

EXPanding Receptive and Expressive Skills Through Stories (EXPRESS)

Language Formulation in Children With
Selective Mutism and Other Communication Needs

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Foreword

To say that I have been touched by selective mutism (SM) is an understatement. From a personal standpoint, understanding and treating SM has been my life's work and passion. Having been touched by SM when my daughter was 3½ years old, I realized the scarcity of knowledge in this area. Many children are misunderstood, misdiagnosed, and mismanaged.

It's been my life's work to help children with SM have their voices heard. As a physician, I began working with families whose lives were touched by this often misunderstood disorder. I started applying my medical knowledge to help them overcome SM. Within my clinical practice at the Selective Mutism Anxiety Research and Treatment Center (SMart Center), which focuses on understanding and treating SM, I realized early on that SM was more than not speaking and there are reasons for the development and maintenance of it.

Based on my experience over many years working with thousands of children with SM, I developed the Social Communication Anxiety Treatment (S-CAT®) approach. To validate this approach, two professors at La Salle University, Dr. Evelyn Klein, a speech-language pathologist and psychologist, and Dr. Sharon Lee Armstrong, a psycholinguist, became the principal investigators of the published study, *Social Communication Anxiety Treatment (S-CAT®) for children and families with selective mutism; A pilot study* (Klein, Armstrong, Skira, & Gordon, 2017). With support from the Selective Mutism Research Institute (SMRI), results showed that children with SM made significant progress in the families and schools where the recommended treatment strategies were implemented.

S-CAT® was designed to increase social comfort and progression of communication with the ultimate goal of increasing verbal output, and it does. However, at the SMart Center we became aware that there were some children who had speech and/or language deficits in addition to their selective mutism. Klein, Armstrong, and Shipon-Blum (2013) developed a technique that enabled identification of these speech and language issues in children with SM even though the children do not usually talk with professionals. Through my association with Dr. Klein, I came to appreciate that specialists in communication sciences and disorders could expand the receptive and expressive language skills of those children with SM who also have communication deficits.

An exceptional team inspired the work to come. Evelyn Klein and Sharon Lee Armstrong along with Donna Spillman Kennedy, a speech-language pathologist who had been integrating aspects of my S-CAT® philosophies into her clinical practice and providing outreach to schools, and Janice Gordon, previously a research associate at SMRI and a graduate student with Carolyn Gerber Satko in the Communication Sciences and Disorders Program at La Salle University, became the authors of EXPRESS. They applied many of my S-CAT® philosophies into the framework of this innovative program.

S-CAT® is based on the understanding that SM is a social communication anxiety disorder and a child's level of anxiety will change from setting to setting and from person to person. Depending on the setting/situation and the child's comfort level, they will move into a different stage of communication. Dr. Klein and authors have incorporated this important aspect of S-CAT® into EXPRESS. Where S-CAT® uses stages on the Social Communication Bridge®, the EXPRESS Program uses levels of communication.

Consistent with S-CAT®, EXPRESS recognizes the importance of a facilitator in treatment. Those with social communication anxiety disorders, such as SM, need someone to facilitate treatment strategies for them to progress and build the proper social communication skills. Therefore, it is also critical that the facilitator is able to reduce or increase communication demands on the child based on comfort level. EXPRESS also gives the facilitator (the Reader who may be a speech-language pathologist, teacher, clinician, parent, or others) the opportunity to do this.

A key aspect of S-CAT® is **helping children acknowledge and assess their anxiety** by rating their feelings using feelings charts (e.g., bar graphs, faces, etc.). This emphasis helps children learn coping skills as they feel more in control and can relate to their feelings. The facilitator respects and trusts the child when they indicate something feels scary or hard and then guides them with strategies appropriate to their comfort level. This allows for more rapport and trust. Within the EXPRESS Program, these same concepts are applied.

Within EXPRESS, as in S-CAT®, the philosophy focuses on ways to initially minimize processing demands. This is beneficial because anxiety disrupts processing and hence reduces thinking capacity and speed. Reasons for the anxiety vary from child to child. While some children with SM may have other anxieties in addition to communication anxiety, many have speech and language deficits and delays, which can further increase anxiety and reduce their ability to communicate effectively. All or some of these sources of anxiety may lead to the development and maintenance of SM. Treatment that focuses on ways to help lower anxiety enables a child to become more communicative. This is also true when working with children who have learning challenges, sensory issues, autism, or difficulties with bilingualism.

The EXPRESS Program reduces anxiety and processing load by using visuals such as pictures and words as well as providing choices and scripted questions in the story activities.

The EXPRESS Program is an excellent adjunct to a comprehensive treatment program for SM and related social communication disorders. It is also a stand-alone tool to help develop receptive and expressive language skills in children at varying stages of language development, even those without SM. The EXPRESS Program provides the child with structured activities using engaging stories and visual materials for learning vocabulary, question-answer routines, story grammar, sentence structures, phonemic awareness, and story generation.

Elisa Shipon-Blum, DO
President and Director
Selective Mutism Anxiety Research and Treatment Center (SMart Center)

Acknowledgments

The first five authors are most grateful for all the knowledge shared by Dr. Elisa Shipon-Blum who has treated thousands of children with selective mutism over many years. Her expertise has helped children with selective mutism communicate and has served as the inspiration for the EXPRESS Program

No project of this magnitude can be accomplished without the support of many. We also thank Robin Kushner, MA, CCC-SLP (Speech-Language Pathologist, Private Practice) who was involved in the initial work on this project, and Kelley Colbridge, Jaclyn Iovine, Samantha Mosca, Sarah Porch, Ashley Stump, Stephanie Weicker, and Owen Zinn, who were graduate students from the Communication Sciences and Disorders Department at La Salle University (Philadelphia, PA). We are most grateful for their ideas and valuable support throughout various stages of the development of EXPRESS. Finally, we are very fortunate to have worked with truly talented editors and a stellar production crew at Plural Publishing. Many thanks go out to Kalie Koscielak and Chip Achorn and their professional staff. Thank you!

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Sharon Lee Armstrong, PhD, is Associate Professor of Psychology and Director of PsyD Research & Dissertations at La Salle University, Associate Faculty Member at Rutgers University Center for Cognitive Science, and Research Consultant at Selective Mutism Research Institute. Her specializations within cognitive science are psycholinguistics, language development, concepts/categorization/semantics, reasoning, decision making, and metacognition, which she has investigated in selective mutism, autism spectrum disorder, schizophrenia, aphasia, and depression. She belongs to the Psychonomic Society, Association for Psychological Science (APS), APA Divisions of Experimental Psychology and Clinical Child & Adolescent Psychology, Selective Mutism Association (SMA), and Society for Philosophy & Psychology. She presents at national conferences (e.g., the

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Janice Gordon, MS, CCC-SLP, is a licensed and certified speech-language pathologist in private practice. Janice obtained her Master of Science from La Salle University, where she was a graduate research assistant and recipient of the Graduate Achievement Award in 2013. Her clinical practice has included assessment and treatment of preschool children with communication disorders in Bucks County, Pennsylvania, and conducting research at the Selective Mutism Anxiety and Related Disorders Treatment (SMart) Center. She presents at national and regional conventions, including the American Speech-Language-Hearing Association (ASHA), Pennsylvania Speech-Language-Hearing Association, SMart Center's Beyond the Basics Conference, and at the Selective Mutism Association's annual convention. Janice is published in *Clinical Child Psychology and Psychiatry*

on the topic of treatment for selective mutism and is a coauthor of the new publication, *EXPanding Receptive and Expressive Skills Through Stories (EXPRESS): Language Formulation in Children With Selective Mutism and Other Communication Needs*. Her diagnostic and treatment approaches are guided by the importance of collaboration between all members of her client's team.



Donna Spillman Kennedy, MS, CCC-SLP, is a licensed and certified speech-language pathologist who has dedicated her career to helping individuals with speech and language disorders communicate effectively. She provides a range of assessment and treatment services to clients across the life span through Integrated Speech Pathology, LLC, where she is a partner. Donna has been an Adjunct Professor at Kean University for 25 years, having taught lecture classes and supervised clinics. Areas of specialization include augmentative and alternative communication and selective mutism. Donna has been a strong advocate for ridding the silence of selective mutism through Social Communication Anxiety Treatment (S-CAT) developed by Dr. Elisa Shipon-Blum. She continues to be devoted to educating professionals and families regarding selective mutism and facilitating

a collaborative approach among all team members to promote successful communication in children. Donna presents on selective mutism and AAC regionally as well as nationally.

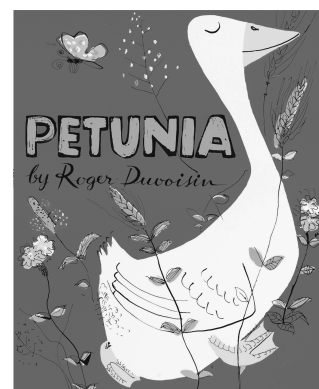
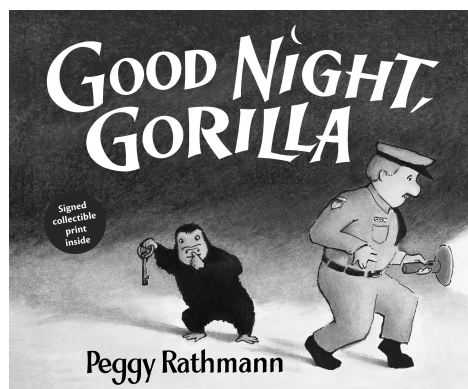
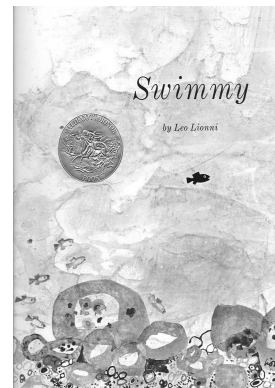
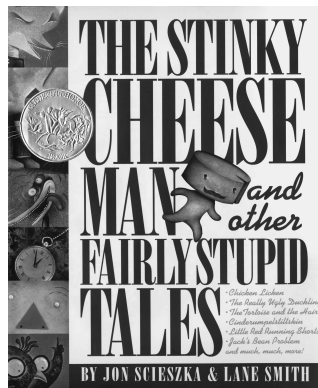
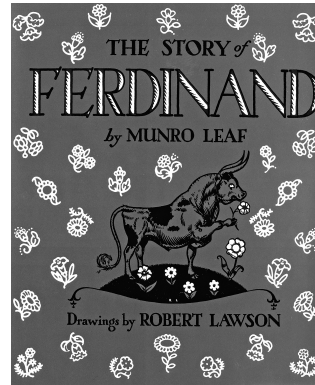
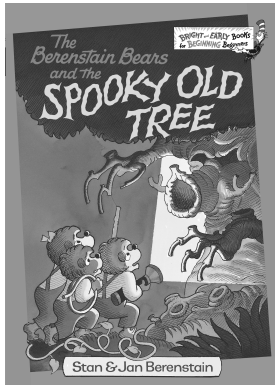


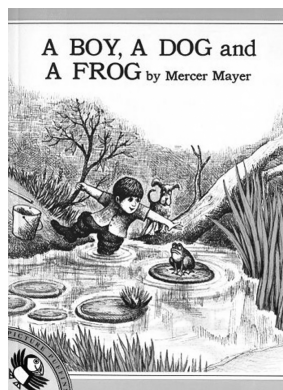
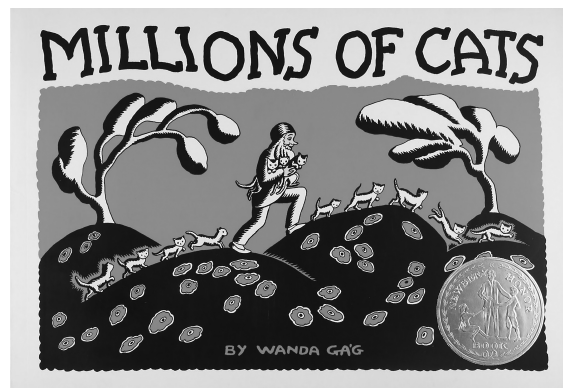
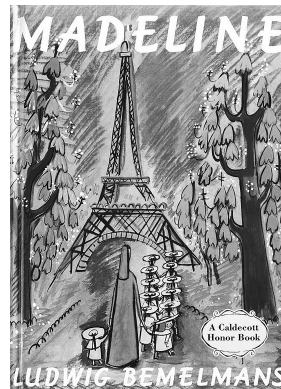
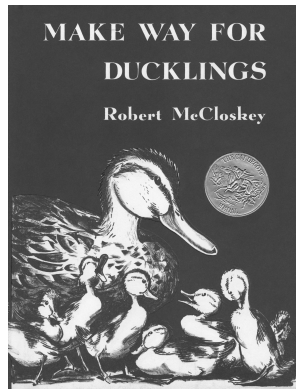
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Elisa Shipon-Blum, DO, is the President and Director of the Selective Mutism Anxiety and Related Disorders and Treatment Center (SMart Center) located in Philadelphia, Pennsylvania. She is Director of the Selective Mutism Research Institute (SMRI), which is a foundation started to study her theories and treatment methodologies on selective mutism. Dr. Shipon-Blum is the Founder and Director Emeritus of the Selective Mutism Association (SMA) and the Clinical Assistant Professor of Psychology and Family Medicine at the Philadelphia College of Osteopathic Medicine. Dr. Shipon-Blum has developed the evidenced-based therapy, Social Communication Anxiety Treatment or (S-CAT), from her years evaluating, treating, and researching individuals with selective mutism.

Some of Your Favorite Stories Are Included in EXPRESS . . .





The EXPRESS Program

EXPRESS: EXPanding Receptive and Expressive Skills through Stories is a story-based program for expanding expressive language formulation for children with selective mutism (SM), other language delays or disorders including language learning disabilities (LLD), autism spectrum disorders (ASD), social (pragmatic) communication disorder (American Psychiatric Association, 2013), or for children learning English as a second language (ESL). It can also benefit typically developing children who have had limited exposure to language, either orally or through reading. EXPRESS provides a tool for clinicians, educators, other professionals, and parents to develop receptive and expressive language skills in children at varying stages of language development. EXPRESS systematically promotes social engagement, communication, and literacy by building vocabulary and phonological awareness, promoting comprehension through question-answer turn-taking, practicing grammatical sentence constructions, and engaging in story-telling.

EXPRESS includes story activity modules corresponding to 25 popular children's stories. Each of these modules requires the corresponding storybook that can be purchased individually or within *The 20th Century Children's Book Treasury* (Schulman, 1998), a compendium storybook that includes all the stories included in the EXPRESS Program.

The EXPRESS Program was developed for children with SM who have reduced communication comfort, and receptive and expressive language challenges, as well as those who encounter difficulty with decontextualized language. It is also recommended for children who lack exposure to English, who do not readily vocalize, or who need to expand their language use.

It is beneficial for children who need more practice understanding and expressing their thoughts with decontextualized language. Decontextualized language is used in schools and this is the primary place where children tend to be mute. Decontextualized language involves making meaning from speech that includes limited amounts of background knowledge, less familiar vocabulary words, distant time referents, clausal structures, and complex syntactical constructions (Gee, 2014). In the school environment, new concepts and specific information are presented through decontextualized language learning experiences. Children with SM are most commonly mute as they encounter greater anxiety with increased cognitive-linguistic demands in that setting. According to Gee (2014) acquiring social language requires learning certain grammatical patterns and how to use them for social purposes. Using high interest stories with pictures and explicit text can help children become more familiar with vocabulary, increasingly complex sentences, and narrative language. When children listen to stories and learn to visualize the text, they often begin to feel more

comfortable expanding their language repertoire. According to Gee (2014), school is decontextualized in and of itself. Interestingly, this is when SM typically first appears and this is when children need to start treatment. Treatment in narrative language has been found to improve language comprehension and production in contexts of discourse and literacy for reading and writing. It is important for academic success, especially in children with language learning difficulties (Gillam & Gillam, 2016). Research has shown that children with language learning deficits need support to generate stories with greater vocabulary, more complex sentences, and literate language including story grammar (Gillam & Johnston, 1992). It has long been known that such work has a positive impact on comprehension, for both reading and spoken language (Reutzler, 1985).

Addressing Communication for Children With Selective Mutism and Other Communication Needs

The Express Program was designed to address communication and language skills in children with SM and other communication disorders. This program was inspired by reports from teachers and practitioners who noted that even when children with SM began to talk, their speech and language abilities were often compromised. The following problems have been identified in children with SM: (1) using sufficient words per sentence; (2) using compound and complex sentence structures; (3) retelling a story; (4) making up a story about a picture; (5) using imagination to convey thoughts; and (6) conveying information using language that was decontextualized (Klein, Armstrong, & Shipon-Blum, 2013) (see Figure 0–1).

The challenge for educators and practitioners is to be able to work with a child who talks minimally or not at all. The EXPRESS program builds communication skills through a systematic cognitive-linguistic approach which incorporates social engagement and learning through the use of children’s literature.

Information About Selective Mutism

Diagnosis of SM is typically made by a clinical psychologist or physician with knowledge about the disorder. Clinical diagnosis falls within the anxiety disorders section of the DSM-5 (*Diagnostic and Statistical Manual*–5th edition; American Psychiatric Association, 2013) (see Table 0–1). According to Kristensen and Torgensen (2001), there is a biological or genetic component of inhibited temperament and anxiety in individuals who have SM. Communication deficits often compound the disorder. However, no specific biological, psychological, or social factors capture the complexity of the development of SM (Viana, Beidel, & Rabian, 2009).

Gathering Information About the Child

A validated questionnaire, used primarily for research purposes, is the *Selective Mutism Questionnaire* (SMQ). The questionnaire is available in the textbook *Treatment for Children*

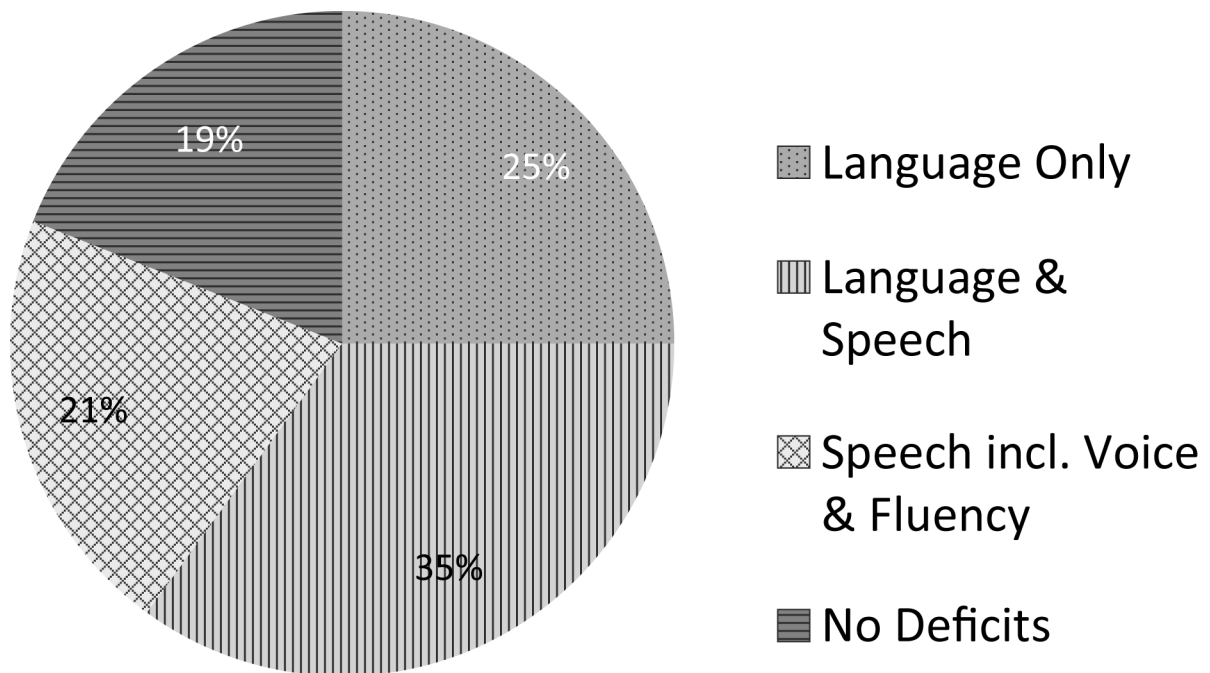


Figure 0-1. Percentage of communication deficits found in 146 children assessed with selective mutism. *Source:* Klein, Armstrong, & Shipon-Blum, 2013.

Table 0-1. Diagnostic Profile of Children With Selective Mutism (DSM-5)

Failure to speak in specific social situations despite speaking in others

Social communication is affected

Duration of at least 1 month (after first month of school)

The disturbance is not better accounted for by a communication disorder, pervasive developmental disorder, or mental disorder

Diagnosed (on average) in 1/142 children

With Selective Mutism (Bergman, 2013). Research on this tool can be found at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2925837/>. For acquiring a comprehensive overview of demographics, symptoms, treatment history, and information about patterns of the child's responding and initiating frequencies and skills across home, school, and public settings with various people, see the *EXPRESS Selective Mutism (SM) Communication Questionnaire for Parents/Caregivers* by Klein and Armstrong (2015) in Appendix D.

Characteristics and Special Considerations When Working With Children Who Have Selective Mutism

Over many years of working with children who have SM and their families, several observations have helped our understanding of how to work more effectively. These include: (1) an inherently timid temperament in many children with SM, (2) anxiety that is primarily in social realms where speech is expected, (3) not wanting to be overtly noticed, (4) an expressed desire to talk but having difficulty doing so, (5) an ability to vocalize that varies with different people and settings, (6) increased vocal tension in certain situations, (7) greater social comfort and control from muteness, (8) concern from family members, and (9) potential enabling from others who speak for them.

Recommended Strategies for Interacting With Children Who Have Selective Mutism

1. Limit direct speech and demands to the child, especially early in the relationship. Direct Wh-questions can be especially challenging. Being assertive and overly friendly can backfire by creating more anxiety. A more passive demeanor is best, at least initially during interactions.
2. Reduce eye-contact and don't focus on the child. Keep your focus on the objects you are working with when treating the child until comfort is achieved.
3. Don't call attention to talking or not talking. Try to avoid using the word *talk* or *speech*. Rather, use terms such as *sounds* and *using your words*.
4. Don't speak about the child in front of the child. Although the child may not be talking, he or she usually hears everything and may misconstrue intended meanings. If you need to speak to the teacher or a parent, do so when the child is not present.
5. Never coerce or trick the child to speak. This will certainly backfire. The child may lose trust in you and your progress may be compromised. Be certain to get the child's permission if you intend to do anything such as audio or videotaping them and playing it for others.
6. Reduce the number of people in the environment and expectations, especially when initiating the EXPRESS Program with the child. Incrementally increase the number of people who are present during the session. The presence of an additional person in the room can change the communication dynamic secondary to increased anxiety, which may cause the child to shut down. Proper preparation can promote communication comfort and success.
7. Any type of communication, including whispering, is better than no communication. Children with SM may have difficulty going from vocalizations (non-speech voicing) to verbalization (spontaneous speech production). This may be explained by the presence of laryngeal tension when attempts are made to initiate speech (Ruiz & Klein, 2014).
8. When asking a question, wait 5 seconds, and then if there is no reply, ask again. Waiting helps children process language and gather courage to try to answer. Asking a second time lets children know you will patiently give them more time and attempts to respond. Remember to avert eye gaze too.
9. Move from open-ended to forced-choice to yes-no questions if the child does not initially answer an open-ended question. For example, if asking, "What would you like to eat for

a snack?” and no answer is given, try a forced-choice question such as, “Would you like crackers, or a cookie, or something else for snack?” If still no answer, attempt a yes/no question. For example, “Would you like a cookie for a snack?”

Using EXPRESS With Other Children Who Have Communication Needs

While EXPRESS was developed primarily for children with SM, it provides a range of receptive and expressive language learning activities to help children who may be withdrawn and have a variety of communication needs. The program can easily be used with those who are on the autism spectrum, have language learning disabilities, social (pragmatic) communication disorder, and those who are learning English as a second language. It can also benefit children who have had limited exposure to language, either orally or through reading. “SM prevalence is higher than initially thought and at least three times higher in immigrant language minority children” (Toppoleberg, Tabors, Coggins, Lum & Berger, 2005, p. 592). Children who are learning English as a second language will benefit from learning new vocabulary in a variety of ways and receiving visual input from the pictures they see within the stories that they listen to in person and through videos. Whether gaining phonemic awareness through learning sounds of letters or using sentence completion (cloze technique) to complete thoughts verbally, children using EXPRESS enjoy the many features it offers. The EXPRESS program can also benefit children who are on the Autism Spectrum at Level 1: “Requiring Support” (DSM 5, APA, 2013). For these individuals, there are noticeable deficits in communication and social interaction which impact social-pragmatic functioning. In addition, anxiety is a common trait among people who have higher functioning autism (Gillott, Furniss, & Walter, 2001). The EXPRESS program provides a consistent and systematic approach within the structure of story activities to promote social comfort and language learning.

Organizational Framework for EXPRESS

The EXPRESS framework builds on the *Social Communication Anxiety Treatment (S-CAT)*[®] (Shipon-Blum, 2015) Model developed by Dr. Elisa Shipon-Blum. S-CAT[®] is an evidence-based program that helps children lower anxiety and increase social comfort for communication (Klein, Armstrong, Skira, & Gordon, 2017). An essential aspect of the S-CAT[®] Program is that it identifies children’s stage of communication comfort, depicted on the Social Communication Bridge[®] (see Figure 0–2). Dr. Elisa Shipon-Blum’s Social Communication Bridge[®] forms the basis for the EXPRESS Program.

The EXPRESS activities work directly with children at their stage on the Social Communication Bridge[®]. Stage 1 of S-CAT[®]–Nonverbal corresponds to language Level 1 in EXPRESS–Nonvocal communication. Stage 2 of S-CAT[®]–Transitional Verbal corresponds to language Levels 2 and 3 in EXPRESS–Indirect Communication and Direct Communication–Limited. Stage 3 of S-CAT[®]–Verbal corresponds to language Levels 4 and 5 in EXPRESS (Scripted Vocalization and Spontaneous Vocalization). EXPRESS builds on S-CAT[®] for

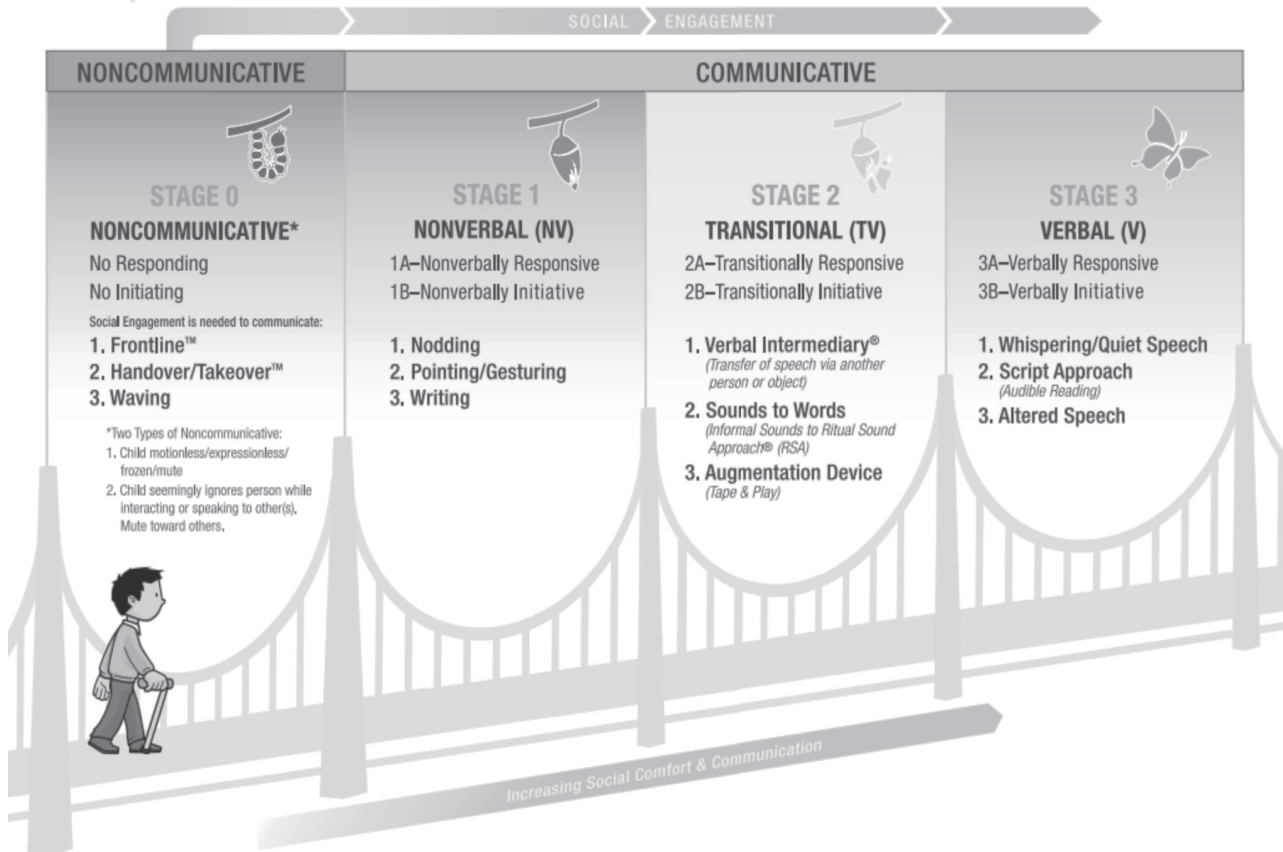


Figure 0-2. The Social Communication Bridge®. Used with Social Communication Anxiety Treatment® (S-CAT®). Used in the treatment of selective mutism. *Source:* Copyright © (2015) Dr. Elisa Shipon-Blum and Selective Mutism Anxiety Research and Treatment Center, Inc. (SMart Center) www.selectivemutismcenter.org. 215-887-5748 smartcenter@selectivemutism.org All rights reserved. This material is part of Dr. Elisa Shipon-Blum’s Social Communication Anxiety Treatment® or (S-CAT®) and is used under license.

children with SM or who have other communication needs requiring receptive and expressive language therapy.

As identified above, the EXPRESS Program includes five levels for expanding communication skills, centered on children’s popular stories. Each level provides increasingly more sophisticated linguistic vocal output. Within each level, the stories increase in complexity. Table 0-2 provides a brief description of the five EXPRESS communication levels.

EXPRESS incorporates a progression of implementation techniques to help children communicate (see Table 0-3, *Communication Expectations*). For each activity, moving across

Table 0-2. The Five EXPRESS Communication Levels

Level 1	Nonvocal Communication	Communicates by pointing, gesturing, nodding, drawing, or writing
Level 2	Indirect Vocalization	Speaks through someone or something else, using a recording device, familiar person, puppet, toy, or action figures (with or without a barrier)
Level 3	Direct Vocalization (Limited): Sounds, Syllables, and Words	Speaks directly to a person, using noises, sounds (phonemes "m-m" for yes; "uh-uh" for no), syllables, and words or simple sentences (may be whispered)
Level 4	Scripted Vocalization	Speaks with rehearsed words, phrases, or sentences that are previously scripted for practice and repetition
Level 5	Spontaneous Vocalization	Speaks spontaneously while interacting verbally with others, responding and initiating with turn-taking

the levels, children begin by responding with gestures and culminate with responding and initiating through turn-taking using spontaneous speech. In addition, performance charting serves to increase communication as children work to gain points and rewards. Motivational rewards are established at the start of each session when children are given a few items from which to choose. As children work through the items, they are provided tokens or chips toward attaining their rewards.

Through the activities in EXPRESS, children with SM and other communication needs acquire key concepts, ideas, and details to build language and increase communication. Each story module has the following components:

1. Literacy level: Lexile level and topics
2. Communication level: 1 (Nonvocal), 2 (Indirect Vocalization), 3 (Direct Vocalization-Limited), 4 (Scripted Vocalization), and 5 (Spontaneous Vocalization)
3. List of materials needed
4. Activities: Story, Vocabulary, Questions & Answers, Sentence Formulation, and Story Generation
5. Vocabulary word list
6. List of sentences
7. Progress monitoring scoring sheet
8. Story Video Links for each story can be found in Appendix C

Components of Children's Story Modules

Within each of the five communication levels of vocalization there are five story activity modules for a total of 25. Each story is further classified according to topic, Lexile level, and guided reading levels (see Appendix A). The Lexile level is a measure of text comprehension difficulty taking into consideration word frequency and sentence length. Also provided are

Table 0-3. EXPRESS: Communication Expectations According to Levels and Activities

ACTIVITIES	LEVEL 1 NONVOCAL	LEVEL 2 INDIRECT VOCALIZATION	LEVEL 3 DIRECT VOCALIZATION (LIMITED)	LEVEL 4 SCRIPTED VOCALIZATION	LEVEL 5 SPONTANEOUS VOCALIZATION
Vocabulary	Child responds using gestures, pointing, demonstrating actions, and tracing letters	Child responds by pointing, demonstrating actions, and tracing letters while vocalizing to a source away from immediate space	Child responds by pointing, demonstrating actions, drawing, making sounds for yes & no, and tracing and naming letters in unison	Child responds by pointing, demonstrating actions, repeating phrases, and tracing and naming letters in unison with adult	Child responds by pointing, demonstrating actions, answering questions, naming letters, and saying written words
Questions and Answers (based on story grammar)	Child responds by pointing to pictures and gesturing (including nodding/shaking head for yes/no)	Child responds to questions given two choices by vocalizing to a source away from immediate space	Child responds by answering questions with sounds for yes and no	Child answers questions given words and phrases to imitate	Child answers questions given open-ended or direct-choice questions
Sentence Formulation (simple, compound, and complex constructions)	Child points to pictures that match sentences said by adult	Child points to pictures that match sentences said by adult and repeats them to a source away from immediate space	Child listens to sentences and repeats initial sounds in selected words	Child observes as adult prints and says words for child to imitate	Child completes sentences given a sentence stem to complete a thought
Story Generation	Child points to a picture and listens as adult generates a story about it	Child points to a picture, names it, and attempts a sentence, vocalizing to source away from immediate space	Child makes initial sound of a word for a picture and listens to adult-generated story	Child repeats adult's sentences to tell a story	Child and adult take turns making up sentences to generate a story

guided reading levels based on the typical grade for reading the stories. The Reader may refer to Appendix B for Lexile levels and grade equivalents.

Components of the story modules include reading a story aloud to the child, building vocabulary, engaging in question-answer routines, sentence formulation, and story generation. Completing a story and all activities often takes more than one session. Therefore, a

second presentation of each story may be read again or accessed through video link (Appendix C). The five primary activities for each story module are broadly described below.

The Story

Storybook reading exposes children to literacy. Research has shown that reading to children and discussing content improves children's vocabulary and increases the mean length of their utterances (Maul & Ambler, 2014). Throughout each story module, children interact and participate through a variety of methods, listed below. It is recommended that the Reader hold the storybook at shoulder height while showing the text and pictures to the child. This provides the child with oral-auditory-visual input while listening to and watching the Reader. This multimodal presentation can help the child visualize the scenes described. Additional presentations of the story may include a video with animations that bring the words to life.

Vocabulary

Vocabulary is at the core of language and forms the building blocks of the phrases and sentences children understand and say. By 24 months of age, children typically have a vocabulary of at least 50 words. The EXPRESS Program employs methods supported by recent research including explicit teaching of word meanings (Coyne, McCoach, & Kapp, 2007), repeated oral readings with explanations of words from a storybook (Biemiller & Boote, 2006), and rich vocabulary instruction (interactive activities that provide experiences for the learner to process word meaning at a deep level). By providing children with such opportunities to hear words and identify, demonstrate, trace, and name their letters, they begin to expand their vocabulary. Vocabulary knowledge is essential to both oral and written comprehension.

Question-Answer Routines

It is important for children to develop narrative skills as narration forms the basis for more successful interactions in the classroom (Davies, Shanks, & Davies, 2004). EXPRESS teaches a narrative framework through question-answer routines. The program progresses from yes/no questions with pictorial prompts to sequential Wh-questions. Yes/no type questions and forced-choice questions require less language formulation in their responses than open-ended type questions. The less children have to formulate, the less stressful the task.

This activity attempts to follow a story grammar model (Moreau & Fidrych, 2002) with questions related to the characters (who), setting (where), initiating event (what), internal responses (how), plans of action (what), attempts to carry out the plan (how), direct consequences (what), and resolution (how). In EXPRESS, questions follow the sequence of the unfolding story. Questions cover portions of the stories with modifications made to accommodate various story structures. For children with language impairment or learning delay, story grammar assists with comprehension and production. Wh-question cards may be used at the Reader's discretion and can be found in Appendix G.

Sentence Formulation

Sentences comprise the components of stories. To be able to tell or write a narrative story, children must draw on event memories and at times imagination. They also need linguistic knowledge to express their thoughts. Kamhi (2014) stated that it is best practice to target the meaning of sentences in context instead of working on sentence structure in isolation. For typical learners, complex-type sentences begin to be produced by children between 2 and 3 years old and 3-year-olds can typically produce conjoined sentences with dependent clauses (Tyack & Gottsleben, 1986). Research indicates that it is best to expose children to target utterances before requiring expression of them (Eisenberg, 2014). Within EXPRESS, children listen to sentences and connect them to pictures in the story. Depending on the EXPRESS level, they may repeat portions or complete sentences related to the stories. The sentences range from simple to compound and complex with input that is provided orally and in writing.

Story Generation

The Reader generates a story based on pictures the child chooses from the storybook. The final activity in EXPRESS involves generating new stories. According to Eisenberg (2014), speech-language therapy should include a structured activity with storytelling and active engagement of the child. Initially, the child listens to a story and decides if he or she likes it. Next, the child contributes words to the development of a story. Ultimately, the child and Reader engage in turn-taking to co-create a novel story. The Reader helps expand the child's story-telling experiences and social interactions using pictured sequences and verbal input.

Where to Start in EXPRESS

Maintaining communication comfort is as important as expecting the child to learn the cognitive-linguistic information within the program. Realistic goals are established prior to each activity because a child may find doing an activity stressful. Therefore, it is important to start at a level within the child's comfort zone. This will typically be how the child communicates with you, the program facilitator or Reader. If the child is nonvocal with you then you would begin at Level 1. Several feeling barometer charts have been included in Appendix E. Information on how to use them is below.

To begin, each activity is explained to the child. The directions are provided within each story module. General instructions are consistent across program levels. Specific directions are provided in accordance with each story activity. After giving the directions, ask the child to point to the face (or another feeling barometer chart) indicating how he or she feels about doing the activity. A sample chart can be found in Figure 0–3 and additional examples can be found in Appendix E. Tell the child you understand that some things are easy, some things are harder, and some things are very hard. By validating the child's feelings, you begin to develop rapport and trust. Respect the child's indicated level of difficulty and don't push the child to do things that he or she rates as beyond capacity. You may need to provide more cues or move backward to a lower level within the program if activities are too difficult for the child.

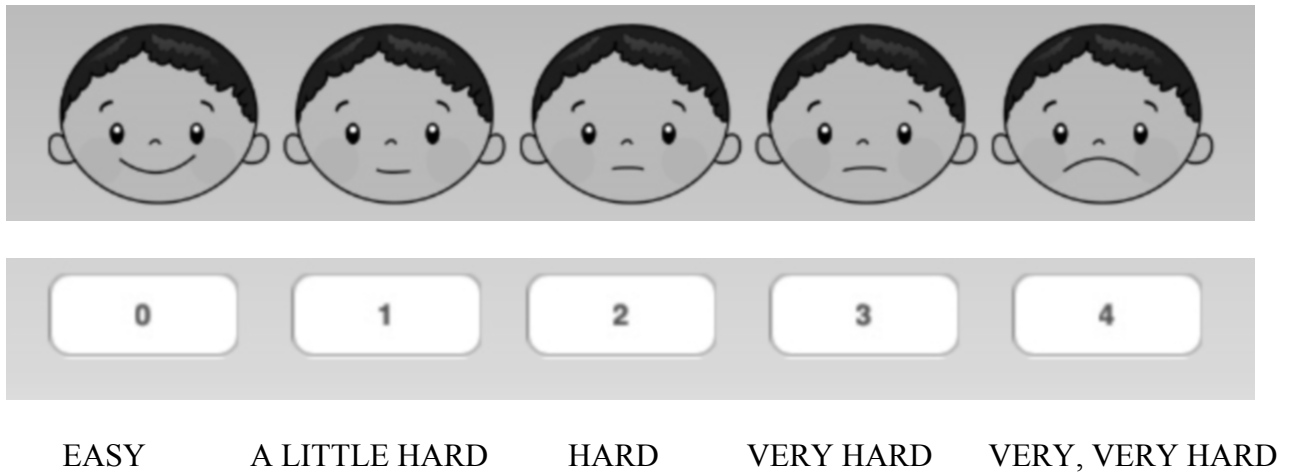


Figure 0-3. Sample feeling barometer chart.

Table 0-4. Guidelines for Choosing a Starting Level in EXPRESS

1. If the child is not speaking with the Reader then begin EXPRESS at Level 1 and progress forward.
2. If the child speaks in front of the Reader but not with the Reader (allowing his or her voice to be heard when speaking to others) then begin EXPRESS at Level 2.
3. If the child speaks to the Reader but in a limited way, using only sounds or yes-no words, begin EXPRESS at Level 3.
4. If the child speaks when words are provided (when giving verbal choices or through imitation), begin EXPRESS at Level 4.
5. If all four levels have been accomplished and the child is ready to engage in some spontaneous vocalization, begin EXPRESS at Level 5.

It is not uncommon to begin at Level 1 and continue through all levels to provide the most language stimulation with the greatest comfort. However, the starting point within EXPRESS is generally based on the level of comfort the child exhibits when interacting with the Reader (clinician, educator, or other) who is conducting the sessions (see Table 0-4).

Advancement Through the EXPRESS Levels

At each level, language is expanded to increase both comprehension and expression through vocabulary, Wh-questions, simple, compound, and complex sentences, and narrative language with story grammar for 25 stories. Children learn about the characters, settings, initiating events, internal responses of the characters, plans of action, direct consequences, and resolutions.