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Expanding Treatment Options for Children With Selective Mutism: Rationale, Principles, and Procedures for an Intensive Group Behavioral Treatment

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Children with selective mutism (SM) experience significant challenges in a variety of social situations, leading to difficulties with academics, peers, and family functioning. Despite the extensive evidence base for cognitive-behavioral interventions for youth anxiety, the literature has seen relatively limited advancement in specialized treatment methods for SM. In addition, geographic disparities in SM treatment expertise and the roughly 6-month duration of some of the supported SM treatment protocols can further restrict the accessibility and acceptability of quality SM care. Intensive group behavioral treatment (IGBT) for SM was developed to expand the portfolio of evidence-based SM treatment options by offering brief, but high-dose, expert SM intervention in a group format for youth ages 3–10 years that can be completed in 1 week. In this article, we outline IGBT for SM program, which has already received initial support in a waitlist-controlled trial. Our presentation is organized around the five main components of the treatment model: (1) individual "lead-in" sessions, (2) camp (i.e., all-day group sessions for children held in a simulated classroom setting, with an emphasis on graduated exposures and structured reinforcement), (3) parent training, (4) school outreach, and (5) booster treatment, as needed. We conclude with a discussion of clinical considerations and future directions for further IGBT refinement and evaluation.

Selective mutism (SM) is a particularly interfering anxiety disorder characterized by a persistent failure to produce speech in settings in which verbalization is expected, despite fluent speech in other settings (American Psychiatric Association, 2013). To diagnose SM, a child's failure to produce speech must extend beyond the first month of school, given that inhibition in new situations can result in initially restricted speech even among nonanxious youth. Research suggests that SM is a relatively rare anxiety disorder with a broad constellation of negative effects (Viana et al., 2009). Prevalence rates have been documented between 0.2 and 1.9% (Bergman, Piacentini, & McCracken, 2002a, 2002b; Elizur & Perednik, 2003; Kopp & Gillberg, 1997; Muris & Ollendick, 2015), with estimates seeming to rise in recent years with improved identification, awareness, and assessment methods. Onset typically occurs in early childhood, between 2 and 5 years of age (Cunningham et al., 2006; Kristensen, 2000). However, most children with SM go undiagnosed until at least age 5 when they begin school (Muris & Ollendick, 2015).

Despite relatively low prevalence rates, SM presents with a wide range of complex challenges in early childhood. School can be extremely challenging for children with SM, as they fail to communicate effectively with teachers, staff, and/or peers, and they commonly fail to demonstrate their full intellectual and social competencies. Family and social dysfunction are quite common, as well (Bergman et al., 2002a, 2002b; Viana et al., 2009). Research demonstrates particularly high rates of comorbidity of SM with other anxiety diagnoses, especially social anxiety disorder and separation anxiety disorder (Kristensen, 2000)—which in turn are associated with additional difficulties across multiple domains—including peer relationships (Cohen & Kendall, 2014; Verduin & Kendall, 2008), family functioning (Swan & Kendall, 2016; Thompson-Hollands et al., 2014), sleep hygiene (Weiner et al., 2015), academic performance (Mychailyszyn et al., 2010), and later substance misuse (Duperrouzel et al., 2018; Wu et al., 2010). Further, a growing body of evidence identifies a roughly 20% subset of youth with SM who also exhibit significant oppositional behaviors (Kristensen, 2001; Steinhausen & Juzi, 1996).

Although a substantial body of literature now documents the effectiveness of cognitive-behavioral interventions for youth anxiety (Comer et al., 2019; Higa-McMillan et al.,

[1] Video patients/clients are portrayed by actors.

Keywords: selective mutism; intensive group; anxiety; treatment; feasibility

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2016; Silverman et al., 2008), scientific advances in the treatment of SM have been quite limited. Only a very small handful of controlled trials have examined SM intervention options, with cognitive-behavioral treatment (CBT) formats garnering the most empirical support to date (Catchpole et al., 2019; Cohan et al., 2006; Kovac & Furr, 2019; Muris & Ollendick, 2015). In the first randomized controlled trial (RCT) of CBT for youth SM, Bergman and colleagues (2013) evaluated a 6-month-long, weekly individual treatment program involving affected children, parents, and their teachers, relative to a waitlist control condition. Their integrated behavior therapy for SM incorporated systematic and gradual exposure to speaking situations, combined with behavioral techniques such as stimulus fading, shaping, systematic desensitization, and contingency management. Bergman and colleagues (2013) found high rates of diagnostic remission (67%) and treatment response (75%), demonstrating the efficacy of the CBT model for youth with SM. A second RCT (Oerbeck et al., 2014) corroborated the efficacy of the CBT model in their version of a 6-month weekly protocol involving children, parents, and teachers, with treatment occurring specifically in school and home settings. For the majority of treated youth, positive outcomes were maintained a year after treatment ended (Oerbeck et al., 2015). Principles from Parent-Child Interaction Therapy (PCIT) have also been applied successfully in treatments for children with SM (Cotter et al., 2018). Specifically, weekly individual treatment combining behavioral techniques and PCIT principles demonstrated significant gains in children's speaking behaviors up to a year posttreatment (Catchpole et al., 2019). PCIT principles including live parent coaching and child directed interaction (CDI) skills (Eyberg & Funderburk, 2011) are used to create a safe and positive environment, as well as support the introduction of unfamiliar individuals.

These initial controlled trials of SM treatment provide critical support for the utility of exposure-based CBT methods that draw on stimulus fading, shaping, systematic desensitization, and contingency management. At the same time, the acceptability of a 6-month treatment course that spans two-thirds of a school year may be somewhat limited for many, particularly when most youth with SM live in regions where access to CBT-SM expertise may be limited. Comer and Barlow (2014) have discussed the poor accessibility of expertise and specialty care for low base rate conditions, such as SM, for the majority of affected individuals. In light of the relatively low base rate of childhood SM, providers with SM clinical experience and expertise tend to cluster in major metropolitan regions and academic hubs. Even among children dwelling in regions characterized by SM treatment expertise, investing the time in weekly treatment for half of a year may present significant obstacles, and other key barriers to care may remain.

Given (a) geographic disparities in SM expertise, (b) observed limitations in the quality of broad dissemination and implementation of treatments for relatively rare conditions and for treatments involving more complex and intensive strategies (Comer & Barlow, 2014), (c) limited dissemination-to-date of the scant literature on SM treatment, (d) limited prior SM experience that can be brought to bear in treatment by typical providers, even if they are working from a supported SM treatment protocol, and (e) the heterogeneous nature of SM across affected youth (Sharp et al., 2007), many youth with SM may particularly benefit from services delivered by providers in SM specialty settings characterized by a high volume of SM patients. This is consistent with strong evidence in medicine that surgical effectiveness is positively associated with surgeon patient volume (Pasquali et al., 2012)—the more patients a provider sees with a particular condition, the more familiar they are with the range of variability associated with such presentations of that condition, and the more readily they are able to navigate positive outcomes among similar new cases. Indeed, malignant tumors are not removed by primary care physicians, they are removed by specialists—surgical oncologists who have completed relevant education and advanced surgical competency training, and who see a high volume of patients with cancer (see Comer & Barlow, 2014).

Despite geographic disparities in the availability of specialty mental health care, recent advances leveraging novel intervention formats have begun to meaningfully extend the reach of expert providers for a range of conditions (Comer et al., 2014). In particular, "intensive" treatment formats—which offer high-dose, condensed modifications of interventions that are typically delivered over longer periods of time—have garnered strong empirical support for a range of youth anxiety disorders (Angelosante et al., 2009; Davis et al., 2009; Gallo et al., 2014; Ollendick et al., 2009; Öst & Ollendick, 2017; Santucci et al., 2009). Importantly, delivering a high dosage of SM treatment in a relatively brief period of time can allow some affected youth to participate in services with specialty providers with extensive relevant experience, even if such providers are not in the family's immediate vicinity (Wu et al., 2010). Although it would not be possible for a family to participate in 6 months of weekly face-to-face treatment with a specialty provider located a significant distance away, abbreviated intensive treatment formats offered in specialty practices open up destination treatment options for some families. Moreover, even among families dwelling in regions characterized by availability of SM specialty providers, the prolonged 6-month duration associated with most of the small handful of evaluated SM treatments can conflict with important competing demands on a family's time.

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Intensive Group Behavioral Treatment (IGBT): Key Components and Procedures

Given problems for many in the accessibility and acceptability of evidence-based SM treatment provided by SM specialists, an intensive treatment option for childhood SM referred to as Intensive Group Behavioral Treatment (IGBT), developed by Kurtz (2016), has grown in popularity (Petersen, 2018; Saint Louis, 2015) and in research support (Catchpole et al., 2019; Cornacchio et al., 2019). IGBT-SM is a blend of PCIT, specifically the CDI phase, and CBT. The benefit of a group-based intensive for children with SM is the opportunity to practice exposures with several other children. IGBT typically occurs over the course of 1–2 summer weeks, prior to a child's transition into a new school year. IGBT programs for SM are typically geared toward children between the ages of 3 and 10, and include five main components: (a) individual "lead-in" sessions, (b) analog classroom (i.e., all-day group sessions for children held in a camp-like setting), (c) parent training, (d) school outreach, and (e) booster treatment as needed (Kovac & Furr, 2019). Although a recent RCT evaluated the efficacy of IGBT for youth SM and showed very positive support (Cornacchio et al., 2019), little has been written in the literature about the principles and procedures that make up IGBT for youth SM. To facilitate improved dissemination of clinical methods for implementing IGBT for youth SM, the present paper provides a clinical overview of the structure and considerations for the IGBT evaluated in Cornacchio et al. (2019). We organize our discussion around Individual "lead-in" Sessions, Camp (i.e., all-day group sessions for children held in a simulated classroom setting), Parent Training, School Outreach, and Booster Treatment as Needed.

IGBT STAFF

The IGBT-SM program requires a 1:1 child-to-staff ratio, an "IGBT lead teacher," and at least one class supervisor. If there are multiple classes, an additional supervisor to oversee the various classes is recommended. The children are always paired with a staff member (herein called "primary counselor"). In many IGBTs, these primary counselors are trained undergraduate students or graduate students looking to gain clinical experience working with anxious youth. In addition to primary counselors matched with each child, a more specialized "IGBT lead teacher" directs the overall classroom and maintains the class schedule. Typically, the IGBT lead teacher is an undergraduate or graduate student with prior experience working with children with SM. Additionally, at least one "class supervisor" is assigned per classroom to assist with challenging situations or times in which multiple staff are needed. These class supervisors are typically advanced graduate students with prior SM experience or postdoctoral students acquiring hours for licensure. However, the class supervisor can also be a licensed clinical psychological if there is only one classroom. If more than one classroom, the program is often overseen by a licensed clinical psychologist (herein called "IGBT director").

Staff are typically recruited through email blasts to psychology listservs (e.g., Div. 53, 16, ABCT, SMA, ADAA child anxiety), as well as local university psychology, counseling, speech and language, and social work departments. During the camp week, staff typically schedule patients for the evening hours. During lead-ins, patients are seen on a priority basis. Additionally, some students continue to take summer courses or work other part-time jobs while also volunteering in the IGBT. Staff training is typically conducted over 2–3 days, reviewing and practicing CDI and VDI skills.

ASSESSMENT

Prior to beginning the camp, children are assessed to determine the fit of the camp. Assessments are often conducted over the phone (specifically for out-of-town families). A diagnostic clinical interview (typically the ADIS) must be conducted to determine if the child meets criteria for SM. Families are excluded from participating if the assessment determines that (a) the child has a more impairing diagnosis than the SM, or (b) if the child is nonverbal with all caregivers.

LEAD-IN SESSIONS

Structure

To facilitate stimulus fading, individualization, child preparedness for the group component, parental support of skills to be learned, and overall program effectiveness, prior to participation in camp, families complete "lead-in" sessions. These sessions are held at the clinic and entail a parent focused Teach session (described below) followed by "fade-in" sessions. These sessions are typically held during the week immediately prior to camp, and the goal of these sessions is for the child to speak to at least two program staff consistently without their caregiver present, prior to starting the group component of camp. Failure to meet this criterion may indicate that the child may not be ready for a group intensive format and may benefit first from other treatment options (e.g., medication, individual intensive behavioral treatment). For children who do not meet the requirement of speaking to two program staff, a modified 1:1 intensive is typically offered to families. Families vary in the amount of Teach sessions and "fade-in" sessions needed, with most families requiring one 45-minute Teach session and, on average, 4 hours of fade-in sessions (typically scheduled in 2-hour blocks

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either on the same day or different days). We describe each of these two types of lead-in sessions, in turn, below.

Teach Session

The Teach session is typically a 45-minute session that orients parents to the skills and structure of the fade-in sessions. It can be held in office, or for out of town families traveling for IGBT it can be held via videoconferencing. Specifically, parents are provided with psychoeducation about the nature of SM, as well as brief overviews of Child Directed Interaction (CDI) skills, Verbal Directed Interaction (VDI) skills, and how to use a contingent rewards to reinforce successive approximations toward increased verbalizations (i.e., "brave talking"). These skills are then role-played to assist parents in learning how to use the skills with their child.

CDI skills are adapted directly from PCIT (Eyberg & Funderburk, 2011) and are used to reinforce children for verbal behavior with positive attention as well as to increase child comfort with new individuals. Whereas the CDI skills were originally developed to reinforce appropriate and compliant behavior in children showing serious conduct problems (see Elkins, Mian, Comer, & Pincus, 2016), in IGBT parents are taught to focus social reinforcement strategies toward child vocalizations, verbal responsiveness, and prosocial behavior. CDI skills are to be employed during interactions in which the parent is to follow the child's lead. Video 1 provides an example of effective CDI skills.

Specifically, during such child-led interactions, parents learn to use Praise, Reflection, Imitation, Description, and Enthusiasm (i.e., *PRIDE* skills) to reinforce positive, brave, and verbal behavior. For example, parents are encouraged to praise their child for wanted behavior (e.g., "great job playing with me," "thanks for using your words"), describe their child's behavior that they want to see more of (e.g., "you're playing with the Legos now," "you're using your words), and reflect any instances of child speech (e.g., child says, "I like blue," then the adult says, "you said you like the color blue"). Additionally, as in traditional PCIT for conduct problems (Eyberg & Funderburk, 2011), parents also learn to ignore minor misbehavior and to avoid commands, critical statements, and questions during CDI.

In the Teach session, parents also learn VDI skills to directly prompt and reinforce child speech in ways that optimize the likelihood of eliciting verbal responses. Parents learn to apply these VDI skills in situations in which their child is hesitant to respond (e.g., when a stranger or adult confederate is in the room). Specifically, after using CDI skills to help ease the child into the situation, parents are encouraged to ask forced-choice questions, in which the answer is given as a choice within the question (e.g., "Do you want to play with the trains or the blocks?"). Open-ended questions (e.g., "What do you want to play with next?") are also encouraged but may be slightly more challenging for children with SM than forced-choice questions. Yes/no questions (e.g., "Do you want to play with the trains?") are strongly discouraged, as children are significantly more likely to answer such questions with a nonverbal response (e.g., head nod, pointing, gesturing) rather than a verbal response. Parents are taught to give their child an ample opportunity to respond (at least 5 seconds) to any given question. Questions can be repeated up to three times (with at least 5 seconds of response opportunity in between) until the child responds. If the child fails to respond after the third prompt then parents are taught to modify the prompt to make it less challenging for the child (e.g., convert an open-ended question to a forced-choice question, or vice versa). If the child still does not provide a verbal response, the child is taken to a separate space to practice. If the child still struggles to respond, then the child is returned to the last situation in which he or she was successful in answering a question. If necessary, the question can be revisited at a later time point, but ultimately the question should never be left unanswered. Parents also learn to use additional prompting, as necessary, to ensure verbal responses. For example, if the child provides a nonverbal response to a question (e.g., head nod), the parent learns to how to prompt for a verbal response (e.g., "I see you nodding your head. Please use your words to answer" or "I see you nodding your head, but I don't know what you're trying to tell me"). Video 2 provides an example of effective VDI skills.

In the Teach session, parents are also introduced to a customized reinforcement system to be used in the fade-in sessions (described below), as well as throughout the camp and beyond. This reinforcement system entails a reward chart presented on a portable dry erase board that incorporates the child's interests (e.g., Paw Patrol, My Little Pony) in the background. For every verbalization and/or positive social interaction the child earns a check. The child can earn up to 12 checks on their reward chart. Once they complete the reward chart they earn a gold coin that can be used to redeem prizes; stickers or other small reinforcers (e.g., jellybeans) may be given instead of checks if the child is unmotivated by the check system. Parents are taught that the reinforcers will be given less frequently over time for increasingly challenging verbal tasks/situations.

Fade-in Procedures

The second component of IGBT *lead-in* sessions promotes child verbalization with the camp staff via stimulus fading. This procedure begins with the child interacting solely with an individual with whom they are comfortable speaking (typically the parent) in a room by

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themselves. The set-up works best when the parent-child dyad is situated in a room with a one-way mirror, behind which the IGBT staff can monitor the interactions. For settings in which an observation room with a one-way mirror is not available, a live observation system can be set up by placing a computer or tablet with a webcam in the room with the parent-child dyad and using videoconferencing to allow the IGBT staff to monitor from a separate room. During these interactions similar to standard PCIT, the parent receives real-time guidance and prompting from the IGBT staff through a bug-in-the-ear device that allows the IGBT staff to speak to the parent without the child hearing. There is a range of technological options that can afford bug-in-the-ear parent guidance, including a walkie-talkie system with an earpiece, a phone with an ear bud, or a Bluetooth earpiece system.

While the parent is alone in the room with the child, the IGBT staff coaches the primary caretaker via the bug-in-the-ear through the skills (i.e., CDI, VDI, reinforcement chart) until the child is relatively comfortable and speaking consistently to the caretaker (i.e., completes at least one reward chart). A new individual (e.g., child's primary counselor during fade-in sessions) gradually moves closer and closer to the child, while the child continues to interact with their parent. The new individual (e.g., child's primary counselor during fade-in sessions) is typically a M.S.- or Ph.D.-level practicum student, extern, or undergraduate research assistant who has been trained on fading procedures and CDI and VDI skills. Using fading procedures (Furr et al., 2019), the new individual only moves closer to the child when the child is consistently verbalizing to their parent. The new individual might start by opening the door slightly and sitting in the hallway looking the other way while the parent uses the CDI and VDI skills and uses the reinforcement chart. After the child eventually resumes consistent speech with the parent, the new individual might open the door further, but still not be directing their gaze at the child. This process continues as the new individual gradually enters the room, and moves slightly closer to the parent-child dyad.

Eventually, the new individual would move close enough that they can hear and interact with the child. When the child is consistently verbalizing in front of the new individual, the new individual may begin to use CDI skills (e.g., praise for speaking) and then VDI skills (e.g., ask the child a forced-choice question), while utilizing shaping (Furr et al., 2019) and positive reinforcement strategies to encourage the child to speak directly to him or her (see Video 3 for an example of a fade-in). Once the child is consistently verbalizing to the new individual, the parent gradually exits the situation at a roughly similar pace (i.e., fade-out). The majority of children meet the criteria of speaking to two camp staff after fade-in sessions using the fading process (Cornacchio et al., 2019). Other methods, including gradual shaping of sounds to speech, iPad games eliciting speech, videos and self-modeling, can be used to prepare the child to meet the criteria to enter camp.

CAMP

Overview

The core of IGBT is a multi-day course of all-day group sessions for children held in a simulated classroom setting, referred to as "camp." In the IGBT model tested by Cornacchio and colleagues (2019), the camp consisted of a 5-day Monday through Friday program held from 9:00 A.M. to 5:00 P.M. during a summer week. Typically, there are between 6 and 12 children in an IGBT classroom, grouped by age (e.g., children aged 3–5, children aged 5–7, children aged 8–10). With sufficient staffing and patient volume, IGBT programs can simultaneously run multiple classrooms at the same time. Given that programs are often run in the summer, many IGBT programs have been run out of schools where classrooms can be rented. Alternatively, conference room space can be used as a modified classroom.

Each child is paired daily with a "primary counselor" (i.e., 1:1 staffing model) who is responsible for assisting the child throughout each task and scheduled activity while using CDI and VDI skills, and the child's reward chart, to reinforce adaptive and speech behaviors. To promote speech generalization, the child's primary counselor rotates throughout the week as the child is deemed ready for this transition. The camp is structured much like a school or camp week. In general, the schedule and domains targeted are similar each day, though the specific activities and level of difficulty of activities changes. The difficulty of daily activities is titrated upward throughout the week in order to promote gradual and systematic exposure to increasingly challenging and more generalizable situations. For example, although a period of time devoted to "warm-up" is allotted each day, the amount of time is reduced (i.e., 30 minutes on days 1 and 2; 15 minutes on days 3–5). Therefore, many activities overlap in content or context, but as the week progresses, counselors challenge children to demonstrate increasing steps toward independence and spontaneity in their verbal and/or social behaviors.

Scheduled Activities

While the schedule for each day is unique, each activity is designed to target and/or simulate an array of experiences that children typically encounter in their daily lives. For example, throughout the day there are a number of tasks that target ordering (e.g., selecting snacks, ordering lunch, treasure chest), speaking with adult figures (e.g., asking for help from camp counselors,

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asking for clues for a scavenger hunt), interacting with peers (e.g., games, sports, lunch), and group participation (e.g., "show and tell," morning meeting, classroom introductions). Figure 1 displays a sample schedule of an IGBT camp.

Each day begins with a warm-up period (i.e., Centers), during which children are engaged in free play. During this time the child interacts with their primary counselor and the counselor focuses on using CDI skills and slowly introduces VDI skills. The goal of this time is to support children in becoming comfortable and feeling successful in the classroom environment without an expectation of speech. The amount of time dedicated toward warm up decreases throughout the week. During activities throughout the rest of the day, counselors engage in CDI and VDI skills, as well as implement the reward chart, scaffolding the level of difficulty based on the child's speech progress and difficulty of the situation.

Each day, the first structured activity is the morning meeting. A different counselor leads the morning meeting each day to provide children with novel social interaction opportunities. Throughout the morning meeting, all the children are prompted to answer questions, share information, and participate in activities in front of the group, much like what most morning meetings entail in early child classroom settings. Morning meeting typically begins with an introductory prompt for children to participate nonverbally, quickly followed by a prompt to share information verbally with the group (e.g., name, game/activity played that morning, number of coins earned so far). Each counselor works with his or her assigned camper for the day to identify appropriate goals for participation. For example, one child may immediately raise his or her hand and volunteer an answer to the IGBT lead teacher in an audible voice without support from his or her counselor, whereas another child may only whisper a response to his or her counselor at the back of the room. The morning meeting also includes a review of the daily calendar (e.g., date, weather) and schedule. During this portion of the morning meeting, children are prompted to answer questions, as well as volunteer to come up to the front of the group to fill in the appropriate information on various boards. Therefore, this activity facilitates both speaking and nonverbal participation in a group setting.

Each day, children either select or are assigned jobs. These jobs also mimic the roles children typically receive in classroom settings, such as "line leader" or "snack helper." Throughout the day, counselors prompt children to remind them of their jobs. For example, at snack time, the IGBT lead teacher may call out, "Who wants to be snack helper today?" and wait for a child to raise his or her hand. The primary counselor paired with that child supports the child in volunteering this information verbally, as well as carrying out the responsibilities associated with his or her job, as needed. For some children, making decisions is a particular challenge (and therefore, an appropriate intervention target). For these children, counselors may initially facilitate job selection by offering fewer options or assisting in selection. However, the goal of this activity is ultimately for children to make decisions on their own.

Below is an example of a counselor assisting a child with participating in job selection in which the child successfully responds to the IGBT lead teacher:

> IGBT LEAD TEACHER: *It is time to pick jobs for today. Raise your hand to tell me what job you want to do today.*
> COUNSELOR [to their assigned child in the group]: *We need to pick a job for today. You can pick to be a snack helper, line leader, or lunch helper. Which job do you want to pick today?*
> CHILD: *Snack helper.*
> COUNSELOR: *Great! You get a check for answering that question. Raise your hand to tell Ms. Jami* (IGBT LEAD TEACHER) *that you want to be snack helper and you will get two more checks.*
> IGBT LEAD TEACHER [to child with hand raised]: *I see you raising your hand. What job do you want to pick today?*
> CHILD: *Snack helper.*
> IGBT LEAD TEACHER: *Great job telling me you want to be snack helper! Here's a coin for answering in front of the group.*
> COUNSELOR [to child]: *Great job being brave saying you want to be snack helper. You get two checks.*

If the child fails to respond in the group, the role of the counselor is to scaffold the question to assist the child in successfully using speech to respond to the prompt. Below is an example of a counselor assisting a child with participating in job selection in which the child has difficulty responding to the IGBT lead teacher:

> IGBT LEAD TEACHER: *It is time to pick jobs for today. Raise your hand to tell me what job you want to do today.*
> COUNSELOR [to child amongst the group]: *We need to pick a job for today. You can pick to be a snack helper, line leader, or lunch helper. Which job do you want to pick today?*
> CHILD: *Snack helper.*
> COUNSELOR: *Great! You get a check for answering that question. Raise your hand to tell Ms. Jami* (IGBT LEAD TEACHER) *that you want to be snack helper and you will get two more checks.*
> IGBT LEAD TEACHER [to child with hand raised]: *I see you raising your hand. What job do you want to pick today?*
> [IGBT lead teacher waits 5-10 seconds for a response and child does not respond. IGBT lead teacher asks the child's counselor for the child's job selection. With that response the IGBT lead teacher reframes the question to a forced choice question.]

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	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00AM	Day planning / supervision with master supervisor Warm up time for separation anxious children	Day planning / supervision with master supervisor Warm up time for separation anxious children	Day planning / supervision with master supervisor Warm up time for separation anxious children	Day planning / supervision with master supervisor Warm up time for separation anxious children	Day planning / supervision with master supervisor Warm up time for separation anxious children
9:00AM	Centers (warm-up activities)	Centers (warm-up activities)	Centers (warm-up activities)	Centers (warm-up activities)	Centers (warm-up activities)
			Morning Meeting	Morning Meeting	Morning Meeting
	Counselor / Kid Introductions	Morning Meeting			
	Morning Meeting		Sports Skills Activity (with non-IGBT classroom)	Art (with non-IGBT classroom)	Travel to Field Trip
10:00A		*I Have Who Has* game			Field Trip Scavenger Hunt
	Create Token Bags / Snack				
		Nurse Preparation			
	All About Me Project / Introductions	Nurse Visit	Bathroom Break / Transition	Show & Tell Practice / Snack	
11:00A			Show & Tell Practice / Snack		
	Snack Shop Preparation	Snack Shop Preparation		Scavenger Hunt	
			Snack Shop		Order Lunch in Field Trip Food Court
	People Bingo Game	*Puppet Making* Activity			
12:00P			Bathroom Break / Transition		
	Bathroom Break / Transition	Bathroom Break / Transition	Lunch (with non-IGBT classroom)	Bathroom Break / Transition	
	Lunch	Lunch		Lunch (with non-IGBT classroom)	Travel Back to School
			Recess		Show & Tell Practice
1:00PM	Recess	Recess		Recess (with non-IGBT classroom)	
			Bathroom Break / Transition		Show & Tell (parents attend)
	Bravery Lesson	Bravery Lesson	Bravery Lesson	Bravery Lesson	
2:00PM					Ice Cream Social (parents attend)
	Brave Muscles Worksheet Treasure Chest	Snack Shop	*Conversation Starters / Brave Muscles* Treasure Chest	Field TripPractice / *Brave Muscles* Treasure Chest	
					IGBT Certificate Ceremony (parents attend)
		Brave Muscles Treasure Chest			
3:00PM	Parent Training Didactics Supervision with head classroom supervisors / Childcare	Parent Training Didactics Supervision with head classroom supervisors / Childcare	Parent Training Didactics Supervision with head classroom supervisors / Childcare	Parent Training Didactics Supervision with head classroom supervisors / Childcare	Treasure Chest
4:00PM		Parent Coaching / Didactics / Roleplays	Parent Coaching / Didactics / Roleplays	Parent Coaching / Didactics / Roleplays	

Figure 1. Sample IGBT Camp Schedule

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IGBT LEAD TEACHER [to child]: *Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
IGBT LEAD TEACHER: *Great job telling me you want to be snack helper! Here's a coin for answering in front of the group.*
COUNSELOR [to child]: *Great job being brave saying you want to be snack helper, you get two more checks.*

If the child still failed to respond to the question with a forced choice question, then the counselor would continue to scaffold the process to help make it easier for the child to verbally respond to the question in the group. Below is the continuation of the sample script if the child would not have responded to the forced choice question:

IGBT LEAD TEACHER [to child]*: Do you want to be snack helper or line leader?* [IGBT lead teacher waits 5 seconds for a response and child does not respond. IGBT lead teacher asks the same question again to give the child a second opportunity to answer. If child still fails to respond, the IGBT lead teacher asks the child's counselor to practice with the child until they are ready to respond. In this situation the counselor would practice and repeat the question with the child until they felt comfortable to answer to the IGBT lead teacher. The goal is to keep the child in the same room to practice, but there is flexibility to take the child to a separate place in- or outside of the room to practice.]
COUNSELOR: *I know that was a little hard. Let's practice what you told me before. Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
COUNSELOR: *Snack helper. Great job telling me! You get one check on your chart. Do you want to practice one more time or are you ready to tell Ms. Jami* (IGBT *lead teacher*)*?*
CHILD: *Practice.*
COUNSELOR: *Practice. Thanks for telling me. You get one check. Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
COUNSELOR: *Snack helper. I love how you said that nice and loud. Raise your hand to tell Ms. Jami you want to be snack helper.*
IGBT LEAD TEACHER [to child with hand raised]: *I see you raising your hand. Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
IGBT LEAD TEACHER: *Snack helper. Great job telling me you want to be snack helper! Here's two coins for answering in front of the group.*
COUNSELOR [to child]: *Great job being brave saying you want to be snack helper, you get three checks.*

For some children, especially on the first day of camp, the group setting is often the most difficult situation for them to engage in verbalizing. If after this type of scaffolding the child still fails to respond, the counselor can choose to continue to scaffold by removing the child and practicing further away from the group, or outside the room. Additionally, the counselor can engage in a different form of scaffolding by changing their own position using shaping strategies. For example, the counselor can have the child stay in the circle and the counselor can move towards the center (towards the IGBT lead teacher) until the counselor is next to the IGBT lead teacher, while continuing to answer the question. Once the counselor is right next to the IGBT lead teacher, the IGBT lead teacher can ask the question. Below is a sample script of such an interaction, after the child failed to respond to the IGBT lead teacher and the child had already practiced with the counselor:

[Child is positioned along the circle, counselor is directly in front of the child in the middle of the circle at close distance.]
COUNSELOR: *I have an idea! When you can tell Ms. Jami* (IGBT lead teacher) *you will get one coin! Let's practice what you told me before. Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
COUNSELOR: *Snack helper. Great job telling me! One check.*
[Counselor moves slightly further away from the child, toward the center of the circle and the IGBT lead teacher.]
COUNSELOR: *Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
COUNSELOR: *Snack helper. Great job telling me! One check.*
[Counselor moves slightly further away from the child, toward the center of the circle and the IGBT lead teacher. This process repeats until the counselor is directly next to the IGBT lead teacher.]
COUNSELOR [directly next to IGBT lead teacher]: *Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
COUNSELOR: *Snack helper. Great job telling me! One check. Now tell Ms. Jami* (IGBT lead teacher).
IGBT LEAD TEACHER: *Do you want to be snack helper or line leader?*
CHILD: *Snack helper.*
IGBT LEAD TEACHER: *Snack helper! Thanks so much for telling me! Now I know you want to be snack helper! You get two coins for being so brave!*
COUNSELOR: *Great job telling Ms. Jami* (IGBT lead teacher) *that you wanted to be snack helper! Here is your coin.*

Lunch and recess are times for children to continue practicing their brave talking and social skills, while also receiving a break from structured exposures. During this time, rather than having each child paired with his or her counselor, a less dense ratio of approximately one

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counselor per four children is utilized. IGBT lead teachers and the child's counselors decide if any of the children may benefit from continued one-on-one time with their primary counselor. This allows counselors to continue to facilitate peer interactions, while also removing some of the intensity and pressure for children to speak consistently. Additionally, while children are invited to participate in occasionally structured activities during recess (e.g., freeze tag), counselors are also encouraged to give children agency in choosing how they would like to spend their time. Typically, this incorporates clinical judgment and balance between placing demands on a child to participate in a group activity and allowing a child to isolate themselves. Ideally, during this time, all children are within close proximity to one another, but specific demands related to participation, socialization, and verbalization are reduced.

In addition to a primary focus in IGBT on behavioral reinforcement strategies, IGBT also integrates emotion recognition skills, cognitive restructuring, and coping strategies into the treatment program. These strategies are incorporated in the form of structured group Bravery Lessons held near the end of each day. The content of the Bravery Lesson varies each day (including review of previously covered topics throughout the week), but typically incorporates activities that teach relaxation strategies, coping thoughts, mindfulness exercises, identifying and sharing feelings, as well as problem-solving anxiety provoking situations (e.g., asking to go to the bathroom at school, approaching or responding to unfamiliar peers). The Bravery Lessons are tailored to classrooms (broken up by age and developmental levels), such that the content and activities are similar across classrooms but are adapted so that they are age and developmentally appropriate. A Brave Muscles activity is also included daily to reinforce the skills by helping children identify how they were "brave" to help them recognize their growth and their successes.

Throughout each day of IGBT camp, children earn coins for their brave behavior by completing their reward chart. At the end of each day, children count the coins they have earned with the assistance of their counselor, and cash them in for a prize from the treasure chest (or prize store). All prizes in the prize store are valued the same. During this activity, children are given the opportunity to independently approach and select the prize they have earned for the day, without support from their counselors. They are asked by the counselor at the prize store to name the prize they have selected and share verbally how many coins they earned throughout the day. The counselor leading the activity scaffolds the question type (i.e., open-ended to forced-choice) as necessary. If the child is unable to respond, they go with their counselor to practice and return to collect their prize when they are ready. If they fail to complete the task without assistance from their counselor, then the counselor can assist with similar scaffolding procedures previously described. However, the goal is for the child to successfully verbally respond with progressively less assistance from their counselor throughout the week.

Once children receive their prize (Monday through Thursday) they are transitioned in to "childcare" from 3:00 P.M. to 5:00 P.M., while parents participate in parent training. During childcare, children are allowed free time to play with any games or engage in any activities they choose. All childcare counselors are trained in CDI skills, and many of them are the same staff members who served as counselors earlier in the day. During childcare, counselors use only CDI skills and do not prompt children to engage or speak, in order to allow children time to relax after a long day. Typically, children engage with one another during childcare and have opportunities for further brave talking practice.

PARENT TRAINING

In addition to participating in an initial individual Teach session at the outset of IGBT and live coaching during lead-ins, parents participate throughout IGBT camp in daily group parent-training sessions, Monday through Thursday from 3:00 P.M. to 5:00 P.M. (during childcare). During this time, a lead clinician (usually the IGBT director or a class supervisor) reinforces the skills that have been introduced in treatment and teaches strategies for implementing them through didactics and role-plays. During these daily group parent-training sessions, parents are more thoroughly introduced to CDI and VDI skills, and are provided a more in-depth psychoeducation on fear, anxiety, and the cycle of reinforcement. Parents are also taught strategies for avoiding "contamination" that can interfere with child progress in new settings. In the context of SM, *contamination* refers to a negative reinforcement process in which repeated exposure in a given setting to acceptance and/or accommodation of nonverbal responses (e.g., teachers accepting nonverbal responses from a child, or a child being allowed to whisper responses to one special friend in a classroom who speaks aloud for him or her) ingrains a child's lack of speech in that setting. When a given new setting gets "contaminated," it becomes increasingly challenging for the child to provide verbal responses in that specific setting, relative to an "uncontaminated" setting. Further, parents are provided with tips and resources for communicating their child's difficulties and treatment strategies to their child's school and teachers. Each day during the latter hour of parent training, parents are coached by a clinician (usually a class supervisor or IGBT lead teacher) as they practice the skills they are learning and lead their child through exposures (e.g.,

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ordering a snack from a snack shop, asking a peer a question in a group, asking for help at the school office).

Children are pulled temporarily from childcare to participate in these exposures while their parents are live coached. Parents rotate throughout the week so that each parent has the opportunity to practice at least once with their child. The IGBT lead teachers arrange for small groups of 2–3 children with their parents to practice the exposures. Given the size of the groups, the rest of the parents are offered an opportunity to have questions answered by the lead clinician about SM, and also offers the group time to share their experiences and/or offer support to other families. The parents are coached on how to practice the tasks prior to attempting them. Based on the child's progress throughout the day, and/or their ability to practice with the parents, the clinician will select a child to attempt the exposure while the other 1–2 children practice. This allows for the clinician to individually coach the parent if their child has difficulty with the exposure. Below is a sample script of a clinician coaching a parent through ordering a snack with their child:

CLINICIAN: *Parents, we are going to practice ordering a snack with your kids. They have already practiced with their counselors during the day. The options for snacks are chips, fruit, or cookies. The chip options are Doritos, Cheetos, and Lays. The fruit is an apple or banana. The cookies are chocolate chip or peanut butter. Practice with your child by asking them what kind of snack they want. Once they select the type of snack, ask them which option specifically. I will be here to assist you before we go ahead and order the snack.*
[The clinician should be able to listen in on all the practice and assist if any of them need help. Once the group is ready or the clinician knows one child is ready, they can head to the order counter.]
CLINICIAN (to family they believe is ready): *Looks like your child is ready. Go ahead and help them order.* (To other families): *Keep practicing and I will let you know when it is your child's turn.*
SNACK CLERK (to child): *What would you like to get?*
[Child does not respond.]
CLINICIAN (to parent): *Let the snack clerk know to give you a minute. Then practice the question again in front of the snack clerk. If they can answer, then have the snack clerk ask again.*
PARENT: *Remember what we practiced. What snack would you like?*
CHILD: *Chips.*
PARENT: *Chips. Great! One check. Now tell her for two checks.*
PARENT (to snack clerk): *Could we ask again please?*
SNACK CLERK: (nods yes). *What would you like to get?*
CHILD: *Chips.*
PARENT: *Great job answering! Two checks.*
SNACK CLERK: *What kind of chips?*
[Child does not respond. Parent practices similar sequence and child still does not respond. The clinician then jumps in to coach the parent on scaffolding the skills.]
CLINICIAN (to parent): *It looks like that one might be a little more difficult. Go ahead and practice where she answered originally. Then practice in front of the snack clerk and then have the snack clerk ask the question again.*

Once the child and family complete the sequence, the clinician then coaches the other parents in the group. Typically, the parents are coached through 3–4 scenarios that include situations with adults, peers, and groups. Parents of other children in the IGBT who are not being coached often rotate through being the snack clerk to give them the opportunity to observe other parent-child dyads and live coaching from the clinician.

School Outreach

Upon completion of the program, families receive a report documenting their child's initial diagnoses, information about the behavioral conceptualization of SM and about IGBT, and specific recommendations about how to manage the child's anxiety and promote child verbalization in the school setting. Furthermore, two 2-hour teacher trainings are offered by a lead clinician prior to the beginning of the upcoming school year. Any teachers or other school staff members involved in the child's care are invited to attend one of the two offered training times. They may attend in-person at the clinic or via live webcast or videoconferencing session. Additionally, the trainings are recorded for teachers unable to attend. Similar to the IGBT parent-training sessions, the IGBT teacher trainings introduce the CDI and VDI skills and reinforcement system, such as a daily report card or behavioral chart as mentioned above, that can help promote child speech and participation. These trainings include didactics and psychoeducation as well as role plays with the other teachers and clinicians. School-home communication is pertinent in order to implement a reinforcement system similar to the camp reward chart. Teachers are also given handouts and recommended readings that review the skills covered throughout the trainings. Handouts include a brief overview of SM, treatment guidelines, CDI rules, how to ask questions, and sample CDI and VDI sequences (treatment guidelines, how to ask questions, and VDI sequences sample included in Supplemental Material).

Booster Sessions, as Needed

Given that families that participate in IGBT often do not live locally and that some children and families still need additional support, we provide the opportunity for

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booster sessions as needed. Depending on a family's need, there are three different types of boosters offered: group booster days, videoconferencing sessions, and in-person individual sessions. Most children have made substantial gains by the end of the camp and benefit most from group booster sessions every few months. The group booster day is run similar to a camp day, often offered on a weekend or school break. Videoconferencing sessions (see Doss et al., 2017) are typically offered for out-of-town families needing additional support. These sessions can vary depending on the child's specific needs and can include practice for a particular situation with which the child is still struggling. For example, a 1-hour videoconferencing session can include practicing a presentation like "show and tell." Additionally, school consultations with teachers or staff, or attending IEP or 504 plan meetings can also be included as a booster session if needed. Lastly, for children who are still experiencing significant difficulties, we offer in-person individual sessions, again focusing on practicing the skills and exposures specific to the child's needs.

EMERGING EMPIRICAL SUPPORT FOR IGBT

Recent efforts have begun to establish the empirical support for IGBT for SM. Several presentations at professional conferences (e.g., ABCT, SRCD, SMA) have shown pilot trials that have demonstrated the clinical significance of the IGBT-SM model, highlighting the effectiveness of the intervention from the open clinical trials (Barroso et al., 2017; Cornacchio, Furr, et al., 2017). However, to date only one study has examined the efficacy of the IGBT-SM using an RCT. A recently completed randomized controlled trial evaluated the feasibility and preliminary efficacy of the IGBT for SM in a sample of children diagnosed with SM between 5 and 9 years old (Cornacchio et al., 2019). This study employed a randomized waitlist-controlled design (N = 29), comparing children receiving IGBT immediately to children on a 4-week waitlist (waitlisted children participated in subsequent IGBT immediately following the 4-week waitlist period). Results demonstrated significant treatment response among children receiving IGBT, whereas children on the waitlist did not improve. Immediate posttreatment results found significantly greater improvements in social anxiety severity, verbal behavior in social settings, and global functioning among IGBT-treated children relative to waitlist children. Follow-up evaluations during the following school year of treated children found that, with time, improvements even broadened across additional domains—such as reduced SM severity, increased verbal behavior in the home setting (e.g., with babysitters, family members) and reduced overall anxiety. These findings include controlling for service use between post and follow-up, where about 35% of families reported receiving some type of mental health service following the IGBT (Cornacchio et al., 2019). Further, the teachers of IGBT-treated children in the following school year reported significantly improved verbal behavior in the classroom as well as significantly decreased academic and social impairment in school, relative to teachers of IGBT-treated children in the year prior to treatment. Moreover, families reported high satisfaction with the IGBT program and low perceived barriers to treatment participation; daily attendance was 100% with only two families (out of 29 total families) choosing not to participate in treatment (both families were waitlisted families choosing not to participate in treatment following the waitlist period). Taken together, these results provide promising initial empirical support for the efficacy of IGBT for SM.

Discussion

IGBT for SM was developed to expand the portfolio of treatment options for youth with SM by offering brief, but high-dose, expert intervention in a group intensive format. IGBT works directly with affected children in classroom-based settings, with parent- and teacher-focused components working to increase speech in new environments and with new individuals. IGBT for SM builds on established cognitive-behavioral treatments for youth anxiety (Kendall & Hedtke, 2006; Suveg et al., 2006), parent training programs for early child problems (Elkins et al., 2016; Eyberg & Funderburk, 2011), and SM-specific weekly outpatient treatment programs (Bergman et al., 2013; Oerbeck et al., 2014). As in other anxiety-based PCIT adaptations (Comer et al., 2012), IGBT for SM emphasizes the use of positive attending behaviors, active ignoring, and modeling to reinforce preferred child behavior (i.e., verbal social behavior) and extinguish patterns of avoidance in anxiety-provoking situations. This intensive treatment also draws heavily on exposure-based strategies to increase child experience with and mastery of verbal behavior in classroom and other social settings, incorporating traditional CBT components such as reinforcement systems, prompting, shaping, systematic desensitization, modeling, and social skills training (see Cornacchio, Sanchez, et al., 2017).

IGBT for SM is novel in structure and intensity. Whereas previously supported treatments for children with SM typically are implemented as individual sessions, once or twice a week (Bergman et al., 2013; Oerbeck et al., 2014), IGBT for SM benefits from access to other affected children via the group setting and allows for more frequent interactions during the camp intensive week. Additionally, the camp has often been conducted in conjunction with other summer treatment programs (if other camp-like programs are offered nearby or within the same organization) and therefore has allowed for

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children in the camp to interact with other children (e.g., typically developing children; children with ADHD) who can often be more challenging for children with SM and similar to school peers. Furthermore, given the typical camp day is intended to have similar activities to school activities, IGBT can help prepare children with SM for the school environment and associated classroom-based verbal expectations (e.g., art class, sports skills/games). For example, on the last day of camp one planned activity is “Show and Tell.” Children with SM often find classroom presentations difficult and holding this activity on the last day of camp gives treated children time to prepare throughout the week with their camp counselor as well as present to the class. The idea is to create as many supportive, yet challenging, verbal expectation opportunities as possible throughout the camp week, affording key therapeutic experiences in which treated children can practice verbal behavior in situations that typically occur in public, school, and social situations.

Given variability in symptom presentations and comorbid diagnoses, a strength of the program is that it is highly individualized to each child, while also capitalizing on the group context to promote speech. For example, some children begin the program only speaking comfortably to their parents, while other children speak to a handful of family members and a very close friend or two. Since the program is individualized, each child’s treatment targets are tailored, with individually attainable goals. Furthermore, many children with SM present with other types of anxiety or behavior problems that can influence their SM treatment. For example, many children may present with debilitating separation anxiety. Children screening positive for separation anxiety may be asked to arrive at camp early each day (e.g., anywhere between 15 minutes to 1 hour early) to begin practicing separation from their parent and take additional time to ease into the parentless setting prior to the formal beginning of the day. During this time, the child and his/her parent typically play together for some time to warm up while the counselor gradually incorporates him- or herself into the play, similar to the fade-in procedure used during lead-in sessions.

Whereas a strength of IGBT for SM is the capability of individualized support in a group treatment setting, this can pose important feasibility challenges. A group setting may require families to delay receiving treatment or difficulty acquiring a group. However, given the difficulties with access to CBT for SM, our experience has been that we often have long wait lists for the group and fill up quickly, suggesting the high need for the program. Additionally, IGBT requires a very low staff-to-child ratio, given that each child has their own personal camp counselor, an IGBT lead teacher, and supervisors. However, IGBTs for SM can be incorporated into academic settings, creating mutually beneficial opportunities for students, interns, externs, and practicum trainees to play key roles in program implementation as part of their training and/or course credit requirements. Moreover, although IGBT may offer some opportunities to overcome traditional barriers to care, the format can also present new feasibility challenges for families that can similarly limit the acceptability of care. Specifically, there can be high costs associated with IGBT participation for families who must travel to attend the camp, including the cost of airfare or other transportation, accommodations, and lost wages or lost revenue associated with a parent taking time off work to help their child participate. For IGBTs run in academic settings, leveraging unused college dormitory space for families in the summer months, operating on sliding scale payment structures, and creating treatment tuition scholarships can help overcome financial burdens for families with more limited resources. Additionally, there remain payer issues and reimbursement barriers for intensive treatment formats, as there is presently variability across insurers with regard to coverage for intensive services. Continued research on intensive treatment formats—with particular focus on issues of cost-effectiveness for insurers and families—will be needed in order to address limitations in relevant coverage.

Despite the limitations, IGBT-SM programs have been conducted in both academic and nonacademic settings demonstrating the feasibility of the model. Given the clinical enthusiasm promising initial support for IGBT for SM (Cornacchio et al., 2019; Kovac & Furr, 2019), future directions in the development, understanding, and dissemination of IGBT for SM should examine for whom the program is most effective and component analyses are needed to consider which components of the treatment model are most critical. In addition, given variability in longer-term maintenance associated with IGBT for SM, future research should evaluate how IGBT for SM can be incorporated into sequenced treatment models. Whereas an IGBT strategy may be highly effective for some children with SM, for others IGBT may not be indicated, may not be indicated in the absence of concomitant additional treatments (e.g., medication), or may not be appropriate without a sequenced treatment plan outlining second stages of treatment. For some children with SM, IGBT may only be the first step of a longer course of sequenced treatments, and for other children IGBT may never be an indicated treatment component. Although our program offers booster sessions as needed, not all families can continue to come to our clinic, and little is known about how to follow-up for families who are not located near an SM expert. Options for treatment following the IGBT include treatment with local generalist providers who receive consultation from

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SM experts, in-person boosters, and remote care (e.g., videoconferencing individual treatment; Doss et al., 2017). Additionally, for children still experiencing significant impairment, multimodal options (IGBT + medication) may be the best. Moreover, considerable research is still needed to examine longer term outcomes associated with IGBT. Although increasing evidence is supporting IGBT for SM (Cornacchio et al., 2019), the potential benefits of group treatments are well known. Dissemination efforts are needed to increase knowledge about IGBT options among families with a child with SM, as well as to increase the availability of providers with proficiency in IGBT methods.

On a final note, although SM is a highly debilitating child anxiety disorder associated with limited availability and accessibility of expert treatment services, increasing support for IGBT for SM offers tremendous promise for meaningfully expanding the portfolio of treatment options for affected youth. Continued research examining the maintenance of IGBT-related gains, the mechanisms of IGBT treatment response, and the role of IGBT in multimodal and/or sequenced treatment strategies is critical for continuing to overcome barriers to quality SM care and return affected youth to more adaptive trajectories of social functioning.

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