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Case Example:
Michael[1], a 6-year-old with Selective Mutism and Social Anxiety

Patient Information: Michael lived in a bilingual Polish/English household and particularly struggled to speak with unfamiliar individuals in either language. When he was 4 years old, Michael attended a Polish-speaking preschool where he started speaking to some teachers, however when he transferred to an English speaking kindergarten at age 5, he became completely nonverbal at school. He demonstrated difficulties regulating his emotions and became very upset whenever things did not go his way. Michael also felt uncomfortable eating in front of others and was afraid to show facial expressions such as smiling or laughing, often hiding his face with his hands.

Why did Michael come to ATSA?: Michael's school social worker noticed he was not speaking in his Kindergarten classroom or at recess and reached out to his parents. After gathering more information from Michael's parents, the school social worker wondered if maybe Michael was showing signs of selective mutism. His parents sought out referral options for an evaluation and decided that Advanced Therapeutic Solutions for Anxiety would be a good fit. They appreciated how ATSA was not only willing to work with Michael in a clinic setting, but they were also willing to work with him in his community and school settings, and train his school social worker and teacher as well.

ATSA Intake Evaluation: In the diagnostic interview with parents, followed by a child observation session, the clinician noted Michael's ability to fluently speak to his mom in Polish and to his little sister in English. When the clinician was present, Michael avoided speaking, and his little sister would speak for him. When the clinician pretended to be busy in another part of the room, Michael spoke to his sister in Polish and English, and to his mom in Polish, but with reduced volume and frequently checking to see where the clinician was. If Michael noticed the clinician looking or listening, Michael averted eye contact and stopped talking, opting for nonverbal gestures instead. Next, an ATSA clinician traveled to Michael's school to observe him there. The clinician noted that Michael was completely nonverbal. He only communicated through nonverbal gestures (e.g. nodding and pointing) or by writing down his response. Teachers and peers would guess what Michael was trying to communicate, and he would nod or shake his head in response. He also exhibited avoidance when playing with peers and would typically watch his peers play from the side rather than joining in with them. At lunch, Michael would not take his food out of his lunch box. Instead, he kept his lunch box unzipped, but closed. He would scan the room first as if to check if anyone was looking, then he would bend

[1] Names and personal details have been changed to protect confidentiality.

down, put his head near the opening of his lunch box, slide his hand into the opening, peek out the tip of his sandwich, take a bite, then quickly let go of the sandwich and allow the top of his lunch box to close. While at the school, the clinician spoke with the teacher and school social worker to gather more information about what they had observed of Michael in the school setting. With information gathered from the parent interview, the observations of Michael in the clinic and school setting, and from talking with the teacher and school social worker, the clinician diagnosed Michael with selective mutism and social phobia.

Initial Treatment Plan:
Due to Michael's lengthy warm-up period of about two hours, it was determined that for the first month, 3-hour sessions were needed in order to make the fastest progress. Hour 1 focused on talking with mom in front of the clinician, Hour 2 focused on transferring verbal relationship to the clinician while separating from mom, and Hour 3 focused on continual verbal interaction with the clinician without mom in the room. The 3-hour doses would begin in the clinic and continue in the community, with the plan to spend more time in the community as Michael's fear of speaking to the clinician decreased each week. The plan also included speaking across people, places, and activities in the community (e.g., library, bakery, park) with the aim to practice responding, initiating, and engaging in spontaneous speech. By watching the clinician interact with and prompt Michael in the community setting, Mom would also learn how to reduce enabling Michael's mutism (i.e., speaking for Michael) and, instead, she would learn how to use prompts that would help Micahel speak to others. This way, mom would practice skills and receive coaching during the session, too, and would be able to keep applying the skills with Michael between sessions. Finally, collaboration with the school social worker was important to ensure treatment progress carried over into the school setting. A meeting with the school team (school social worker, teacher, parents, and ATSA clinician) was planned to provide psychoeducation to the school team and help the school social worker develop a plan for Michael to practice speaking in the school setting. Email communication and phone calls with the school social worker would follow throughout treatment.

Short Term Results: In the first intensive session, Michael struggled to verbalize with his therapist and became very distressed when it was time to separate from his mom. However, after enjoying the first community outing, Michael became excited and motivated to "earn" going outside the clinic again. The next three sessions moved faster, with Michael talking directly to this therapist within 60 minutes, then 30, then 15 minutes, respectively, allowing Michael and the clinician to establish a strong verbal relationship. The clinician was then able to serve as verbal intermediary (instead of mom) to expand Michael's speaking across people, places, and activities. The community outings were based on Micahel's interests, which included reptiles. So when it was time to visit snakes, Michael's mom had to use *her* brave, too. Michael reasoned that if he had to step out of his comfort zone, so did mom! So she bravely held a snake, much to Michael's amusement!

After four 3-hour intensive sessions, Michael was ready to move to 1-hour sessions, which continued in the community settings every other week. Michael was also ready to move from

individual sessions to group sessions, where he practiced interaction with peers. Michael joined ATSA's one-hour weekly Lunch Bunch group therapy, which addressed his fear of eating in front of others and fear of social interaction.

Despite all the progress being made in the clinic and community settings, gains did not transfer into the school setting as easily. A school exposure session was held with the school social worker in which the ATSA clinician served as a verbal intermediary for Michael, coached the school social worker on how to prompt Michael, used stimulus fading to transfer verbal relationship to the school social worker, and then faded out as Michael continued verbalizing with the school social worker - all completed during the lunch-recess period. The plan was for the school social worker to continue a weekly "Lunch Bunch" at school with Michael and two peers once a week, rotating through the peers so Michael's fear of speaking could extinguish with each encounter and speaking could generalize across classmates during lunch recess. The school social worker would also push into the classroom to serve as a verbal intermediary to help Michael respond verbally to his teacher, then systematically fade out, aiming for Michael to respond verbally directly to his teacher without the school social worker.

Long Term Results: With nine months of treatment during his kindergarten year, Michael made significant progress. He talked more in school, including playing with and talking to his classmates and raising his hand to answer or ask questions to his teacher. He talked more in community settings and was no longer reliant on using his mother as an intermediate to respond to others. Michael became more comfortable speaking openly with his therapist, school social worker, and his teacher (first by whispering, then increasing to voice volume). Through group therapy at ATSA and social exposure sessions in the community, as well as the Lunch Bunch sessions with the school social worker and classmates, Michael has developed relationships with his peers. At the end of the school year, he enrolled in summer sports, was able to talk to his coaches and teammates, and realized his athletic talent, which increased his confidence. Weekly therapy was reduced, and it was decided that Michael should continue his extracurricular sports activities over the summer. To ensure a strong start to first grade, Michael enrolled in ATSA's Adventure Camp, which is a five-day group intensive (Mon-Fri, 9am-3pm) that runs the first week of August. Adventure Camp simulates school activities and field trips to ensure students start their new school year speaking. During Adventure Camp, Michael's fear of speaking to others, eating in front of others, and fear of showing emotions greatly diminished. He began first grade fully verbal with his classmates and new teacher. Micahel graduated from treatment at ATSA in the fall of first grade.