

**Comments by Clinical Editor**

The author suggests how practitioners might empathize with parents during Play Therapy.

By **Esther B. Hess** PhD, ABPP, RPT-S

# Breaking Down Barriers

## Helping Asian American Parents Seek Play Therapy for their Children with Selective Mutism

“Selective Mutism is a psychiatric disorder that affects seven out of every 1,000 children making it almost as common as autism” (Brown, 2005, p.9). It is an extreme form of social anxiety disorder where “a child cannot speak in select settings, most typically at school, even though they can (usually) speak normally at home” (Cole, 2006, p. 57). Despite the current understanding in pediatric research that advocates the benefits of early identification and early intervention in children impacted by disabilities (Cooper, 1981; Garland, Stone, Swanson, and Woodruff, 1981; Maisto and German, 1979), I have noticed in my own clinical



practice, a concerning trend within first generation Asian Americans; specifically, a delay in parents getting their children who are impacted by Selective Mutism play therapy intervention services well into adolescence.

Jai Kim (not the patient's real name) is a case in point. Jai was first brought for counseling services when she was 14 years old. She had been characterized as being 'extremely shy' and socially isolated as a young child. Although she was somewhat animated at home and considered an excellent student academically, she never spoke to anyone at school. This young lady was brought in for clinical services only after the school counselor convinced the parents of the gravity of the situation. Both parents immigrated to the United States from Korea in their late twenties. The counselor emphasized the possibility of Jai's prolonged silence impacting her academic success in high school. Children with Selective Mutism do not outgrow the disorder. Social anxiety becomes more defined the older a child gets. It then becomes more difficult to treat Selective Mutism

once the symptoms have been in place for several years (Shipon-Blum, 2003). Adolescence for those affected by Selected Mutism is characteristically marked by social isolation and withdrawal from most classmates and peers, (Shipon-Blum, 2003).

What are factors that potentially contribute to parental delay within this specific community in reaching out for services for their children with Selective Mutism? Additionally, what if anything can be done to support early intervention? A number of studies have been conducted with the aim of investigating the importance of culture in the outlook of Asian American parents toward their children with disabilities (Kramer, et. al, 2002, Huer, Saenz, & Doan, 2001; Parette, 2002; Parette & Huer, 2004, Leong & Kalibatseva, 2011). Chan reported that Asian American families often attributed their child's disability to supernatural influences or sins committed by the child's ancestors (1997). Due in part to these beliefs, the family experiences a great deal of shame because of their child's condition (Hanson, Lynch, & Wayman, 1990; Sotnik, 1995), while at the same time, feeling a strong sense of obligation to care for the child (Chan, 1997).

The idea of parental shame needs to be examined as a potential contributing factor towards the delay of intervention services. While the concept of shame and parenting has traditionally been explored from a psychoanalytic/attachment perspective (Mahler, 1975), for the purposes of this paper, shame will be examined in the rather familiar context of how parents often blame themselves for their children's disorders. It

is important to understand that although environmental stresses play an important role in anxiety and other mood disorders, most children with Selective Mutism have a hereditary predisposition to anxiety disorders (Shipon-Blum, E., 2003). Parents are often confronted with painful recollections of their inhibited childhoods as they watch their child with Selective Mutism struggle in the social world.

Fifteen years ago, these children were known as elective mutes, and their silence was seen as willful and manipulative. The diagnosis was changed to selective mutism in the fourth edition of the American Psychiatric Association's diagnostic manual (DSM-IV-TR). The new definition reflects a greater understanding that children suffering from Selective Mutism are not choosing to be silent nor refusing to speak or being oppositional. They are literally so anxious that they have developed maladaptive coping skills to combat anxiety that most often includes avoiding social interactions.

This revised definition helps parents and professionals

understand that Selective Mutism is not a child's response to some sort of familial abuse, but rather an expression of one of the most extreme forms of social anxiety (Hess, 2008).

The child may have a variation of the same disorder that the parent

struggled with as a child. Daniel Wong's (not patient's real name) father, a first generation Chinese American, describes himself as a shy retiring man. He admits that even as an adult he is rarely comfortable in public. His social anxiety prevented him from accessing the IEP (Individual Educational Plan) for his son, despite the fact that Daniel was completely mute at school until the age of 9 years.

It has been asserted by D. W. Sue (1998) that Asian Americans usually avoid seeking mental health treatment since there is a shame factor and stigma attached to a person who needs to utilize these types of services. Furthermore, Asian Americans may have views of mental health care as being Western-based forms of treatments that are absent of cultural and linguistic considerations that may make the experience more relevant and understandable to members of this group. Other researchers have discussed the lack of willingness to seek mental health services in terms of culturally-based psychological barriers and the incompatibility of mental health services with Asian Americans' needs (Zhang, Snowden, & Sue, 1998). In these studies, psychological barriers were defined as specific cultural values and attitudes about mental illness. It has been argued that there is strong stigma and shame associated with the recognition of mental illness in Asian

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cultures (S. Sue, 1993). Considering that mental illness carries such negative connotations, disclosing or having public awareness of such issues about a family member might embarrass one's family. Additionally, it has been suggested that Asian Americans tend to value solving personal difficulties through personal efforts (Tamura & Lau, 1992) instead of using formal mental health services, which may bring shame upon their family (Sue & Morishima, 1982). It can be further posited then that there is a cultural norm within this community that values the quiet compliant behavior of the individual, for the greater good of the group. Consequently, a child silenced by Selective Mutism may not initially arouse parental suspicion or concern. Because of these values and attitudes, psychological distress may manifest as somatic complaints, thus, masking the actual mental health issues that may be troubling the individual. Even when there is the recognition of a potential psychological cause for the somatic complaints, Asian Americans may still choose not to discuss their discomfort because of the negative social stigma attached to such a disclosure and consequent feelings of shame and self-denigration.

Another key consideration in the acceptance and coping process that potentially contributes to the acceleration or delay by parent for intervention for their child impacted by Selective Mutism is rate of acculturation.

For example, Parette, Chuang, and Huer (2004) found that Chinese American families tended to have a more positive outlook toward their children's disabilities rather than viewing their children as a source of shame. The authors offered two explanations for these findings. First, at least one parent in these families was more highly educated (although "highly educated" was not operationally defined) as well as educated in the United States, which broadened their understanding of their children's disabilities. Furthermore, these parents were better informed about the resources available to their children as well as the legislation that protected their children's rights. Second, these Chinese parents were professionals who had lived in the United States for more than ten years, which gave them time to acculturate and be more experienced with the American culture. The parents who were more acculturated appeared to have a more extensive support system, which facilitated them coming to terms with their child's condition.

Selective Mutism is an extreme form of social anxiety that impacts thousands of children worldwide (Hess, 2008). This paper does not present itself as a random sample of the greater Asian American community who seek help for their children with

special needs. These findings are stimulated from observations in my private practice experience and are meant to open discussion for the need to educate families in the Asian American community both in terms of their child's disability and available treatments. By helping Asian American families come to a better understanding of the American culture and what resources and legislation exist to support them in meeting their child's needs, clinical intervention may influence the process of acceptance and coping with this significant social anxiety disorder (S. Sue, 1993; Sue & Morishima, 1982).

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