Let's Talk about Selective Mutism:

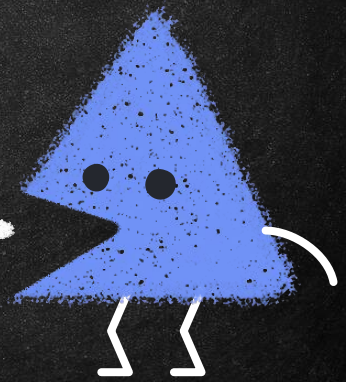
An Introduction to the Disorder and interventions

2022-2023

Maria Huerta, Mental Health Liaison
Vira Caro-Michel, BCBA
Vivian Rodriguez-Eads, Ed.D, WACSEP Program Lead

Overview

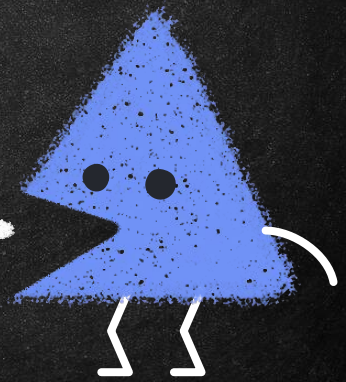
- Overview of Selective Mutism
- What it can look like in schools
- Educational Supports
- Consultation and Collaboration
- Assessment
- Treatment



Objectives

By the end of this presentation, Participants will;

- Understand the relationship between SM and anxiety
- Recognize symptoms manifested in the school setting
- Learn about a variety of interventions to address SM



Overview of Selective Mutism

What DO we know?

- Quite rare
- Not fully understood
- Can Co-occur with other disorders
- Can look different in student
- One treatment does not work for all
- It is related to anxiety
- Some students with SM participate in school activities despite their lack of speech

Common Misconceptions

- ➜ Oppositional (has been observed talking with friends)
- ➜ Children will grow out of it
- ➜ Choosing not to speak (with staff)
- ➜ Just being rude/stubborn
- ➜ Mutism is within the child's control
- ➜ They were traumatized

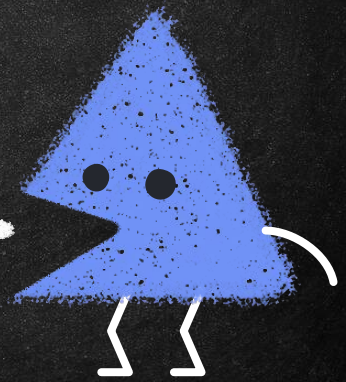
Maya Angelou

Becoming a mute in the aftermath of childhood trauma

Source: Selective Mutism Association Hear Our Voices Panel
https://www.selectivemutism.org/resources/archive/videos/hear-our-voices-panel/

Possible co-morbidity

- Anxiety
- Autism Spectrum Disorder
- Developmental delays
- Depression
- Language Problems
- Obsessive Compulsive disorder (OCD)
- Panic Disorder



Etiology

Genetic

- Anxiety
- Social Anxiety
- Separation Anxiety
- Phobias

Disposition

- Shy
- Inhibited
- Withdrawn/ Reserved

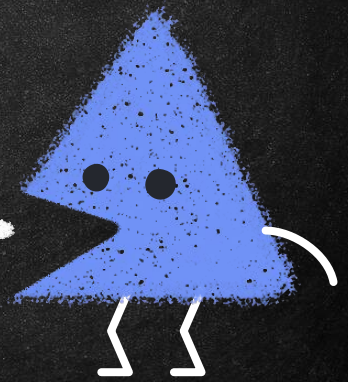
Environmental

- Avoidance
- Reduced opportunities for socialization
- Fear of unwanted attention/Fear Conditioning
- Reinforcement/ Maintenance

DSM-V Criteria for Selective mutism
Under the category of Anxiety Disorder

Diagnostic Criteria: 312.23 (F94.0)

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

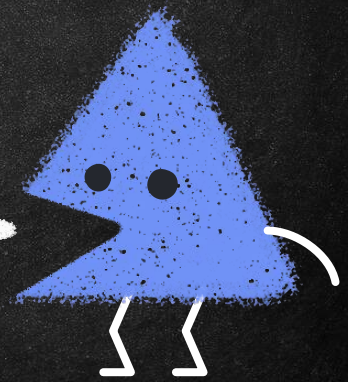


Arbanas, G. (2015)

Selective Mutism (SM)

An anxiety disorder characterized by a persistent failure to speak in one or more social situations for at least 1 month. Children usually develop SM before the age of 5, but it may not be diagnosed until school-age, when the disturbance becomes more noticeable and/or interfering.

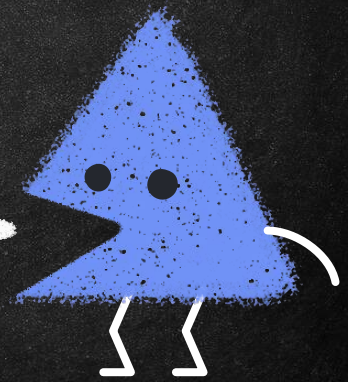
The MINT Anxiety Program at Florida International University's Center for Children and Families



It's anxiety

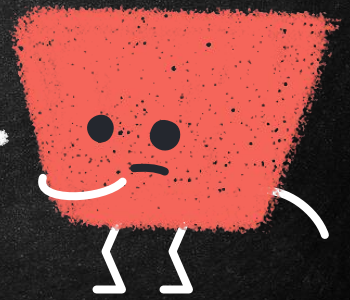
Because Selective Mutism is an anxiety disorder, if left untreated, it can have negative consequences

- ➜ Worsening anxiety
- ➜ Depression and manifestations of other anxiety disorders
- ➜ Social isolation and withdrawal
- ➜ Poor self-esteem and self-confidence
- ➜ School refusal, poor academic performance, and the possibility of quitting school
- ➜ Underachievement academically
- ➜ Self-medication with drugs and/or alcohol
- ➜ Suicidal thoughts and possible suicide



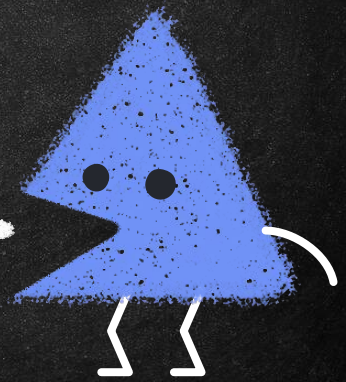
Selective Mutism

- Usually speak comfortably at home
- An *anxiety-based disorder* - Phobia
- Social skills among children affected by selective mutism vary greatly
- Seems to be higher in bilingual students
  - Silent period
- Older children with SM often lag behind socially
  - Less experience socializing



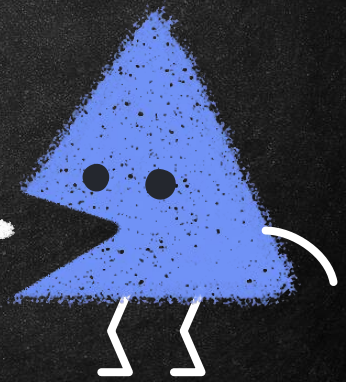
Things to consider:

- In general, the student with SM finds it much easier to respond than to initiate communication.
- Progress can be more difficult and slow once a child has reached the age of eight or nine
- Older children have developed more complicated profiles, influenced by their experiences and environmental stressors



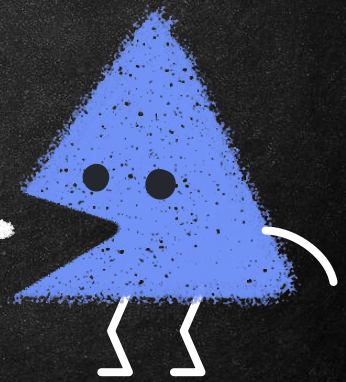
When to support

- ➜ Early identification is critical:
  - Selective Mutism may become entrenched in older students making it difficult to treat effectively
- ➜ Young children who receive prompt and appropriate treatment now can make great strides



Students with Selective mutism

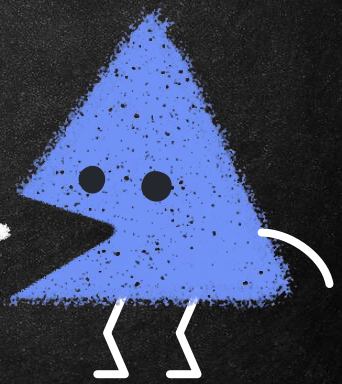
- Pressure to verbalize can overwhelm the student
- Expectation to speak could possibly elicit a
- *fear response*
  - *Freeze up/ Unable to speak*
  - *May have developed phobias*
    - *Speaking*
    - *Having their voice heard*
- Fear of receiving unwanted attention if they should start to speak makes it harder to imagine changing (i.e. people making a big deal)



Older Students with Selective Mutism

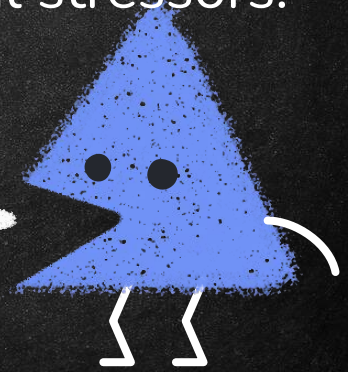
- ➜ May have received no treatment
- ➜ May have experienced inappropriate treatment and negative reinforcement.
- ➜ Instead of being helped to control their anxiety and become more comfortable at school
  - Pressured to do things they feared (speaking)

Selective Mutism Information & Research Association: http://www.selectivemutism.org.uk/



Older Students with Selective Mutism

- ➜ May have developed ingrained behavior patterns
- ➜ May have developed maladaptive coping mechanisms
  - Avoidance (situations that make them anxious)
- ➜ May have developed more complicated profiles,
  - influenced by their experiences and environmental stressors.
  - *Not speaking has become a habit that is difficult*
  - *to break*



Selective Mutism Information & Research Association: http://www.selectivemutism.org.uk/

Impact of selective mutism

Academic

- Unknown strengths or challenges
- Difficulties or Unable to assess abilities
- Not responding verbally to school staff or peers
- Difficulties with certain tasks (e.g., reading out loud)
- Long latency in responding

Social/Emotional

- Difficult to make and sustain friendships
- Treated as younger/less capable
- Higher school refusal
- More likely to self medicate
- Difficulties communicating nonverbally (e.g., freezing, poor eye contact)

Self-Advocacy

- Unable to ask for help on assignments
- Unable to get needs met
- Not voicing personal needs

Different levels

LOW Profile

- May be overlooked
- May whisper or speak softly
- No spontaneous communication/ requests
- May speak infrequently
- Fear of consequence outweighs not speaking

HIGH Profile

- Easier to notice
- Remains silent with certain individuals
- Speaking outweighs fear of consequence

Johnson, M. and Wintgens, A. (2016)

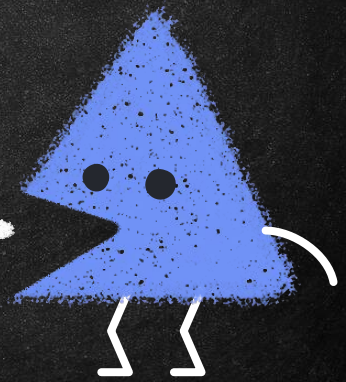
Youth with SM experiences

Source: Selective Mutism Association Hear Our Voices Panel
https://www.selectivemutism.org/resources/archive/videos/hear-our-voices-panel/

Youth with Sm EXperiences

1. What were some of the consistent themes?

2. What stood out to you?

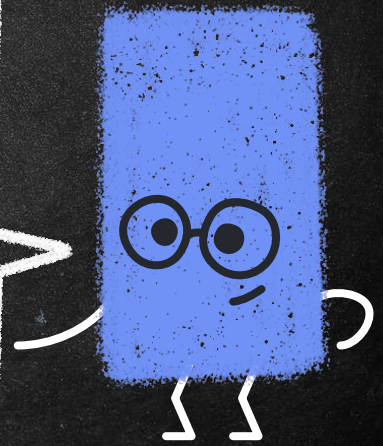


Educational Supports

Some things we can do:

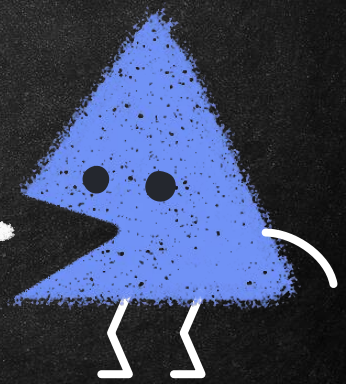
1. Ensure that teachers understand the behavioral characteristics of the disorder and allow the child to communicate by nonverbal means as long as necessary.

2. A nurturing, comforting classroom environment and flexibility within the classroom setting and schedule also are important factors in a multifaceted treatment program (Shipon-Blum, 2003).



In the classroom

- ➜ Allow student to sit with classmate(s) whom they are familiar with.
- ➜ Do not force student to engage in social situations or communication.
- ➜ Identify a “safe place” where the student can go if/when feeling overwhelmed.
- ➜ Offer field of options for response
- ➜ Allow the student to respond in a low whisper
- ➜ Provide scripts when possible that they may utilize

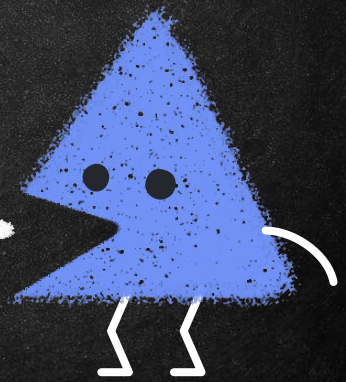


Consultation and Collaboration

MULTI-FACETED APPROACH

- Families may need to be linked to outside support services.
  - Check with the families to ensure the resources continue to be accessed.

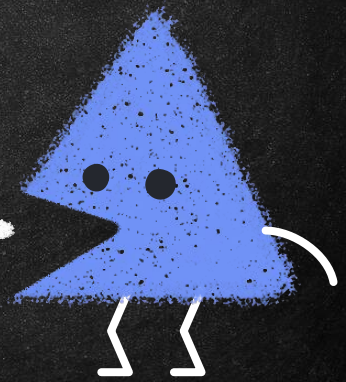
- Collaborate with outside service providers. Ask what are they working on.
  - What are the treatment goals?
  - How is the student responding the services?



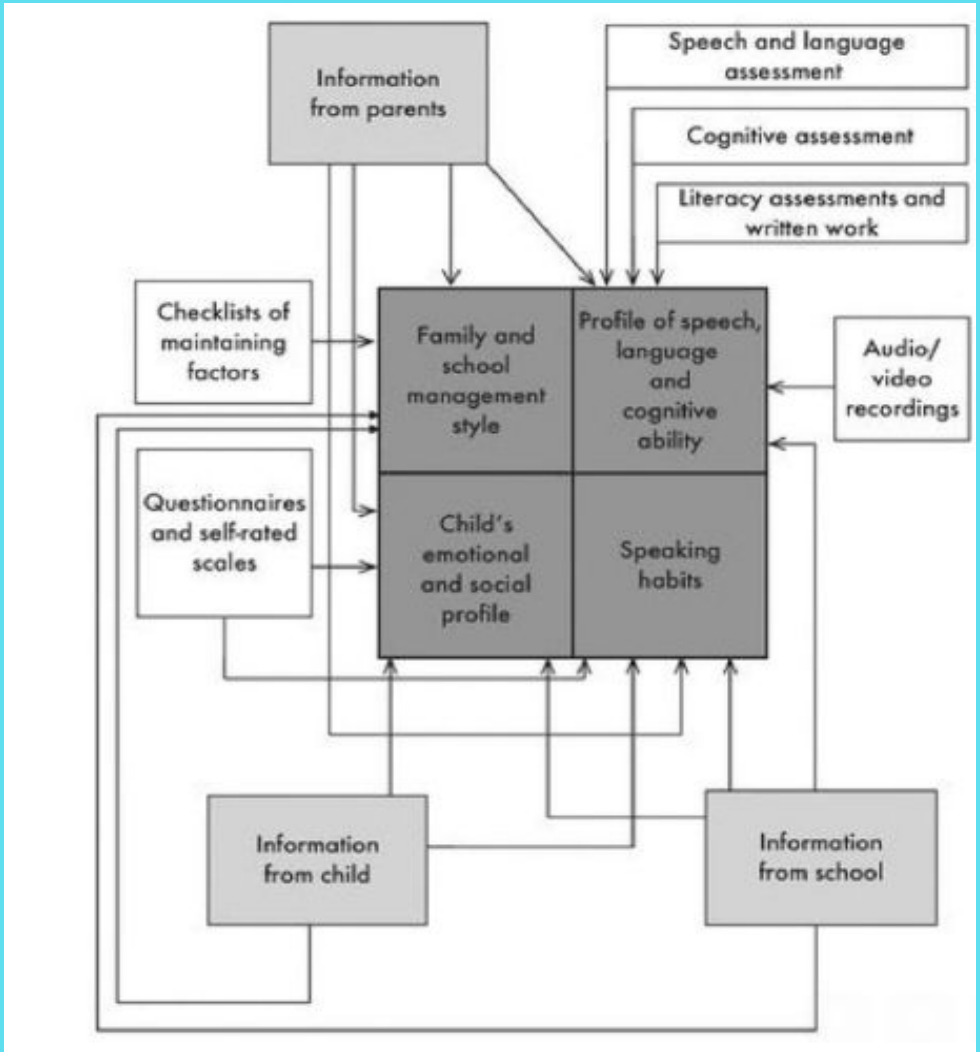
MULTI-FACETED APPROACH

- It is important to address anxiety in a variety of settings, and involve teachers, peers, parents, and other family members during the treatment process.

- Work with parents in providing psychoeducation and training



Assessment

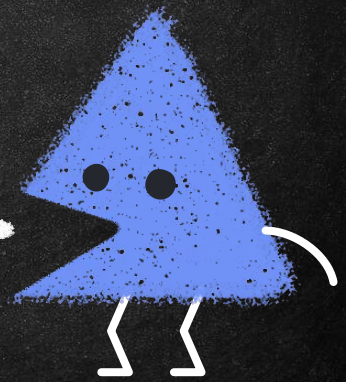


The assessment framework

Johnson, M. and Wintgens, A. (2016), p. 60

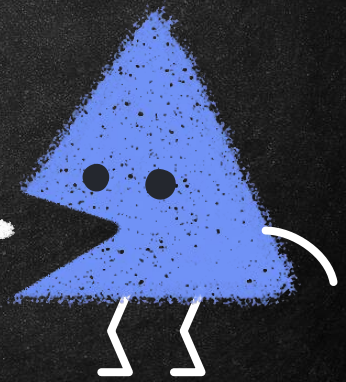
Assessment Considerations

- Consider that this will be an assessment that will require additional planning and sources of data.
- It is important to determine where the student is (Low, High)



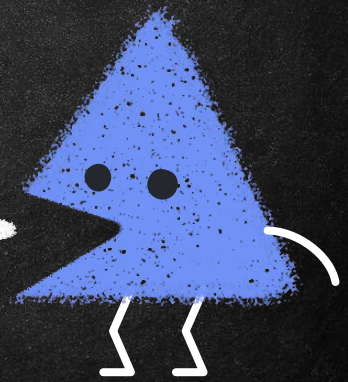
Some Sample Questions for Assessment

- When in the community do they speak to clerks, waiters, order food etc?
- Do they ask for help when they need it? Request things?
- Does they play video games? If Yes, are they interactive? Do they speak with anyone else who may be playing the game?

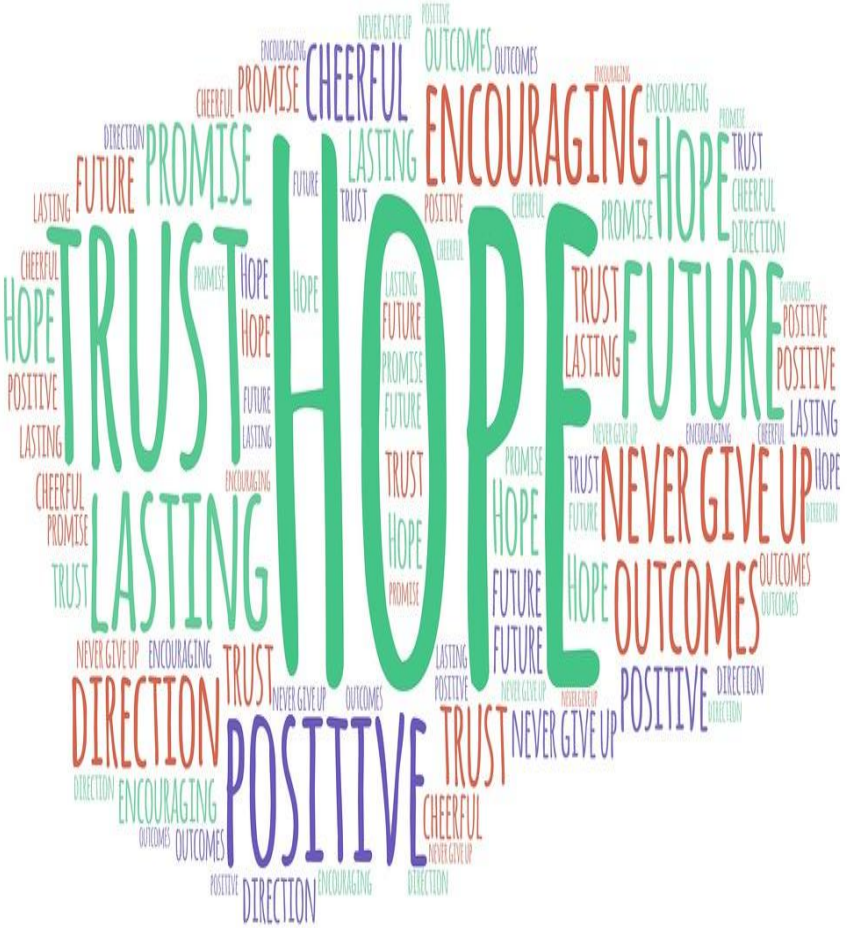


Some sample questions

- When did the student stop talking?
- Do they answer when asked a question? If so, how? (gestures, whispers, paper and pencil)
- Do they speak on the phone? Facetime? Text?
- Do they call a pet, or speak with a pet?



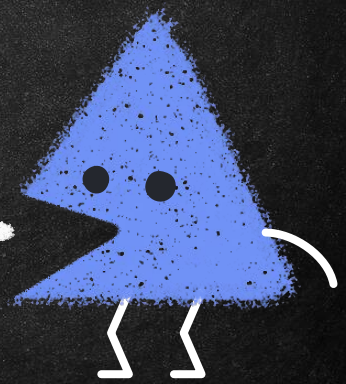
Treatments/ Interventions



Application of Interventions

Determining Goals

1. What is the student's current level of functioning?
2. What areas for improvement have been identified by the student, school, staff, and family?
3. Choose a realistic number of goals to target (2-3)
4. Develop Bravery Ladders to examine gradual progression of expectations with goals



Bravery Ladder Broad Goal

Goal: Getting more comfortable answering questions in front of groups of people

Answer questions in a large group at school

Answer questions in a small group with teacher and 3 preferred peers

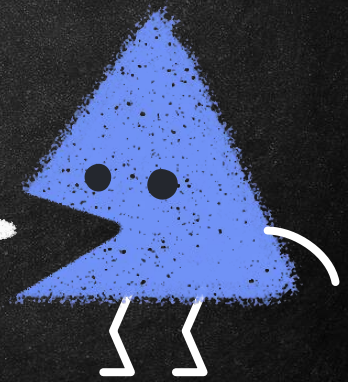
Answer questions in a small group with teacher and 2 preferred peers

Answer questions in a small group with teacher and 1 preferred peers

Answer questions to a teacher at school in a classroom 1:1

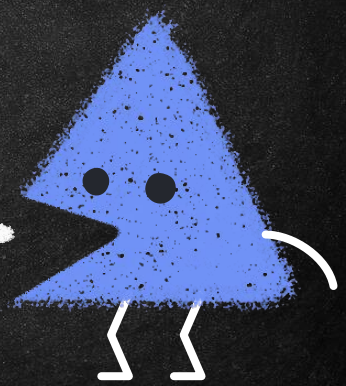
Answer questions to a familiar person at school while 1:1

Answer questions to a familiar family member



High Profile SM Case Example

- High Profile SM
  - Difficulties with attendance
  - No verbal communication at school
- Has been in a setting for students Emotional and Behavioral Disabilities (EBD) with therapeutic focus for a year.
- Level of anxiety can fluctuate.
- Goal is to increase ability to tolerate remaining in the classroom.



Bravery Ladder Broad Goal- High Profile SM Case Example

Goal: Getting comfortable remaining in the classroom

Coming to the classroom first then counseling room, then transitioning to classroom, and ending day program office for incentive for 5 hours.

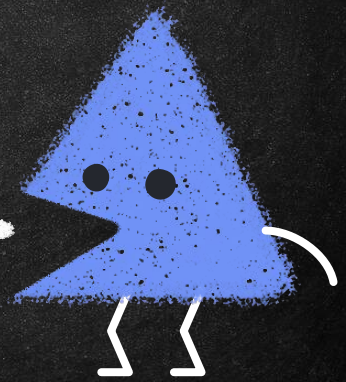
Coming to the classroom first then program office for counseling & incentive for 5 hours.

Coming to the classroom first then program office for counseling for 4 hours.

Coming to the counseling room and program office for two hours.

Coming to counseling room while parent waits in the car for 45 minutes.

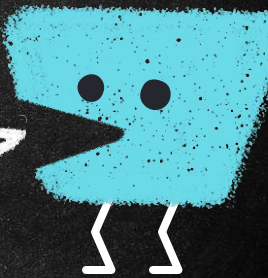
Getting out of the car to the campus gates.



Practices that Have supported Progress

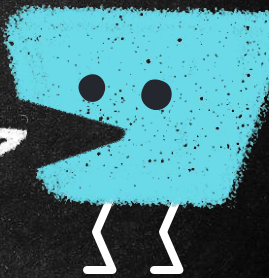
- Daily Communication with parent regarding drop off and pick up.
- Meaningful & tangible incentives
- Determining the details such as the staff who will meet the student.

- Considering the student's tolerance for transitions
- Being intentional in expanding the number of team members that can work with the student



Practices that Have supported Progress

- Starting with open-ended questions first, then forced choice.
- Games such as Uno, board games, or drawing.
- Nonverbal signals for basic needs.
- Providing options in written form and student can point.
- Prompting the student to communicate in writing.
- Hands on and high interest projects.



Student Check-In

How does the anxiety feel today? *

	0	1	2	3	4	5	6	7	8	9	10	
Not at all	○	○	○	○	○	○	○	○	○	○	○	Worst Imaginable

How is your body feeling?

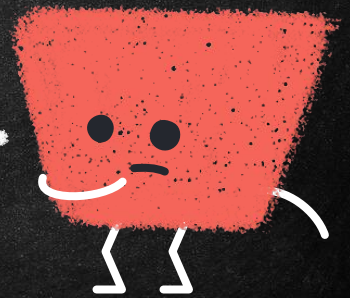
- [ ] Fast or slow breathing
- [ ] Normal breathing
- [ ] Normal heartbeat
- [ ] Fast heartbeat
- [ ] Shaky or sweaty hands
- [ ] Muscles feel tense
- [ ] Stomach pain
- [ ] My body feels great

List at least one coping skill you can do in class if you are beginning to struggle.

Your answer

Remember, I am here if you need me! I hope you have a nice day! -Ms. H

- The student went from not responding while in counseling to completing this check-in.
- The insight is used to guide accommodations and interventions



Student Data Sheet

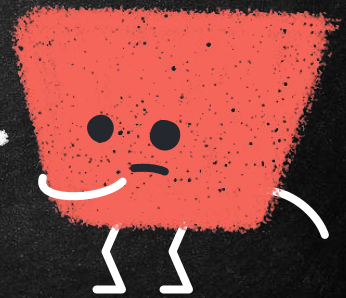
Name:_____
Date:_____

Work Goals
1 Start on time (1 point)
2 Staying on Task (2 Points)
3 Finishing (2 points)

Daily points:

Arrival to School:	Arrival to Room:	Room number:	
Subject	Work Goals	Room worked in	Notes
Period 1 8:00-8:42	1 2 3		
Period 2 8:45-9:25	1 2 3		
Period 3 9:28-10:08	1 2 3		
Nutrition 10:08-10:18			
Period 4 10:21-11:01	1 2 3		
Period 5 11:04-11:44	1 2 3		
Period 6 11:47-12:25	1 2 3		
Lunch 12:25-1:00			
Time left:			

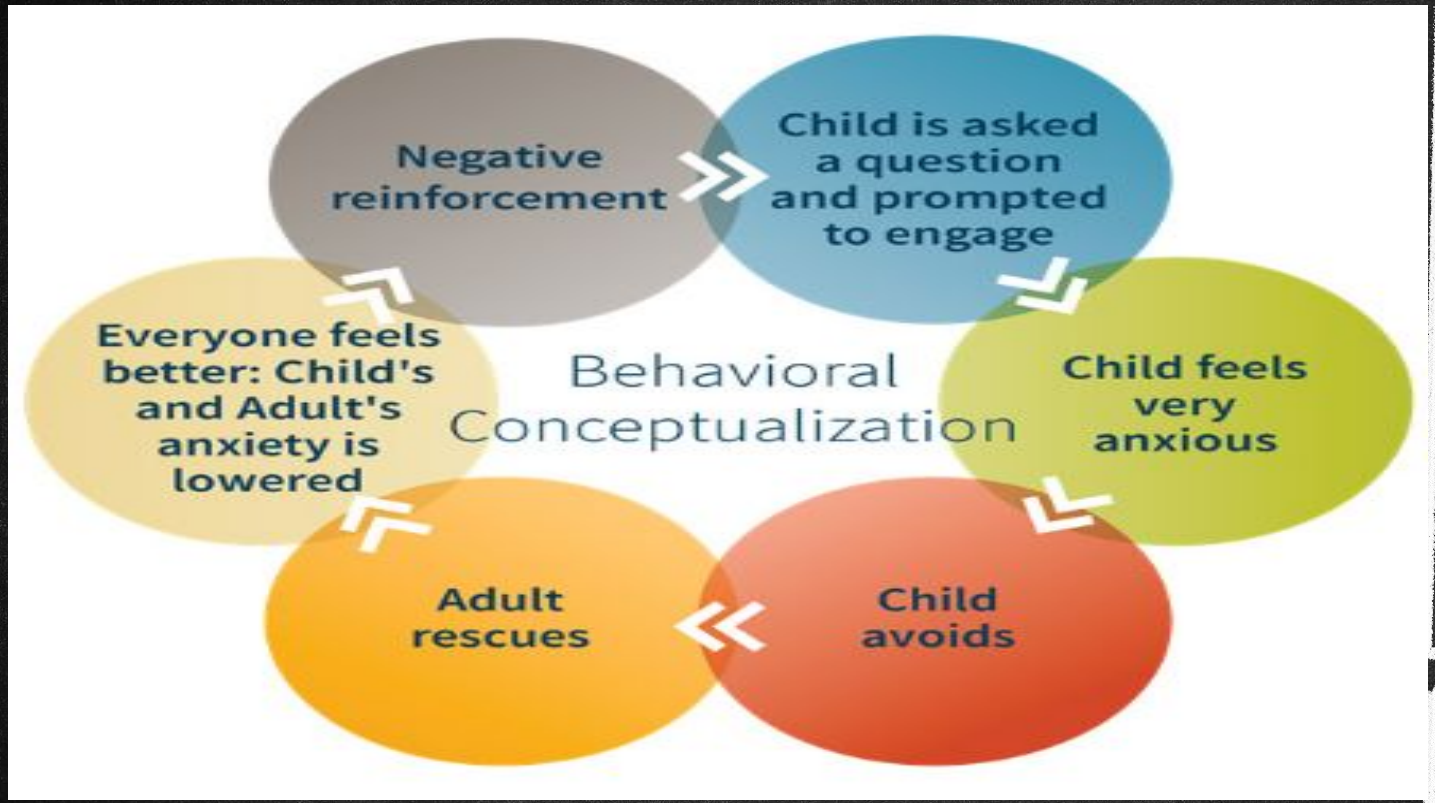
- Daily Point Sheet to track time spent at school and rooms.
- Minimum day schedule example.

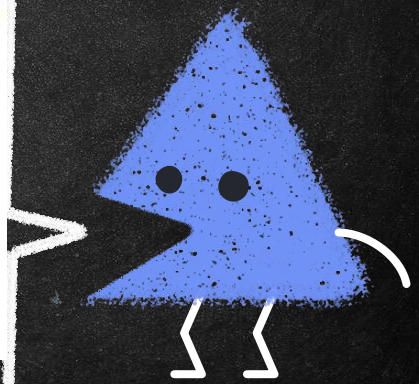


Strategies and Interventions

What have we learned so far about some basic strategies we should try when addressing SM?

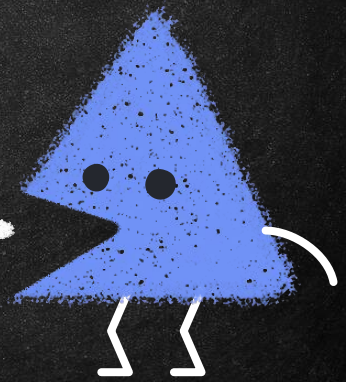
A-B-C Contingency involved in SM





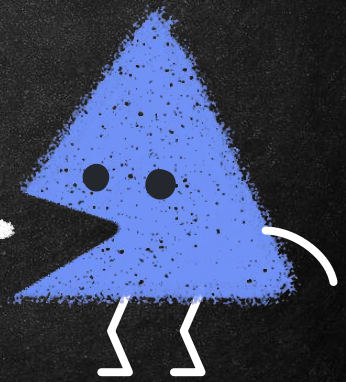
Supporting students with SM

- Is a balancing act
  - Initially you want to provide the student with the accommodations needed to ensure/increase their comfort level in the school setting.
  - These accommodations are useful but should quickly be paired with other interventions in order to see an increase in communication.



Accommodations monitored

- At all times the team must monitor the progress the student is making in the accommodations/plan.
  - The team keeps track of the progress the student is making in their communication.
    - Always make sure that the accommodations are not interfering with the student's growth.



Accommodations Monitored cont...

- Monitoring accommodations should be ongoing to track progress
  - We should see progress
- Types of data
  - Frequency
  - Monitor a GAS goal
  - This allows us to see if accommodations are still needed

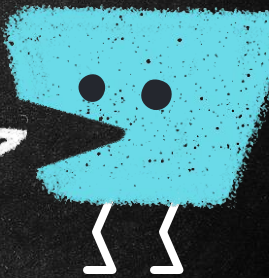
Accommodation Plan

GOAL	ACCOMMODATION(S)	MONITORING PLAN (Person, Method)
1. Talking 1:1 with primary staff	-seated near peer that child speaks to already -do not require verbal responses -Use direct commands rather than questions -Try forced-choice questions	Teacher GAS tracking % of answering questions from teacher, spontaneous speech to teacher, and communication around teacher

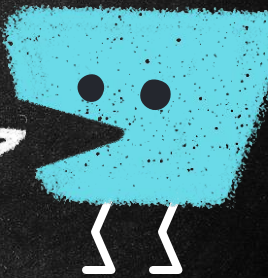
GOAL ATTAINMENT SCALE WORKSHEET

Goal attainment scaling (GAS) provides a method for monitoring treatment progress regarding a target behavior or problem situation. The basic elements of a GAS are a 7-point scale ranging from a 0 (skill not evident) to +6 (reaching or exceeding a goal). By using the numerical ratings for each of the 7 behavior descriptions or benchmarks, the respondent should be able to provide a daily report of treatment progress. Please provide three ratings per day by marking the number 1, 2 and 3 in the appropriate box for the day. 1 = answering questions from others, 2 = nonverbal participation, 3 = speech with peers

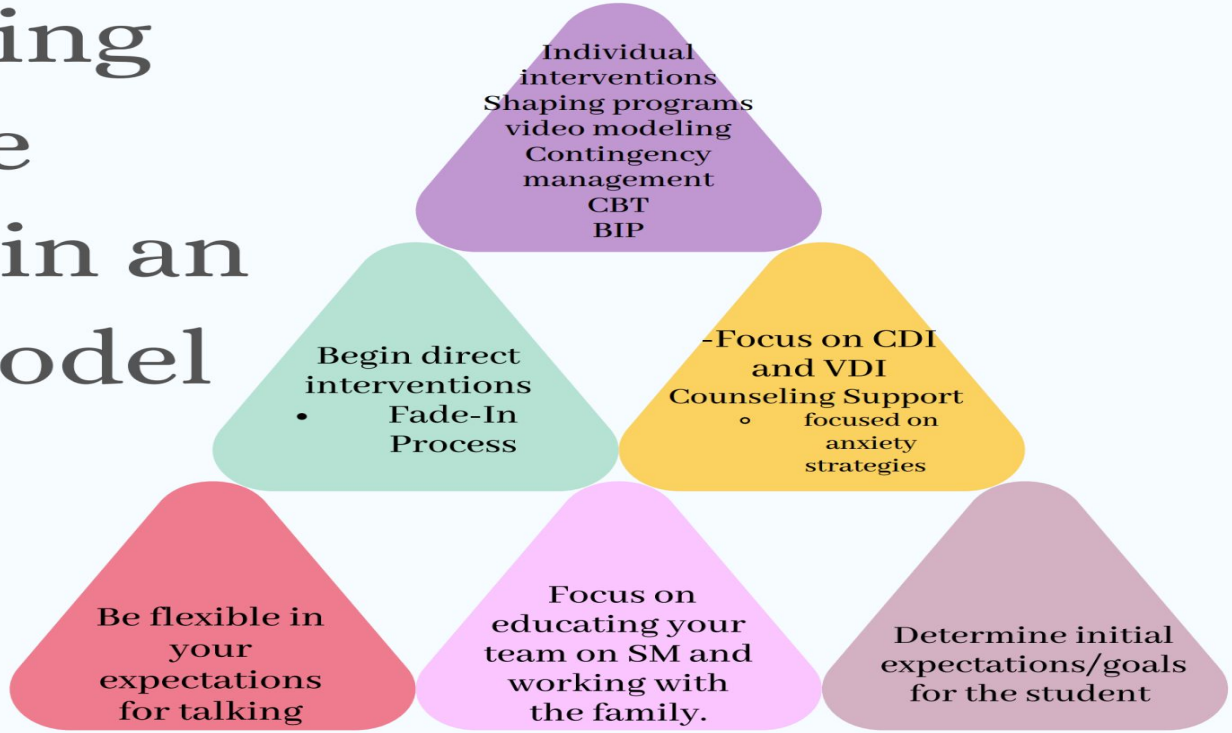
	Monday	Tuesday	Wednesday	Thursday	Friday
+6					
+5					
+4					
+3					



What are GAS goals?? How do we determine the levels



Supporting Selective Mutism in an MTSS model



Individual Strategies & Interventions

1. Fade-in (Stimulus Fading)
2. Shaping Programs
3. Self-Modeling (video-modeling)
4. Contingency Management (A-B-C)
5. Cognitive Behavioral Therapy
    a. Cognitive Distortions

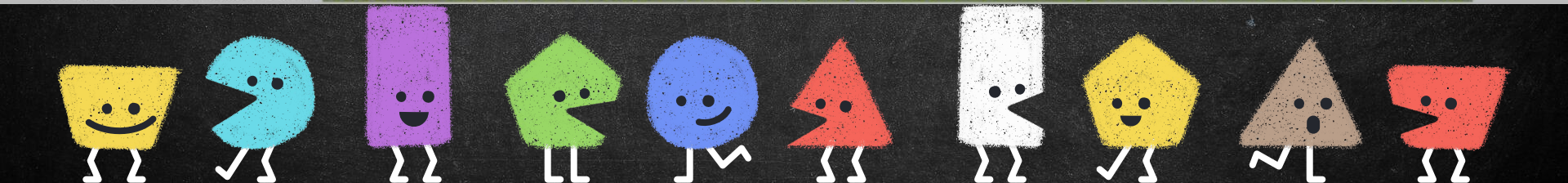
Handouts - Google Drive

Brittany Bice-Urbac...

Skills for Fade-In Process

1. Child Directed Interaction (CDI)
   - Used at start of fade-in when child may be nonverbal
   - Time without verbal expectations
   - PRIDE Skills (Praise, Reflect, Imitate, Describe, Enthusiasm)
2. Verbal Directed Interaction (VDI)
   - A period of specific prompting to verbalize
   - Used once a child is displaying increased comfort and engagement in fade-in
   - Prioritizes forced-choice questions (e.g., “Is that Lego green or blue?”)

More information on CDI/VDI can be found at Selective Mutism University :Selective Mutism University (thinkific.com) and SM 101 Webinar: Webinar Selective Mutism 101: Myths, Tips, and Treatment | Selective Mutism Association

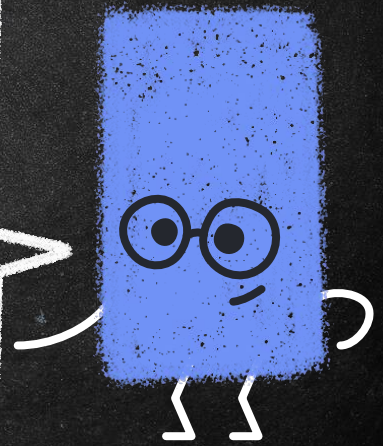


Warm-Up/Fade-In Sessions:

- Should include a stimulus for speech (e.g., staff child talked with last year, parent, peers that child is verbal with)
- No talking expectations initially (e.g., free play, games)
- Use of forced-choice responses if child does become verbal
- Reinforcement for use of brave words
- Done outside of whole-class instruction (e.g., before school year, mornings before school starts, after school)
- Warm, welcoming, fun

Warm Handoff:

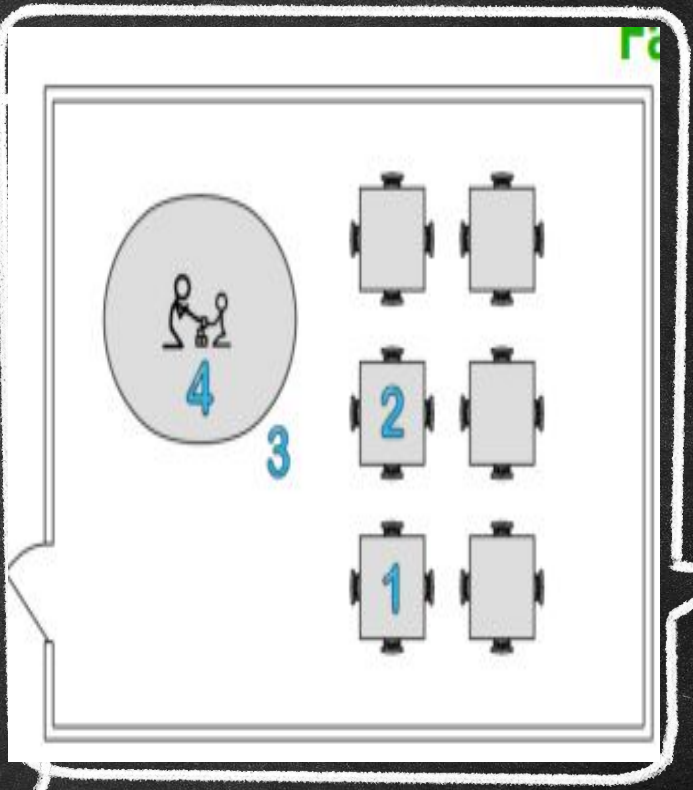
- Used for Children that are continuing in another grade of school
- Steps taken in the end of school-year or during summer before start of new school year

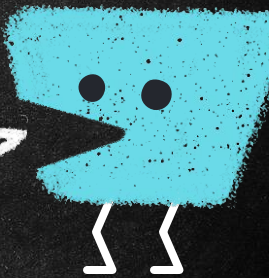


Stimulus Fading

Stimulus Fading-

- Have the child engage with someone they interact with freely and slowly begin introducing the new person.

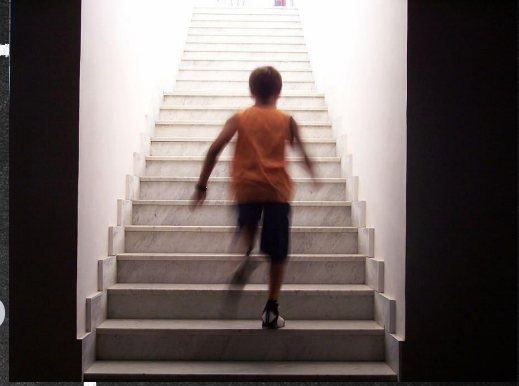


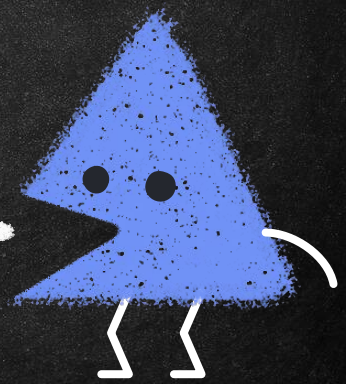


SHAPING

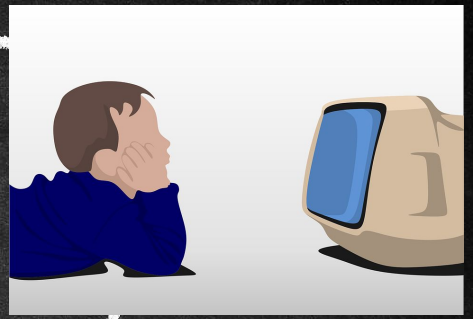
- Reinforcing Successive Approximations to the desired goal.

- Using positive reinforcement everytime the child comes closer and closer to the goal behavior/expected behavior



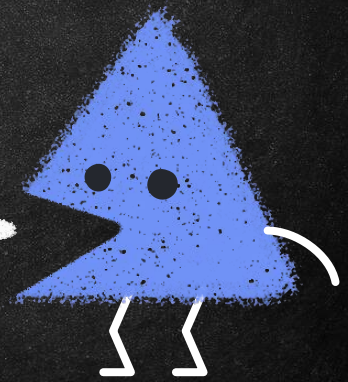


Self Modeling/Video-Audio



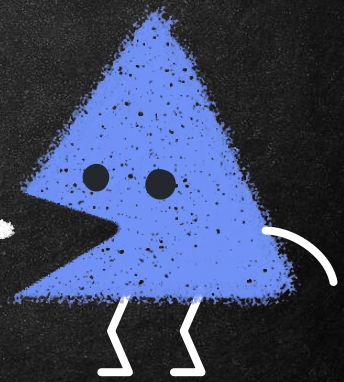
1. The child is recorded while they speak and answer questions within a comfortable environment.
2. The tape is then edited to portray the child speaking in settings such as school.
3. The child listens to the tapes repeatedly, often in the company of family members or friends, in order to become accustomed to hearing him/herself speak in these settings

(Blum, Kell, & Starr, 1998)



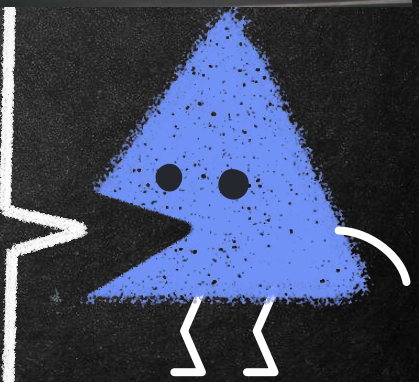
Contingency Management

- The use of positive reinforcement as encouragement for the child to practice verbalizations.
- Often used in conjunction with systematic desensitization
  - in which the counselor sets goals of increasing difficulty with corresponding rewards for each leveled task that is completed (Lescano, 2008).



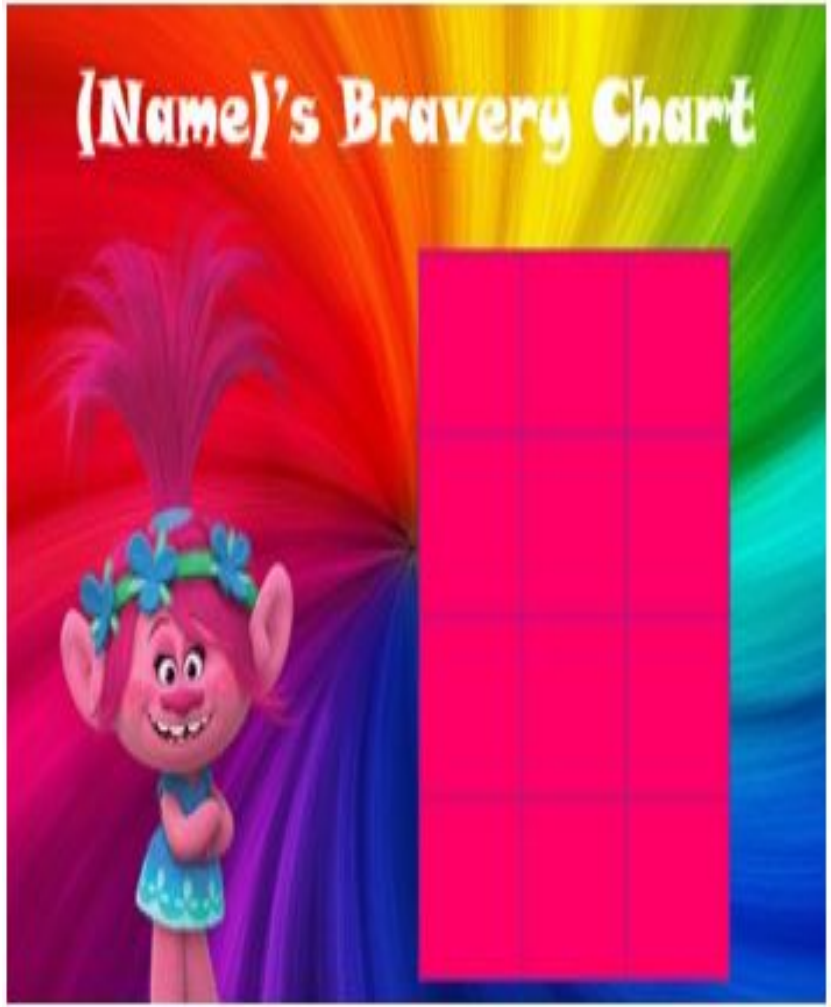
Contingency Management

Contingency management systems allow children to receive tangible rewards for their brave behavior and should be used alongside other positive social and verbal reinforcement methods (e.g., enthusiasm, labeled praise)



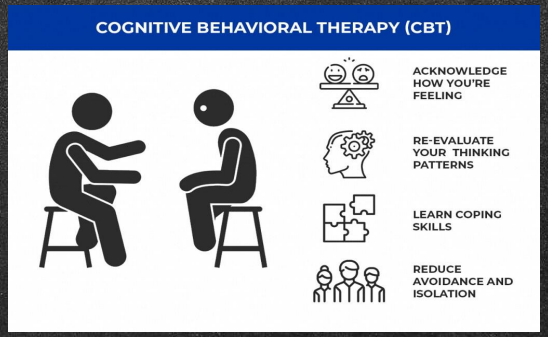
Bravery Charts

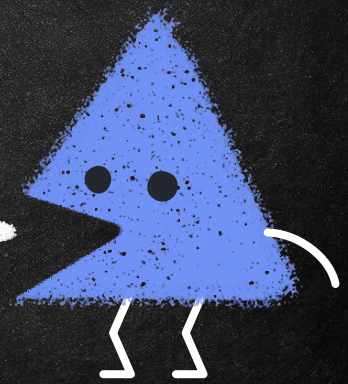
1. The child receives a check on his or her chart each time he or she demonstrates a brave behavior (e.g., audible speech)
2. Once the child has filled up the chart, he or she receives a token and the chart is wiped blank, so that the child can continue earning checks
3. At the end of the bravery practice (e.g., a session), the child trades in his or her tokens for a reward



Cognitive-Behavioral Approach

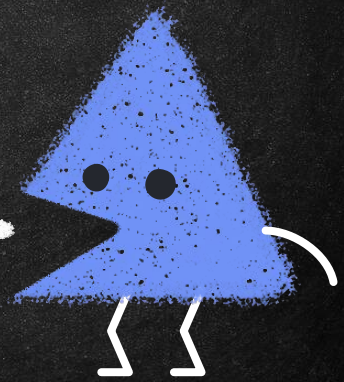
- CBT, is a practical, action-based treatment program that incorporates many of the aforementioned behavioral techniques
  - systematic desensitization
  - stimulus fading





Cognitive Distortions

- Negative thoughts lead to negative behavior; in other words, if your child only tells themselves, "I can't talk," then it's difficult to reverse the effects of SM.
-
- However, they can reframe this perspective by building a more positive attitude. "I can try to talk, and if I work at it, one day I will!"



15 COGNITIVE DISTORTIONS

15 Common Cognitive Distortions that Influence Your Thinking Patterns

1. POLARIZED THINKING

When you have an "All-or-Nothing," or "Black and White" thinking pattern. Desire to be perfect or you are a complete failure.

2. MENTAL FILTERING

NEGATIVE MENTAL FILTERING
Focuses on negatives of a situation and filters out positives. Negative details are magnified.

DISQUALIFYING THE POSITIVE
Acknowledges positives but refuses to accept it. Finds excuses to turn it into a negative one.

3. OVERGENERALIZATION

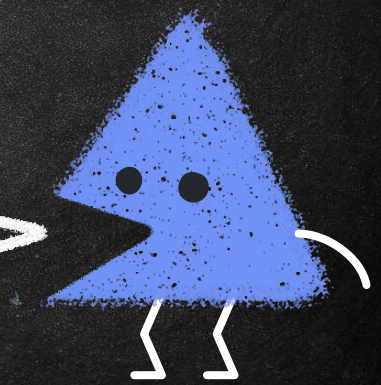
Focuses on a single event and makes a conclusion based on a single piece of negative evidence. Incorrectly conclude all similar events going forward will result in the same negative experience.

4. JUMPING TO CONCLUSIONS

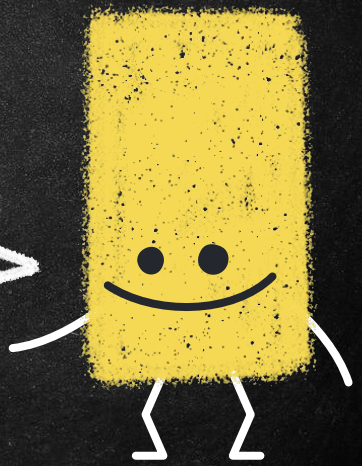
MIND READING
Know what others are thinking. Assumptions of their intentions occur with no evidence.

FORTUNE TELLING
Make conclusions and predictions with no evidence and can have negative outcomes.

[Handouts - Google Drive]

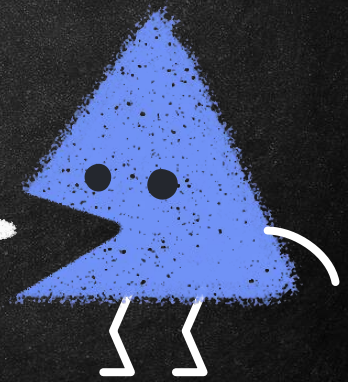


Goal Setting
What are you addressing



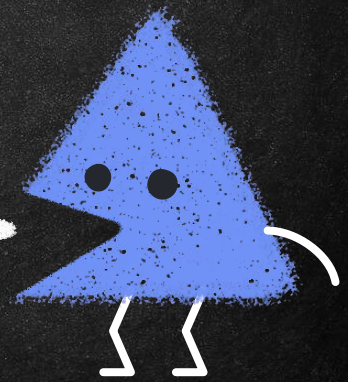
The Effectiveness of Treatment Depends on:

- How long the person has had selective mutism.
- Whether they have other comorbid disorders i.e. learning difficulties, language disorder, other anxieties.
- The cooperation of everyone involved with their education and family life.
- As well as the goals/plan we set



Goals During Counseling

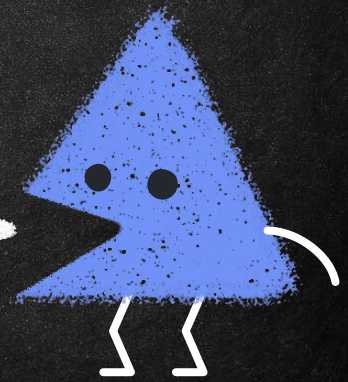
- An immediate goal is to build rapport and a trusting counseling relationship with the child
- Providing opportunities for communication but not expecting them to speak
- Don’t make a big deal out of their speaking
- Treat them the same as everyone else



Focus on expectations/goals

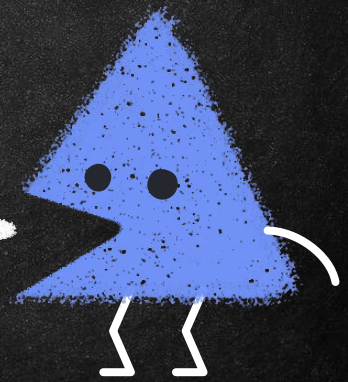
The overall goal should be to increase speaking

- With more people
- In more places
- In more situations
- With longer sentences, etc.



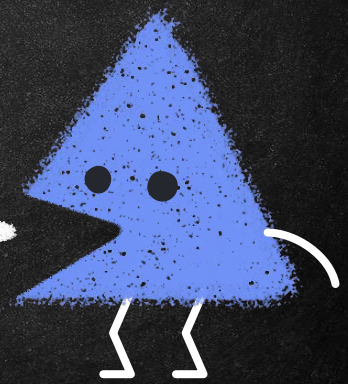
Increase expectations Gradually

1. Nonverbal responses
    a. Increase engagement with preferred peers and staff to entice communication
2. Verbal responses
    a. Forced choice ex: apple or banana?
    b. Increase practice opportunities/expectations gradually
3. Work on higher level goals
    a. Self-advocacy- asking for help in the classroom
    b. Following up with a comment/question in conversation
    c. Social skills



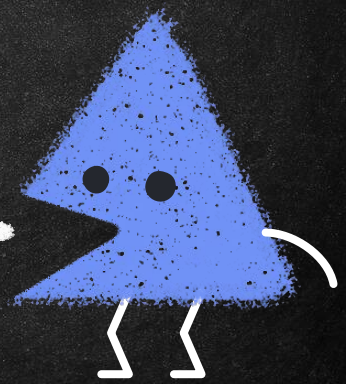
Goals focusing on Self-Advocacy

- Making choices
- Asking for help
- Asking questions/clarification
- Expressing their needs/wants
- Becoming an active participant in developing their goals/plan



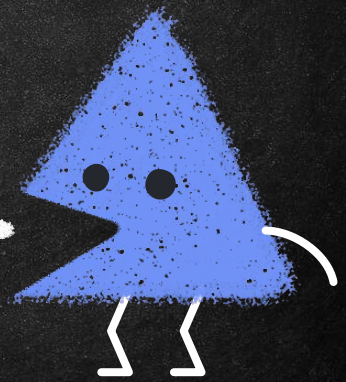
Goals focusing on Social Skills

- Will increase participation with peers in unstructured or structured setting
- Will engage in cooperative play with peers
- Will respond to questions from peers/adults
- Will initiate conversation with peers/adult
- Will invite a friend to join an activity
- Will comment/ask questions during an activity
- Will demonstrate problem-solving skills around classroom difficulties.



Goals to Address Anxiety

- increase the use of breathing skills
- Increase the use of positive self-talk
- Increase the use of positive coping skills
- Participate in tracking (self-management) comfort level across speaking practices
- Functional Communication: Request a break



Additional Resources

Classroom Discussions with Peers

If the child/family consents. Topics to address in whole class communication may include:

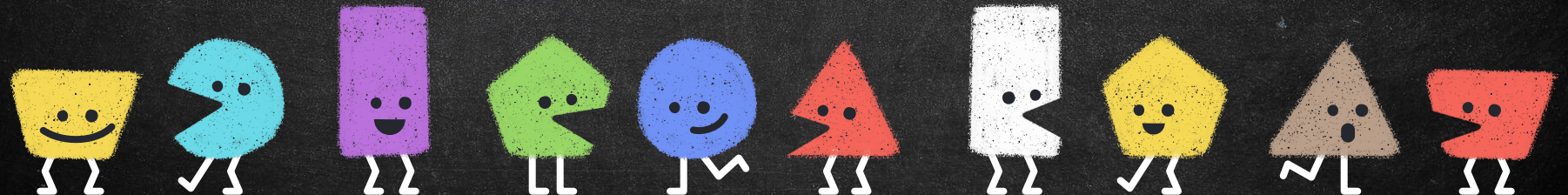
1. The child can talk and is working on building their bravery muscles for speaking in school
2. Including the child in class with help them feel more comfortable
3. Do not try to force or pressure the child to speak
4. If the child does speak, do not make a big deal of it
5. It is helpful if peers give the child the opportunity to speak for themselves instead of answering for them
6. Asking choices may help the child feel more comfortable

Peer Role in Intervention

If peers are stimulus for speech, find opportunities for:

- Paired peer activities with comfortable peer
- Small group activities gradually incorporating new peers
- Classroom games that allow for verbalization with peers (e.g., Would you rather, BINGO game)
- Lunch Bunches
- Opportunity to record with a peer

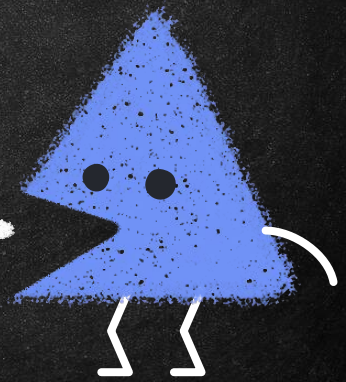
Work with peers to avoid the peer speaking for the child or sending message that the child is not capable of verbalizing



Book Recommendations

Book Recommendations for students, parents and teachers.

https://drive.google.com/drive/folders/1VTCopH4khG4M4wlFXU5L95QEdxepx7kF



Helpful Resources

https://www.nhs.uk/mental-health/conditions/selective-mutism/

SMart Center: Selective Mutism, Anxiety, & Related Disorders Treatment Center

Child Mind Institute

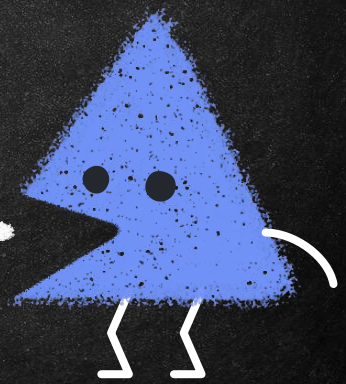
The MINT Anxiety Program at Florida International University's Center for Children and Families

Selective Mutism Association

Verywell mind

Hear Our Voices Panel (video 60 min)

Selective Mutism Information & Research Association (SMiRA)



References

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (fifth edition). Arlington, VA: American Psychiatric Association.

Amir, D. (2005). Re-finding the voice: Music therapy with a girl who has selective mutism. Nordic Journal of Music Therapy, 14 (1), 67–77

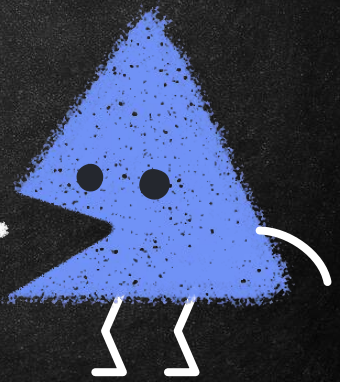
Arbanas, G. (2015). Diagnostic and Statistical Manual of Mental Disorders (DSM-5). *Alcoholism psychiatry research, 51*, 61-64.

Blum, N. J., Kell R. S., & Starr, H. L. (1998). Case study: Audio feedforward treatment of selective mutism. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 40–43.

Cline, T. and Baldwin, S. (2004) Selective Mutism in Children.

Elizur, Y. and Perednik, R. (2003) Prevalence and description of selective mutism in immigrant and native families: a controlled study. Journal of the American Academy of Child & Adolescent Psychiatry, 42, 12, 1451–1459.

Johnson, M. and Wintgens, A. (2016) The Selective Mutism Resource Manual (second edition). Abingdon: Routledge.



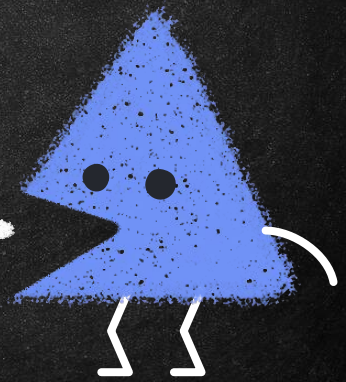
References

Lescano, C. M. (January 2008). Silent children: Assessment and treatment of selective mutism. The Brown University Child and Adolescent Behavior Letter, 24(1), 6–7.Cline, T., & Baldwin, S. (1994). Selective mutism in children. San Diego, CA: Singular.

Muris, P., & Ollendick, T. H. (2015). Children Who are Anxious in Silence: A Review on Selective Mutism, the New Anxiety Disorder in DSM-5. *Clinical child and family psychology review*, *18*(2), 151–169. https://doi.org/10.1007/s10567-015-0181-y

Sharkey, L., MC Nicholas, F., Barry, E., Begley, M. and Aherbn, S. (2008) Group therapy for selective mutism: a parents' and children's treatment group. Journal of Behavior Therapy and Experimental Psychiatry, 39, 538–545.

Shipon-Blum, E. (2003). The ideal classroom setting for the selectively mute child. Philadelphia, PA: Selective Mutism Anxiety Research and Treatment Center.



Thanks!