UNLOCKING THE MYSTERY OF SELECTIVE MUTISM

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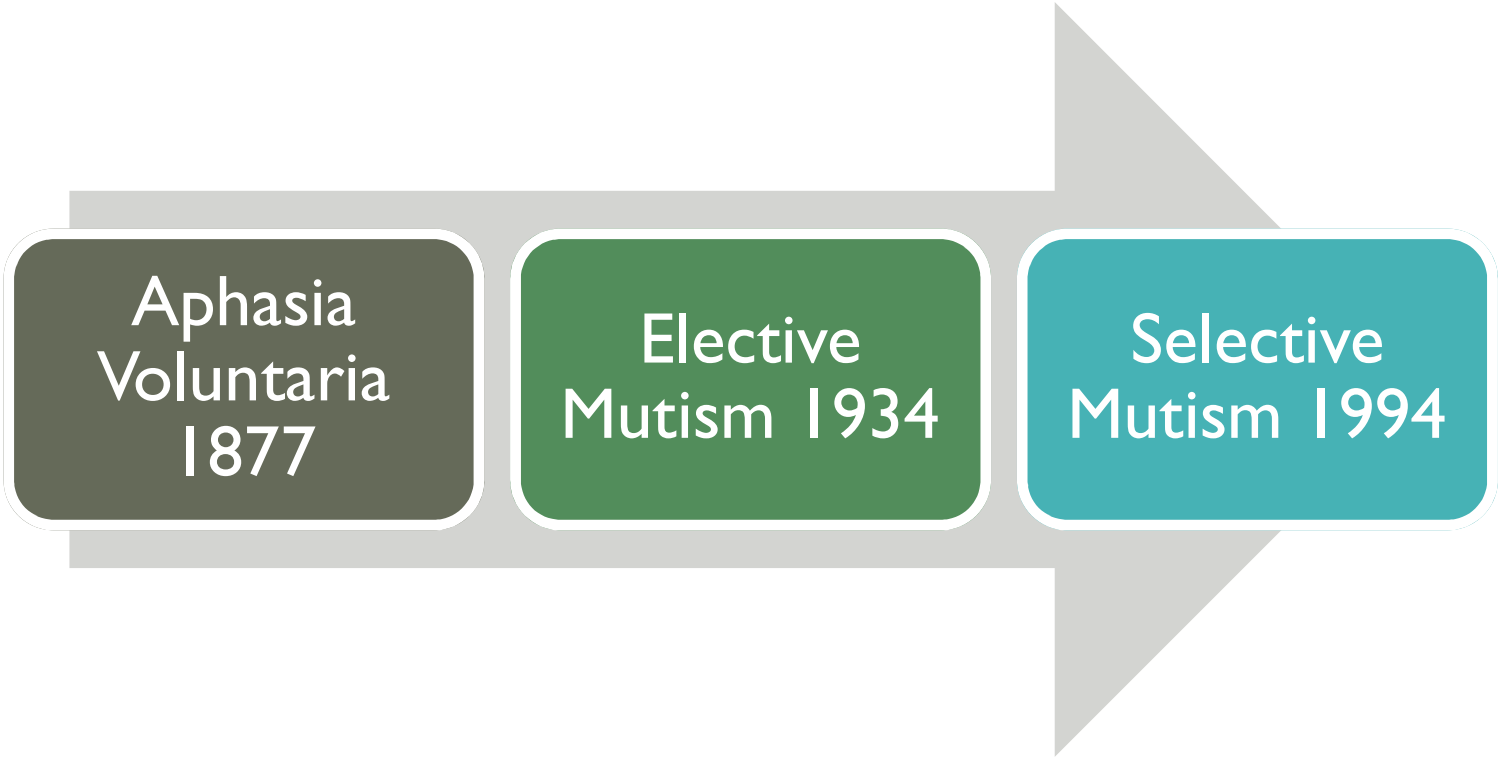
INTRODUCTIONS!

- Introduction
  - Books
  - Schedule for today, what we hope to accomplish
  - Selective Mutism Association – www.selectivemutism.org
  - Dr. Aimee Kotrba's monthly newsletter – sign up at www.thrivingmindsbehavioralhealth.com
- Involvement of audience, how to ask questions, making this interactive

INTRODUCTION TO SELECTIVE MUTISM

HISTORY OF SELECTIVE MUTISM



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

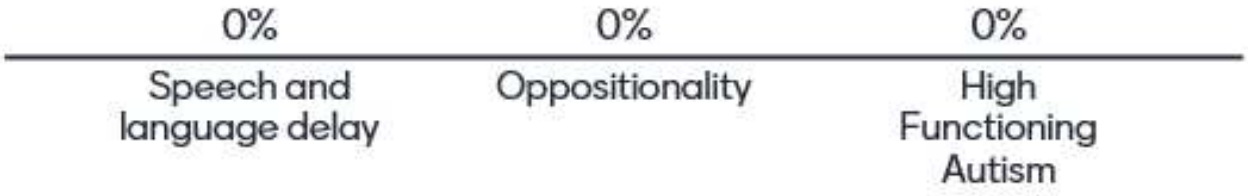
COMMON TRAITS

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

Go to **www.menti.com** and use the code **49 90 85**

Most common misdiagnosis of SM?

Mentimeter



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SHYNESS VS. SELECTIVE MUTISM

SHYNESS

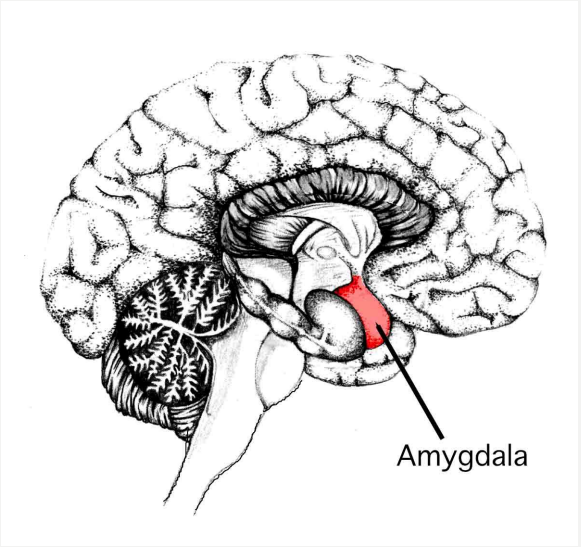
- Slow warm up period
- Can often respond with a nod or small smile
- Same demeanor everywhere – quiet and reserved

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

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



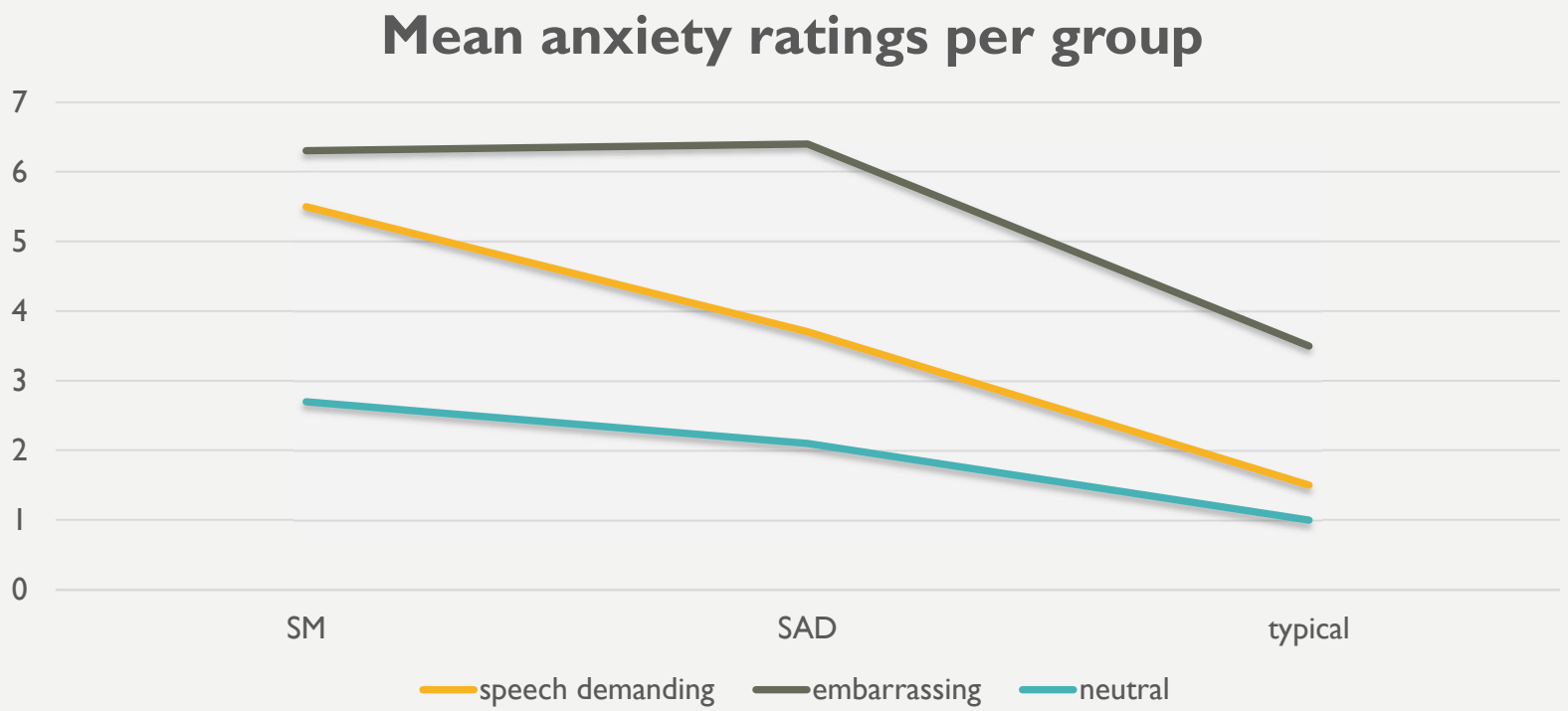
PHYSIOLOGICAL CHARACTERISTICS

- 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.

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

SM VS SOCIAL ANXIETY



Schwenck, C., Gensthaler, A., & Vogel, F. (2019)

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)

COEXISTING PROBLEMS CONT.

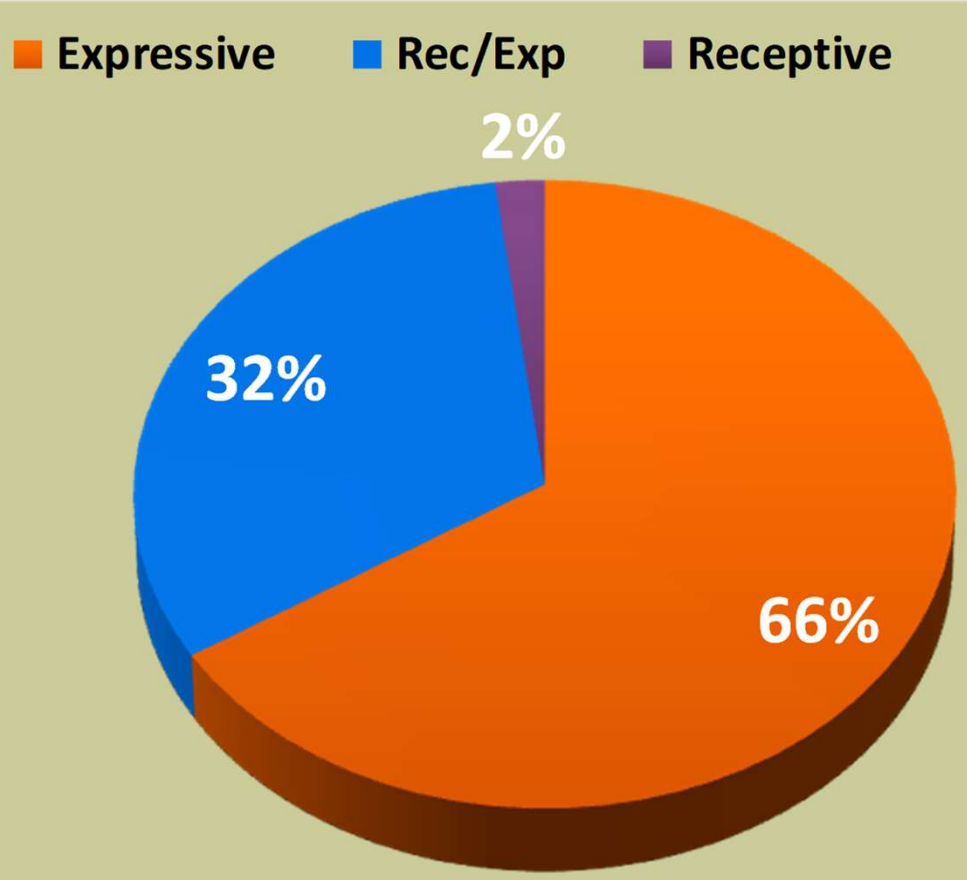
Language Based Learning Disorder or communication deficits

- 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

59.6% (87 OF 146) CHILDREN PRESENTED WITH LANGUAGE DEFICITS



Difficulties noted:

1. Conveying information using decontextualized language;
2. Using compound & complex sentence structures;
3. Using sufficient words per sentence;
4. Retelling a story;
5. Making up a story about a picture;
6. Using imagination to convey thoughts

Klein and Armstrong, 2014

Anxious

Anxious-Oppositional

Anxious-Communication Delayed

TYPES OF SELECTIVE MUTISM

PARENTING FACTORS

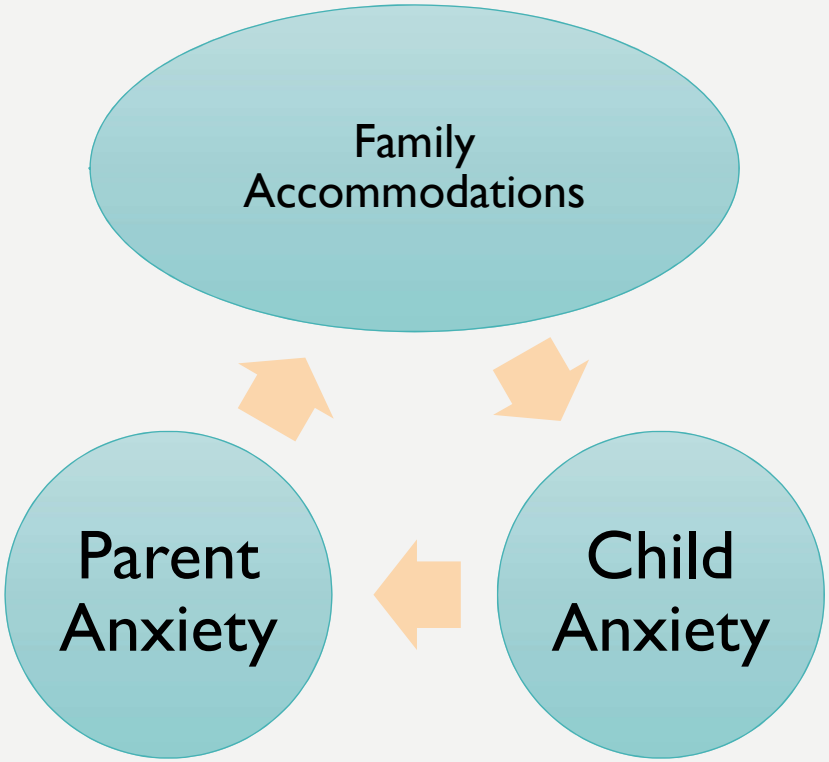
Preventive Factors

- 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

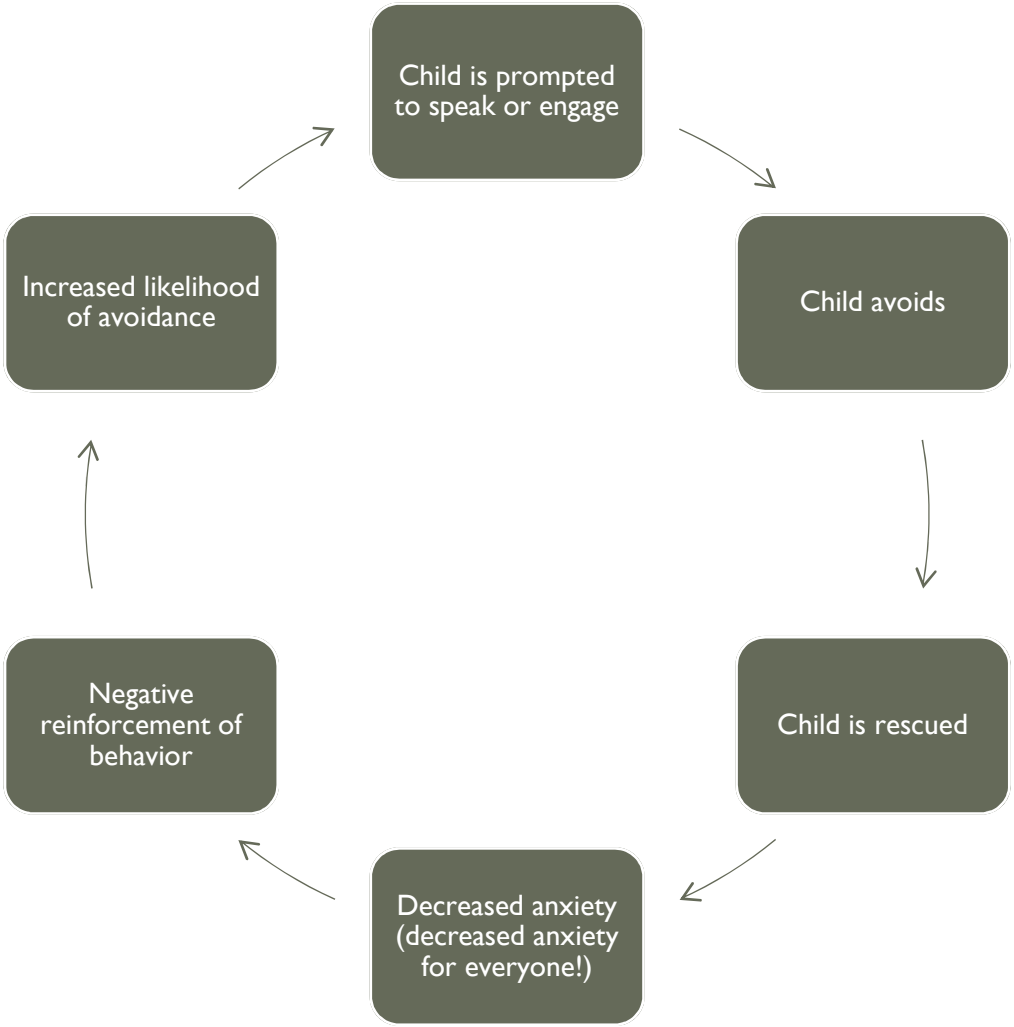
FAMILY RESCUING/ACCOMMODATING



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

CONCEPTUALIZING SELECTIVE MUTISM



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

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?


I want to talk but I just don't know how to say it.
I can't talk to that person!
If I talk I might say the wrong thing.
If I talk everyone will look at me!
It's too hard!

SCHOOL IMPLICATIONS

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

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

EVALUATION OF SELECTIVE MUTISM

DIAGNOSTIC INTERVIEW

Modes of Communication	Family	Child
• Who • What • Where • How • Speech issues?	• Genetic history • Home life description • Recent stressors	• Behavioral characteristics • Medical history • Repetitive or restricted interests, obsessive thoughts, etc.

EVALUATIVE TOOLS

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

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

Name of Child:_____ Completed by:_____ Date:_____

Selective Mutism Questionnaire* (SMQ)
(to be filled out by parents)

Please consider your child's behavior and activities of the past month and rate how frequently each statement is true for your child.

AT SCHOOL

	3 Always	2 Often	1 Seldom	0 Never
1. When appropriate, my child talks to most peers at school.				X
2. When appropriate, my child talks to selected peers (his/her friends) at school.				X
3. When called on by his or her teacher, my child answers.				X
4. When appropriate, my child asks his or her teacher questions.				X
5. When appropriate, my child speaks to most teachers or staff at school.				X
6. When appropriate, my child speaks in groups or in front of the class.				X
How much does not talking interfere with school for your child? (please circle)	Not at all	Slightly	Moderately	Extremely

0+0+0+0+0+0=0 /6=School=**0**

WITH FAMILY

	Always	Often	Seldom	Never
7. While at home, my child speaks comfortably with the other family members who live there.	X			
8. When appropriate, my child talks to family members while in unfamiliar places.		X		
9. When appropriate, my child talks to family members that don't live with him/her (e.g. grandparent, cousin).		X		
10. When appropriate, my child talks on the phone to his/her parents and siblings.	X			
11. When appropriate, my child speaks with family friends.		X		
12. My child speaks to at least one babysitter.		X		
How much does not talking interfere with family Relationships? (please circle)	Not at all	Slightly	Moderately	Extremely

3+2+2+3+2+2= 14/6= Family=**2.33**

IN SOCIAL SITUATIONS (OUTSIDE OF SCHOOL)

	Always	Often	Seldom	Never
13. When appropriate, my child speaks with other children who s/he doesn't know.				X
14. When appropriate, my child speaks with family friends who s/he doesn't know.			X	
15. When appropriate, my child speaks with his or her doctor and/or dentist.		X		
16. When appropriate, my child speaks to store clerks and/or waiters.				X
17. When appropriate, my child talks when in clubs, teams or organized activities outside of school.				X
How much does not talking interfere in social situations for your child? (please circle)	Not at all	Slightly	Moderately	Extremely

0+1+2+0+0=3/ 5= Other=**.6**

Total 0+14+3=**17**

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 spanning three domains: at school, with family, and in social situations. Parents rate the frequency of each item using a 4-point scale (3=always, 2=often, 1=seldom, 0=never for speaking situations).

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

	Child's Score	Average Scores For Children with SM who are Age 3 – 5 years	Scores for Children with SM	Scores for Children without SM
School	0	.33 (-.11 - .77)	.30	2.65
Home/Family	2.33	1.62 (.99 – 2.25)	1.70	2.90
Public/Social	.6	.28 (-.12 - .68)	.34	2.50
Total	17	13.18 (7.14 – 19.22)	12.99	46

	Child's Score	Average Scores For Children with SM who are Age 6 - 8 years	Scores for Children with SM	Scores for Children without SM
School		.54 (0 – 1.08)	.30	2.65
Home/Family		1.52 (.90 – 2.14)	1.70	2.90
Public/Social		.40 (-.07 - .87)	.34	2.50
Total		14.37 (6.93 – 21.81)	12.99	46

	Child's Score	Average Scores For Children with SM who are Age 9 - 11 years	Scores for Children with SM	Scores for Children without SM
School		.62 (.06 – 1.18)	.30	2.65
Home/Family		1.58 (.85 – 2.31)	1.70	2.90
Public/Social		.53 (-.03 – 1.09)	.34	2.50
Total		15.73 (7.9 – 23.56)	12.99	46

Bergman, R. Lindsey, Keller, Melody L., Piacentini, John and Bergman, Andrea J. (2008) *The Development and Psychometric Properties of the Selective Mutism Questionnaire*. Journal of Clinical Child and Adolescent Psychology, 37: 2, 456-464.

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

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

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

DIRECT OBSERVATION

- 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?

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)

LITERATURE/RESEARCH ON SELECTIVE MUTISM

TYPES OF TREATMENT

BEHAVIORAL THERAPY (OR CBT WITHOUT THE C)

DIR/FLOORTIME,

PSYCHOANALYSIS

PLAY THERAPY

MEDICATION, AND

FAMILY INTERVENTION AND PARENT TRAINING

OVERVIEW OF BEHAVIORAL TREATMENT

- Emphasis placed on environmental determinants of behavior
- Behavior was, to some degree, a result of learning, and can therefore be unlearned
- Treatment consists of modifying environment, systematically practicing new behaviors, and identifying factors that maintain avoidance behavior
- Belief that kids do well *if they can*

RESEARCH ON BEHAVIORAL TREATMENT

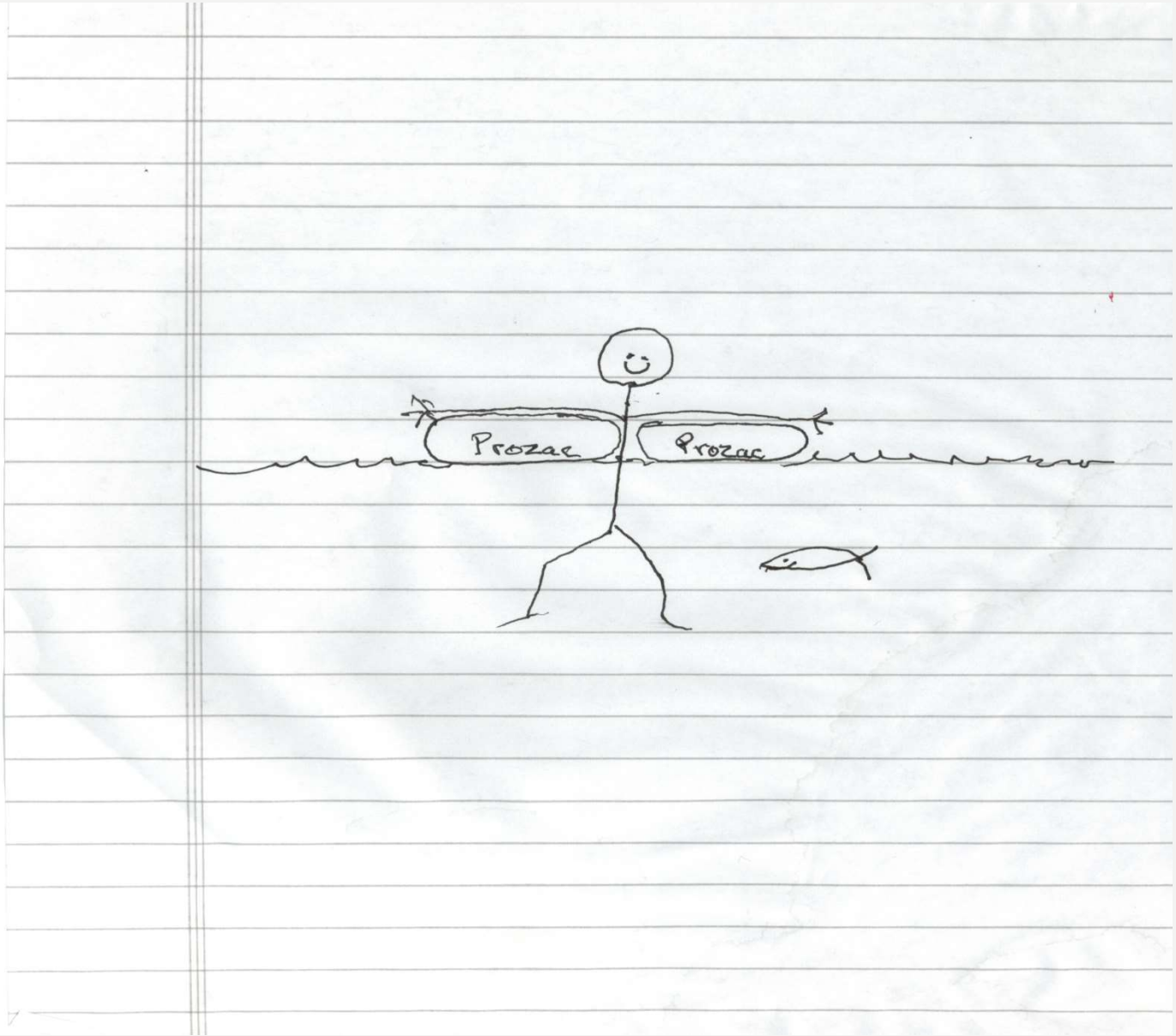
- Most supported treatment per research
  - Kratochwill, 1981; Krohn et al, 1992; Leonard & Topol, 1993; Tancer, 2002;
  - Oerbeck et al, 2014; Bergman, 2014
- Effective in increasing production of speech in social situations
  - Stone & Kratochwill, 2002
- Even more effective when combined with behavioral school and home-based exposure program
  - Bergman, 2005
- Exposure-based practice may be more effective than parent-focused contingency management
  - Vecchio & Kearney, 2008

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

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?


Prozac
Prozac

MEDICATION

UNLIKELY TO MEDICATE

- Less severe impairment
- No CBT trial in the past
- Low comorbities
- 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

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.

EVIDENCE-BASED INTERVENTION

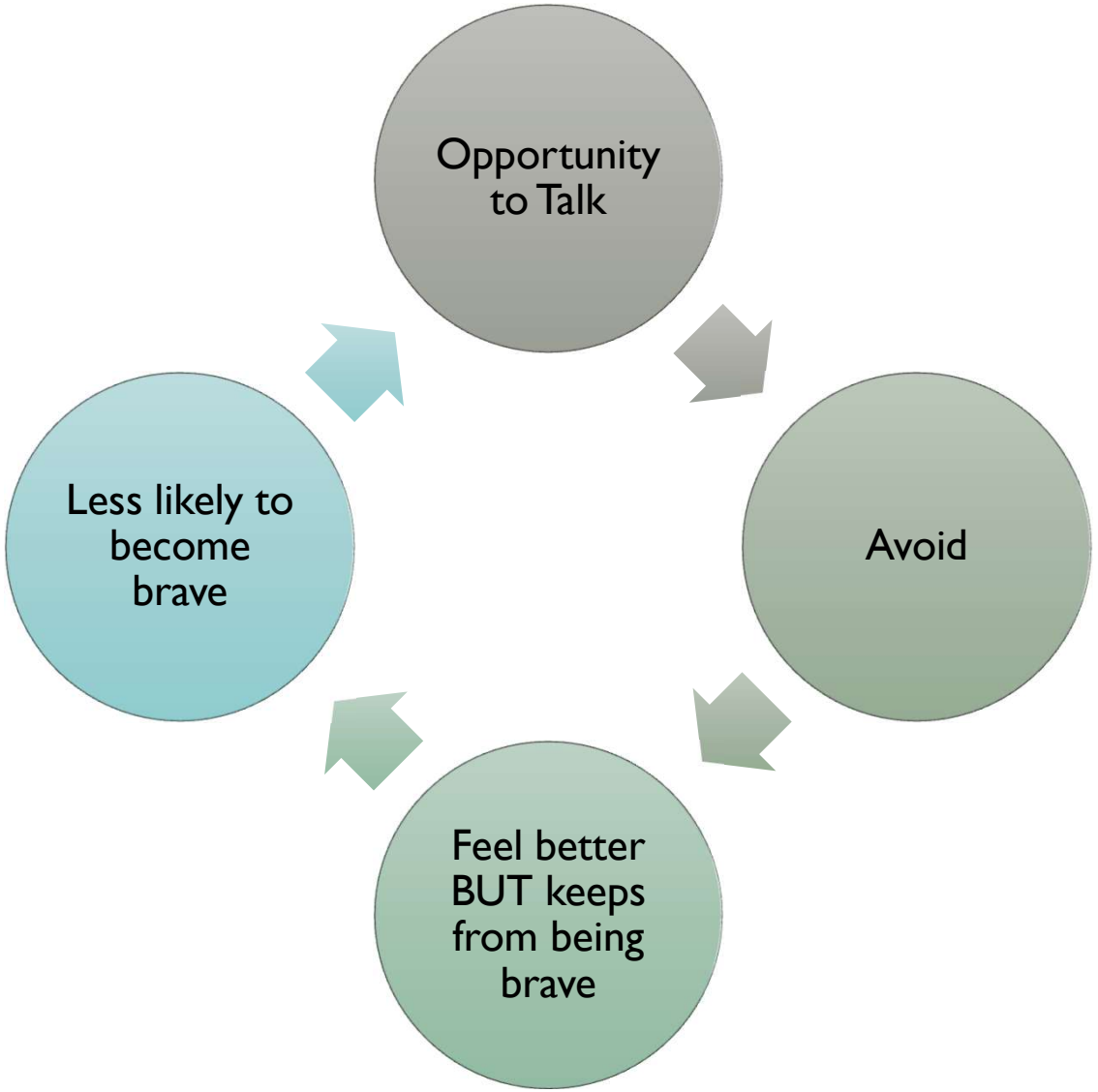
BEHAVIORAL TREATMENT

TEAM APPROACH

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

"SCARED CYCLE"



"BRAVE CYCLE"


Opportunity to Talk
Practice being brave!
Feels a little hard
Get braver and stronger

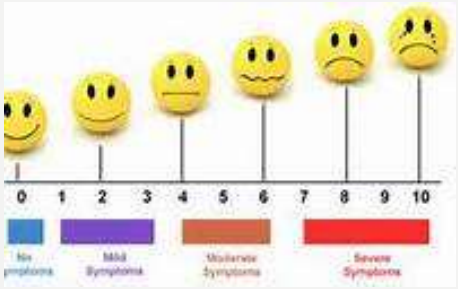
ASSESSING ANXIETY LEVEL

1-5 temperature rating

Provides us with information to develop treatment

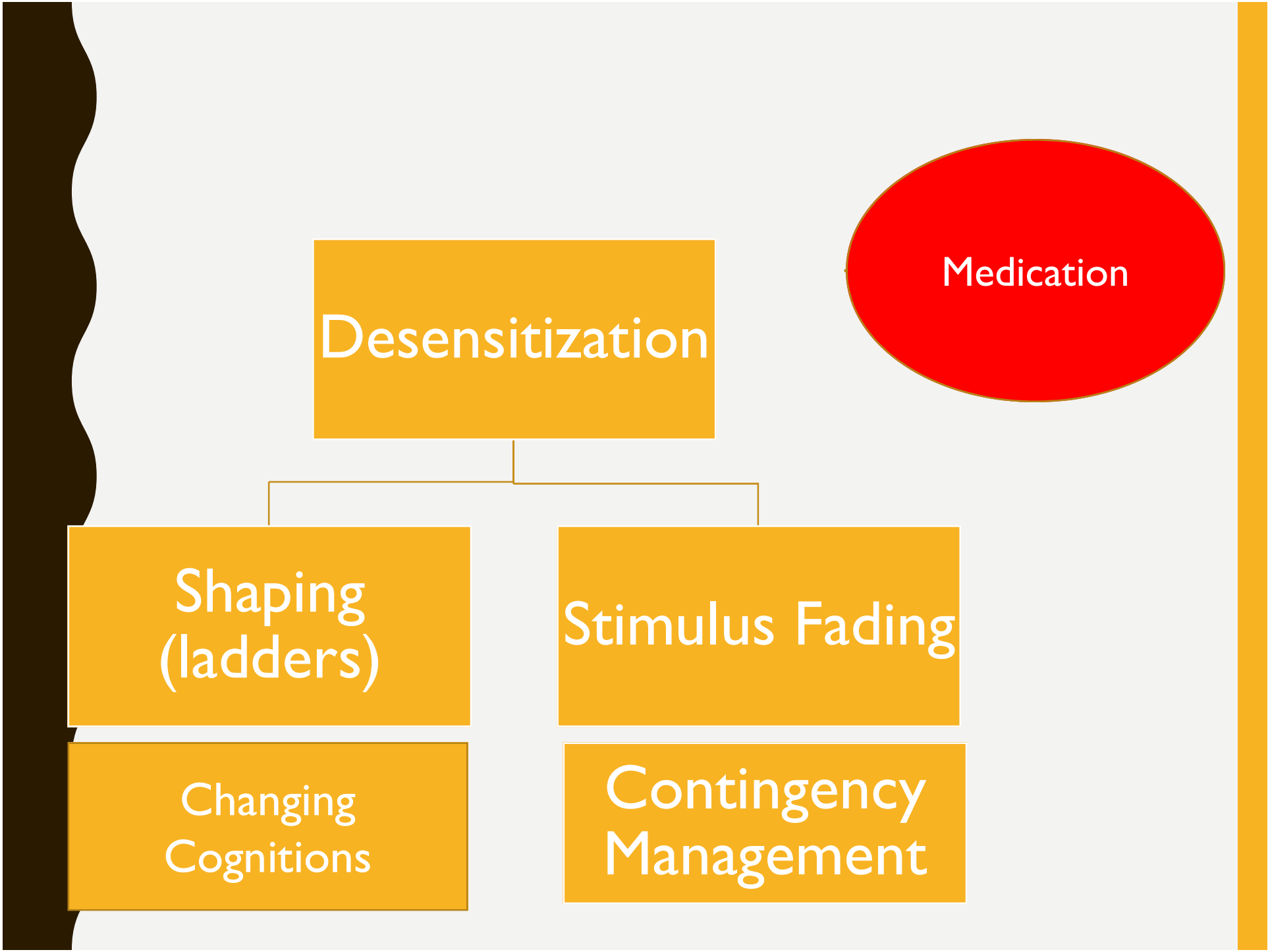
Helps monitor progress

Provides child with a way of communicating about fear/anxiety



ASSESSING ANXIETY LEVEL

- Teach scale
- Start having them rate
- May need to do with parent
- Overraters and underraters


Desensitization
Medication
Shaping (ladders)
Stimulus Fading
Changing Cognitions
Contingency Management

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!

Challenge Pathway Planning

Which Challenge Pathway are you ready to conquer?

Responding to peers at a public playground

8

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

7

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

6

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?"*

5

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

4

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

3

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*

2

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*

1

Which factors might influence progress?

THE AUDIENCE

- *This interaction should be private with no other adults present (could make it harder)*
- *It's best if the peer is a girl*

THE ENVIRONMENT

- *We should go to Liberty park because it tends to be quiet*
- *It's best if it's not too cold when we do the challenge*

THE SPEECH DEMAND

- *Start with forced-choice questions and then move on to basic questions with one word answers.*
- *If she whispers, 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 adjusted or re-ordered. I won't know until we try!*
- *If peers ask why she doesn't talk, or if she freezes, 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.

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.

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

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!!!

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

TYPES OF QUESTIONS

Yes/no

Forced choice

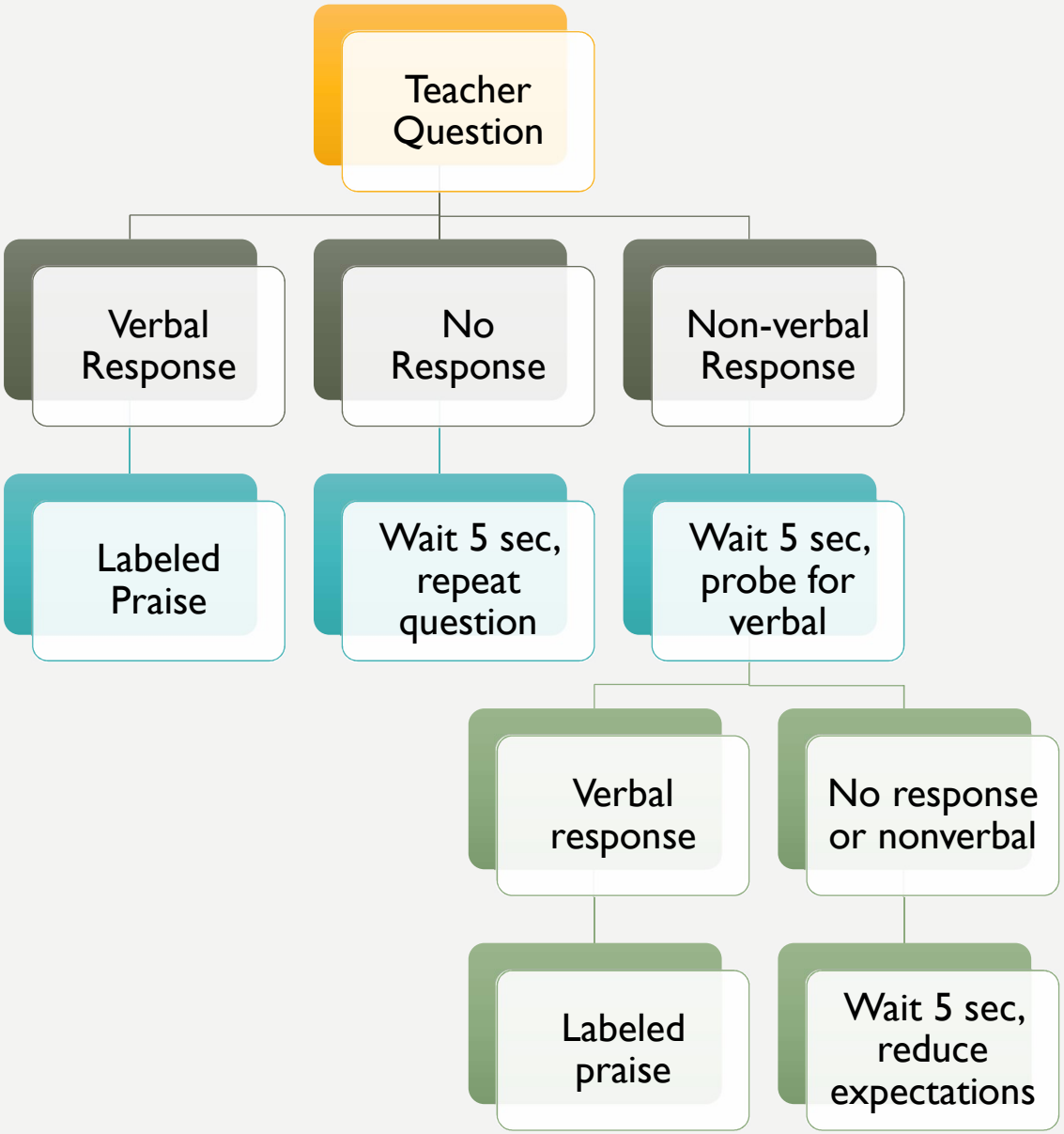
Open ended

Stay away from….

- Complex questions
- Really open-ended questions
- Feelings questions

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?


Teacher Question
Verbal Response
No Response
Non-verbal Response
Labeled Praise
Wait 5 sec, repeat question
Wait 5 sec, probe for verbal
Verbal response
No response or nonverbal
Labeled praise
Wait 5 sec, reduce expectations

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

GENERALIZING SKILLS

- Pathway Hazards
  - –People
  - –Environment
  - –Speech demands

  **Only change one at a time!

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.)

COMMUNICATION LADDER

INDEPENDENT SUCCESS

HIGH SUPPORT

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

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

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

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

TIPS FOR ENCOURAGING SPEECH

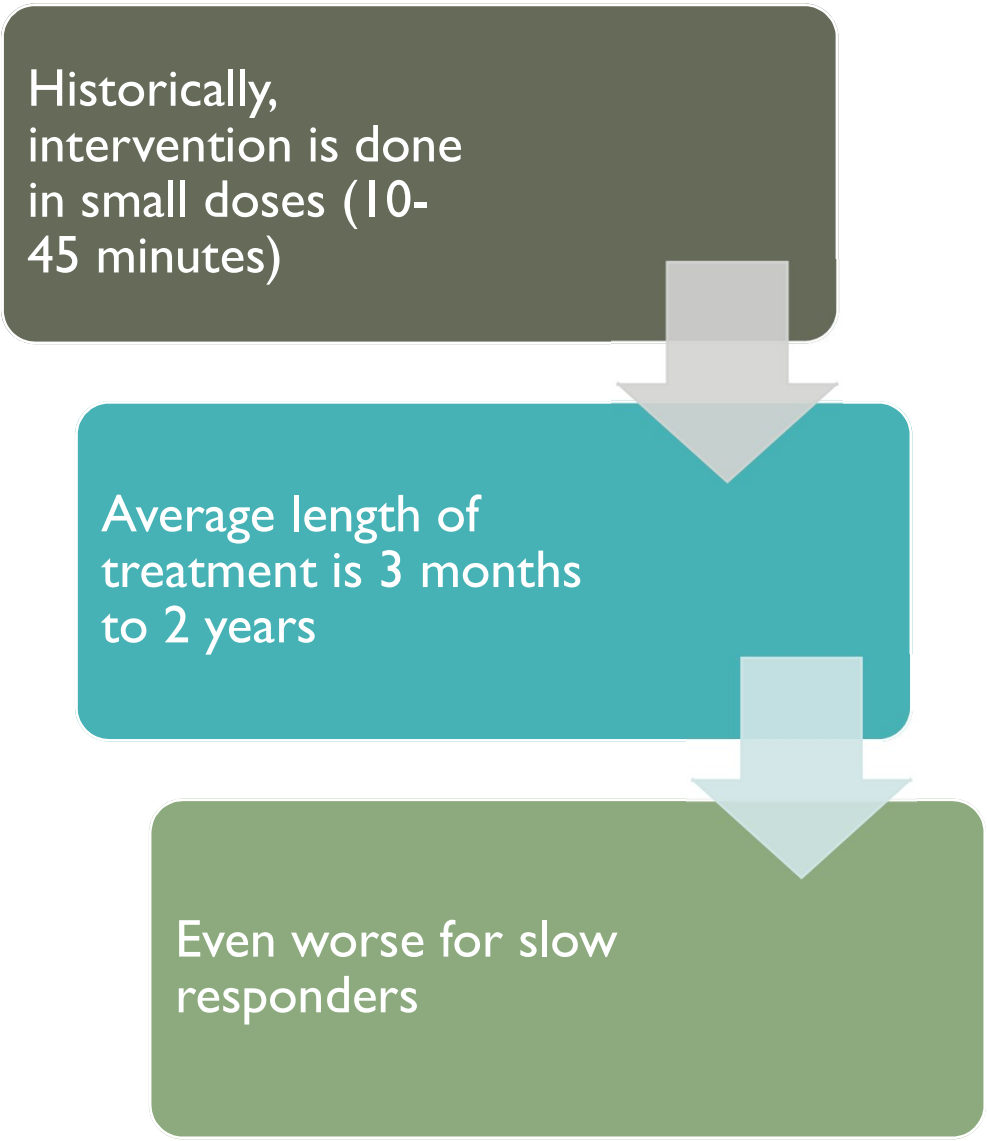
- REMAIN CALM!!!
- Use specific praise
- Judicious use of direct prompts to speak
- Brave talking is target behavior, not correctness
- Always wait 5 seconds for reply – child needs opportunity to respond
- Try to always ask forced-choice instead of yes/no questions (to avoid head-shaking)
- Use situations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

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)

BENEFITS OF INTENSIVE INTERVENTION?



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

INNOVATIVE INTERVENTIONS CONT…

- In school intensives
- In clinic intensives
- In camp intensives (group treatment)

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July 27-31, 2020

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! ☺

COMMUNITY

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!

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

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

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

FAMILY MEMBERS

- Education
- Practice Partners
- Additional advocates in community settings

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

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

ONLINE INTERVENTION FOR SM

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

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

IDEAS FOR EXPOSURES DURING SOCIAL DISTANCING

- 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

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


Fischereiamt
Blumen

SCHOOL ACCOMMODATIONS FOR SELECTIVE MUTISM

- IEP or Section 504? Which is better?
- How do I request a special education plan?
- If IEP, what identification?
  - Other Health Impaired - Limited strength, vitality or alertness due to chronic or acute health problems which adversely affects educational performance - 34 C.F.R. § 300.8(a)(9)
  - Speech/Language Impaired - Communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment that adversely affects educational performance - 34 C.F.R. § 300.8(a)(11)
  - Emotional Disturbance - Condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance - 34 C.F.R. § 300.8(a)(4)

WHICH IS BETTER – IEP OR SECTION 504?

IEP

- Disability that adversely affects educational performance
- Child requires special education and direct instruction
- Child may require related services

SECTION 504

- Currently have a disability which affects a major life activity
- Child requires accommodations to access major life activities
- Child may require related services

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)

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

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?

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

GENERAL TREATMENT BENCHMARKS

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

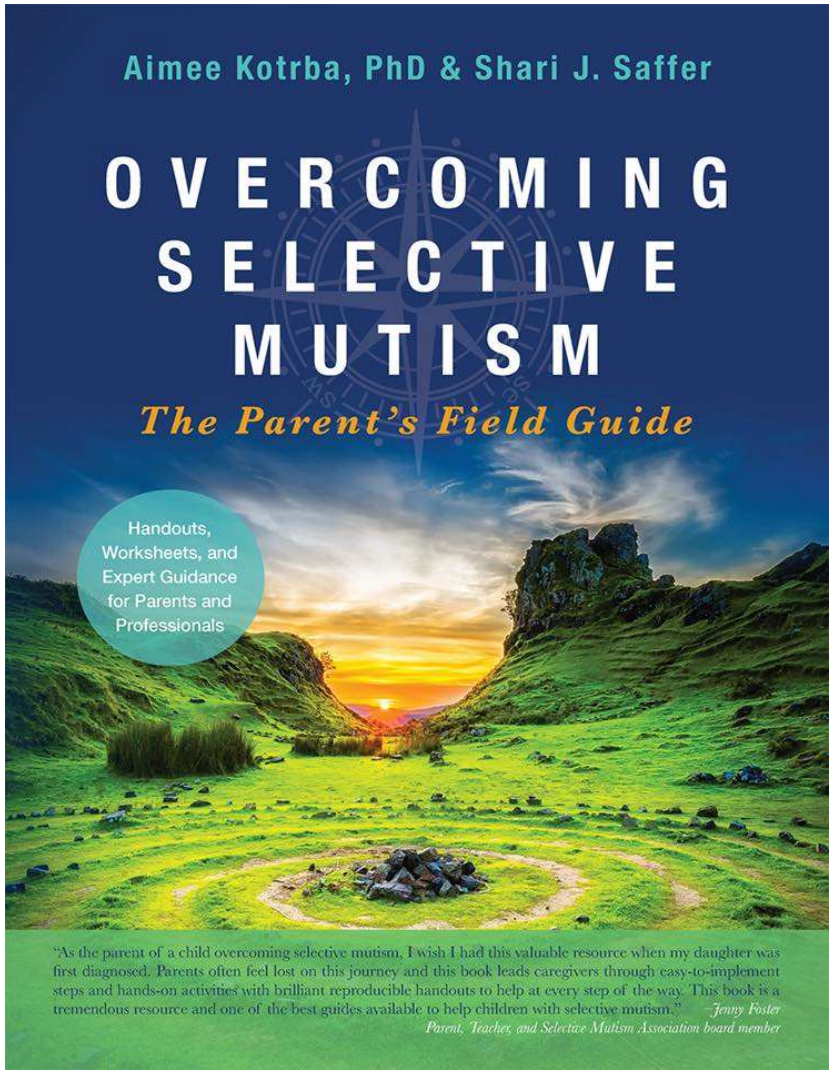
By 12 weeks the child should seem confident that gains are being made

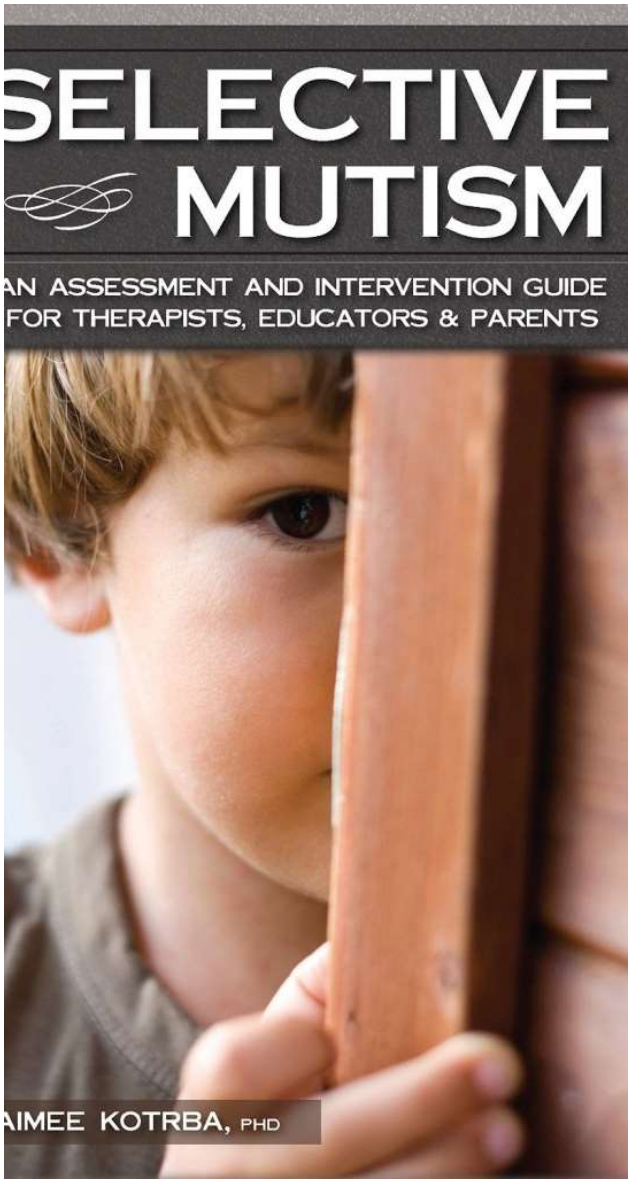
TREATMENT REVIEW

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

AVAILABLE BOOKS ON SM





QUESTIONS?

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