Additional advocates in community settings



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## EXTRACURRICULAR ACTIVITIES

- Consider sharing some information
  - Quick facts regarding SM and ways to engage a child with SM
- Arrive early
- Playdates with teammates
- Visit the location periodically



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## PLAYDATES

- Select a peer
- Prep the parents and the peer
- Set goal with your child (maybe!)
- Start in your home (keeping environment stable
  - stimulus associated with speech)
- Structure of playdate
  - Activities that elicit speech
  - Have child talk to you in front of peer
  - Be playful and fun
  - Consistency of practice
  - How to fade out



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## ONLINE INTERVENTION FOR SM

IF YOU NEED HELP, THRIVING MINDS CAN PROVIDE INTERVENTION OR CONSULTATION!

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## STIMULUS FADING ONLINE

- Parent and child play a game with computer/phone/ipad nearby
- New person signs on and busies themselves in background
- New person moves closer to screen but ignores
- New person begins to comment on the activity, then reflects what child is saying
- New person relays questions through parent and then reflects
- New person asks FC questions directly of the child
- Parent begins to disengage
- Parent leaves the room or goes as far away as possible

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Phone call practices

Phone call bingo

Make a poll and call people to ask favorites questions. Share results on social media!

Read aloud

Call restaurants to order or see if they are open

Play a game online with someone

Send videos back and forth with teacher

**IDEAS FOR EXPOSURES DURING SOCIAL DISTANCING**

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**GAMES TO PLAY ONLINE**

Guess who

Headbanz

Hangman

3 clues (to guess an item)

Would you rather game

Tell me what to draw

I spy

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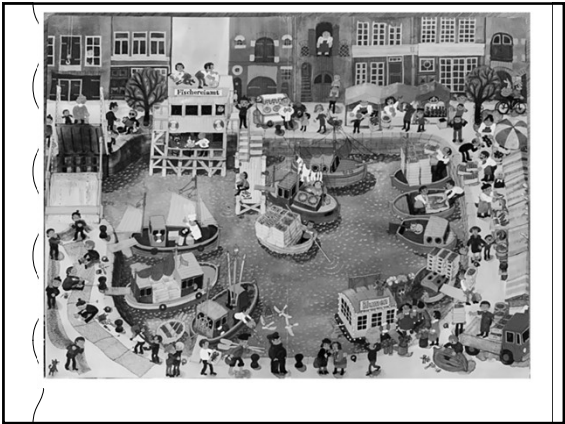
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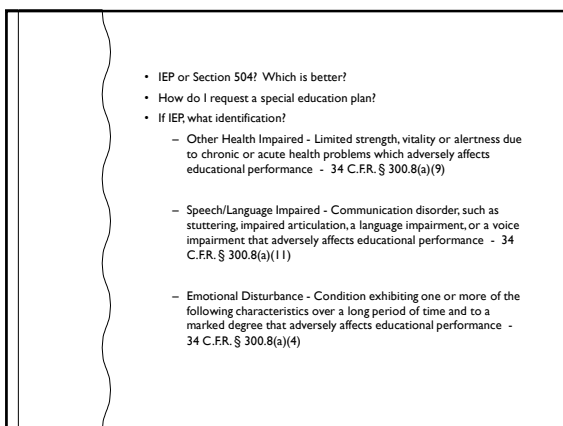
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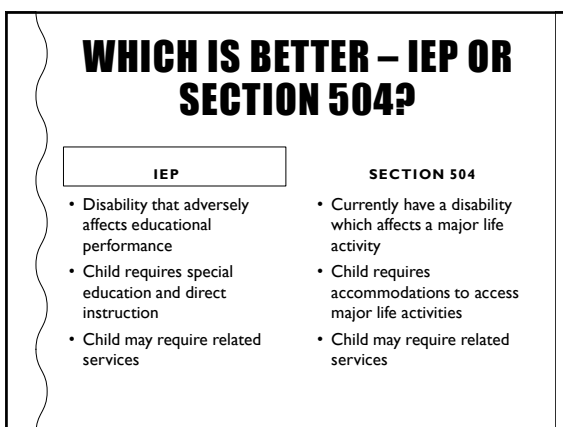
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**SPECIFIC SCHOOL INTERVENTIONS  
AND ACCOMMODATIONS**

- Desensitization in school with keyworker
  - 5-10 minutes of practice daily
  - As structured as possible
  - Consider fading with teacher and PW
  - Team meetings and communication
- Participating (at least) nonverbally
- Chores and responsibilities
- Extracurriculars
- Seating arrangement/small group activities
- Conversational partners/conversational visits
- Allow for early arrival (warm-up time)

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**SPECIFIC SCHOOL INTERVENTIONS,  
CONT...**

- Nonverbal evaluation methods
  - Audio or videotaping
  - Written testing
  - Parent report
- Provide practice experience in advance
- Transition plan for the next year begins in April
- Teacher and peer selection for class
- Do school visits/teacher visit during summer
- Scheduled times/bathroom buddy for bathroom breaks

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**FACTORS TO  
CONSIDER IN  
CREATING THE  
RIGHT  
ENVIRONMENT  
FOR SM KIDS**

- Familiarity of audience (but beware "contamination"!)
- Gender
- Size of audience
- Location (private vs. public)
- Expectation of response (open ended vs. yes/no vs. forced choice)
- Eye-contact
- Language purpose – tested or graded?

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## GENERAL TREATMENT BENCHMARKS

- By a few sessions, child should not look angry or frightened to start sessions
- By a few sessions, progress should be obvious – even if slow but steady
- By 2-3 sessions, children are usually talking to me in the room alone
- By 4-6 sessions, children are usually talking to me with parents/siblings in room



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By 6-8 in-school weeks, most are talking to an adult without parent present in room

By 8-12 in-school weeks, most are talking to multiples of teachers or peers, even if in contrived situations

By 12 weeks the child should seem confident that gains are being made

## GENERAL TREATMENT BENCHMARKS

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## TREATMENT REVIEW

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### IMPORTANCE OF EARLY INTERVENTION

- Minimizes negative impact on the child
- Prevents situation from becoming worse
- Prevents mutism from becoming engrained
- Prevents repeated ineffective attempts to elicit speech
- Minimizes emotional and physical strain caused to parents and teachers

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### AVAILABLE BOOKS ON SM

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### QUESTIONS?

Thriving Minds –  
[www.thrivingmindsbehavioralhealth.com](http://www.thrivingmindsbehavioralhealth.com)  
 (734) 433-5100  
[akotrba@thrivingminds.info](mailto:akotrba@thrivingminds.info)

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