REALTIME FILE

FDLRS-ANXIETY FOR STUDENTS ON THE SPECTRUM OR HAVE SPECIAL NEEDS
APRIL 16, 2020

CAPTIONING PROVIDED BY:
ALTERNATIVE COMMUNICATION SERVICES, LLC
www.CaptionFamily.com

*****

Captioning is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

****

>> Hello, everybody, and welcome.
I don't know about you all, but I was certainly enjoying that music.
It is 1:00, and we said we would start promptly at 1:00, so we will get started.
Good afternoon, everybody.
I am a coordinator with the FDLRS administration project, and we welcome you to this webinar.
The webinar today is entitled Anxious Child, and we're so excited to have you join us for this collaborative partnership we have with CARD.
For those of you not familiar with CARD, it is the Center for Autism and Related Disabilities.
Like the FDLRS administration project, CARD is a part of the Florida Department of Education, bureau of exceptional education and student services.
You may hear it referred to as BEES, because we love to use acronyms in education.
FDLRS itself provides -- we have 19 centers throughout the state, and we provide all sorts of things.
We have professional learning opportunities, we have our tech folks who go into the classroom and support people with technology.
We have our parent and child specialists.  So definitely check out our website, FDLRS.org.
And you will see the abundance of things we have to offer.

Go on our website and check out everything we've offered.
We've offered accommodations in a virtual setting.
We've offered coping skills.
ABCs of behavior.
So definitely check that out.
There are recordings on there, if you've missed it.
There are lots of resources that went with those webinars.
So, definitely go ahead and check all that out.
Today's recording of the webinar and any additional resources will also be on the website.
Just give us a day or two to get all that information posted.
And if you're here today, you can go ahead and re-review it.
If you have a friend who's missed it, they can catch the recording.
And also, Marlena will be providing us with some additional resources that we will post.
So I just want to thank some of our team members that we have here today.
We have Karen Geisel, Sara Gaines, Shannon McCosker.
They're all part of the FDLRS admin team, and we're very appreciative of having them with us today.
We also have a captioner with us.
And you can see her typing everything that I'm saying and scrolling through at the bottom left-hand side of your screen.
And, of course, we have our presenter.
So it's truly our pleasure to present to you Marlena Jenkins.
She is a lead clinician at UF Jacksonville.
She's one of the FDLRS multi-disciplinary center folks.
She works with the division of Neurodevelopmental Pediatric & Autism Center.
She will provide us today with a detailed review of anxiety and anxiety-related symptoms in children.
She'll discuss behaviors that are often -- that we often see pretty common across the board when we talk about anxiety disorders and she'll have some great recommendations of what parents can do.
She'll provide us with strategies and techniques we can implement, either at home or at the school level.
So if you have any questions for her, there will be an opportunity to ask those questions at the end of the presentation, so just be sure to jot them down as you're thinking of them.
Without further I do, I would love to present to you Ms. Marlena Jenkins
>> MARLENA JENKINS: Thank you so much.
I hope everyone is doing well during this time of uncertainty.
Definitely, as we've been thrown into this new terrain, a lot of our students who have already had underlying anxiety-related symptoms or formal diagnoses are definitely amongst those who are going to be struggling, if they have not already started.

So, hopefully today I will leave you with at least one nugget of information, something that you didn't know before logging on. Something that will hopefully enhance and improve your ability to serve our students, your ability to work with your own children, if you're a parent and have logged on today.
So that we can improve outcomes.
I do want to give this one disclaimer.
I am not a mental health provider.
I am not a licensed psychologist.
I am a special educator and former private school administrator. One who has worked in the field of applied behavior analysis as a board certified assistant behavioral analyst.
And one who has worked with several students in countless schools serving students with a variety of diagnoses.
So the goal is to present you guys with something that is not overly technical, because I want everyone to be able to understand the content, and then make good use of the strategies that we will discuss.
Our agenda for the next couple of hours, we're going to start off by defining anxiety.
And we're going to look at this according to the diagnostic and statistical manual.
So when we're talking about specific disorders, I will be referencing clinical criteria.
It will not be my opinion.
It will be what all psychiatrists, psychologists, medical providers will utilize when they are exploring and official diagnosis of an anxiety-based concern.
We will also be discussing these symptoms that are related to children in adolescence.
We'll discuss strategies that you guys will hopefully be able to implement in all settings.
We'll touch a little bit on how to make referrals.
And then we'll spend some time discussing and hopefully having some good, deep conversation.
When you see the little guy thinking there, that really is for you to take that thought back to your environment, your educational or home community, and have deeper conversation with those people that you work closest with.
So the goal is that you will take this information back and continue to bring forth fruit in the coming months, even after we are over COVID-19 and the immediate effects, there will still be countless children and adolescents who are affected by trauma and the lingering effects of what they've seen happen with their siblings, their family members, their peers in school, their teachers.
And they will rely on us to provide some support and guidance.
What is anxiety?
A feeling of worry, nervousness, or unease.
It typically is about something that is going to happen, but the

individual is uncertain about the outcome of that situation.
For example, I may be invited to go to a birthday party, and I've never gone to a birthday party before.
I've watched shows about parties, I've heard other family members or peers talk about parties, but because I myself have never set foot into that setting, I began to worry and I began to contemplate what may happen.
And instead of my mind taking me to the positive things that might happen, I start to marinate and dwell on the things that may happen that are negative.
And these thoughts then cause me to have unease, nervousness, and eventually anxiety about this situation.
And then depending upon how I respond, I will either step into that party and begin to face my fear, or I will avoid that party.
And we'll talk about what happens when you avoid.
How anxiety is strengthened and its muscles are built up because we have not been able to face that fear.
It is important to remember that a lot of students and individuals who are struggling with anxiety symptoms, they have the desire to do that action.
They have the desire to step out and engage in that situation.
But because of the unease and the fear, they are paralyzed and they don't know what to do.
So I want you guys to think about why we label a lot of these behavioral manifestations as noncompliant.
Because by definition, noncompliance is that person not willing, being unwilling to engage in a behavior that they have all of the prerequisite skills, all of the background knowledge to be able to do.
But they are unwilling to engage in that performed behavior that is requested of them.
So with our students and individuals who are struggling with anxiety, if they have that desire to do it, we need to reconsider why we are defining it as noncompliance and how we can redefine that behavior moving forward.
So let's talk about the cycle of anxiety, also known as the cycle of avoidance.
It starts off with anxiety, which is that situation, as we've just discussed, that is causing that feeling of unease.
You start to develop these symptoms where you become in contact with an anxiety-provoking trigger.
And you just want to get away from those feelings as quickly as possible and by any means possible.
After having anxiety step one, you move into the avoidance stage.
And your feelings start to become so overwhelming that you want to just avoid it altogether because you are working to remove those negative feelings, the feelings that are causing you to question, to doubt.

The feelings that are, in some cases, starting to bring up a physiological response of sweating and racing heart beat.
If you do not face that fear in that moment, you will start to engage in step three, which is short-term relief from anxiety.
You made that decision that you are going to avoid -- I'm not going to go to the birthday party.
I'm going to respond to the person who invited me and I'm going to make up an excuse.
I've got a cold.
I've got too much homework to do.
I don't have a ride.
And in the moment, I start to feel good because those feelings are gone, and I'm like, whew!
I have avoided all of the drama that I perceive is associated with going to this birthday party.
What happens over time, even though I felt good right then in that moment, I might start to dwell and think about what happens now when I return to school.
Or I return to those people who invited me to their party.
And they're talking about what happened at the party and now I'm left up.
So it starts to bring up these other thoughts of being socially isolated because I'm missing key points and information that all my peers are discussing.
And then it starts to fortify my thoughts of, well, see, I shouldn't have gone to the party anyway because this is what was going to happen.
I was going to continue to be isolated.
And the end is that step four, long-term anxiety growth.
Because I avoided and I made that choice to not face that fear or to not request help and find a way to overcome, not to embark upon using coping strategies, my anxiety has grown.
And now the next time I am invited to a similar situation, I am going to be more likely to avoid it in the future.
For one, because my anxiety is so strong and it's been so fortified, because I avoided.
But two, because I've never learned a way to cope and overcome those negative thoughts as they approach.
Let's break down the statistics.
7.1% of children who are ages 3-17, that's all of the kiddos that we are working with, living here in America have diagnosed anxiety.
They have officially received that medical label.
But the hurdle is that only 6 in 10 of them, when they're teenagers, are actually receiving treatment.
We're going to have to ask ourselves what is that hurdle, that barrier keeping us from getting 6 out of 10 teenagers treatment?
Is there a stigma?
Is there a lack of understanding of what interventions can do for them?

When a lot of individuals receive a label of any type, the first thing that pops into their mind is wondering, am I going to be placed on medication to address this?
And as we know as providers, there's many opportunities to receive intervention that do not require med management.
There's some that do.
And that may be a barrier that many families are experiencing, not being able to pick apart what level and stage their child or adolescent is at.
Where do they start with treatment.
And ultimately how the entire family unit can enroll and receive quality family and group therapy to address some of these very strong components of anxiety that have built up over time.
Children ages 3 to 17 with behavior problems, more than one in three of those children also have diagnosed anxiety.
So thinking about our students who are receiving services under exceptional student education, student services.
Many of them, whether they have a diagnosis on the autism spectrum.
Whether their label is emotionally behaviorally disturbed.
Whether they are a student with a specific learning disability.
There are always residual behaviors that are associated with these labels.
And if those behaviors are not able to be intervened upon and intervened upon consistently and in all environments, that student may develop negative thoughts, negative self-talk, the inability to cope, the inability to process what is going on as it relates to their deficits in comparison to their learning expectation in their peers.
And that ultimately can produce these signs of anxiety.
Diagnostically, these concerns must cause clinically significant distress or impairment in all environments of life.
And so when we're looking at children that we served here in our multi-disciplinary center, we ask, how are things at school?
And we give ratings scales and questionnaires for school personnel.
We ask, how are things going at home?
And we get the ratings scales and opinions, clinical opinions of those individuals who are working with a child or teen in the home environment.
And if they are receiving additional therapies, we ask for that input because we need to know how widespread is this distress.
How widespread is this impairment.
The symptoms also cannot be accounted for by another mental disorder or by substances, medications, or medical illness.
So individuals who start to explore with self-medicating and they are engaging in a lot of these other behaviors that oftentimes get mislabeled as anxiety.
If that is the effect of their self-medication, clinically, it will not be warranting that official label.

Separation anxiety disorder.
We're going to break down in the next few slides the main diagnostic labels, I guess you'd say, the main forms of anxiety disorders that are affecting the children that we work with and serve.
Separation anxiety, when I first think about it, I think of a toddler between maybe 16 and 36 months who only wants to stay with their mom or their dad.
They really built a connection and a relationship with a preschoolteacher or grandparent who was the caregiver.
And they struggle every single time they are left with someone else.
And when we think about these various stages of life, toddler, kindergarten, in later elementary school, in high school, we think about it being developmentally appropriate at these markers.
Because scientifically, we understand that children go through these various stages of life.
And as you've developed a strong connection and relationship with someone, as you linked that concept between "I want something" or "I need something" and there's a specific person who can get that done for me, and because of that, that is the person that I prefer.
When that person is removed or there is fear of that person being removed, either momentarily or in the long run, these students start to feel these feelings of separation anxiety.
Now, clinically, the symptoms need to last at least four weeks.
A lot of the symptoms can vary, from the concern being the caregiver is the person who was removed, or the child, the teen is the person who was removed.
Someone being fearful that they will be kidnapped.
Someone being fearful that their loved one that they have grown to have that attachment with is going to be removed from them by accident, by death.
And as it manifests in our children in adolescence, we will start to see many of them have that persistent reluctance or refusal to go to sleep, to be away from these main caregivers.
Children who used to love going on sleepovers, leaving the home and engaging in activities away from that caregiver may now start to retreat.
And they want to have that caregiver with them for the majority of their day.
This is very difficult for young children that we see here at our clinic because it creates a pattern of co-sleeping.
As a parent, you want to be able to get rest and you want to have retreat, but you have a child who will not go to their room or stay in their room.
And they will cry and whine and scream.
And then you're faced with, well, do I just let them sleep in my bed, or do I sleep in their room so that the house can get some

peace.
But all that is doing is creating a short-term relief for anxiety for your child, and it is building long-term growth of that child's anxiety.
And over time, we start to see the parent's anxiety is actually triggered because of the stress that their child's behavior is causing on the family unit.
Generalized anxiety disorder is excessive anxiety or worry about a variety of events or activities.
I love that image, because that little girl is thinking about so many different things.
But the key is that the worry is disproportionate to the actual risk.
All of the rabbit hole path, about the birthday party, some of those could have happened, but many of them were disproportionate.
Because the reality is I was invited to the birthday party, so at least the person whose party it is wants me there.
But as I start to go through this cycle of all the things that could go wrong, I never once latched onto, but I am wanted, I am desired, and because of that, I hopefully will be included.
We know there's always exceptions.
We know there's times where our children can be set up for failure by other individuals, because they just don't have the ability to understand what our children are dealing with.
We do have to work to be aware and discern as the adults in their lives to help process that.
The vast majority of situations that we are invited to are intended to be positive and are intended to work out for the good of all.
This worry is difficult for the person to control, but the symptoms have to last at least six months.
So those students who were struggling right now because of the current COVID-19 situation and they never struggled before, right now, they are really only at about month one of that worry.
And so while their parent and their online educators and support teams might start to notice a lot of these symptoms, they are still going to need a bit more time and data collection to really present that child for formal evaluation.
Parents are always encouraged at the first sign of concern to speak with their medical providers and educational providers, but also tempering it to say sometimes more data collection, more data is just needed.
It's needed to determine if interventions are working and appropriate and it's needed to continue to drive that process hopefully for the betterment of the student.
The symptoms for generalized anxiety disorder are worry, and this worry is associated with at least one in the following children.

As we get on to adults and older adolescence, that number goes up where there's more that's expected or required.
But children need to have one.
Restlessness, fatigue, the impaired able to concentrate, irritability, increased muscle aches and soreness, and difficulty sleeping.
This could be falling asleep or staying asleep.
In more severe cases, it can be associated with nausea or diarrhea.
When I first started reading these components, it really became my area of wanting to geek out, if I could say I really found a link to ADHD when I read a lot of these symptoms.
I know a lot of individuals with ADHD, children, adolescents, adults.
I said a lot of theme have these same exact behaviors that they experience as individuals with ADHD.
So, again, I would say let's start to think deeper about the parallel amongst the continuum of all of these labels and diagnoses.
And let's think about not so much latching onto the behavior, but looking at the behaviors and working to develop as teams quality interventions to address the behaviors.
If I address the behaviors, it doesn't matter what I'm calling it.
Because I have addressed the behavior.
I've intervened in a positive, appropriate, consistent matter that is able to be duplicated across settings and environments and with adults, and because I'm able to do that, that student will engage in a higher level of productivity, engagement, involvement with their environment, and success.
Specific phobias.
The clinical description is marked or persistent fear that is excessive or unreasonable.
And it's cued by the presence or anticipation of a specific object or situation.
So there's many people, when I think about a phobia, I think about things like heights, I think about snakes, I think about spiders, and I really apologize if any of you guys are triggered by me saying those words.
Those are my personal areas of fear.
You have to have that stage of overcoming to say I have a fear, but what is my likelihood of actually coming into contact with that fear.
And if I do come into contact with that fear, how do I perceive it would turn out?
Many of the fears we hold from being a young child all the way through adulthood, many of those fears, we may never actually come into contact with.
Especially if we are savvy and we have coping strategies, coping skills, we're well-connected, we utilize our resources.

We may be able to find useful ways to avoid, and that's where avoidance is not necessarily consistently a bad thing.
We will find functional ways to avoid and work around these phobias.
Symptoms for any type of a phobia-based diagnosis are at least six months.
Anyone who says they are fearful of something one month, but then you are then watching a TV show about it later, that doesn't equate to them having a specific phobia.
It may mean that specific presentation, when they first viewed it, was harmful or caused them distress or was just nerve racking.
And it may mean that after they learned more about it, they no longer were fearful.
And that's just a part of learning and growing and maturing and development.
Some examples of phobias in children, that I'm sure if you guys were all unmuted, many of you would say you have these same exact areas of concern.
I think about predators.
Many children are scared that someone is going to come after them if they have been exposed to that in past.
They definitely should be receiving counseling and services to address those recurring thoughts.
I think kids are watching Halloween-based movies and ghosts, monster, zombie based movies a lot more now.
That's very popular in Hollywood.
And so many of these children and teens while watching them are struggling to cope with the residual thoughts that they have when they try to go to sleep later at night.
And so just keep in mind that a lot of the things that kids are fearful of are things that we as the adults in their lives could work to eliminate or at least minimize some of that exposure once we're aware that that's a concern.
But there's other things, though, like parents dying, or thunderstorms, or making a mistake, or a medical operation, being in the dark, being teased.
Those are things that are inevitable.
At some point, those things will happen in everyone's lives.
And those are not the things that we should avoid having conversation about.
We should expose children to those topics as it is developmentally appropriate and as they have the maturity and the language to understand those concepts.
We use a lot of social stories in our clinic, essentially a story written from the child or the adolescent's perspective, and it is about a situation.
And you talk about specific behaviors that will occur, the environment.
And then you talk about the outcome.

And hopefully, you're focusing on that new replacement behavior that the student is going to engage in.
So they're fearful of making a mistake.
Instead of staying silent during class, the end of that social story would display the child asking a question or answering a question openly in class.
And their response would be the peers and the teacher are receiving it well.
Therefore, that student is reinforced and that behavior is strengthened.
The anxiety is lessened, because they see that it wasn't so bad.
And in the future, they're going to be more likely to put themselves out there and raise their hand to contribute in the classroom.
OCD is one of the most overused labels.
The layperson will often say, oh, I have OCD.
I like to wash my hands a lot.
I have OCD.
Oh, I never like to leave a cabinet open in my kitchen.
I have OCD.
Clinically, that may not qualify for OCD.
There's a difference between a preference in wanting something to be a certain way, and actually having that official label of OCD.
It is characterized by obsessive and intrusive thoughts that trigger related compulsive behaviors.
So because I have a thought about someone breaking into my home, that is my intrusive thought.
My new compulsive behavior to lessen that thought is repeatedly checking my doors and my windows.
Now, that is a good practice to put into place if I've actually left my doors and windows unlocked before, and if I've been burglarized.
But the average person could probably just check once or twice and be okay.
But because individuals with true OCD are not able to reprogram their thoughts, they get stuck on that obsessive and intrusive thought pattern.
And because they get stuck, they will repeatedly, almost like you were just stuck in a hamster wheel, they will repeatedly get up to check doors.
They will repeatedly get up to check windows.
Even when they know that those doors and windows are secure.
You can use visual aids.
You can have a locked and an unlocked visual that is printed and laminated, and it's placed on the door.
You can also work with that child about only checking those doors, only checking the locks, only flipping the lights.
All of these areas.
You can give them a limit, a number of times that they are able

to engage in that.
Similar to talk cards.
Children who like to call out in class and they monopolize the time in class, you can give them a talk card.
It essentially says you can interrupt or ask X number of questions and when you've reached that limit, you're done.
And then you put in place an additional consequence to hopefully lessen that behavior.
So for OCD, if the I have a student and I'm taking baseline data and they check their door 20 times in an hour, I'm going to start off there, and they're going to get 20 cards.
They're able to check it 20 times, because that's where I know they're currently functioning.
But after we have implemented with the help of a licensed mental health counselor, licensed psychologist, a true clinical team, after we have started to address the underlying concerns, the underlying thoughts, I might decrease that and say 18.
And then overtime, I go to 12.
And 8.
Until I get down to what is actually a socially appropriate level.
That's one point in intervention that we need to be mindful of.
Many of us who work in the therapy field, we always work to get our kid or our clients' behaviors down to zero, but that might not actually be where the socially appropriate level is.
It's okay to check your door once or twice.
So me forcing a child to get down to zero when they will see everyone else in society check a couple of times is not going to actually help them maintain that behavior in the long run.
Because they're going to want to increase it to meet the expectation that their peers are engaging in and that leaves them susceptible to have spontaneous recovery.
Which is when a behavior that was previously extinguished, it was previously eliminated, it comes back.
Because something in the environment reinforces it.
So we need to keep that in mind as we are creating all of these interventions.
The goal is not to get everything down to zero all of the time.
The goal is to hopefully give that student, child, adolescent, individual a level that is socially appropriate and maintainable and appropriate for their environment.
And that's going to be different for every student, every setting, and every family.
I've already spoken through many of these examples, but under the compulsion section, right now in light of what's going on medically, all of these items related to cleanliness and hand washing are being pushed a lot.
And it's creating a lot of rigid behavioral patterns that as providers and family members, we're going to have a hard time undoing, you know, in three years when we look back and

everyone's still overusing hand sanitizer and all of these materials.
So I do think we need to also be able to teach our students that expectations change based on the presenting concerns.
Right now, there's a high concern related to healthy behavior, covering your mouth, watching your hands, keeping proper social distancing.
But I need to make sure that that doesn't last forever, because it might not be socially appropriate in two years, or it might continue to be socially appropriate in two years, depending upon how society responds.
So, when we're working with our children and our teens, we really should strive to avoid talking in absolutes, especially when they're absolutes that we cannot control.
If you know 100% that you were in control of something, sure. Tell your child, tell your student it will always be like this. But there are very few things that we ourselves, by ourselves, are in complete control of.
And because of that, we need to teach variability.
And you can prepare as the parent, as the educator, as a support personnel, you can program into your lesson ways to have variability, to be spontaneous, to have those accidents occur. Because then you are prepared, your team members are prepared, but your student or your child is the one who is unprepared and you get to talk them through that and walk them through how to handle it.
Panic disorder.
Panic disorder is a recurrent excepted or unexpected panic attacks and money or-of the following symptoms.
Has to be present at least one month.
Many people think of anxiety, they think of this panic disorder aspect, that initial gut blow that hits you when something is uneasy and something is unsettling.
You begin to feel flushed.
You may have a sense of losing reality in what's going on around you.
Many people say that they pass out when they experience these severe and profound symptoms of a panic disorder.
And it really doesn't matter if it's an activity that you've done countless time, because one aspect might be different in that situation and it causes you to experience that momentary state of panic.
I like to think there's many Sundays that I sing at my place of worship, and I'm typically pretty chill when I'm singing, and it doesn't cause me any stress.
But about a month ago, and I know Dr. Umpenhour will remember this.
We were at a meeting and her supervisor Marianne asked me to sing.
And I froze.

I completely froze.
And it was really uncharacteristic of me because I tend to kind of be pretty easy going.
And it wasn't the fact that I felt like I wasn't going to sing on key.
But the one aspect that was changed was setting.
It was environment.
I wasn't in a location where I had practiced and rehearsed and felt comfortable with, that I knew the ins and outs of.
I was in a meeting room with a bunch of other representatives from around this state and it caused me to feel that immediate sense of panic.
Now, I could have overcome that by singing and I didn't.
I thought of a second backup plan, and I whisper sang in Marianne's ear.
So hopefully, the next time I see her, a little bit of my confidence will be built up.
My long-term anxiety, I will be able to face it because I've paired Marianne now with this situation in a positive way.
And that's what's needed for a lot of our students who are facing this immediate sense of fear, for them to have someone or something that they can pair in a part of way to help override the sense of unease and uncertainty that the rest of the situation is giving them.
This can be a person, but again, you don't want it to be this same person because now you may be reverting back to creating some unhealthy boundaries, leading to some separation-based concerns.
So you might want to have a variety of people.
Or having the student practice that skill in a variety of locations on a bunch of different days, with a bunch of different peer groups or audience members.
To help address all of the situations that could potentially occur to then eliminate that sign of panic that they would feel in that moment.
At least one of the attacks has been followed by one or more months of one or both of the following.
Persistent concern or worry about the future.
Wondering, what's going to happen the next time?
What's going to happen if this happens again?
Also a significant change in behavior related to the attacks.
This is that avoidance-based behavior that people start to engage in to completely eliminate that panic related situation.
So I reworked my entire dynamic so that I can avoid what triggered my panic and now I don't engage in that feeling anymore.
The feeling is gone.
But the question that you would ask is, is your new set of behaviors sustainable.
In the situation that I gave with singing in the conference, can

I avoid that conference in the future?
The answer is no, so that would not be a functionally appropriate for me to engage in.
I have to come up with ways to avoid that fear, or ways to divert that attention in another direction and get the focus off of me.
Social anxiety disorder.
Affecting many of our children.
Because of the harshness that I think a lot of peers are presenting right now.
As it relates to social maturity and how well we are able to teach our kids to problem solve and to accept and handle people and things that are different.
When those types of lessons are not in place, it really does put children at higher risk to feel anxious with their peers, and anxious in social situations.
And so this is really where the individual fears that he or she will act in a way or show signs of their anxiety that will be negatively evaluated.
And it's hard for a student to want or trust that they can be vulnerable in front of someone or in front of groups of people, and that those people will not shun them, nor that those people will think negatively about them.
It takes a lot for someone to step out into their peer group and say I struggle with something that you all love doing, but that's why I never participate.
Can we try to do something different so that I can participate?
And it's hard to convince peers to do that.
Especially younger children because we're kind of inherently selfish and we want to do what we want to do.
But that's one aspect of intervention that needs to take place, is teaching the child how to present that fear to those that they trust.
In a way that will help them to build up their self-esteem and their confidence.
But if these symptoms last at least six months in children or adolescents where you're seeing that they are consistently avoiding these social situations, then it warrants them getting some consultation, to look and see if there's some further concerns.
This form of anxiety can be generalized where the fear is present across any social situation.
Or it can be specific.
Some children do not want to eat in public because they do not want people watching them while they eat.
Public speaking is one that kind of plagues many people.
Talking with certain roles or people is also one.
As we go deeper into that, you know, talking about these aspects of selective mutism that we'll get to.
That does affect many children.

The main note for social anxiety disorder that I wanted to make sure you guys were aware of is, in children, the anxiety must be present in peer situations and not only interactions with adults.
So children who avoid talking to adults, they will laugh and have hilarious times with their friends, and those that they're comfortable with.
We need to step back and look at some of the other behaviors that might be associated.
We need to look at that underlying relationship and determine what might be motivating or reinforcing the child to avoid certain adults.
And then not avoid other adults.
For selective mutism, this is where students have a consistent failure to speak in specific social situations in which there is an expectation for speaking.
Most commonly, this will occur at school, where the child only speaks to their caregiver, typically the caregiver that they have developed a sense of bonding and strengthened relationship with.
And when they get to school, they do not engage in talking with anyone else.
They may whisper to their caregiver or to the other children or the adult that they have built their relationship with.
But someone who is not that person requests any type of social response from them, the child will traditionally not respond.
And the duration for these types of behaviors is at least one month.
And as with all others, the symptoms, they cannot be better accounted for by another mental disorder or by medications or medical illness.
Now, the key for selective mutism is that you have to use the person that the child is comfortable speaking with to transfer that comfort level.
It's very difficult when it's a parent or caregiver, or when it's someone who is typically not present in the environment where the difficulty is occurring.
Because now you have a second set of concerns that you're working to address.
If the child only speaks to their dad, and you want them to speak at school, is it feasible -- is it appropriate for dad to sit in school all day?
I would say, no, not in the long run.
We need to be able to transfer some aspects of that relationship from dad to a teacher.
Or to a peer.
But in the immediate sense, what we are working to intervene on that behavior, we have got to find ways to make school remind the child of dad.
While that child is receiving counseling and services,

definitely through a licensed provider, we have to look at how we can make that environment seem as comfortable as possible.
But also looking at alternate response methods.
The child doesn't have to speak every response.
He or she may be able to write or type.
You may be able to build a connection with another student by designating someone as a scribe.
And that student who is the scribe should be one that closely resembles or has a lot in common with your target student.
So if it's a boy and he loves Pokemon, then you might pick another boy who loves Pokemon.
You wouldn't pick a girl who loves Barbies.
Because they may not inherently have anything in common that is going to make that child want to warm up to the other child.
So in the beginning, taking a lot of observational data, asking the parents and those who do know the child well and are able to speak with their child, asking them to complete reinforcement preference assessments.
That is going to be very helpful in determining what motivators you are going to be able to implement and how powerful those motivators are.
And you do not want to overuse reinforcement and you also do not want to dangle reinforcement in front of your students.
If the student engages, they deserve reinforcement.
So we have to step back and look at how we can pair that situation that is fear-provoking and anxiety provoking, how we can pair it with reinforcement so that it is desirable, the student wants to be there, wants to engage, and wants to take those risks to make mistakes.
But in the beginning, the student may never, you know, may never encounter a corrective-based dynamic.
Everything that they do, everything that they say is going to receive praise and reinforcement.
Because you are simply trying to increase that child's ability to speak openly in that setting.
And after that is answered, and that behavior is strengthened, now you do always go back to what is the socially appropriate response and you start to shape up those behaviors, which we'll talk about.
Anxiety across the ages.
In childhood, as we discussed, there's separation anxiety, generalized, and social anxiety.
Selective mutism and phobias are typically seen in our younger children.
As children age and become teens, we start to see phobias, generalized and social anxiety, and panic disorders.
And this can vary.
There's always exceptions to the rule.
Many of these symptoms will continue on through adulthood and they may be managed and under control for periods of time, and

things that happen as we become young adults, finding ourselves, exploring, making mistakes, those situations may trigger the recurrence of a lot of these underlying anxiety-based symptoms that we thought were once addressed.
Anxiety, like many other diagnoses, are things that the individual is susceptible to struggling with for the rest of their life.
So while they may seem stable and may seem like they're managing and doing well, we always have to be able to teach our student, our teen how to keep a handle on their internal temperature.
How to be able to self-monitor and say, well, I'm not seeing any outward effects or signs of anxiety.
But do I have a low boil on the inside that is always kind of waiting and teetering on the edge.
And we've got to be able to teach our children how to monitor that and manage that and ask for help or implement a coping strategy before a lot of these external responses occur.
So, is it time to be concerned?
When thinking about the student, the child, several students that you work with and know, has their worry last for months?
And has it lasted kind of consistently and across many different types of dynamics in life?
Or has that child had a rough patch where it's been hiccup after hiccup, trauma, hiccup, trauma.
In those types of situations, it's hard for the child to recover especially if they don't know how to cope.
But if the child has had this persistent level of worriness and nervousness and unease, inability to try new things and get out there and it's lasted for months, it's time to start making those referrals.
It's time to start questioning and asking some of these important things of service providers, on how they've seen your child and student engage and behave, and noticeable changes they've observed in their relationship with the student.
Is the worry causing physical distress?
Students who refuse to go to school, they can't get out of bed.
They seem overly irritable or angry.
Students who seem to be very confident, but now they're asking for a lot of reassurance, especially reassurance related to things that they've mastered.
That's a big one.
Being aware of what your student can do so that you know if their questions and requests for assistance are related to confidence or is it related to content.
Things that are related to content, we have to go back and reteach and explore other ways to help the student understand and make meaningful usage of the information.
But reassurance that's related to confidence, when that student was typically pretty confident, we need to ask ourselves what could have shot that confidence.

What has caused them to now question the things that we know that they're able to do.
And it might have been one major event, it might have been a series of minor events.
In that situation, the severity of the event is in the eye of the student, because something that we think is minor, they might hold onto and it might linger with them for several days.
Or weeks or months.
Students who become overly or excessively self-critical, and ultimately, students who engage in self-harm or have suicidal ideation are those who should receive immediate attention.
I know it is very scary and it is unsettling for parents and for school personnel to have to make that call regarding the safety of a student, but if we're unable to utilize other intervention methods to maintain safety for the student and for those around them, we oftentimes have to take those steps.
And there are agencies and there are support programs that are in place to work with families and transition you in a smooth way after those feelings of suicidal ideation or self-harm have been stabilized.
Those specific behaviors take a long time to address.
And it takes a community that is willing to consistently dedicate themselves to maintaining safety for that student in the long run.
Thousand we'll talk about restructuring thoughts.
This is a strategy for students who struggle with kind of projecting what they think will happen in a situation, even before it has occurred.
So for this example, the anxious thought could be a thunderstorm.
There was a thunderstorm here two nights ago in Jacksonville, and in that situation, you could either be flooded with feelings of unease and worry about the power going out, not being able to finish work assignments, not being able to get things done.
Or you could understand and go through self-talk and coping to say, this happens and it will pass.
And if it happens and these things occur, this is my plan on how I would address them.
So in this example, the anxious thought is the storm might cause lightning to strike our school and hurt me.
Now, we all know that that is something that could happen.
But we would talk with our student about what evidence there is that that thought is true.
So the truth is, lightning can strike buildings.
It has before and it will continue to do that.
And lightning can strike people who are not under shelter, which is why you're advised during a storm to seek shelter immediately and various types of shelter are actually discussed to enhance your ability to maintain safety during that period.
Now, what evidence is there that that thought is false?

The chances are that lightning won't strike our school, especially if lightning has never struck the school in the past. The building is built to handle storms and to keep people safe. And if lightning does strike the school, it will hit the roof and the roof will protect me.
If the roof does catch on fire, I'll evacuate.
And then you would create an emergency plan with that student. Emergency plans have to include every individual based on the setting that the student is in.
So for this example, the target behavior is a concern with school.
So the emergency plan needs to be written with the student's IEP team, those members of administration, and ESC support team and gen ed team so that everyone is aware of that student's specific emergency plan.
It should not contradict any school level responses that the student should engage in.
For example, if there was an evacuation but the student's emergency plan said they need to find a safe room, that contradicts that everyone in the school needs to evacuate and therefore that wouldn't be an appropriate response for the emergency plan.
After going through all of that with your student, their new thought, hopefully the one that you would help them to come to, is that even if lightning does strike the building, I can remain safe.
And I'll follow my emergency plan.
And at that time, you would review the emergency plan with the student.
It's helpful to have the student review the plan often, but you do not want them to review it so many times that they are stuck on that topic.
The reasonable time needs to be set with that team, to say how often are there thunderstorms in our area?
Are they projected to occur more often this season than last season?
And if so, let's set a reasonable number of times or a reasonable number of opportunities that the student has to request to review their emergency plan.
Students who are older teenagers, those who have the language ability and understanding, should write their emergency plan to talk about what they are able to do on their own and what they need help facilitating.
Children who are younger, those who do not have a language level or understanding, will need a lot more guidance from staff and adults, which will make it harder for you to restructure their thoughts.
Because they will be reliant upon you to give them the verbiage and the language that should be used to then mirror the activities or actions that they should engage in.

Questions to ask when you have false thoughts.
So I was invited to a birthday party and I really felt like it was going to be a horrible situation because the kids really don't like me anyway and they only invited me to make fun of me.
Let's say that's my false thought.
Carry that false thought through these questions, that I as a student would be prompted to ask myself either independently because I'm at that level or with the aid of an adult.
So do I know that for sure if I go to this birthday party I'm going to be made fun of?
Do I know that that will really happen?
And the adult would talk me through that.
How likely is it true, right?
How likely is it really going to happen that if I go, everyone there, all of them spent their afternoon planning how to embarrass me.
And even if I do go to the party and some kids choose to not talk to me, can I live through it?
Can I find shelter and assistance in the kids who I do know are my friends?
Or the person who invited me.
Could I cope if that really did happen?
Do I have the coping mechanisms, or do I need help?
If I need help, who would be at that party to help me cope in that moment?
If my escape hatch is my parent or caregiver or someone who is not present, I'm going to have a very difficult time coping in that situation by myself, especially if everyone around me is someone that I do not trust.
Or I have a negative view of that relationship.
Or a negative view of their intentions towards me.
And have I been able to cope with this in the past?
Have I ever gone somewhere, walked into the cafeteria and had kids not welcome me to sit next to them?
Have I ever done that before?
And how did that work out?
Did I live through it?
Was it okay?
Am I going to be able to make the best of it and move on?
Now, these questions in reality don't go that easily.
It takes a lot of time and practice to reframe someone's thoughts, especially when those thoughts have been so strengthened by long-term anxiety growth.
So you can't just fly through these questions.
You wouldn't even pick all of these questions.
You would just pick two or three to sit and have quality, deep conversation with that student about -- at the point when you're aware that they are having an anxiety-based thought.
So what do we do now?
We define the behavioral manifestation and we collect data.

I'm a behavior analyst.
I'm a special educator.
I love data.
I love reading about data that's been collected.
I get really excited when service providers that I'm working with have collected data.
And they can talk in a fluent and accurate manner about what is going on.
It really strengths the team, because then everyone can get a clear understanding of what the targets are and how to look for them in other settings.
By collecting data, you start to understand what triggers the behavior.
You start to understand what can decrease the behavior and what can strengthen the behavior.
And you start to understand under what situations this behavior even occurs.
You have to also make sure that your behavioral definition is both observable and measurable.
By being able to clearly define how this anxiety is manifesting in a student, you are able to say to a math teacher who may have never met the student, when you see the student and they engage in rapid pacing back and forth, when they engage in self-talk that lasts for more than two minutes, when they get up and down out of their seat, requesting to use the bathroom more than five times in your class period, that can be signs of that student experiencing anxiety.
And because I gave clear numbers and clear examples of that behavior, now that math teacher who is new to that student has a better chance of giving me accurate data, which will lead me to hopefully a meaningful and accurate intervention plan to help that student.
You want to pick a child who is similar to that child or teen.
You also want to make sure that the environment can support you arranging frequent learning opportunities.
While they may be just like your target student, that probably isn't the student you want to select, because they cannot tolerate handle -- their environment can't support frequent opportunities with our target student.
You may pick a senior student to be some type of a model for a freshman or a sophomore, because the goal is that that senior student would have the time, the level of maturity, the level of making it through those similar situations and making it to the other side safely and healthily and with clarity of mind.
They will be able to serve as a peer model for our younger students.
Also using pivoting in the natural environment.
Let's say you have multiple students, and you have your one target student who is engaging in a set of behaviors.
Let's use the example of repeatedly getting up and down out of

the seat to request a break to the bathroom.
If I'm looking to decrease that behavior because it is not appropriate for the learning environment, it's causing a distraction, they are not able to maintain engagement with the content because I stop as the teacher every time a student gets up and I comment about that student getting off task.
Instead of me focusing on that student now, as soon as the student stands up, I might pivot to a student who is engaging in the appropriate target behaviors, and I give them specific label praise during that time.
I thank Shannon for remaining in her seat and working on her assignments.
I praise Shannon for using a certain level voice for speaking.
As soon as my target student clues into that, and they do the most basic behavior that is headed in the right direction, and that's the key to remember, the most basic behavior, do not jump to expecting 100% accuracy.
Because it's a new behavior for the student.
So the second my target student engages in that most basic step, I give it back to them, and I praise them with some specific labeled praise that is meaningful to them to hopefully get that to be their new response moving forward.
You always will have your background teaching time, hopefully your one-on-one time, where you can reflect with that student and talk to them about what was triggering them.
Hey, I noticed you got ready to get out of your seat, but you sat back down.
Can you tell me what you're thinking when you stood up?
What were you trying to accomplish?
What were you going to ask me?
You can ask all of those questions later, but in that moment, your goal is to lessen the impact on the learning environment, try to keep your student engaged, and to give them a new set of behaviors to engage in when they have that feeling.
You want to maintain open lines of communication, and once you develop a plan with your team, stick to the script.
Role play as a team without your student being there so that you can talk about the things that might pop up.
The what ifs.
Because you know we all think about the what ifs when we're drafting a plan.
Well, what if this happens?
I know this plan is not going to work.
Well, what if he does this?
Well, we're not going to all be able to stay on track if he does that.
Practice it then.
Talk about it.
So that when your student tries to go rogue on you, you understand at least a few different paths that you would take in

that moment.
If you don't know what to do, stick to the plan until you can maintain safety, and then redirect.
Reconvene with your group.
And say this happened today.
I had no clue how to handle it.
Can we talk about what to do if that behavior occurs again?
Because it will occur again.
You just want to make sure in that moment in your uncertainty, you don't do something that is going to reinforce the behavior.
You want to at least do something that is going to neutralize it so that you lessen the chance that behavior will occur again, because if you reinforce it out of fear or out of being flustered and not knowing what to do, if you reinforce it, the next time that it occurs, it will be bigger and badder than ever.
And you are going to continue to be ill-equipped and unprepared because you are not able to think clearly about an intervention.
If you always take yourself back to the function, you will be able to create an intervention.
And we will talk about function shortly.
So, targeting physical feelings.
These are some strategy, when we're talking about these panic-based disorders, and we're thinking about the physiological response that oftentimes crops up.
There's some things that we can do to just naturally slow our body down.
Slow breathing.
There's no way you can slow your breathing down and continue to breathe quickly, right?
Those are contradictions.
So if we work on controlling our breathing, setting up a metronome, they can be cheap on Amazon, and you make it go faster or slower, and teach your student how to inhale and exhale with the metronome.
Deep abdominal breathing that involves placing your hands on your abdomen and actually focusing on how it feels as you inhale and as you exhale.
Teaching your student how to do a body scan.
For younger students, I remember in elementary school, we would take the large sheets of banner paper and you would lay down and someone would trace you.
You can use that for our preschool and younger children to do body scans where you have them mark on their body where they start to feel these different feelings.
And have their use their words and you as the adult draw pictures for them.
I feel like there's butterflies or I feel like there's ants crawling on me, and you might draw little pictures.
Or you might use symbols similar to the way that you have when

you go to the doctor for pain, and they have you label on your body where you're feeling pain and what that pain is.
Doing something similar with your children.
To help them take an immediate account of how their body feels from head to toe.
And lastly, imagery breathing.
Teaching your children how to think of various things.
It can be an item, it can be a location, a scenario, scenery.
Have them breathe slowly, calmly, and think about those calming environments or items while they're taking their deep breath.
One example is 54321 grounding technique.
You name five things that you see, four things that you physically feel, three things that you hear, two things that you smell, and one thing that you taste.
And the goal for a lot of the breathing techniques is you are working to restructure, reframe, in some ways distract your body so that it can get off of this heightened physiological response.
Once it's able to do that, you will then be able to have a doorway in to start getting these coping strategies into that student's mind, and have them have a greater chance of processing it and remembering it and ultimately learning how to implement it and use it in the future.
4-7-8 breathing is a technique that's on YouTube.
It's from Go Zen.
It's a pretty silly video.
I've played it for a bunch of kids and they laugh.
If you guys watch it, you'll know exactly the part I'm talking about.
It's a cute video that talks about how to take your deep breaths.
So instead of just telling a student inhale and exhale and do it slowly, you're actually giving them second markers on how to inhale, how to hold, and how to breathe out.
And as they practice that, we were teaching them how to expand and then release.
And as they do this repeatedly, the goal is that their body will start to relax.
If you hold it for seven seconds, it is very difficult to slowly breathe out for eight seconds.
Be you want to teach your student to avoid that massive rush of air.
You want them to control that air as it comes out for eight seconds.
But some children might not be able to do it for that long, so you might say 4-4-6.
Or 4-4-4.
The numbers really don't matter.
You just are really wanting them to inhale, hold for a long enough time to pause their body, to kind of calm down.

And then give them that slow ability to exhale.
Now discussing the bravery ladder.
I really love this for young children.
A lot of boys that I've worked with have enjoyed using this because they can make it seem, you know, well -- you know, they can make it seem a little bit more masculine, I guess you'd say.
It doesn't have anything related to kind of girly concepts that a lot of boys might shy away from.
But they have a ladder, and you can have the young man draw out a ladder, and you can actually have them use popsicle sticks to make a ladder.
I'm a fan of using tangible materials when you have them available.
Things that are tangible that people can feel.
They tend to build a better connection with it.
And they have a sense of ownership when they've created it.
So you can have the student paint their ladder that's made out of popsicle sticks.
They can color on it.
And then you can have them build their ladder.
Each step is a stage in them being more brave.
In the beginning, you may only put two steps or you may put all of the steps that are related but you put a barrier that tells a student they only have to go so far.
As they go through this process, they can earn bravery dollars, that they can cash in for specific reinforcing items or activities with either school members, representatives, or their family and community.
Bridging the gap between home and school is very difficult, so if you were to have a bravery ladder that transitioned from school to home, then you would be able to tie those environments together and you can have the student start off with steps -- for example, steps 9 through 7 in one location and then they finish the rest of the steps in another location.
In this example, it's specifically related to schools.
And it's specifically related to that target behavior of a student who was apprehensive or nervous to talk with other peers.
So they go from the easiest behavior, which is at the bottom of the ladder, number 9, practicing making eye contact with a teacher when she's talking.
And they work their way up from being able to face stuff, being able to answer a question, number 7, when the teacher is previously prepared the student to answer.
So they said ahead of time, I'm going to call on you to answer number 5.
Let's practice what you are going to say when I call on you to answer number 5.
That's done in private.
That's done as you're teaching.

The preteaching portion.
Then you move on to number six where the student is answering the question that they're not prepared to answer.
And that step between 7 and 6 may take you a month to get there, depending upon how that skill is strengthened and reinforced, or how it may have been inadvertently or accidentally punished, the student may struggle and they may need to have some preparation and prompting.
But you do want to make sure, with step 7, you don't linger so long that your student becomes prompt dependent.
It is not realistic for the student to have a private prep session every time they have a lesson occur.
So you do want to make sure that you only do that step for so long and then you forced the process, even if you have to do it in super small steps.
As the student continues up the bravery ladder, they go to the lunchroom, they sit at the table with some kids that they know, and then they go to the lunchroom and they sit at the table with the kids, so they know and they're able to join into a conversation.
When the student has reached that level, number one is thought to be the hardest behavior, what they were most fearful of doing.
But when they reached that step on the bravery ladder, they really should get the biggest payoff at that point.
Going to school.
So this is the example that I was speaking about prior to where I said you bridge both environments.
Step number seven, I woke up on time this morning, and it works you all the way up to the hardest, which is I left for school on time, had no reminders, I entered the school building all by myself with no fussing.
I changed my worry thoughts and noticed that I can still go to school even when I am anxious about it.
And the thought is that as soon as that student gets on the bus or if they're dropped off, there's going to be a representative at the school who is going to specifically receive that student, check in with him or her, make sure that actually number one is actually true.
No fussing, that they entered the school building by themselves, that's the goal.
And that person delivers the reinforcement.
So it's immediate and the student is not having to enter the school, go to the media center, wait for the bell to ring, go to first period, and then they get their reinforcement.
That's too big of a delay for many of our students.
And that delay right there can deter the future ability or their progress with using that skill fluently.
So the reinforcement has to be delivered so immediately, and then you teach the student how to handle the delay.

You teach the student how to handle waiting and eventually how to accept the word no.
It might seem a little bit cliche or trivial to some of you guys, but you have to teach students how to accept the word no.
Because if they don't know how to accept it, either because they've never heard it or because when they have heard it, they've been able to turn that no into a yes, they will struggle immensely when they're in an environment where they hear no and it means no.
Coping cards.
The coping cards are really simple.
You can make them out of Post-its.
You can create a Word document.
I know there will be a folder when Dr. Umpenhour uploads all the materials.
There will be a folder with materials I'm referencing.
Some of them are already created and some will just be the links for you guys to review them and create them at your own leisure and with the rest of your team.
Again, everything that you guys read, all the resources that you review, please make sure that you are not implementing them in a bubble.
Go back to your team, share them, make sure that they've appropriate and relevant.
If you're a parent, talk with the other caregivers that know your student, that watch your student.
Talk with other siblings to see how things are going, if those siblings are old enough and able to give you quality input.
The big thing is that you don't ever want to just implement something by yourself.
Because all you are doing then is changing that behavior when it's with you.
You're not doing anything to generalize and branch out those new replacement skills to other environments and other people.
So coping cards are just little palm sized cards.
I know Dr. Pincus says that they're colorful cards, but they don't have to be colorful.
They can all be the same color.
You can have your student color them.
But they have little sayings on them that are meant to redirect, refocus, and encourage your student.
I like to laminate them and put them on a little book ring, because then students can loop it to their belt loop or they can clip it on their backpack, and it's right there with them.
And the cards can be written in code, as long as everyone know what is the code means so that other kids don't look and see a card that says, I can conquer the worry monster today.
Because if another child looks over and sees that written down, they might start to question, well, what's the worry monster?
And that can provoke other anxiety related thoughts for the

student.
But using a code that everyone understands can be a good trick to help that student kind of maintain privacy and also not be subjected to additional questions from those around them.
These cards are appropriate for children who are five to 14 years old, and this is also looking at developmentally, so if we have a child who is 8 years old, but they had a significant or profound intellectual disability, they may not be appropriate to use coping cards, because they have to have the prerequisite skills to be able to take them out, read them, understand what the reading means, and the behaviors that they're reading is prompting them to engage in.
So these are some examples of some coping cards.
The previous 54321 grounding activity was also a coping strategy.
That's written on a coping card.
And you will just cut these out.
And they're very clear.
They can be as wordy as they need to be for the student based on their level of understanding, and based on the amount of prompts that that student needs.
In the beginning, if I'm working with a student, I'm going to help them select a handful, three to five, maybe seven cards.
We're going to read through them.
I'm going to have a student read through them and tell me what they think it means.
So if we read, use a healthy coping strategy, and they pick write in the journal, and the student doesn't know what that means so write in the journal, I would not put that specific strategy on the card for that student.
I may put something else, like spend time coloring.
If the student doesn't know what it means to meditate, I would cross that off.
So you have to definitely personalize these cards so that they are things that the student also will not fight to do, that they may want to do or they find naturally calming or reinforcing.
All of these strategies are things that should be leading the student away from that problem behavior or the anxiety-provoking behavior.
So we don't want to list off strategies that include skills that the student cannot do.
Talking maps are really cool for kids who have or struggle with selective mutism.
So in this example, the student has to fill out the grid.
So as they talk to mom, they might talk to mom at home.
And they want to work their way across the grid.
Talking to mom at school and all of those different areas.
Going to grandma's house and continuing to talk to mom.
Once they get a good ways through, you can pick another person and say we're going to pick a teacher and target school first,

because that's the place where you are most likely to see your teacher.
But, I'm also going to have some prior conversation with my teacher and I'm going to let her know that you're going to have a soccer game on Thursday evening and I've asked her if she'll swing by so that you can just say hi to her.
I'm preparing the student, I'm asking my teacher to go somewhere that is not expected, to therefore teach my student that it's okay when you see someone out of their customary environment, it's okay for you to be able to respond in a certain way to them.
The goal for the student might be to fill the entire grid, or the goal might be for them to just fill the grid, you know, going across for specific rules.
As I mentioned earlier, when we're thinking about behavioral manifestations and the definition that we give to behaviors, every behavior serves a function.
All of the functions are things that we engage in.
So these are not things that are specific to students with disabilities.
Every person, every animal, plants even engage in behavior because it serves a function.
Some flowers lean towards the sun for the function of being able to soak up more nutrients.
They won't lean towards a cloudy, foggy area.
They're doing that for survival, reproduction, and growth.
And so us too engage in behaviors so we can escape something, avoid it, so that we can gain access to it.
Things can be automatically reinforcing.
The automatically reinforcing behaviors that people engage in can be things like clicking a pen.
A lot of women will cross their legs and swing their foot.
Twirling hair, chewing on gum.
These are all behaviors that we do that are automatically reinforcing.
And oftentimes, you don't even know what you're getting out of doing it, but somehow, it's calming or self-soothing to you.
Behaviors can be attention maintained, meaning that you're doing it to gain attention from something in your environment.
Typically it's motivated by a person who means a lot to you.
So I might engage in some behaviors in front of one person and not engage in those behaviors with someone else because their attention is not that valuable to me.
But there's other children who don't discriminate that well and they will engage in that target behavior because any attention is better than no attention.
So these are the children who will do things that are socially inappropriate and distracting, because the reprimand that they receive in that public environment is still more meaningful to them than them sitting alone and not getting any attention.

And when those behaviors are occurring, we have to step back and say, am I only talking to them student when they are engaging in that target anxiety-based or problem-based behavior?
Is that the only time I'm engaging with my children, to ask them questions and drill them on their day, or correct them, review a report card or a teacher note?
And if that's true, we need to look at how we represent our attention, to be during times when there's no correction warranted.
So that students can understand that they engage in appropriate behaviors that warrant attention, and when that happens, they get more meaningful attention than they do when they engage in these problem behaviors.
Lastly, power and control.
Some people, some adults who do this, they do this because they want it to be their way.
And by any means necessary, they are going to accomplish getting their mission the way that they want it done.
And these situations, I love to make those students my main helper.
You want to do it your way.
Let's talk through your strategy.
But remember, this is the ultimate goal for your class, or this is the ultimate goal for you.
But you choose your path.
And as long as your path hits on these points, I'm good with it.
Because I don't have to have control over every aspect of your learning, as long as you are learning.
And that's something that as educators, we have to let go of a bit as well.
We don't have to dictate every ounce of that process, but if our goal is for the student to walk from the cafeteria to the classroom with their hands by their side and their mouth quiet, keep a bubble is what I hear a lot of kindergartners say.
If that's the goal, that's the goal.
So it doesn't matter any other way the student accomplishes that, as long as they met those two areas.
Their hands are by their side, and they had a bubble in their mouth.
I'm good.
So changing behavior.
Behavior is changed by either reinforcing it or punishing it.
And as a behavioral analyst, we look to exhaust all the reinforcement-based measures before we switch over to punishment.
Punishment really is something that should be implemented with behavioral analytic members, those who understand the consequences of punishment.
But anything that increases the likelihood of that behavior occurring again is punishing.

If I yell at a student because he or she is yelling in an anxiety-based cycle and I yell at them, and that behavior just shuts down, it ends right there, I've punished them in that moment.
Now, that punishment is either going to help me for the future or it's going to drastically harm my ability to set the stage for the future.
So we have to always say, is my goal to increase the behavior or decrease the behavior?
Based on whatever that answer is, now you start to develop your interventions.
For every behavior you look to decrease, you need to have a new behavior that you want to increase, because if all I do is take skills and behaviors out of someone's repertoire, I have not removed that innate need and desire.
They still have that.
And because they still have that, they're going to find other ways to get that accomplished.
So, post-crisis, I like to recommend reflective journals.
Writing, audio recordings, all of those things are easy to implement in the classroom.
Students can take time sitting in a corner, on a bean bag chair.
They can go to guidance and they can do a little reflection.
But each time using the peer modeling.
Having the student learn to create a self-evaluation or ratings scale.
Gratitude journals are super cheap on Amazon, and you can find them in religious undertones and you can find them at just our generic and more secular.
So that you don't have to ascribe to any certain method or discipline to be able to utilize a gratitude journal, but for students who struggle with negative self-talk, and negative frames of mind and referencing, having them repurpose that and reframe it to say what they are thankful for can do a lot to reshape that situation.
For some children, especially those who may have lower language levels, they might just need a nap, because they are engaging in such high levels of anxiety and such a heightened level of physiological response that their body is just tired.
They've been breathing hard for a long time.
They've been pacing for a long time.
They may have started engaging in tantrum behaviors.
And the best thing that they can do is rest.
When they rest, give them that time alone.
When they wake up, ease them into that reflective process.
Don't just toss them back into the learning environment.
Ease them into reflection period, to see if those behaviors are going to come up again.
You don't want to just throw them back into the learning environment and have the behavior represent itself, because now

you're just going to create a cycle and a learning pattern that is going to be very difficult in the future.
How I feel.
This is one template that I like to use for younger children.
You have a child label their feeling using the words in the box or other words that you want to teach and provide.
And you have a student write out or they can draw for students who might not be able or they can type.
They feel this way because.
And then what they did about it.
How did they respond.
Something else they could do in the future.
This is the problem solving, the brainstorming, the learning that is needed to occur to change that behavior in the future.
And you see there's a library of things they can choose from as far as what they could have done.
But you can also help them create or they can prewrite things that they feel like they could do in the future.
Things to do.
Remember, it's okay to allow your student to experience these anxiety-provoking thoughts.
We all do.
So, teaching students that they should never face that fear is not going to be an appropriate way of responding.
Validate your student's feelings and encourage your student to be brave.
We should never bend over backwards to avoid all of these anxiety-provoking situations.
We shouldn't alter our entire lives in the environment in the long haul because we want to avoid.
That may need to be done in the beginning to help strengthen some of these skills or help our child or student become more resilient, but it should not be avoided moving forward.
We should never minimize the student's feelings or tell them how they should feel.
We should help them come to the conclusion, fill in the gaps where they're struggling based on their developmental level or their language age, but we shouldn't just tell them all of the information, because now we're just creating someone who is going to regurgitate it, but have no learning and no deeper meaning and processing.
And because they don't have learning, they're not going to be able to recognize the similarities and then generalize it in the future.
And we should additionally avoid overly reassuring our student or trying to remove the student from the anxious situation.
Joining your student in a situation, taking note of how they respond, and then helping them reflect later is the best response that we can provide.
So it takes a village.

Select an accountability partner.
If you are a parent, I do not recommend that you are the accountability partner, especially if your student is an older teenager.
Because, news flash, it's not cool for a mom or dad to go to high school, right?
So, take an accountability student, or accountability partner, who is someone who that student is going to admire, look up to, wanting to talk to or engage with.
For older students in middle school and high school, this may be a coach.
A lot of them, it's also a resource type teacher.
A lot of kids find the music teacher or the art teacher to be a cool person to hang out with because they don't feel as though their academic rigor is going to stress them out as much as some of these other subjects.
For that reason, maximize on that and ask those teachers, those staff members if they would help be an accountability partner for either student.
That person is responsible for helping to redirect your teen or student back to their task.
They have to commit that time.
If it's something who has back-to-back classes and could not step out to help that student, that might not be the person to pick, or you may set up a schedule, and you might say well, Mrs. Smith is available from 7:50 to 9:15.
And the next person is available from this time to this time.
As your student gets stronger, you're going to teach your student how to hold onto those fears and reflect and then meet with that person at the end of the day, or they meet with them just during a lunch period and then at the end of the day.
So you want to ease the student off of needing that support all day, to being able to use it in a more socially appropriate and acceptable way.
Seeking professional help.
These are some resources that I've gathered for you guys.
CBT, you do not have to be -- cognitive-behavioral therapy.
You do not necessarily have to be licensed in the sense of being a psychologist to implement this.
But you do need to have quality and ethical training.
So if you're interested in learning more about it because of your role as being a guidance counselor or a therapeutic team member, I encourage you to research it.
And to speak with the professionals around you to determine what sites are reputable, how could I maintain appropriate levels of supervision and guidance from those entities that are licensed, so that I make sure what I'm implementing is ethical, safe, and appropriate.
And then lastly, here are the references and resources, as I said.

These will be in a folder that will be uploaded in a few days along with a PowerPoint presentation on FDLRS.org.
And I'd like to thank you guys for your time today.
Right now, I guess we'll take some final questions, or thoughts, takeaways that you all might have.
>> Thank you so very much, Marlena.
That was great information and awesome tools that we can get and start to implement right away.
I even downloaded that YouTube video that I'm going to check out a little bit later.
So, I did turn it on and saw that it was a little weird, as you said.
But I'm sure it will give us the technique that we need to take a look at.
So I definitely do that.
And as Marlena said, the PowerPoint from today's session, as well as any additional resources that you shared with us today, will be on the FDLRS website.
So you could go to www.FDLRS.org for today's information and information on any of the other websites.
The other webinars that we have hosted.
Right now, some of you are already filling out the evaluations.
So if you wouldn't mind, just taking a second or two to do that.
And then if any of you have questions, please stick around and we will open up a question and answer layout so that you can pose your questions to Marlena.
And she will be sure to give us some good answers or let us know where we can find them.
So, just complete the evaluation and we'll be back in just a minute to get your questions.
All right.
It looks like the numbers aren't changing too much, so we're going to go ahead to the question layout so we can get some questions answered.
If you didn't have a chance to do the evaluations, we'll go ahead and bring it back up at the end.
So if you want to stick around, ask your questions, and finish your evaluation, if you haven't already.
Let me go ahead and switch to our questions.
Marlena, if you can just remember to repeat the question for those people who are with us on a device who may not see the questions.
>> And while we're waiting for questions to come in, I just wanted to thank our captioner, again, Kacie, for being with us this afternoon.
We always appreciate your help.
So far, Marlena, quite a few thank yous, but no questions yet.
We'll just give it another minute or so and see what questions people have.
>> MARLENA JENKINS:  All righty.

I think I see -- thank you, Amy.
Amy said, I did not have a question, but I do have a comment. This was exceptionally good material presented beautifully and smoothly.
Thank you.
So there is a question from Marty.
Hi, Marty.
Are anxiety disorders typically genetically or environmentally inherited?
Oh, good question.
So, remember at the beginning, I said I'm not a licensed mental health counselor or licensed psychologist.
But based on my research, I have found that, yes, you can -- if you have an anxiety disorder can make your children more susceptible to starting to have some of these anxiety-based symptoms.
But I think the debate is on whether or not your child is learning from your -- and I'm going to say this, there's no better way to say this, but from your poor example of coping, is the student learning from that example, and then reproducing it because they don't know or they're not consistently exposed to a proper coping mechanism.
So I can make someone more susceptible or more likely to develop or kind of have their barrier down a bit genetically, if myself -- if I struggle with anxiety or have ADHD and other complications.
But ultimately, if I'm practicing and modeling appropriate coping, I'm hopefully decreasing the chances that my child will start to engage in these behaviors themselves.
Marty, I hope that that answered your question.
Veronica said that she entered the meeting late.
Will there be a link to the PowerPoint or transcripts?
Yes, there will be on FDLRS.org website.
We will have the PowerPoint and all of the additional materials that have been discussed today.
Melanie asks, do you think that anxiety is often masked and treated as ADHD, especially in ASD?
ADHD, attention deficit hyperactive disorder, you can have an inattentive type, and then ASD is autism spectrum disorder.
Yes, I do think that those two diagnoses are often kind of all jumbled into anxiety.
There's a nice piece of research, I'll try to find it and add it to the materials, that does show the overlap between ASD, anxiety, and ADHD.
Additionally, IND, intellectual disability, and when you have either of those primary diagnoses, you are kind of inherently now more at risk or more easily affected by a lot of these residual components.
So if I have a difficult time attending because I have ADHD, and my peers bring that information up to me, if I do not know a

better way of resolving the situation, I may become anxious because I don't know how to handle it.
Therefore, now if that consists -- if that continues for the required criteria length of time, I could now receive a diagnosis of anxiety, in addition to already having ADHD.
For JP, your question, what was the length for the YouTube video?
It's GoZen.
It will be with the list of materials.
Go Zen is kind of a collection of videos and tools for children to address a wide variety of topics, but there just specifically is a video that is on the 4-7-8 breathing.
So if you were to search 4-7-8 breathing and type in Go Zen, it will take you directly to the cartoon.
It's a teacher with three other teens sitting in the grass, like in a park.
Claudia -- hi, Claudia.
I'm a T.A. for pre-K and kindergarten.
If a child shows phobias or fears and is telling other kids and/or screaming, what is a way of handling the rest of the class?
Oh, good one.
So whenever you have a student who is engaging in problem behavior, that externally presents for others to see, you always want to have a time where you can teach to the whole class without the student present.
And that time is not to bash the student, but that time is for you to talk as much as you are able to and permitted to by the parents and/or the agency that you're working through, for you to be able to talk through some of those behaviors and your expected response from them.
So, for example, if I'm working with a student who consistently calls out in class and other kids giggle, I'm not going to get very far talking to everyone together, because they each have a separate set of skills and a separate set of motivating variables.
But if I find a way for another teacher to pull the target student and do something fun, not punishing, so that I can talk with another small group of students about their laughter and give them a second set of behaviors to engage in, now when I reintroduce my student, my other students hopefully have a replacement skill for them.
Because their laughter or their response that might be inappropriate or joining in is also due to their skill deficit or their performance deficit.
It's just because of my target student that those behaviors came out.
So we would need to find ways to separate and then educate and then teach new sets of behaviors for everyone specific to what their role and contribution is to the situation before bringing them all back together.

And that's also where you have to teach all of your students that everyone's going to receive reinforcement at different rate and in different amounts and in different types.
The same we all do with adults.
We get paid the same amount even when we think we're completing the same as our peer.
So you would do the same thing for your students.
The students who are laughing because of the behavior, you would talk to them about what their reinforcement needs to be.
A student who was engaging in the screaming, you would talk with them about what their reinforcement needs to be.
Danielle has asked, in addressing behaviors rather than labels to create effective interventions to promote student success, I wish more educators understood the concept of punishment in ABA.
If you continue to take away playground time and a student's behavior does not decrease, as you intend, then you are not punishing that behavior and need a more effective intervention to require the desired change.
Exactly, Danielle.
If that behavior doesn't decrease, it's not punishment.
It's reinforcement.
That's the definition.
Also, making sure that whatever the consequence is, meant to be punishment or reinforcement, it needs to be tied to that behavior.
So me not completing a task in class, but missing my recess is not necessarily going to translate back to class when I get in the class.
But me having to continue until I finish and then being able to join when I do might be a more appropriate response.
Also, looking at ways that you can anticipate the behavior before it occurs so that you don't do something punitive or something that you can't follow through with, will likely be a better response.
Donna, how do you address the issue if a child has issues with an adult?
Looking at ways that you can pair.
So, the word pair, P-A-I-R.
It means to make something that maybe is not reinforcing, to make it now reinforcing.
So for a lot of children, when they're in kindergarten and in pre-K, you have to pair academics with something that is meaningful to them because a kindergartner doesn't care that they're getting a high school diploma.
In so what you would do with that adult is find some way to make that adult reinforcing and positively meaningful to that student.
And that can be just time where that student does not place any demands, and all they are doing is engaging in child directed instruction, child directed play, which actually is a term from

PCIT, parent child interaction therapy.
There's also a TCIT, which is teacher-child interaction therapy.
And during that time, you only follow the lead of the child.
So if that's something that an adult is struggling with, how to get the child to comply, how to get the child to overcome a fear, I would explore either of those products, TCIT, or PCIT to see if you can find a therapist that can work with the adult and the child to reframe that.
John has asked, how would you preteach to students now the need to hand wash -- sorry.
Sorry.
How would you preteach to students now that the need to hand wash now is higher than usual, but try not to reinforce the behavior to become a compulsion.
For that aspect, I would probably set markers that are based on the interaction.
So there's no need to continue washing your hands, even though the CDC will say, like, every 20 minutes or something, I think I read in one article, that you should wash your hands.
The reality is if you have not come into contact with new materials or new people, you don't need to just excessively wash your hands.
So, I may give either time markers and say, if your environment or your activity stays the same, then you can wash your hands once every 30 minutes.
But if you come into contact with a new person, or you pick up new items, then you should hand wash or use hand sanitizer after that period of time.
In giving it a concrete kind of indicator, as to what should prompt that behavior, may make it a little easier to follow than just saying, you should always wash your hands, you should always use hand sanitizer because we're trying to keep germs down.
That's too generic and arbitrary.
Delroy asks, is anxiety a cause of multiple behaviors?
It is a direct result of having a lot of those symptoms.
So depending upon what specific anxiety-based concern you're looking at, you cannot have a diagnosis warranted unless you engage in certain sets of behaviors.
So if that's what you're asking, I would say, yes, anxiety is the end result label that you receive when you engage in a set of behaviors consistently across a designated period of time.
And all of those behaviors or symptoms, you would find in the diagnostic and statistical manual fifth edition, DSMV.
Jen asks, were any strategies shared for nonverbal Karen?
I didn't specifically go into students that are nonverbal.
I will do some additional research and add that to the documents that are uploaded on the FDLRS.org website.
The main thing to think about is those who may have the true form of autism, big A, we also like to look at self-stimulatory

behaviors.
We assume automatically that their self-stims are a sign of anxiety.
But for some children, their self-stims are actually their soothing or calming mechanism and the lack of those behaviors, meaning students who might rock or pace, students who stop engaging in that could actually be a sign of their anxiety being triggered.
So ultimately, we have to step back and take data to look at when the behaviors that we are observing are occurring, under what situations are they occurring, and then how does their presentation alter, change, increase, decrease as we manipulate these variables.
Also they may engage in self-harm because they're feeling these physiological feelings and changes that they cannot articulate. They might try to actually get them off of their body, or out of their system.
And so we need to be mindful as well that students who can't tell us that their stomach is hurting, students who can't tell us that the pain that they're feeling might start to punch or hit or kick or head butt, engage in other behaviors, they might request pressure from us, hugs.
I've seen a lot of children who will engage in very increased and strong body bumping because they will bang into people, they will bang into items, because they are feeling internal discomfort.
So we just have to always back up and look at, is there an underlying medical concern that the student cannot articulate?
And if so, how do we address that medically?
And then if not, we move on to the behavioral strategies to address that behavior.
Barbara has asked, how can I make a 7-year-old boy who won't discuss his feelings about anything start to share what is upsetting him?
Well, I'll start off by saying we first off can't necessarily make him, but we can work on ways to help him overcome his fear.
But if that student -- in looking at the previous slides and some of those symptoms, if that student is engaging in several of those symptoms, I would say you would -- depending upon your role and relationship with the 7-year-old boy, try to get him a referral for some consultations.
Because the one thing you don't want to step into accidentally while we're all trying to help, you don't want to step into a situation where a child discloses trauma, or some type of a situation that we are not qualified to address depending upon the role that you're in.
So I would step back and I would first say, are there adults that this 7-year-old boy does talk to?
And if so, what information are they able to ask him about me?
Are they able to say what do you think about Miss Barbara?

She's a cool lady.
Every time I see her, she's doing X, Y, and Z.
And gauge how that student responds just when somebody talks about you.
Because if they can't even tolerate someone talking about you, you may need to chime in, have another qualified person facilitate that environment with you.
And that's working that student at that bravery ladder.
-- up that bravery ladder.
So step number 9 is, you need to work on them being able to tolerate someone talking about you and introducing the idea of them talking to you all the way up the ladder to them actually talking to you on their own.
Shari says, have you found that some students that appear to have anger problems are actually due to high levels of anxiety?
Yes, and some of the tools that I'm going to post are about anger management with anxiety.
It really depends on what's been reinforced for that student.
You latch onto the first behavior you can think of, and if that's anger and it works for that student, then they're more likely to pick that behavior in the future.
So the anger is just the manifestation of not having a better coping strategy to use, or the anger could be the result of it being modeled for them in the future.
Or excuse me, not in the future.
Being modeled for them in the past.
Richard, awesome information.
Challenge is the current increased anxiety given the change to a new way of learning and the change in the environment and how educators manage that remotely with parents, especially in scenarios where kids required time to adapt to change.
Regardless, this was very good information for a parent like me who has now become an educator.
Thank you, Richard.
Yeah, we talked yesterday during a technical assistance call that I did with a couple of my clinicians here on how parents were not prepared -- I mean, educators were not, but parents were not prepared to become educators at home.
Many of the parents that we are working with don't even know what level their child is functioning on academically, and now they are the person sitting at home helping them to facilitate academics.
So that is creating a whole new world of anxiety for the entire family dynamic.
Now, whether that results in formal anxiety-based diagnoses or whether it just results in anxiety symptoms that we all at some point in life experience, this new way of life has thrown everybody for a bit of a hurdle.
Maria says, once treated, how likely is it that anxiety symptoms will return?

I don't know the answer to that.
It depends on the person.
It depends on how well and fluently they're able to use those coping strategies.
And it also depends on the depth of their anxiety that they are experiencing.
Some people may have relapses with their anxiety and they need to go into stronger types of programs.
As I said at the beginning, not all interventions require medication management.
But some do.
And so I think that people will kind of be triaged based on the presenting concerns.
And some providers are aggressive and they go right into medication management with counseling and others will start off with just counseling, because of either the comfort level of the student, the age of the student, the comfort level of the family, and the appropriateness based on other medical concerns that the student has.
Yeah, Melanie says, I've seen a lot of kiddos with ASD and anxiety that give stimulants and they become super hyperfocused.
We talk about that a lot, that a lot of children who have anxiety, that is misdiagnosed or thought to be ADHD, when they are placed on a stimulant and they hyper focus on their anxious behavior or their anxiety provoking situation, that actually is a trigger -- incorrect word -- that actually is a tip for us that that may really be anxiety and not ADHD, because when a child is experiencing true ADHD, then many of these medical interventions and therapeutic interventions in combination should decrease those effects.
But if they get worse, the first thing we always look at is there really some anxiety that was missed.
Can you please repeat the part about after a child has rested not to bring them right into the assignment?
Yes.
So, after someone has engaged in problem behaviors, they take a nap, any type of crisis, or just series of behavioral difficulties, you never reintroduce them right to the situation.
Because all you're doing is asking for the situation to go into a cycle where the problem behavior occurs.
If you think about it as a continuum, and I start off calm, I go up to the top of a hill where my crisis is.
As I start going down that hill, I am closer to going back up than I am to the bottom, where I'm calm.
The term that's used in professional crisis management is stable functioning.
And if I can't get back there and I can't get to some place where I'm calm and stable before I'm reintroduced, I'm more likely to turn right back around and go right up that hill, because those behaviors are still fresh on my mind, and they're

easy for me to implement.
So we should always spend time separating the situation from the student, redirecting them, not avoiding them, but redirecting them.
Then reflecting.
Then talking about what they should do when they return to the environment.
Then putting them in the environment with support to help remind them when they start to edge back up.
Hey, we talked about these strategies we're going to use now that we're back in class.
Do you need a break?
I might prompt it before the problem behavior occurs.
Do you need to take a break?
Do we need to take five?
If the student says yes, I let them do it.
But I need to monitor for escape.
You don't want a student to start asking for breaks all day long to avoid an escape of these activities that are triggering anxiety, or just activities that they are unable to do.
Jen asked, is anxiety typically a result of adverse childhood experiences?
I'm unfortunately not qualified to answer that.
Based on my research, anxiety is based on a lot of experiences, one of which could be adverse childhood experiences.
But for more information, I'd reach out to licensed mental health counselors that are in your area, licensed psychologists that are in your area to get additional information on that.
Kristen says, I have a kindergarten student who has never talked to me, but I've heard him talk to his mom twice.
Now that we are teaching remotely, how can I help him?
If there's a way for you to co-teach with mom and get mom to do a lot of the talking and you provide the praise and reinforcement, that would be where I would start.
If we were face-to-face, that's what I would do.
I would have mom, who has had a history of being able to deliver information clearly.
I'd have her do all of that.
And then I would be the goodie person, and I would reinforce and praise and give that kid all that love.
And then over time, mom would start talking less and I would start talking more.
I would still not give anything -- provide any corrective information.
But I would slowly increase my time engaging with the student and decrease mom's.
You may also need to, since we are teaching remotely, just prerecord some messages that the mom plays for that child throughout the day that's just you praising the child, and it should be just specifically praise phrases that she can even

say, oh, Ms. Kristen told me to tell you she loves how you are blank, blank, blank.
So now every time the child hears something positive and reinforcing, he's hopefully, or she's hopefully associating your name to that action.
Dr. Umpenhour, do you want me to -- I know that we are at our time.
Do you want me to continue?
>> You are correct.
I know we are ending at 3:00.
I was just putting your email address in the reminders pod.
So if anybody else has any additional information, they can email you there.
So, for those of you who didn't get your questions answered, or have additional questions, please see the blue that says Marlena.Jenkins@jax.ufl.edu.
And we thank you again for your participation today, and Marlena.
Wow, what a fabulous job.
We very much appreciate you and thank you for all that you do for CARD and our districts and all of our students.
Thank you so very much.
Be well, everybody.
Stay safe.
And wash your hands.
>> MARLENA JENKINS:  Thank you.