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A Friend in Me: A Mixed Methods Feasibility Study of an Online Self-Compassion Intervention for Children and Their Caregivers

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A FRIEND IN ME:

A MIXED METHODS FEASIBILITY STUDY OF AN ONLINE SELF-COMPASSION INTERVENTION FOR CHILDREN AND THEIR CAREGIVERS

By

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"In the embrace of community, I found my voice, my purpose, and my unwavering strength."
- Yara Liceaga-Rojas

To the little girl who once sat in the audience of graduation ceremonies, shedding tears as others received their Ph.D., now it is your turn. You are right where you belong.

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ABSTRACT

Yearly, millions of children are diagnosed with mental health conditions. However, as the need for age-appropriate interventions and mental health services increases, the amount of available and accessible resources for families has failed to meet the growing demand. This study evaluated an intervention program developed to help address this deficit and provide children and their caregivers with a developmentally appropriate intervention targeted at improving well-being over time. *A Friend in Me: A Self-Compassion Training for Children and their Caregivers* is based on the trademark Mindful Self-Compassion program developed by Kristin Neff, Ph.D., and Christopher K. Germer, Ph.D., but focuses on children in middle childhood, ages 7 to 12. Until now, there has been little research on the impact of self-compassion training with children in this age group. However, preliminary evidence from research on adolescents suggests that intervention programs that include mindfulness and self-compassion have a significant positive impact on long-term prevention of adverse child outcomes and on children's' abilities to regulate and speak about their emotions. The present study utilized a mixed-methods embedded design where quantitative data were collected and analyzed at two time points, pre-test and post-test and qualitative data were collected and analyzed once following the completion of the *Friend in Me* intervention. This design was implemented to gather a deeper understanding of participants' perspectives on program feasibility and acceptability, and to help examine the intervention outcomes shown in the quantitative data collection. Quantitative results indicated statistically significant increases in children's levels of self-compassion and in positive parent reports of parent-child relationship quality; all other variables did not show statistically significant results from pre to post-test. Additionally, attendance and retention data were analyzed. Findings indicated that the *Friend in Me* intervention was a feasible and acceptable training program for children in middle childhood and their caregivers. Qualitative results also highlighted five themes for feasibility and acceptability, 1) training need, 2) favorite elements of the training, 3) enhanced understanding of the concepts, 4) self-compassion implemented in daily life, and 5) suggestions for change. Qualitative results also found two overarching themes representing participant's' experiences which were defined as 1) mutual learning and 2) increased positive perceptions of parent-child relationship quality.

Quantitative and qualitative results were analyzed together to generate deeper insights to inform future studies more fully. Feasibility studies are a crucial step in determining whether a larger more controlled intervention study to test for efficacy is justified. Additionally, feasibility studies help refine the research design and intervention protocol. Findings from the current feasibility study indicated promising results that the *Friend in Me* intervention should be further explored in a larger controlled study to gain more information on how this intervention compares to basic mindfulness training and other social-emotional learning intervention programs. Moreover, the study results ultimately highlighted a resource available to children and their caregivers who may be struggling to find available and accessible help when it comes to managing and learning more about mental health in this age group.

CHAPTER 1

INTRODUCTION

Significance

Children's mental health is in crisis. A recent study conducted by the Health Resources and Services Administration (HRSA) found that between 2016 and 2020, the number of children in the United States 3-17 years of age diagnosed with anxiety increased by 29% and those with depression by 27% (Lebrun-Harris et al., 2022). These numbers represent a steady and significant increase that has been occurring in the number of children diagnosed with mental health conditions. While some of the escalation in diagnosis may be correlated to the Coronavirus Pandemic, the rise in youth mental health concerns started many years before the pandemic; the pandemic just exacerbated these trends (Lebrun-Harris et al., 2022). Since 2020, the proportion of emergency department (ED) visits for children experiencing mental health-related emergencies, particularly when other services were unavailable or not accessible, increased by approximately 24% and 31%, respectively, for children ages 5-11 years and 12-17 years when compared to 2019 (Leeb et al., 2020). When deconstructed, rising diagnosis numbers illustrate that children are experiencing stressors, challenges, and global contexts that deeply impact them.

Considering that research shows mental health concerns often commence in childhood and can significantly impact all areas of a child's life, it is crucial to intervene early and provide caregivers and children with strategies and skills that support children's mental health needs (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021b). Nevertheless, despite the evident necessity of mental health care availability for children, these services are often inaccessible or too sparse to accommodate the growing demand. Too often, children in the United States with a mental health concern or disorder do not receive the treatment they need. One report examining data from the 2016 National Survey of Children's Health, a nationwide parent-proxy survey of U.S. children under 18, found that approximately half of all children in the United States with mental health disorders are not treated (Whitney & Peterson, 2019). With this in mind, one option to help make mental health care more widely available and accessible to children is program-based training or interventions.

Moreover, intervention-based training programs have the added benefit of allowing for a more systemic approach to care, as parents and other family members, such as siblings, could have the opportunity to work on their mental health together. For children, being mentally healthy can make the difference when it comes to meeting developmental and emotional milestones, learning healthy social and emotional skills, and cultivating coping strategies to help build resilience. Furthermore, research has shown that interventions completed in supportive environments where children feel safe can help mitigate the risk of adverse social outcomes and help promote the caregiver-child relationship (World Health Organization, 2009).

Recently, studies on adolescents and adults have investigated the impact of self-compassion on mental health and well-being. The research showed that these programs focused on self-compassion successfully reduced anxiety, depression, perceived stress, and negative affect (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). Furthermore, numerous studies on self-compassion indicate a strong association between self-compassion and emotional well-being, coping skills, lower levels of anxiety and depression, decreased rumination and fear of failure, and more satisfying personal relationships (Neff, 2003b; 2009a; 2009b). However, until now, there has been little research on the impact of self-compassion training on children, particularly those ages 7-12. This age group is important to study because there is evidence that many children will show symptoms and be diagnosed with a mental health disorder before the age of 14 (Solmi et al., 2022). Additionally, research has shown that by age 6, children can express concern for others and learn more effective ways to communicate their thoughts, feelings, and experiences (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021a). Young children are capable of learning compassion for themselves and others, and getting support along the way will help them maintain these practices over time.

Generally, parents, or primary caregivers, are children's first teachers. They begin to educate through their actions, reactions, and through what they reinforce. Therefore, teaching parents about compassion for themselves and others concurrently with their children may help parents self-soothe and then model positive coping strategies to children to show them a new way of becoming aware of and processing their feelings (Abdullah, 2020). Although there are several ways that parents can cultivate and encourage self-compassion in children, there is limited psychoeducation about compassion in the parent-

child relationship to pull from. Therefore, this study evaluated the feasibility of the program *A Friend in Me: A Self-Compassion Training for Children and Their Caregivers* as a means of teaching children and their caregivers about self-compassion, other-compassion, and the role compassion could play in the parent-child relationship. This intervention is specifically designed for children in middle childhood, ages 7 to 12, and is meant to assist parents in learning and teaching coping skills that may help their children navigate the challenges they are confronting. Children, especially younger children, are likely to hold fears, worries, and anxieties and could generally be overwhelmed, but they may not have the skills or language to share those feelings (Johnson, 2020). The *Friend in Me* training could ultimately provide children and parents with the language and skills they need to process their feelings, both those that are positive and those that may stem from pain, fear, grief, or suffering. There is a clear need to find cost-effective interventions, and interventions focused on compassion may be particularly helpful, as compassion has been shown to mitigate symptoms related to emotional and behavioral health disorders as children age into adolescents and, unfortunately, the number of children experiencing mental health concerns only continues to rise (Marsh et al., 2018).

Background

As was previously stated, middle childhood is a pivotal period of development and challenges. It is typically defined as the time when children are between 6 and 12 years of age and is a developmental period characterized by rapid cognitive advancement, physiological shifts, and social changes (Mah & Ford-Jones, 2012; National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021a). During this time, children start to pay more attention to how others view them, learn more comprehensive ways to express thoughts and feelings, and begin to form their identities as they examine their roles in relationships, gain new responsibilities, and explore the expectations of their environments (e.g., home, classroom, or peer spaces) (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021a). During this critical time, children start to consider who they are and their role in their life stories. This period in their lives is vital in laying the foundation for a child's worldview, values, and behavior choices (Mah & Ford-Jones, 2012).

Moreover, this time in a child's life is also significantly challenging for parents and caregivers. A study conducted by OnePoll of 2,000 parents found that one in four surveyed

parents believed their children tended to have their biggest meltdowns between the ages of six and eight and named age eight the most challenging parenting year (Anderer, 2020). Parents from the survey acknowledged the difficulties of raising a child as they become more independent. In addition, they noted that age eight marks a transition in attitudes, behaviors, and hormones (Anderer, 2020).

Consequently, the parent-child relationship is incredibly important to focus on during this developmental period. As parent-child interactions become less frequent, and child-peer interactions become more frequent, parents need to consider how to model prosocial behavior best and prepare their children internally and externally for new social scenarios (Maccoby, 1984; Mah & Ford-Jones, 2012). Internally, children in this age range are navigating new and foundational questions around their identity, exploring their roles in school and family and friend relationships, and are starting to desire independence and increased autonomy. Externally, along with other relationships, the parent-child relationship is experiencing systemic shifts. Parents are called to adapt and meet their children where they are developmentally. Overall, parents have the task of balancing structure while encouraging more independence in their children and maintaining a nurturing and warm parent-child relationship (Maccoby, 1984). As parents and children learn to operate in this new period of development, the parent-child relationship can act as a strong support system if it consists of kindness, non-judgement, intentionality to respond with awareness and nonreactivity, open communication, and a mutual willingness to accept influence, all of which are components of self-compassion (Maccoby, 1984; Neff, 2003b). Parenting a child in this age group is challenging, but parents are called to model compassion and remember that being a child in this age group also comes with its own struggles.

Yet, children in this age range often go understudied and are even considered by some to be the "forgotten years" in research, as most developmental research is focused on early childhood or adolescence (Mah & Ford-Jones, 2012, p. 81). Middle childhood needs to be remembered in the research, as it is where research that does exist shows behavior problems to be more prevalent (Ghandour et al., 2019). According to the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (2021b), attention-deficit/hyperactivity disorder (ADHD), behavior problems, anxiety, and depression are the most diagnosed mental health disorders in children during this time.

Approximately 9.4% or 6.1 million children aged 2-17 have received an ADHD diagnosis, approximately 7.4% or 4.5 million children 3-17 years old have a diagnosed behavior problem, 7.1% or approximately 4.4 million children 3-17 years old have been diagnosed anxiety, and approximately 3.2% or 1.9 million children 3-17 years old have a diagnosis of depression (Danielson et al., 2018; Ghandour et al., 2019). Furthermore, research has shown that children who have been isolated, as was common practice for months at the start of 2020, and are experiencing loneliness are at an even greater risk for depression and anxiety (Loades et al., (2020).

In conjunction with parent support, teaching parents and children about compassion may act as a buffer against some of these symptoms, as is illustrated in the literature. Compassionate individuals have been shown to have higher levels of happiness, lower levels of depression, and a higher ability to regulate physiological reactivity to stress; additionally, compassion has been linked to higher levels of well-being (Cosley et al., 2010; Shapira & Mongrain, 2010; Zessin et al., 2015). Furthermore, Hintsanen et al. (2019), in a 15-year longitudinal study with 2,761 participants, found that the quality of the parent-child relationship, in terms of emotional warmth and closeness, may contribute to higher offspring compassion in adulthood. The extant literature highlights clear support for a compassion program involving both children and their caregivers.

Purpose of the Study

With this need in mind, *A Friend in Me: A Self-Compassion Training for Children and Their Caregivers* was designed by Lorraine Hobbs and Dr. Amy Balentine as a developmentally appropriate mindful self-compassion program for children in middle childhood (7-12 years old). Lorraine Hobbs is the Youth and Family Programs founding Director at UCSD Center for Mindfulness, and Dr. Amy Balentine has a Ph.D. in clinical psychology and is the owner and director of Memphis Center for Mindful Living, LLC. Lorraine Hobbs and Dr. Amy Balentine also ran the *Friend in Me* training program and were the practitioners for this study. This training is based on the trademark Mindful Self-Compassion program developed by Christopher K. Germer, Ph.D., and Kristin Neff, Ph.D., and similarly to that program, utilizes a combination of age-appropriate exercises – mindfulness, yoga/mindful movement, art, meditation practices, and multimedia – to cultivate kindness, encourage insight, build skills of self-awareness and empathy, and strengthen the capacity for greater emotional regulation and stronger emotional resilience.

The age group for this training was chosen because middle childhood-appropriate interventions that provide coping skills may help younger children successfully navigate the challenges confronted during this time and set them up for increased cognitive and emotional awareness from an early age. In addition, preliminary evidence from research on adolescent and adult populations suggests that a program including training in self-compassion and mindfulness could significantly impact the long-term prevention of adverse child outcomes (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). The following study aimed to determine if this innovative self-compassion training was feasible, acceptable, and if participation in the training resulted in increased self-reported self-compassion, other-compassion, and positive perceptions of the parent-child relationship. It also examined participants ʾgeneral experiences of the program through semi-structured interviews to gain deeper insight into program feasibility and acceptability. Research that is developmental in concept will provide researchers and practitioners with additional knowledge on intervention impact for this age group.

Research Questions and Hypotheses

The specific research questions (RQ) and hypotheses (H) of the study were as follows:

1. RQ1: Does child compassion increase after completing the *Friend in Me training*?
    a. H1: Children's levels of self-compassion will be significantly higher at post-test in comparison to levels of self-compassion at pre-test.
    b. H2: Children's levels of other-compassion will be significantly higher at post-test in comparison to levels of other-compassion at pre-test.
2. RQ2: Does parent compassion increase after completing the *Friend in Me training*?
    a. H1: Parents' levels of self-compassion will be significantly higher at post-test in comparison to levels of self-compassion at pre-test.
    b. H2: Parents' levels of other-compassion will be significantly higher at post-test in comparison to levels of other-compassion at pre-test.
3. RQ3: Do levels of parent-child relationship quality increase after completing the *Friend in Me training*?
    a. H1: Children's reports of parent-child relationship quality will be significantly higher at post-test in comparison to reports of parent-child relationship quality at pre-test.

    b. H2: Parents' reports of parent-child relationship quality will be significantly higher at post-test in comparison to reports of parent-child relationship quality at pre-test.
4. RQ4: To what extent do parent participants believe the *Friend in Me training* was feasible and acceptable?
5. RQ5: What are parent and child participants' general experiences of the *Friend in Me training*?

Definition of Terms

1. Self-compassion: Being open and in touch with one's suffering and treating oneself with kindness in times of struggle; consists of three components 1) self-kindness vs. self-judgment, 2) common humanity vs. isolation, and 3) mindfulness vs. over-identification (Neff, 2003b).
2. Other-compassion: Other-focused attitudes of emotional responding, cognitive understanding, and paying attention to suffering; consists of three components 1) kindness vs. indifference, 2) common humanity vs. separation, and 3) mindfulness vs. disengagement in response to the suffering of others (Pommier et al., 2019).
3. Parent-child relationship quality: The extent to which a parent or child feels that the relationship is characterized by warmth, affection, and open communication (Pianta, 1992).

CHAPTER 2

LITERATURE REVIEW

Introduction

This chapter demonstrates the intervention's significance by examining extant research on self-compassion, other-compassion, and parent-child relationship quality while focusing on the developmental impact the *Friend in Me* (FIM) intervention could have on children and parents. Social learning theory was used as a framework for the study. The self-other awareness, central to this theory, can be seen at the foundation of the *Friend in Me* training. Importantly, this chapter focuses on established research related to compassion interventions and demonstrates the literature gap while highlighting the benefits of the FIM program.

Theoretical Framework: Social Learning Theory

Social learning theory, proposed by psychologist Albert Bandura, considers how cognitive and environmental factors interact to influence learning and behavior (Bandura, 1977). Bandura emphasized the significance of observing, modeling, and imitating behaviors, attitudes, and emotional reactions (Bandura, 1977). The foundation of social learning theory was in classical and operant conditioning; however, it expanded on these other behavior-based learning theories by adding two key ideas. First, social learning theory believed that a meditating process occurs between stimuli and response; second, it proposed that behavior is learned from the surrounding environments through the process of observational learning (Bandura, 1977). Bandura believed that direct reinforcement could not account for all types of learning, as Skinner (1938) suggested, and tested this idea through the Bobo Doll Experiment. The Bobo Doll Experiment demonstrated that reinforcement is not the sole factor that accounts for learning and showed that children, after only ten minutes of exposure to the modeling stimuli, were inclined to imitate observed behavior (Bandura, 1965). During the experiment, parents unconsciously sent the children implicit messages about acceptable behaviors through their actions. Although this experiment had flaws, it supported Bandura's theory. Some limitations of the experiment were that it took place in a laboratory setting and therefore may not be considered generalizable to real-world scenarios, the study may not have done enough to limit the risk to children who could have learned aggressive behavior from this experiment, and no

follow-up data were collected to assess the long-term impact (Bandura, 1965). However, this was ultimately a groundbreaking study and laid the foundation for researchers to continue investigating the impact of observed behavior, specifically of observed violence, on children's behavior.

At the core, Bandura showed that social learning theory is relational. This relational framework can be seen in the three key concepts Bandura outlined following the Bobo Doll Experiment. First, he argued that people could learn through observation by watching others model information and behavior; second, he stated that internal mental states are an essential part of this process and, finally, he acknowledged that just because something has been learned, a behavior change is not guaranteed (Bandura, 1977). During this process, learning occurs indirectly; however, that does not mean learning is passive. Instead, people can intentionally choose what to model to teach others the desired behaviors. For example, a parent could intentionally choose to keep their voice low during conflict to model conflict without yelling and demonstrate emotional regulation to their child. The child is learning indirectly, but the parent's actions are deliberate.

While observational learning can occur at any age, it generally tends to occur in childhood (Cherry, 2022). As children start conceptualizing their identities, observational learning plays a prominent role in socialization. While children spend a large portion of their days in school, their primary teachers are still their parents during middle childhood. Parents lay the foundation, through modeling, for the ways children learn to interact with others. Studies suggest that imitation of behaviors with social understanding tends to begin around age two (Cherry, 2022).

However, as Bandura (1977) argued, for observed behaviors to be effectively learned and imitated, there needs to be buy-in from the child, a cognitive awareness. Four steps facilitate this awareness in the observational learning and modeling process. First, learning requires attention, next one has to be able to recall or retain information learned through observation, then they need to be able to use that retention to reproduce or imitate the observed behavior; finally, there needs to be motivation for the behavior to continue (Bandura, 1977). Reinforcement and punishment come into play during the final step, motivation. For example, suppose a child sees another child being praised or rewarded for constructively communicating their feelings. In that case, they may start to imitate this action in hopes of receiving the same incentive. To describe the process of social learning

more accurately, Bandura renamed the theory Social Cognitive Theory in 1986 to increase focus on the cognitive component. The relevance of this cognitive component to learning will continue to be discussed.

Moreover, social learning theory can be used to understand ways in that positive role models can be used to encourage behavior changes. For example, children will be significantly influenced by how their parents interpret the world when looking at relational self-compassion. Research has shown that children who grow up with highly critical parents tend to deeply internalize those messages and speak and act critically toward themselves (Neff, 2011). However, if those same children had seen their parents model self-compassion and other-compassion, they would have recalled and retained a different message and then imitated different behaviors over time. The self-other awareness central to this theory is the foundation for self- and other-compassion. Therefore, the following study examined the proposed association between the *Friend in Me* training, self-compassion, other-compassion, and parent-child relationship quality utilizing the theoretical framework of social learning theory.

Compassion Research

A History of Compassion

While researchers have only recently started to examine compassion and its role in suffering, resilience, and well-being from a Western context, compassion has a long history rooted in the foundation of Buddhism and Eastern philosophy. From a Buddhist perspective, compassion is an underlying concept defined as the "heart that trembles in the face of suffering" and, at times, can also be translated as "the heart that can tremble in the face of suffering" (Feldman & Kuyken, 2011, p. 144). Fundamentally, compassion originated as a response to suffering. Therefore, to have compassion, one has to acknowledge that all of humanity will face challenges and adversity throughout their lives that will cause suffering and that all pain cannot be 'solved 'or 'fixed 'because suffering is a reality of living (Feldman & Kuyken, 2011). Compassion allows people to change how they view and conceptualize suffering because it opens people up to new and more collective perspectives on misfortune and healing. As a result, there is a more profound acknowledgment of communal pain and suffering.

Since the beginning of Buddhism's early evolution, it is suggested that the concept of compassion inspired the Buddha to commence his spiritual journey after being exposed

to the suffering of others (Pandit, 1999). Thus, compassion has always been a relational process. However, since its origin, it has taken on several definitions. Some remain close to the initial Buddhist thought on the concept, and some have shifted away from the Buddhist interpretation.

For example, in 2005, the first known scale solely devoted to measuring compassion and love was published as the Compassion Love Scale, which aimed to examine other-centered love (Sprecher & Fehr, 2005). This scale conceptualized compassion as an other-centered love that people extend to those close to them and to all of humanity in general. This conceptualization considered the selflessness, love, and kindness present in the Buddhist interpretation of the concept. Still, it did not touch on the common humanity and mindfulness pieces that also exist in the fabric of the Buddhist definition. Other research has viewed compassion as an evolutionary response, intrinsically within people, stating it increases people's capacity to care for infants through the promotion of caring, soothing, empathy, sympathy, and non-judgment (Gilbert, 2010, as cited in Feldman & Kuyken, 2011).

More recently, as the definition of compassion has evolved and, in some ways, gone back to the source, compassion is now more widely theorized through the definition offered by Kristen Neff (Neff, 2003b). Neff's conceptualization realizes the Buddhist principles of compassion and includes intentions of self-kindness, common humanity, and mindfulness (Neff, 2003b). This approach to compassion is the foundation for the definitions of self-compassion and other-compassion that were utilized in this study.

Self-Compassion

The key to self-compassion lies in the compassion piece. Compassion, as conceptualized initially, is to be able to notice suffering and then suffer or experience pain with someone. It recognizes that all humans experience suffering or hurt in some form and offers space in that suffering to be seen and heard rather than judged. Therefore, the goal of compassion is to connect on a human level and help lighten suffering. Self-compassion embodies compassion and then turns it inward. It involves giving oneself warmth, care, kindness, and understanding during difficult or painful experiences without self-judgment (Neff, 2011). For example, consider a time when you put yourself out there, maybe in a job, in your family, or in a relationship, and the result was not what you had hoped for. Perhaps an opportunity you were hoping for did not work out, or a relationship you wanted to grow

ended abruptly. In moments like this, it is easy to turn inward and blame yourself, be self-critical, or ignore any unpleasant or painful feelings that may arise. However, there are other avenues. Instead of falling into self-judgment, criticism, or avoidance, you might shift to offering yourself kindness and understanding. You may consider what you could do to bring yourself comfort in the difficult moment, encourage yourself with meaningful self-talk, offer forgiveness or gratitude, or take a moment to sit mindfully with those uncomfortable feelings and recognize that they are temporary and do not need to be overidentified with. All of these acts represent self-compassion. To have genuine compassion, one must be able to extend understanding, kindness, and care for themselves (Neff, 2011). Therefore, compassion, both in general and from the perspective of self, moves beyond empathy as it includes the desire to help others alleviate their suffering on top of the intellectual and emotional comprehension of others 'suffering encompassed by empathy (Birnie et al., 2010).

As defined by Neff (2003b), self-compassion is thought to consist of three main components: self-kindness vs. self-judgment, common humanity vs. isolation, and mindfulness vs. over-identification. Self-kindness focuses on cultivating understanding and kindness for yourself and letting go of harsh judgment, negative self-talk, and self-criticism (Neff, 2003b). Common humanity offers a shift in perspective. When one can place their experiences in the larger human context and see themselves as a part of humankind, there is a sense of togetherness versus seeing themselves as isolated or separate from others (Neff, 2003b). Finally, mindfulness versus over-identification refers to the ability to recognize painful or negative thoughts with a balanced awareness, not getting stuck in them, or over-identifying with those thoughts and feelings (Neff, 2003b). Self-compassion invites people to recognize the possibility that they are worthy of self-acceptance and gentle understanding both in easier moments and in times of hardship or suffering.

Moreover, the cultivation of self-compassion is vital at an early age. Self-compassion has been linked to enhanced psychological health, with adults who are more self-compassionate demonstrating higher personal initiative, happiness, and optimism, along with lower expressions of depression, anxiety, stress, rumination, perfectionism, and fear of failure (Heffernan et al., 2010; Hollis-Walker & Colosimo, 2011; Neff, 2003a; Neff et al., 2005; Neff et al., 2007). Thus, research into self-compassion has the potential to be far-reaching, as children who are able to be more compassionate towards themselves and

others may experience fewer adverse child outcomes and a greater sense of acceptance and connection to self and others.

Mindful self-compassion. To that end, self-compassion not only entails the core component of mindfulness but in and of itself is a mindful practice. While mindfulness is one of the three main components, it is also an overarching way of being, where one is being "mindful" or remembering the core components of self-compassion and acting on them. Mindful self-compassion combines mindfulness's awareness, emotional regulation, and healing aspects with the self-kindness, shared understanding, and self-soothing essential to self-compassion (Neff, 2003b). Mindful self-compassion is both an intra- and interpersonal experience, as it is necessary to be mindfully aware of personal suffering, show oneself kindness, and extend that compassion to others (Moreira et al., 2018; Neff & Germer, 2013). Germer (2009) noted that practicing mindfulness in this way is more targeted, as it focuses on intentionally developing emotionally to overcome feelings of personal suffering. Traditionally, mindfulness was seen as not simply "paying attention in a particular way, on purpose, in the present moment, non-judgmentally" (Kabat-Zinn, 1994, p. 4) but was conceptualized as a means of promoting psychological well-being and reducing suffering; suffering that is seen as fundamental to the human condition (Chiesa, 2013; Hanh, 1998).

In addition, like mindfulness, self-compassion is a skill children can learn through observed storylines. Caregivers play a prominent role in how children first learn to view and internalize themselves and others. Joseph Chilton Pearce once said in the Introduction to Teaching Children to Love by Doc Lew Childre, "For only as we ourselves, adults, actually move and have our being in the state of love, can we be appropriate models and guides for our children. What we are teaches the child far more than what we say, so we must be what we want our children to become" (Chilton Perace, 1996, as cited in Neff, 2011). Caregivers and parents, like children, make mistakes and sometimes act in ways that demonstrate a lack of self-compassion, which is part of being human. However, when caregivers and parents have the skills to both own those mistakes and apologize without being overly critical of themselves, they are storying for their child(ren) that they are allowed to make mistakes without overidentifying with feelings of failure or loss of self-worth (Neff, 2011). Living and showing self-compassion in this way has the potential to

help children bring self-compassion to mind in their behaviors toward themselves and others (Neff, 2011).

Other-Compassion

As discussed, compassion is inherently relational because it calls for people to extend understanding, kindness, and care to others in pursuit of helping to lighten, validate, and normalize the suffering they are experiencing (Neff, 2011). As can be seen, compassion for others, or other-compassion, and self-compassion hold closely related ideas; however, these concepts have mainly been studied separately, so little is known in the research as to what extent they resemble or differ concerning their correlates (Lopez et al., 2018). A review of three evolutionary arguments on what compassion is and how it evolved suggests that compassion arose as an emotional response rooted in promoting cooperation and protection of more vulnerable people and those who suffer (Goetz et al., 2010). Therefore, like Neff's definition of self-compassion, other-compassion involves noticing the suffering of another person and being motivated or having the desire to help alleviate that suffering (Goetz et al., 2010; Neff, 2003b). This same review also argued that other-oriented compassion could be a state or a trait (Goetz et al., 2010). As a state, other-compassion is more context-related, often brief, and initiated by a clear cause; as a trait, other-compassion is experienced more consistently across various situations and is not context or time-dependent but more of a general emotional response (Goetz et al., 2010). More in line with the trait definition of other-compassion, Pommier et al. (2019) defined other-compassion as other-focused attitudes of emotional responding, cognitive understanding, and paying attention to suffering consisting of three components 1) kindness vs. indifference, 2) common humanity vs. separation, and 3) mindfulness vs. disengagement in response to the suffering of others. This definition follows Neff's conceptualization of self-compassion and consists of similar components altered to fit the other-oriented context (Neff, 2003b). This definition was used for the focus of this study.

Overall, very few studies have explored the relationship between other-compassion and self-compassion (Lopez et al., 2018). However, the few studies that have looked at other-compassion and self-compassion found that similar brain regions are engaged when expressing self and other-compassion and that individuals who are more compassionate towards others may potentially be more compassionate towards themselves (Breines & Chen, 2013; Longe et al., 2010; Lutz et al., 2008; Neff & Pommier, 2012, as cited in Lopez

et al., 2018). However, it is also possible to have different levels of compassion depending on whether someone focuses that compassion on themselves or others. In addition, research has demonstrated that people tend to have more compassion for others than for themselves (Pommier et al., 2019). That is why it is essential to measure both concepts separately and concurrently.

This study contributed to the research on self and other-compassion because it examined self-and other-compassion as a within-person variable to determine any discrepancy between the two. Additionally, as participants engaged in an intervention focused on compassion, it was also interesting to see how self-reports of perceived parent-child relationship quality in terms of closeness and conflict looked before and after the intervention.

Research in Parent-Child Relationship Quality

Parent-Child Relationship Quality and Compassion

The attention placed on the parent-child relationship throughout research and history cannot be emphasized enough. The literature has continued to highlight the impact of individual and bidirectional dimensions of the parent-child relationship that influence relationship quality and long-term child outcomes. As with compassion, parent-child relationship quality has been conceptualized in a multitude of ways throughout extant literature. One way parent-child relationship quality has been examined is through the lens of emotional warmth and acceptance (Hinstsanen et al., 2019). Research thoroughly demonstrates the importance of parent-child relationship quality, yet there needs to be more consensus about what quality means. For the purpose of this study, and to clearly designate the meaning behind the language, parent-child relationship quality was conceptualized as the extent to which a parent or child feels that the relationship is characterized by warmth, affection, and open communication (Pianta, 1992).

The quality of the parent-child relationship is essential for many reasons. Overall, positive parent-child relationships have been associated with better adjustment in children and fewer behavioral problems (Hazel et al., 2014). Additionally, children who feel closer to their parents are more likely to learn from them. Social learning theory has found that children are more inclined to pay attention to and imitate the behaviors of those they regard as similar to themselves (Bandura & Walters, 1963). Therefore, the way parents manage their big feelings and behaviors plays a substantial role in helping children learn their own

regulation strategies and coping skills, which can influence how they view themselves. In order to learn these skills, parents need to be open to their children observing them during both the positive times and the times of struggle. This level of honesty encourages open communication, which is significant because there is strong evidence in the research that emotionally open parent–child communication in middle childhood is associated with more constructive child coping (Gentzler et al., 2005). It is evident in extant literature and theory that parent-child relationship quality is a key component to parenting and that parental warmth or closeness is a core component of what determines "quality" (Hinstsanen et al., 2019).

There is no doubt that the quality of the parent-child relationship has long-term effects on both children and parents. Nevertheless, research has only recently investigated how emotional warmth and closeness in the parent-child relationship may impact compassion in adulthood (Hinstsanen et al., 2019). Hinstsanen et al. (2019), to the author's knowledge, conducted the first known study examining whether emotional warmth and acceptance, qualities of the parent-child relationship, predicted children's compassion decades later in adulthood. Their longitudinal study consisted of 2,761 participants drawn from an ongoing study and used a combination of parent-report at baseline and child self-report over three time points to measure participants 'compassion and perceptions of parent-child relationship quality in terms of emotional warmth and acceptance (Hinstsanen et al., 2019). The study found that parent-child relationships characterized by high levels of emotional warmth predicted higher levels of compassion in children into adulthood; however, parental acceptance was not associated with an increase in offspring compassion into adulthood (Hinstsanen et al., 2019). These findings highlight that warmth in the parent-child relationship helps build compassion and that compassion can be developed early in life, as participants were initially assessed when they were between the ages of 3 and 18 years old (Hinstsanen et al., 2019).

Moreover, while research is limited, what does exist speaks to the benefits of compassion for both children and parents. The parent-child relationship is bidirectional, so it stands to reason that increasing compassion for both the parent and child or for even one member of the system would alter that system's function. Moreira and colleagues (2015) studied 171 family dyads composed of children/adolescents aged 8-18 years old and the

child's mother using self-report measures to assess mothers' reports of attachment, self-compassion, and parenting stress along with their child's report of quality of life. The results showed a significant negative association between maternal self-compassion and parenting stress; however, bivariate correlations showed a non-significant association between self-compassion and children's reported quality of life (Moreira et al., 2015). Therefore, the researchers concluded that parent self-compassion plays an indirect, bidirectional role in children's adjustment through its direct impact on the mother's parenting behaviors and attitudes. From this association, researchers can also hypothesize that cultivating self-compassion can help parents cope with their own frustrations, struggles, or negative emotions that may lead to stress and experiences of difficulty in the parenting role (Moreira et al., 2015). Self-compassion may give them space to be kinder to themselves and less critical about their parenting skills, which, in turn, could lead to more self-acceptance and acceptance of the child and their behaviors (Moreira et al., 2015). Compassionate parenting requires awareness, acceptance, and an attitude of nonjudgement that are often connected to mindfulness. Research has also recognized and addressed this link. Higher levels of self-compassion are associated with higher levels of mindful parenting (Moreira et al., 2016).

The extension of mindfulness to the parent-child relationship is called mindful parenting. Mindful Parenting was initially described as being present and paying attention to a child non-judgmentally (Kabat-Zinn, 1997). Five elements of Mindful Parenting emerged from this concept and research into mindfulness interventions and parenting studies (Duncan et al., 2009). The five elements focus on listening with full attention, practicing self-regulation in the parent-adolescent relationship, maintaining emotional awareness of the self and of the adolescent, cultivating non-judgmental awareness of the self and the adolescent through openness and acceptance, and including compassion in the parent-adolescent relationship for the self and the adolescent (Duncan et al., 2009). There has not been extensive research done into the five specific elements of Mindful Parenting; however, the research that does exist supports the use of Mindful Parenting as an intervention in mental health care, as it has been shown to be effective with children, parents, and the family system (Bögels et al., 2014). In addition, Miller et al. (2015) found that parents who could cultivate this mindful compassion towards their children expressed more warmth and less negativity during parent-child interactions. These findings support

the assumption that the way parents relate to themselves may be significantly associated with adopting a specific way of being in the parent-child relationship, such as expressing greater care and emotional warmth/connection, and with how they relate to their children.

Moreover, interest in mindfulness-based training programs for children has been rising, and more children engage in mindfulness practices each year. Approximately ten times more U.S. children ages 4-17 used meditation, a mindfulness practice, in 2017 than in 2012 (National Center for Health Statistics, Centers for Disease Control and Prevention, 2018). There are clear benefits to interventions that include mindfulness. Research on the efficacy of mindfulness-based interventions for youth has suggested benefits in mindfulness, depression, anxiety, attentional control, and externalizing behaviors (Dunning et al., 2019; Lee et al., 2017; Ridderinkhof et al., 2018). Until now, there has not been an adaptation of the Mindful Self-Compassion program for children in this age group, and very little research has been done to assess the impact of self-compassion training on children. However, recent research examining mindful self-compassion programs for adults and adolescents found that these programs reduce anxiety, depression, perceived stress, and negative affect (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). Furthermore, numerous studies on self-compassion indicate a strong association between self-compassion and emotional well-being, coping skills, lower levels of anxiety and depression, decreased rumination and fear of failure, and more satisfying personal relationships (Neff, 2003; 2009a; 2009b).

Self-compassion and mindfulness skills can be protective factors for adolescents ' adjustment as they are inner psychological resources (Moreira et al., 2016). Therefore, before entering adolescence, children should start to practice and foster these skills, and since parents are children's first teachers, these lessons should begin with them. In addition, parents must be offered support and have opportunities to learn about the significance of warmth, how to create warmth and connection in the parent-child relationship, and how it relates to the development of compassion in their children (Hinstsanen et al., 2019). For this reason, the current study further examined the association of self-compassion and mindfulness with the parenting dimension, utilizing a self-compassion intervention that encompassed mindfulness targeted at increasing parent and child levels of self-compassion, other-compassion, and positive perceptions of parent-child relationship quality.

Developmental considerations of the parent-child relationship. As children age and reach middle childhood, they experience developmental shifts, including rapid cognitive advancement, physiological shifts, and social changes (Mah & Ford-Jones, 2012; National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021a). As these changes occur, parents must also reciprocate and develop with the child to employ new techniques that fit the child's development level. Examining bidirectional relations allows researchers to gain a deeper, more fully understood outlook on the parent-child relationship, leading to increased effectiveness in the production of intervention programs (Bronfenbrenner & Evans, 2000). Despite this, few studies have explicitly looked at the parent-child relationship during middle childhood. The lack of research is so apparent that middle childhood is often considered the "forgotten years" compared to early childhood and adolescence (Mah & Ford-Jones, 2012). However, middle childhood is a critical period in a child's life and could potentially be the optimal time for child-centered interventions.

During middling childhood, one of the most prominent tasks children are faced with is developing and shaping their self-concept (Mah & Ford-Jones, 2012; Markus & Nurius, 1984). Children need to come to terms with their own needs and the needs of others as they experience more contact outside of the home. Children in middle childhood are better able to empathize and consider the perspective of others, are more aware, have a greater potential to be influenced by the views and opinions of others, are more strongly impacted by social reinforcement, and are experiencing rapid cognitive growth (Bhana, 2010). A combination of factors and relationships influences self-concept, but it develops through the child internally creating meaning about their worth. Children in this stage have more access to opinions than ever before in their development journey. They enter school and have increased contact with society and the media outside of the home, both of which send out messages about what is desirable or undesirable in society. Children may not be fully able to grasp the depth of these messages at a young age. However, they do have a strong sense of social understanding, which allows them to consider other people's appraisals of them and then integrate those into their self-concept (Markus & Nurius, 1984). Loving and supportive parents, peers, and teachers who focus on making children feel competent can foster this type of development.

One of the core components of self-compassion is self-kindness versus self-judgment. Having higher levels of self-kindness through cultivating self-compassion would help children in this critical phase give themselves more grace and non-judgmental acceptance when confronted with difficulties or experiences that may feel like a failure. Children who are kind to themselves may be better able to accept who they are versus trying to fit into a role or identity other people or society may want them to be or lead them towards (Neff, 2003b). It will also be necessary for children at this age to gain an understanding of common humanity versus isolation. In middle childhood, children are developing the ability to focus on others versus just on themselves (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021a). While this awareness is developing, if they can learn that people are similar in their emotional process (i.e., we all experience pain and suffering), they will be more prepared to see struggles as a shared experience versus something that happens to them alone (Neff, 2003b). Finally, children who can be mindful versus over-identifying with their emotions will gain knowledge and a deeper understanding of their emotional needs and different emotional states while maintaining perspective and learning the skills to help them get out of those painful feelings (Neff, 2003b). Future research using the *Friend in Me* training program could specifically evaluate how the program influences self-concept and which constructs of the program and self-compassion are associated.

Although children are shifting to spending more time at school, parents are still children's first teachers and play an essential role in a child's development story. Since parents play such a prominent role in how children first learn to view and internalize themselves and others, intervention programs must include psychoeducation for both parents and children. Studies have found that parents who have attended a parent training program report improved communication with their child, an increased capacity to empathize and be affectionate with their child, increased feelings of closeness to their children, a desire to spend more time playing with their child, an increased ability to establish age-appropriate expectations, and an enhanced understanding of the importance of listening to their child and seeking to understand of their behavior (Butler et al., 2020). Since parental influence decreases as children age, research suggests that these qualities of a parent-child relationship, and increased parental warmth, may be more important to

cultivate earlier on with younger children (Hay & Ashman, 2013). That is why studying parent-child relationship quality from this perspective in this age group is vital.

Compassion Interventions

Compassion-based interventions have been gaining traction in research. Over the last 20 years or so, compassion-based interventions have seen evident growth aimed at improving psychological functioning and well-being (Kirby, 2017). However, as discussed, compassion has been defined in different ways throughout history and lacks a uniform meaning/definition. Consequently, various interventions have been devised to explore and develop compassion for self and others. Kirby (2017) completed a review to critique the similarities and differences between all known compassion-based intervention models at the time. The review critiqued *Compassion-Focused Therapy* (CFT) (Gilbert, 2010), the *Mindful Self-Compassion program* (MSC) (Neff & Germer, 2013), *Compassion Cultivation Training* (CCT) (Jazaieri et al., 2013), the *Cognitively Based Compassion Training program* (CBCT) (Ozawa-de Silva & Negi, 2013), the *Cultivating Emotional Balance program* (CEB) (Kemeny et al., 2012), the *Being With Dying Program* (BWD) (Halifax, 2013), the *ReSource Training Protocol* (RTP) (Bornemann & Singer, 2013), and the *Compassion Meditation* (CM) and *Loving-Kindness Meditation* (LKM) (Hoffmann et al., 2011).

Of the interventions evaluated, all included psychoeducation, a mindfulness component at differing levels of focus, a compassion meditation or a loving-kindness meditation, an experiential or active component to the training/program, all included some form of home practice or homework for participants, and all had the ability to be delivered in a group format (Kirby, 2017). All the interventions were also manualized programs aside from CFT, a form of psychotherapy (Kirby, 2017). It is also not surprising that the interventions teach and view compassion differently. For example, the MSC program (Neff & Germer, 2013) focuses on self-compassion, whereas the other interventions focus on a more general form of compassion. The interventions also utilized different activities or experiential components. For example, the CEB and BWD integrate some yoga-based training (Halifax, 2013; Kemeny et al., 2012). Moreover, there is a lack of uniformity in intervention length, frequency, and homework/home practice guidelines. Interventions included in the review ranged from approximately 18 hours (CCT) to 54 hours (CEB); some included daily practice, while some included weekly meetings (Kirby, 2017).

Additional interventions have been evaluated utilizing randomized control trials and stem from some of these seminal studies. For example, the *Making Friends with Yourself* (MFY) program for adolescents (Bluth et al., 2016) derives from the original intervention, the *Mindful Self-Compassion program* (MSC), created by Neff and Germer (2013). MFY sampled 34 adolescents aged 14-17 utilizing a waitlist-controlled crossover study (Bluth et al., 2016). The impact of the 6-week MFY program was assessed regarding the feasibility and acceptability along with participant reports of mindfulness, positive and negative affect, self-compassion, life satisfaction, perceived stress, anxiety, depression, and social connectedness (Bluth et al., 2016). The MFY program was found to be a feasible and acceptable program for adolescents. Feasibility was assessed through attendance and retention rates. Attendance ranged from 78%-89% in the two cohorts, and study retention was 86% (Bluth et al., 2016). Acceptability was measured through qualitative analysis of in-program discussions and homework completion. Overall, adolescents in this program reported that the mindfulness and compassion skills they learned were "applicable and useful in their daily lives, [they] felt that they benefited from coming to class and indicated that they used the practices during moments of stress" (Bluth et al., 2016, p. 489). Following the intervention, participants saw a significant increase in their reported levels of self-compassion and life satisfaction along with decreases in reported levels of depression compared to the waitlist control group (Bluth et al., 2016). The researchers also found greater mindfulness, social connectedness, and lower anxiety trends when comparing groups (Bluth et al., 2016). This study was not without limitations; however, the MFY and its findings lay a solid foundation for future research of the MSC targeted at a different population, such as children. Some limitations of the MFY study were the smaller sample size, a lack of diversity in gender in the sample, as most participants were female, there was no follow-up with participants, and there were limitations inherent in a waitlist control, as effects on the treatment group may be overestimated. The current study followed similar procedures to assess the MSC program with children in middle childhood. In addition, it addressed some of the limitations of the MFY study, including conducting a follow-up interview with participants and having a more diverse sample in terms of participants' gender.

The current study encompassed the key components present in the established compassion intervention programs, including psychoeducation, a compassion meditation or

loving-kindness meditation, an experiential or active component to the training/program, and some form of home practice or homework for participants. It was delivered in a group format with parents and children and modeled the MSC program (Neff & Germer, 2013) and the MFY program created for adolescents (Bluth et al., 2016). The study aimed to fill in some important gaps that exist in the research on compassion interventions. To the author's knowledge, there has been limited research into a self-compassion program for children and their caregivers in this age group. However, research into the efficacy of mindfulness-based interventions for youth suggests benefits in the areas of mindfulness, depression, anxiety, attentional control, and externalizing behaviors (Dunning et al., 2019; Lee, 2017; Ridderinkhof et al., 2018).

While mindful self-compassion programs for adults and adolescents have been developed, more research needs to be done to assess the impact of self-compassion training on children. Consequently, this study's results may help provide a complementary intervention for children to promote self-compassion, other-compassion, and increase positive perceptions of parent-child relationship quality. Moreover, results may indicate the need for a more extensive and well-controlled study.

CHAPTER 3

METHOD

Until now, there has been little research on the impact of self-compassion training on children ages 7-12. However, recent research examining mindful self-compassion programs for adults and adolescents found that these programs reduce anxiety, depression, perceived stress, and negative affect (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). Furthermore, numerous studies on self-compassion indicate a strong association between self-compassion and emotional well-being, coping skills, lower levels of anxiety and depression, decreased rumination and fear of failure, and more satisfying personal relationships (Neff, 2003; 2009a; 2009b). By building the capacity to become more self-aware, kids develop greater resilience and emotional strength in the face of adversity.

Therefore, the current study used quantitative and qualitative data to evaluate feasibility and acceptability along with relevant child and parent psychosocial outcomes of the *Friend in Me* training. The study involved two groups with child and caregiver dyads who participated in the live online *Friend in Me* training. The first group had six dyads, and the second group had five. After attrition, the second group ended with four dyads. In total, ten dyads, 20 individuals, completed the *Friend in Me* training program. The participants in each group attended the six-week long live-online training with the practitioners. To be a study group member, the participants had to fill out a survey via Qualtrics to determine study eligibility. Following this survey, participants who were screened in received confirmation of their eligibility along with the pre-test survey link. Participants were engaged in the consent process prior to participation, and consent forms were completed for the caregiver and assent forms for the child electronically (see Appendix B). All participants received identical surveys to minimize confounding experiences and maintain consistency.

Additionally, the training was offered to participants at a reduced cost of $250 with additional incentives. If both the child and caregiver participants completed all surveys required by the study, they received the training for $0. The researcher also obtained funding to compensate the participants for the qualitative interview. If participants agreed to complete the interview component of the study, they received a $20 Amazon gift card in appreciation of their time. Overall, participants completed two surveys, one before the

training, pre-test, and one after the training, post-test. Data from the pre-test, post-test, and qualitative interviews were used to answer the research questions.

Overview of Approach

This study utilized a mixed-methods embedded design as outlined by (Creswell, 2014a). In this design, quantitative data were collected and analyzed at two time points, pre-test and post-test, and qualitative data were collected and analyzed once following the completion of the *Friend in Me* intervention. This design was implemented to gather a deeper understanding of participants' perspectives on program feasibility and acceptability and to help examine the intervention outcomes shown in the quantitative data collection (Creswell, 2014a). This mixed-methods design evaluated data utilizing a quantitative core component with an embedded qualitative supplementary component, as qualitative data were supporting (Morse & Niehaus, 2009). The design was built off the hypotheses that the *Friend in Me training* would increase self-and other-compassion and positively impact parent-child relationship quality. Therefore, the study first sought to test those hypotheses through quantitative data analysis and then through embedded qualitative analysis post-intervention. The human subjects approval letter for this study can be found in Appendix A.

Research Questions and Hypothesis

The specific research questions (RQ) and hypotheses (H) of the study were as follows:

1. RQ1: Does child compassion increase after completing the *Friend in Me training*?
    a. H1: Children's levels of self-compassion will be significantly higher at post-test in comparison to levels of self-compassion at pre-test.
    b. H2: Children's levels of other-compassion will be significantly higher at post-test in comparison to levels of other-compassion at pre-test.
2. RQ2: Does parent compassion increase after completing the *Friend in Me training*?
    a. H1: Parents' levels of self-compassion will be significantly higher at post-test in comparison to levels of self-compassion at pre-test.
    b. H2: Parents' levels of other-compassion will be significantly higher at post-test in comparison to levels of other-compassion at pre-test.
3. RQ3: Do levels of parent-child relationship quality increase after completing the *Friend in Me training*?

H1: Children's reports of parent-child relationship quality will be significantly higher at post-test in comparison to reports of parent-child relationship quality at pre-test.

   a. H2: Parents' reports of parent-child relationship quality will be significantly higher at post-test in comparison to reports of parent-child relationship quality at pre-test.

4. RQ4: To what extent do parent participants believe the *Friend in Me training* was feasible and acceptable?
5. RQ5: What are parent and child participants' general experiences of the *Friend in Me training*?

See Figure 1.

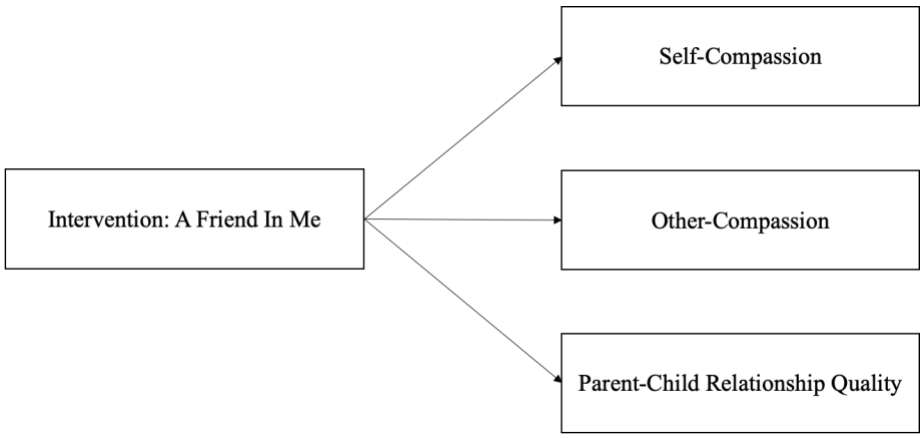

Figure 1.

Operational Model

Recruitment

Recruitment took place over eight months. The initial sample goal for the study was 20 parents and 20 children aged 7 to 12, for a total of 40 participants. The final sample consisted of 10 parents and 10 children aged 7 to 12, for a total of 20 participants. Participants were recruited through snowball sampling via flyers, social media, and the Florida State University website for the *Friend in Me training*. There were two training groups. The first group consisted of 12 participants (6 children and 6 parents), and the second group consisted of 10 participants (5 children and 5 parents).

Eligibility

All participants were screened before admission to the study for inclusion and exclusion criteria. To be admitted, participants had to identify as a primary caregiver, age

21+, to a child between the ages of 7-12 without a known severe psychiatric illness (psychotic illness, active suicidality, active trauma symptoms). Caregivers were not limited to biological parents but included anyone who identified as a primary person responsible for the child's needs. In cases where caregivers were married or cohabiting, only one member of the parental dyad was included due to the possibility of the data no longer being independent. During the application for inclusion in the intervention, participants were excluded if they had a child who did not meet the required age range of the study (7 to 12 years old) or if their child had a known psychiatric illness (psychotic illness, active suicidality, active trauma symptoms) — the participants who were screened in met all inclusion criteria. Demographic information for all child participants who were screened in is summarized in Table 2, and demographic information for all parent participants who were screened in is summarized in Table 3.

Incentives

The *Friend in Me training* was offered to participants at a reduced cost of $250 with an additional incentive to reduce the cost of the training. If both the child and caregiver participants completed all surveys required by the study, they received the training for $0. The researcher also obtained funding to compensate the participants for the qualitative interview. If participants agreed to complete the interview component of the study, they received a $20 Amazon gift card in appreciation of their time. The PI then relayed this information to the practitioners; the practitioners, Lorraine Hobbs and Dr. Amy Balentine were responsible for collecting and managing payment for the training.

Data Collection

Procedure

Following approval from the Institutional Review Board (IRB), the participant recruitment and data collection began. The researcher created a Qualtrics (Qualtrics, 2021) survey that included information about the study and procedures, informed consent process, demographic information about the participants, along with the parent measures (the Self-Compassion Short Form (SCS-SF), the Compassion Scale (CS), and the Child-Parent Relationship Scale Short Form (CPRS), and child measures (the Self-Compassion Scale for Children (SCS-C), the Compassion Scale (CS), and the Child-Parent Relationship Scale Short Form (CPRS) (see Appendix C for non-copyrighted measures). The informed consent process advised participants on the study purpose, procedures, potential risks and benefits

of participation, confidentiality, the voluntary nature of the study, contact information for the researcher, the survey incentive, a statement of consent, and assent requirements for child participants. Interested participants were asked to complete the online application linked in the resource materials to determine study participation eligibility. Once screened in, participants received an e-mail confirming their eligibility that included links to the pre-test measures for both the parent and child. After both the parent and child completed the pre-test measures, participants were provided log-in information and information on payment for the *Friend in Me training* by the practitioners. The six-week live online training took place via a HIPPA-compliant version of Zoom. Following the training, participants were contacted via e-mail to complete the post-test survey and sign up for the optional semi-structured interview (see Appendix D). The PI contacted participants who agreed to the interview to meet via a HIPPA-compliant version of Zoom. Twelve participants agreed to the interview. The PI, the parent, and the child met for a semi-structured interview, which took approximately 30 minutes. Parents and children completed their interviews individually. Participants were separated to increase the data accuracy and ensure the information gained was as close to what the interviewee was thinking at the time (Creswell & Poth, 2014b). Following the interview, the participants were provided a $20 Amazon gift card via e-mail in appreciation for their time.

Confidentiality

Participants were informed about the confidentiality policies during the informed consent process. Additionally, the researcher utilized a secure Florida State University Qualtrics survey system to keep participant responses confidential (Qualtrics, 2021) and stored all participant data and interview responses on a password-protected computer in an encrypted file. Furthermore, all online contact for training and meetings was conducted through a HIPPA-protected Zoom account, and no numbers or account information were saved outside of the Qualtrics survey system.

Measures

Quantitative Data

The online surveys were administered at pre-test and post-intervention. The survey included the following measures.

Demographic Characteristics Survey

The researcher collected data on the parent participants 'age, relationship to child, gender, race and ethnicity, education level, typical yearly income before taxes, employment status, religion/spirituality, history of mindfulness-based practice both informal and formal, and number of children. The researcher also collected demographic information on the participating child via the parent participant which will include age, gender, race and ethnicity, education (grade) level, history of a formal severe psychiatric illness, and history of formal mental, physical, emotional, or other behavioral illness.

Self-Compassion

Child Measure. The Self-Compassion Scale for Children (SCS-C) was utilized to address the self-compassion of children on six components 1) self-kindness versus 2) self-judgement 3) common humanity versus 4) isolation and 5) mindfulness versus 6) overidentification. The SCS-C is developmentally appropriate as it is adapted from the SCS-SF for children under 14-years-old and is brief, consisting of 12 self-report items centered on the six components (e.g., "when I fail at something important to me, I feel like I'm not good enough") (Raes et al., 2011). Responses are measured on a 5-point Likert scale (1 = almost never; 5 = almost always). The scale is broken up into positively worded self-compassion items ($\alpha = .81$) and negatively worded self-compassion items ($\alpha = .83$) (Sutton et al., 2018). Higher scores reflect greater self-compassion. For this study, the SCS-C presented a negative alpha value at pre-test ($\alpha = -.23$) and at post-test ($\alpha = -1.44$). A negative number typically indicates that something is wrong with the data. Therefore, data were reviewed for accuracy and the researcher found no errors; all items were correctly reverse scored. To determine if this low alpha value was due to the use of the SCS-C as a total measure of self-compassion, as opposed to evaluating the positive and negative subscale items, internal reliability for each subscale was tested. The alpha value for the positive subscale remained unacceptable at pre-test ($\alpha = .39$) while the alpha value for the negative subscale was acceptable at pre-test ($\alpha = .65$). The alpha values for the positive and negative subscales were acceptable and strong at post-test; $\alpha = .84$ and $\alpha = .89$ respectively.

Parent Measure. The Self-Compassion Scale – short form (SCS-SF) is a 12-item self-report measure that assesses various aspects of self-compassion, including one's sense of common humanity, mindfulness, and self-kindness (Raes et al., 2011). The SCS-SF

utilizes a Likert scale (1 = almost never; 5 = almost always) and asks the participant to examine how often they behave in a certain manner. The scale reportedly demonstrates adequate internal consistency (α = 0.86), with higher scores reflecting greater self-compassion (Raes et al., 2011). The SCS-SF presented an unacceptable alpha value at pre-test (α = .53) and a marginally acceptable alpha value at post-test (α = .64). To determine if the low pre-test alpha value was due to the use of the SCS-SF as a total measure of self-compassion, as opposed to evaluating the positive and negative subscale items, internal reliability for each subscale was tested. The alpha values for the positive and negative subscales were acceptable and strong at pre-test; α = .83 and α = .76, respectively. The alpha values for the positive and negative subscales were acceptable at post-test; α = .92 and α = .90, respectively.

Other-Compassion

Child Measure. The Compassion Scale (CS) is a 16-item measure that assesses compassion for others (Pommier et al., 2019). The CS was modified to be developmentally appropriate for the target age group, children 7 to 12, and focuses on how often children think they behave in a stated manner. For example, item 12, "I feel that suffering is just a part of the common human experience," was modified to "I believe that we all experience hard times in life." The CS has 16 items in total measured on a 5-point Likert scale (1 = almost never; 5 = almost always). The CS total scores have been found to be reliable across studies (α = .77 to .99), with higher scores reflecting great other-oriented compassion (Pommier et al., 2019). The CS presented an acceptable alpha coefficient at pre-test (α = .61) and at post-test (α = .66).

Parent Measure. The Compassion Scale (CS) was utilized to assess parent compassion for others (Pommier et al., 2019). The CS is a 16-item measure where responses are measured on a 5-point Likert scale (1 = almost never; 5 = almost always). CS total scores have been found to be reliable across studies (α = .77 to .99) with higher scores reflecting great other-oriented compassion (Pommier et al., 2019). The current study showed strong reliability for this measure (α = .94). The CS presented an alpha coefficient of α = .59 at pre-test = and α = .98 at post-test.

Parent-Child Relationship Quality

Child Measure. Child-Parent Relationship Scale Short Form (CPRS) is a 15-item self-report instrument designed for mothers or fathers to assess their perceptions of their

relationship with their son or daughter (Driscoll & Pinata, 2011). The items are rated on 5-point Likert scale, and the ratings can be summed into groups of items corresponding to conflict and closeness subscales. It is applicable to children ages 3-12 and was modified to match the child's perspective. The CPRS has been shown to be reliable (α = .83) (Driscoll & Pinata, 2011). Data were analyzed by subscale. The alpha value for the conflict subscale was unacceptable at pre-test (α = .48), while the alpha value for the closeness subscale was acceptable at pre-test (α = .72). The alpha values for the conflict and closeness subscales were acceptable and strong at post-test; α = .83 and α = .89 respectively.

Parent Measure. Child-Parent Relationship Scale Short Form (CPRS) is a 15-item self-report instrument that was designed for mothers or fathers to assess their perceptions of their relationship with their son or daughter (Driscoll & Pinata, 2011). The items are rated on 5-point Likert scales and the ratings can be summed into groups of items corresponding to conflict and closeness subscales. The CPRS has been shown to be reliable (α = .83) (Driscoll & Pinata, 2011). Data were analyzed by subscale. The alpha value for the conflict subscale was acceptable at pre-test (α = .88) as was the alpha coefficient for the closeness subscale at pre-test (α = .77). The alpha coefficient for the conflict subscale at post-test was acceptable (α = .95) and the alpha value for the closeness subscale was also acceptable (α = .99).

Feasibility and Acceptability

Feasibility was assessed through attendance and retention data. A 75% attendance and 80% retention rate was established as a measure of feasibility; this is in accordance with previous studies (e.g., Sibinga et al., 2008 as cited in Bluth et al., 2016; Mendelson et al., 2010). Acceptability was assessed through qualitative data which explored how participants engaged in the content of the program along with participants 'feedback on the various program activities and overall experiences.

Qualitative Data Collection

Since this study was one of the first implementations of a mindful self-compassion program for children ages 7 to 12, hearing the opinions, suggestions, and feedback of the participants in their own voices provided a rich source of descriptive data to inform refinement and future implementation of this program. The researcher conducted semi-structured interviews with those participants who consented via Zoom after completing the *Friend in Me training*. Interviews were conducted with both the parent and the child

participants separately. The interviews focused on participants' general experience of the *Friend in Me training*, key points they remembered from the program, and changes they noticed in the parent-child relationship. Interviews were recorded with participants' consent and were then transcribed, read, and coded for themes (Creswell & Poth, 2018). Interviews were conducted until saturation or redundancy was reached. Saturation occurs "at the point in [qualitative] data collection that signals little need to continue because additional data will serve only to confirm an emerging understanding" (Suter, 2012, p. 350).

Following data collection, transcripts of the audio-recorded semi-structured interviews were imported into Atlas-ti 22 software to analyze the qualitative data. This software was used to analyze transcriptions based on conventional content analysis, a process in which codes are derived directly from data (Hseih & Shannon, 2005). The researcher used this information to conduct a narrative analysis of the data following the steps outlined in Creswell and Poth (2018). Transcriptions were reviewed to obtain a broad understanding of the course and participant experiences as they relate to the research questions. Memos were created in Atlas-ti 22 to begin to identify initial codes and corresponding categories and themes.

Intervention

A Friend in Me: A Self-Compassion Training for Children and Their Caregivers

The online program, *A Friend in Me: A Self-Compassion Training for Children and Their Caregivers,* has been utilized with parents around the globe, and the developers and practitioners of the course, Lorraine Hobbs and Dr. Amy Balentine, have completed several trainings. The *Friend in Me training* was created to be a developmentally appropriate, self-compassion intervention for children to learn social-emotional skills to help them develop compassion, mindfulness, empathy, kindness, and increased self-regulation. Although an adolescent program has been developed, the *Friend in Me training* is one of the first created specifically for children and their caregivers. While not explicitly a treatment program, research into the efficacy of mindfulness-based interventions for youth suggests benefits in the areas of mindfulness, depression, anxiety, attentional control, and externalizing behavior (Dunning et al., 2019; Lee et al., 2017; Ridderinkhof et al., 2018).

The developers and practitioners of *the Friend in Me* training program, Lorraine Hobbs and Amy Balentine, have completed the *Friend in Me* teacher training and have extensive professional backgrounds in mindfulness. They jointly led both groups through

the training intervention and followed a manualized guide to deliver the program in support of treatment fidelity. Altogether, the *Friend in Me training* consisted of six 90-minute sessions. The first hour was for both the parent and child, and the final 30 minutes were allotted for the parents only. The last 30 minutes offered parents a space to debrief with the practitioners and to learn practical advice on continuing and encouraging home practice with their children. During this time, they also received brief lessons in self-regulation and co-regulation with their children, along with adult-oriented practices and teachings in self-compassion. The practitioners kept in contact with the participants via e-mail throughout the course of the program, which was predicted to help with potential attrition. Like the adult *Mindful Self-Compassion* program (Neff & Germer, 2013), each weekly session of *Friend in Me* training program had a specific theme. The intervention protocol is summarized in Table 1.

Intervention Protocol

The *Friend in Me training* consisted of six 90-minute sessions. The first hour was for both the parent and child, and the final 30 minutes were for the parents only. Each session followed the same procedures but centered on different themes. Each parent/child session began with a main topic introduction, followed by a guided reflection, guiding principles, an informal mediation, a topic exercise, and a discussion. After the first 60 minutes, parents transitioned into the parent-only session. Those sessions were 30 minutes long and began with a main topic introduction which was followed by an opening meditation, journal/writing activity, and a discussion portion. Throughout the sessions, parents and children were invited to reflect and ask any questions that arose. See Table 1 for details on the intervention protocol.

Table 1.
A Friend in Me: Intervention Protocol

Week	Main Topic	Session Themes	Exercises
Module 1	A Friend in Me - Learning to Be Kind to Myself	Introductions What is Self-Compassion? Mindfulness & Self-Compassion	Rainbow Yoga/Breathing Can I be a Friend to Myself? Balloon Breathing Meditation Collecting Clues: Writing your Clues Down in your Detective Notebook Coaching Your Child - Building a Mindfulness Practice at Home
Module 2	Becoming A Mindfulness Detective	Definition of Mindfulness Learning to Quiet a Busy & Wandering Mind Here & Now Stone Discussion on Mindfulness	Mindful Listening Using Our Senses to Explore Eating like Detectives Silent Zombie Walk - Soles of the Feet Meditation Compassionate Body Scan Collecting Clues: Writing your Clues Down in your Detective Notebook
Module 3	Growing Kindness: Uncovering a Brave Heart	Empathy, Kindness & Compassion Discovering Kind Words Just for Me Growing Compassion and Kindness	Three Soothing Breaths Loving Kindness for Someone I Care About Lion's Breath Loving-Kindness Wishes Just for Me Collecting Clues: Writing your Clues Down in your Detective Notebook
Module 4	Discovering My Superhero, a Kind and Compassionate Part of Me	Steps to Self-Compassion Inner Bully	A Person Just Like Me Melting Snowman Activity Discovering our Brave and Compassionate Superhero Collecting Clues: Writing your Clues Down in your Detective Notebook Self-Compassion Break for Parents
Module 5	Taming Your Inner Dragon, Getting to Know Your Big Emotions	Upstairs/Downstairs Brain	Dragon's Breath Yoga Posture Name It to Tame It Meditation Experimenting with Oobleck Art Activity Soft, Soothe, and Allow Breathing with a Friend Collecting Clues: Writing your Clues Down in your Detective Notebook "Taking in the Good"
Module 6	Finding Gratitude and Appreciation for the Good Things in Life	Gratitude What Would I Like to Remember? Closing Ceremony	A Kind & Compassionate Friend Discovering Gratitude for Small Things Uncovering Self-Appreciation What's in My Detective Notebook? Collecting Clues: Writing your clues down in your detective notebook

Table 2.
Child Demographic Information

Child (C) #	Gender	Age	Race	Diagnosis
C1	Female	10	Black	ADHD
C2	Male	7	Multiracial	None
C3	Female	11	White	None
C4	Female	9	Biracial	Grief
C5	Male	8	White	None
C6	Female	7	White	None
C7	Female	8	White	Anxiety + ADHD
C8	Female	10	White	OCD
C9	Male	12	Hispanic/Latino	None
C10	Male	8	White	None
C11	Male	12	White	ADHD
C12	Male	11	Multiracial	Anxiety
C13	Male	9	White	ADHD

Table 3.
Parent Demographic Information

Parent (P) #	Gender	Age	Race	Mindfulness Experience
P1	Female	36	White	None
P2	Male	56	Multiracial	Yes, Formal
P3	Female	45	White	Yes, Formal
P4	Female	43	Biracial	Yes, Formal
P5	Female	41	White	Yes, Formal
P6	Female	41	White	Yes, Informal
P7	Female	49	White	Yes, Formal
P8	Male	45	White	Yes, Formal
P9	Female	35	Hispanic/Latino	None
P10	Female	29	White	Yes, Informal
P11	Male	34	White	Yes, Informal
P12	Female	50	Hispanic/Latino	Yes, Formal
P13	Female	45	White	Yes, Informal

Data Analyses

Preliminary Analyses

All participant quantitative survey responses were recorded in the Qualtrics system. Once all responses were gathered, they were exported from Qualtrics to a secure Microsoft Excel file, then converted to an SPSS (IBM Corp, 2020) file. Data analyses were organized and tested using SPSS to check distributions and possible correlations.

Quantitative Data Analysis

Within Group Analyses. A paired sample t-test was used to test the research questions by comparing pre-test and post-test measures for both parent participant responses and child participant responses. A paired sample t-test was fitting because the PI looked at measurements taken from the same participants at different time points. From this

analysis, the researcher was able to determine whether or not there was statistical evidence that the mean difference between paired observations was significant.

Sample Size Limitations. To address the smaller sample size, the researcher also calculated Hedges ’g scores for effect size, as this complies with current recommendations and has been used in complementary studies (Cumming, 2014; Kline, 2013; Wilkinson & APA Task Force for Statistical Inference, 1999 as cited in Bluth et al., 2016). Hedges ’g includes a correction factor for small samples, which makes it a better fit than Cohen’s d for this analysis. This analysis choice is also based on the suggestions of the complementary Making Friends with Yourself study completed by Bluth et al. (2016).

Qualitative Data Analysis

This study utilized a mixed-methods embedded design as outlined by (Creswell, 2014a). After quantitative data were collected and analyzed at two time points, pre-test and post-test, qualitative data were collected and analyzed once following the completion of the *Friend in Me* intervention. This design was implemented to gather a deeper understanding of participants’ perspectives on program feasibility and acceptability and to help gain a more complete understanding of the intervention outcomes shown in the quantitative data collection (Creswell, 2014a). Qualitative data were collected via semi-structured follow-up interviews with consenting participants until saturation was reached. Saturation was achieved when key themes were consistently indicated (Creswell, 2014a). Interviews were then transcribed, read, and coded for themes.

Procedure. The researcher utilized narrative analysis to gain a deeper understanding of how the intervention participants viewed the story of their experience in the *Friend in Me training*. Narrative inquiry does not have a formal set of procedures, as it is a more fluid form of analysis (Creswell & Poth, 2018). First, the researcher contacted participants in the intervention group following the post-test to determine which participants would participate in follow-up interviews. Participants who agreed were then contacted during week 7 of the study, one week after post-test, for the semi-structured interview with the PI via a HIPPA-compliant version of Zoom. Following the semi-structured interview, the researcher conducted a narrative analysis of the data following the steps outlined in Creswell and Poth (2018). The researcher organized and prepared the data by transcribing all interviews using the Atlas-ti 22 software and reading them over to obtain a general sense of the information and started to look for various perspectives in the

responses. Then, the researcher began the narrative coding process. During this stage, the researcher needed to be context-sensitive (Czarniawska, 2004, as cited in Creswell & Poth, 2018). Following this step, the researcher analyzed the stories participants shared by reorganizing or re-storying the data into a general framework that fits. While completing this step, the researcher paid close attention to potential dichotomies, silences, any contradictions, and any themes or categories that may have emerged while negotiating meaning in the text (Creswell & Poth, 2018). Finally, the researcher fit the narrative into the research and presented it in written form. This represents the final interpretation and considered the personal, social, and historical context of the lived experiences shared by the participants (Creswell & Poth, 2018).

CHAPTER 4

RESULTS

Preliminary Analyses

Preliminary analyses performed before completing the paired sample t-tests included scanning data for outliers and missing values. Results indicated that the data were normally distributed, and data were missing at random. All participants who completed the training (n = 10) had complete data for pre-test and post-test. Participant responses were exported from secure Qualtrics survey responses to Microsoft Excel (version 2016) files (Qualtrics, 2021). Parent responses were matched via ID numbers to corresponding child responses. The Excel files were then converted to an SPSS (version 29) file to perform analyses. Tables were generated to display correlations, means, and standard deviations of the study variables for both the child and parent participants these are presented in Table 4 and Table 5.

Research Questions 1, 2, & 3 Findings

To address research questions (RQ) 1, 2, and 3, a paired sample t-test was conducted on both the data for the child participants and the parent participants.

Research Question 1: Does child compassion increase after completing the Friend in Me training? Results of the paired sample t-test for research question 1 showed a statistically significant difference in children's levels of self-compassion before and after taking the *Friend in Me training* (p = .048). Additionally, the effect size for this measure using Hedge's g was negative ($\hat{g}$ = -.537). However, there was not a statistically significant difference in children's level of other-compassion from before the training to after taking the training (p = .687). Yet, the effect size showed small effects for this measure ($\hat{g}$ = .120).

Research Question 2: Does parent compassion increase after completing the *Friend in Me training*? Results of the paired sample t-test for RQ 2 showed no statistically significant difference in parents 'levels of self-compassion before the training compared to after taking the training (p = .560). The data did show a small effect size for self-compassion in parents ($\hat{g}$ = .175). Moreover, there was not a statistically significant difference in parents 'levels of other-compassion (p = .329). However, the data did show

that parents' mean score of other-compassion increased from pre- (M = 58.6) to post-training (M = 59.8) but the effect sizes was negative for other-compassion ($\hat{g}$ = -.298).

Research Question 3: Do levels of parent-child relationship quality increase after completing the *Friend in Me training*? To test RQ 3, a paired sample t-test was conducted with both child and parent data to look at two separate factors included in the Child Parent Relationship Scale Short Form measure: conflict and closeness. Results of the analysis of the children's data showed that there was not a statistically significant difference in children's perceived levels of conflict (p = .658) or closeness (p = .181); however, children's perceptions of the presence of conflict in their relationships with their parents did show mean level decreases from before the training (M = 24.0) to after the training (M = 23.2), where a lower score shows perceptions of less conflict in the parent-child relationship. Additionally, the effect size showed small effects ($\hat{g}$ = .132) for conflict and medium effects ($\hat{g}$ = .419) for closeness. Results of the analysis of the parents 'data showed that there was a statistically significant difference in parents 'perceived levels of conflict (p = .010) and closeness in the relationship (p = .011). The effect size for conflict also showed large effects ($\hat{g}$ = .931) for conflict but showed a low and negative effect size for closeness ($\hat{g}$ = -.923).

Research Questions 4 & 5 Findings

Research question 4 was addressed using both quantitative data and semi-structured qualitative interviews, and research question 5 was addressed solely through the semi-structured qualitative interviews. The researcher provided all participants with the opportunity to participate in an interview and collected narratives from the individuals who agreed to participate. The interviews followed a semi-structured interview guide and consisted of some probing questions as appropriate to maintain the flow of natural conversation and gain a deeper understanding of the participants 'experiences. Child participants were always interviewed first, without their parents present followed by parent participants without their child present. The inclusion of narratives allowed the researcher to provide thick and rich descriptions of the data and ensure participants' intended meaning was conveyed.

Research Question 4: To what extent do parent participants believe the *Friend in Me training* was feasible and acceptable? To determine the feasibility of the intervention

for both the child and parent populations, the researcher examined attendance and retention. To determine acceptability and gain a deeper understanding of participants' view on feasibility, the researcher investigated qualitative data collected via semi-structured interviews with both child and parent participants. Cohort 1 consisted of 12 participants, six pairs, who completed all six classes. Cohort 2 consisted of eight participants, four pairs, who completed all six classes. Both cohorts followed the same survey and training protocol. Attendance was good, with a mean proportion of $M = 0.97$ for Cohort 1, and $M = 0.91$ for Cohort 2. No more than two classes were missed by participants in Cohorts 1 and 2. Reasons for a slightly lower attendance in Cohort 2 may have been due to the time of year (e.g., starting a new school year, holidays). After enrollment, one pair withdrew from Cohort 1, and one pair withdrew from Cohort 2. Another pair in Cohort 2 withdrew due to a family emergency during the course. This results in a retention rate of 77%. Additionally, the program's design increased feasibility, as Zoom-based programs are shown to increase the feasibility of extending recruitment geographically and expanding the inclusivity of the study to help gain diverse participants (Oliffe et al., 2021).

Further qualitative data was collected to assess the acceptability and feasibility of the program. The research highlighted five overarching themes that answered RQ 4 and described the acceptability and feasibility of the intervention. The five overarching themes for acceptability and feasibility were defined as: training need, favorite elements of the training, enhanced understanding of the concepts, self-compassion implemented in daily life, and suggestions for change.

Training need. Of note, several parent participants discussed the "need" for the Friend in Me training. Participants illustrated the lack of general availability of courses like this one for this specific age group and stated several instances of looking for a similar class and not finding anything before the Friend in Me training.

> "We were at the point where we were looking for a therapist. This was exactly what we were looking for. I can't stress to you enough how great this was and how important this is because there are so many kids that if I were to send [child] to therapy, he would sit there for five minutes and not know what to talk about. Doing this, an ongoing everyday thing, it's just simple, a simple change in how he thinks and how we think and I'm glad that we came across this because it's exactly what he needed and what we needed for him."

Similarly, another parent participant shared that they had "a lot of gratitude for the training," and how it impacted themselves, their child, and their relationship.

> "This is like the exact kind of thing that's needed everywhere, just more honest metrics from honest people… more one-on-one kind of stuff like this. We appreciate it for sure."

Another parent discussed potential long-term impact of the training.

> "I would just say to myself, 'if I was seven years old learning and stuff, where would I be right now 'So, I wish I had that opportunity, and I don't want to cause him to have a negative experience. So, if I can just be with whatever he's doing and let that be okay, then it could grow into something great"

Favorite elements of the training. As a whole, both child and parent participants mentioned breathing techniques as one of their favorite elements of the training. For example, a few participants voiced that they liked techniques learned such as rainbow breathing, lion's breath, dragon breathing, 3D or balloon breathing, and three soothing breaths, and found those activities to be calming and easy to practice in their daily lives. One child participant shared that "breathing helps me, like when I'm in a hard situation, it helps me stay calm." In the quote below, another child participant shared how he and his mom have been using the breathing techniques he learned and liked in the training.

> "I like the 3D breathing or the balloon breathing and the rainbow breathing meditation… When I'm in a hard situation, it helps me stay calm… I learned that there were different kinds of ways to breathe and also different kinds of meditations, and my mom has an app, and we listen to one of those meditations and we do it just about every day."

Several other child participants stated that the tool that was most useful for them was the mindfulness jar. The mindfulness jar is a container filled with water and glitter that is used as a tool to help people calm down. They are simple to make and portable. One child shared that he and his dad made two jars so that he could keep one in his room and one around the house for when he needed to calm down. Another child stated that the jar taught him to slow down. "It's like slowing down your thoughts and emotions that are bothering you like the glitter in the jar."

Along with breathing techniques, parent participants also noted more concrete elements of the training that they found helpful, such as the homework, the structure of the training, and the simplicity in how the concepts were explained to the children. In the quote below, one parent with previous mindfulness experience shared how he found this training to be different in positive ways that helped his child.

> "Rather than picking any individual exercise, what I'll say is the simplicity of the way the information was transmitted was spectacular. I've done two mindfulness teacher training programs in the last two or three years, and I'm going to use some of these tools from here: they're easier explanations… I was blown away by it on a number of occasions. I thought they just explained concepts better than I've been doing it or learning about it for years. To give an example, the idea of checking in with yourself. I've been doing that since some program I went to in 2007, and it's always been a little abstract, but just having a diagram with the six weather patterns for the kids to talk about it: it's so simplistic."

Another parent noted how the homework assignments provided structure to the course that was helpful and naturally created quality time with their child.

> "The homework was a good thing, that like 'kinda forced you to do it, you know, instead of focusing on yourself, focusing on your kid, which was a good thing. So, you know, we're going to definitely continue to do it. It helps, and the teachers did a good job with having the parent and the kid work together."

Enhanced understanding of the concepts. During the six-week program, child and parent participants developed a greater understanding of the construct of self-compassion. The child participants largely expressed starting to build their definition of compassion. They used words and phrases such as, "kindness," "loving," "caring," "having feelings for somebody else and what they care about," "helping yourself with problems and trying to make yourself feel better," "showing gratitude," "having empathy and sympathy towards somebody," "to have feelings and be able to communicate them," "when you understand how someone else is feeling and how you're feeling," and compared compassion to their "inner superheroes." Child participants were able to discuss both other and self-compassion.

> "Self-compassion is like taking care of yourself, like, let's say you're not feeling happy that day, you 'gotta do something that will make you happier and like take care of you."

Parents mentioned including more self-compassion in their current definition and in how they make meaning of the term.

> "Initially, I would say that it was something that I would always consider for other people, like being compassionate for other people, like for my kids, for my husband, for my family, and my friends, and to be empathetic and caring for others. Now it's a two-part definition, and so that is a part of it, but what comes before that is compassion for myself, and I'm finding that when I have that compassion for myself, I'm more readily and more easily able to give that to my children and my friends"

Several parent participants also expressed enhanced understanding of their child's feelings and struggles. One parent shared that he found it important to share his own struggles with his daughter more openly. "I'm an adult, and I still am struggling. I think that was really helpful for her to hear that. Like an adult can have those issues, those concerns or worries or whatever." Another parent talked about being better able to see their child's struggles and relate to them.

> "Doing all this, I see in him his struggles. I see his struggle to love himself through certain parts, and I felt that. So, seeing it put it in that perspective for me definitely changed how I was not just reacting but interacting with him as well… he's just eight, but those eight-year-old thoughts are still just as big."

Self-compassion implemented in daily lives. Throughout the interviews, participants relayed ways they were able to implement the self-compassion and mindfulness tools they learned in the training in their daily lives to contend with stressors or difficulties. Both child and parent participants demonstrated reproduction of the learned skills through practice, which leads to improvement and eventual skill advancement (Bandura, 1977). In the following quote, one child participant shared how he uses some of the breathing techniques at school and shares how self-compassion has helped him respond differently to challenging situations with his peers.

> "I liked the rainbow breathing. So, like usually when I'm in class or something, I do it in my own dinosaur arm way, so no one sees it, so I act like I'm stretching and then I breathe when I'm overwhelmed with some work I have to do, and it calms me down a little bit… usually at school when somebody would make me mad, it's like very annoying… I'm just responding differently to problems that come up."

In the quote below, one parent shared how her son has been practicing his new ability to show compassion and understanding to his younger brother.

> "After doing this class, I saw him be more compassionate toward his four-year-old little brother, like using little terms or phrases that helped him. In the past, even if he was the one that made the mistake, he would get frustrated with his little brother, but I saw him after this class start doing things differently and understanding that his little brother is four and he doesn't think the same way or isn't able to do the same things, and that didn't really start until after we did this."

Several parents mentioned integrating the self-compassion and mindfulness tools into their child's routine.

> "Everything that we did in the class was so helpful for me because we'd get the information and we'd talk about the information, and then I'd do it with [child] after, and that's what actually made the difference. We've done some mindfulness at home, but this deepened that, and this made us think a little bit differently in terms of compassion as opposed to just like mindfulness alone… it's made a difference in how we do things every day like after school. Now, we do one of the mindfulness journals, or before bed we get to it, and that's new, and that's made him start thinking about himself as well and noticing it's not everything that's going on but what I'm doing with it and how I'm feeling about it and how I can make a difference in that."

Suggestions for change. Although there were fewer comments related to aspects of the training that were less appealing to participants than those that were appealing, participants commented about elements of the program that did not work as well for them and made suggestions for changes. Mainly, these recommendations were related to the training being held online and the time commitment the training required. Some

participants felt that, while there were some benefits to the online platform, that it also made it more difficult for children to focus and stay engaged. In the following quote, one parent shares how the uptick in online learning since the pandemic has affected her child's ability to learn online.

> "COVID totally ruined any kind of computer learning at all. It ruined any kind of like computer learning for him. So, like even I know his school was only online for a short amount of time, but it was really hard for him to sit still for it. So, during this class, the first 15 min were like great, and he was focused and ready to do it, and then after that, it just he couldn't."

One parent suggested using more "brain-body breaks" in the child portion of the training. Another discussed shortening the child portion to 30 minutes and then doing 8 weeks of training instead of 6 weeks. One parent also noted that their child was the only girl in one of the training groups, and that was "awkward" for her. In this case, the parent suggested having a larger group; however, also acknowledged that his daughter, "might not have talked," if there had been more children.

Child participants shared similar concerns with the timing. Several stated that some of the time in the training could be "boring." One child shared that she gets "less distracted in person." However, several participants also acknowledged some benefits to being online, such as having a more diverse group of participants.

> "The only thing that I would change, which is impossible, is to have it in person... But that said, if you're in person, you lose the ability to show that you have kids from all over the world and not just like in your neighborhood that have the same feeling… At the end of the day, you can't have somebody from Alaska, you can't have somebody from Colorado or whatever in-person. So that's the advantage of being able to do it via Zoom as well."

The results indicate that the *Friend in Me* training was found to be both feasible and acceptable. Additionally, the data confirmed the first hypothesis of RQ1, that children's levels of self-compassion would be significantly higher at post-test in comparison to levels of self-compassion at pre-test and the second hypothesis of RQ 3, that parents 'reports of parent-child relationship quality would be significantly higher at post-test in comparison to

levels of self-compassion at pre-test. While the quantitative data did not show statistically significant evidence for the remaining hypotheses, the qualitative data highlighted themes related to the concepts of self-compassion, other-compassion, and parent-child relationship quality that provide evidence for an overall positive participant experience of the training.

Research Question 5: What are parent and child participants 'general experiences of the *Friend in Me training*? Overall, there were two overarching themes that answered RQ 5 and described participants 'experience in the training. The two overarching themes representing participants 'experience were defined as: mutual learning and increased positive perceptions of parent-child relationship quality.

Mutual learning. In general, all participants reported learning from each other throughout the six-week training. This is consistent with the theoretical framework of the study, as observing each other helped participants form ideas on new behaviors and then learn how to preform those new behaviors (Bandura, 1977). Child participants shared ways that parents modeled prosocial behavior and how they were able to learn through watching their parent.

> "So, before if you made her mad or you just did something that's very frustrating to her. She'd go from 0-100 like that. Now, after the class, it'll go from 0-5 and will pick up the more as you annoy her or something. So, she's able to calm it down more. I don't really get mad a lot, but if I do get mad, I can calm it down faster. She showed me that."

Moreover, parents noted areas where they were more cognitively aware of their actions.

> "I'm modeling as well. I think "How am I going to re-regulate? How am I going to get regulated? I'm not frustrated, I'm me, but I'm feeling frustrated. What am I 'gonna do?""

Parent participants also noted areas where they learned from their child or times when their child reminded them of some of the concepts learned in the training. For example, a parent noted that if her child noticed her upset, he would reminder her to "take three soothing breaths, mom" or offer some soothing touch. Therefore, there is evidence that information was this coded by the child and then served as a guide for how they responded to an action (Bandura, 1977).

> "We were in the car once and something was happening. I don't remember what, but I was very frustrated with him. He and my other son were getting in trouble, but he was the one who initiated it, and he was like, 'Mommy, do you need to take a deep breath? 'I was like, 'you know what, you're absolutely right, I do. 'It was just like the simple reminder of, if I'm telling you to do that and if I'm working on that with you, then I need to do the same thing. Like I said at the beginning, we're the examples. So, for him to sit there and be able to think about it like that was a big difference."

Additionally, a mutual learning process took place between the child participants in the study. Many children noted how helpful it was to hear other children all over the country shared similar experiences with them. One child participant shared that she "learned that there are so many people who have struggles like me."

Increased positive perceptions of parent-child relationship quality. Over the course of the six-week training, both child and parent participants developed increased positive perceptions of the parent-child relationship and a greater understanding of each other.

> "Now, I feel like, with the tools that we gained from the class and the fact that we are practicing on our own, we're able to have those conversations and say, "hey I need a second" or "this is what I need right now," and he understands… it's opened up the communication a little bit more when it comes to understanding our own feelings and seeing each other."

Many participants discussed a "team" mentality in the parent-child relationship that was not present before.

> "Now she and I are like a team, we're a team. We're a team that has problems, but we're a team that's going to work towards fixing them together. And I think that's kind of cool."

One child noted that he and his dad, "were copycats," because they were both engaging in the class, doing the activities, practicing at home, and learning together.

> "I realize how much my parents show up and how much my dad is trying to understand how I'm feeling and help me."

Another parent participant expressed that the training was helpful in, "bridging some gaps that had been growing" in the parent-child relationship. Noting that although quality was improved, there were also relationship breaks that were repaired, "harder edges have been softened."

> "Our relationship has changed slightly so far as sowing the seeds for working with it."

Parent participants also attributed the increase in positive perceptions of parent child relationship quality to the quality time built into the Friend in Me training.

> "Sometimes, I wonder if he just enjoyed the time with me more so than the actual practice. So that was a huge help, and that's one of the things I like about the continuity. I tried to keep up. I tried not to worry too much about how interested he was in this today, is he doing this right, or is his mind wandering to the point where he can't even do it... The time together with me was great for him, and it was for me too."

Table 4.
Correlation Table for Child Participants

	N	Correlation	Significance One-Sided p	Two-Sided p	Mean	Std. Deviation
SCS-C PRE	10	.197	.293	.586	36.1000	3.63471
SCS-C POST					38.5000	2.71825
CS-PRE	10	.726	.009	.018	58.1000	6.67416
CS-POST					57.4000	7.51591
CPRS-CONFLICT PRE	10	.618	.028	.057	24.0000	4.54606
CPRS-CONFLICT POST					23.2000	7.035641
CPRS-CLOSENESS PRE	10	.859	<.001	.001	31.0000	3.85861
CPRS-CLOSENESS POST					29.8000	5.02881

Table 5.
Correlation Table for Parent Participants

	N	Correlation	Significance One-Sided p	Two-Sided p	Mean	Std. Deviation
SCS-SF PRE	10	.667	.018	.035	39.1000	1.448754
SCS-SF POST					38.3000	1.732372
CS-PRE	10	.671	.017	.034	58.6000	1.351542
CS-POST					59.8000	1.496663
CPRS-CONFLICT PRE	10	.922	<.001	<.001	24.9000	2.405780
CPRS-CONFLICT POST					21.9000	2.157416
CPRS-CLOSENESS PRE	10	.938	<.001	<.001	29.4000	1.439136
CPRS-CLOSENESS POST					31.5000	0.921954

CHAPTER 5

DISCUSSION

This chapter will focus on a discussion of the study results. A discussion related to significant findings and non-significant findings is presented. Additionally, previous literature that supports and contradicts the results are also considered to further reinforce the significance of the findings and the purpose of the study. Finally, the strengths and limitations of the study, along with clinical implications and ideas for future research, are presented.

Compassion, Parent-Child Relationship Quality, and A Friend in Me

The primary aim of this study was to assess the feasibility, acceptability, and preliminary outcomes of "A Friend in Me: A Self-Compassion Training for Children and their Caregivers." In addition, the study assessed the outcomes between the *Friend in Me* training, self-compassion, other-compassion, and perceptions of parent-child relationship quality for children in middle childhood and their caregivers. The study results were mixed, indicating support and rejection of various study hypotheses. Findings can be understood through social learning theory and extant research. Overall, results from this study indicate a significant relationship between child self-compassion and the *Friend in Me* training, along with a significant relationship between positive parent perceptions of the parent-child relationship and the *Friend in Me* training.

Child Compassion and A Friend in Me

The hypothesis that children's levels of self-compassion would be significantly higher at post-test compared to levels of self-compassion at pre-test was supported. This finding is backed by previous literature that indicates self-compassion trainings created for younger people predict increased self-compassion at post-test (Bluth et al., 2016). One explanation for this finding could be the use of consistent measures. The current study followed past research recommendations and used a variation of the Self-Compassion Scale for children (SCS-C). Moreover, this finding is further reinforced by theory. This hypothesis was formulated with Bandura's social learning theory in mind. As such, it is possible that the ability for children to observe their parents take part in the training, practice the skills at home, and have them reinforce the learning enhanced children's

capacity for learning self-compassion and gaining increased self-compassion over the course of the six-week training.

Furthermore, the qualitative data supported an increased understanding of self-compassion for the child participants and expanded on the quantitative data. During the post-test interviews, child participants shared how they make meaning of self-compassion. They were also able to label specific ways they have continued to implement self-compassion in their daily lives, both on their own through practices like rainbow breathing and with their parents through practices such as journaling together or checking in with each other about their feelings. Moreover, children in the interviews shared how these skills have gone beyond the context of the home environment and have impacted how they react with peers at school. This is an important finding for this study because of the prominence peer relationships hold in this age group (Mah & Ford-Jones, 2012). Results lend support to the idea that self-compassion trainings for children in this age group are feasible, acceptable, and influential on the outcome of self-compassion for children.

The hypothesis that children's levels of other-compassion would be significantly higher at post-test in comparison to levels of other-compassion at pre-test was rejected and no statistical significance was found. While research supports that most people have different levels of compassion for themselves and others, this finding contradicts the literature, as research has demonstrated that people tend to have more compassion for others than for themselves (Pommier et al., 2019). One explanation for children in this age group demonstrating more self-compassion than other-compassion may be where they are developmentally. Children in middle childhood have a more realistic sense of self than younger children as they work towards increased autonomy and self-efficacy, which is the belief that they are capable of reaching specific goals or carrying out specific tasks (Bandura, 1977). There are very few studies that have explored the relationship between other-compassion and self-compassion (Lopez et al., 2018). Results add to the literature on these concepts and support the idea that it is important to measure both concepts separately and concurrently.

Parent Compassion and A Friend in Me

The hypothesis that parents' levels of self-compassion would be significantly higher at post-test compared to levels of self-compassion at pre-test was rejected and no statistical significance was found. One explanation for this may be that parent participants were more

focused on helping their child through the practices and did not focus as strongly on themselves. Additionally, there is literature to support that some parents may struggle with self-compassion because of how they learned to define it. Many adults may view self-compassion as a form of self-pity, a weakness, as something that undermines motivation to do better, as narcissistic, or something that is selfish (Neff, 2015). The qualitative data of the current study supported this. One parent shared, "Self-compassion means, or at least the way I view it, and it's not the right way to view it, is that you're selfish. So, I was trying to tell my daughter about self-compassion, and she didn't get it… but self-compassion is really tough, and I guess this is what it was, it's giving yourself a break. But I'll tell you that the tough thing with that is the first reaction you feel is, why am I feeling good; why am I worried about myself, I'm being selfish, like I should be worrying about other people, so I want her to see it differently."

However, there were parent participants whose interview responses were in discordance with the quantitative findings. For example, several parents shared stories about being able to expand their definition of compassion to include themselves, "Initially, I would say that [compassion] was something that I would always consider for other people, like being compassionate for other people, like for my kids, for my husband, for my family, and my friends… now it's a two-part definition, and so that is a part of it, but what comes before that is compassion for myself, and I'm finding that when I have that compassion for myself, that empathy for myself, I'm more readily and more easily able to give that to my children and my friends."

The hypothesis that parents' levels of other-compassion would be significantly higher at post-test in comparison to levels of other-compassion at pre-test was rejected and no statistical significance was found. This hypothesis was based on extant research that found people tend to have more compassion for others than for themselves and that it is easier to choose to feel compassion with someone you are close to, such as a family member (Penn State, 2021; Pommier et al., 2019). Therefore, the current study's quantitative findings contradict what is found in the literature. However, this hypothesis had discrepancies between the quantitative and qualitative data. During the semi-structured interview, several parent participants noted feeling better able to identify and understand their child's struggles. One parent responded "Doing all this, I see in him his struggles. I see

his struggle to love himself through certain parts, and I felt that." Overall, discrepancies in findings suggest a need for additional research on this variable.

Parent-Child Relationship Quality and A Friend in Me

The hypothesis that children's reports of parent-child relationship quality would be significantly higher at post-test compared to reports of parent-child relationship quality at pre-test was rejected and no statistical significance was found. These findings contradict what is primarily seen in the literature. Research suggests that children do feel more connected and have increased positive feelings about their relationships with their parents when their parents take time to listen to them, make them a priority by spending time with them, play with them, and create rituals together (Milkie et al., 2010; Milteer et al., 2012). One explanation for these results may be confounding factors such as the context in which the children filled out the survey; time of day, mood, atmosphere, and other factors outside of the control of the research may account for the results. Additionally, another possibility is that the study was underpowered statistically and was, therefore, unable to answer the research question of interest.

However, even though quantitative data showed that there was not a statistically significant difference in children's perceived levels of conflict or closeness to their parents, the qualitative data encompassed stories of children seeing their parents "show up" and try to understand how they were feeling. In this way, the qualitative data presented a nuanced understanding of the effects of the training on children's perspectives on the parent-child relationship and how it may have changed over the course of the six-week training.

Additionally, the form of questions, survey versus interview, may also be one explanation for why the findings are discordant. Children may have been more likely to provide responses they thought would be considered desirable if parents were present while they completed the survey, versus in the interview where they answered questions without their parents present. Since surveys were conducted in the home, there is no way to know how this process went.

The hypothesis that parents 'reports of parent-child relationship quality would be significantly higher at post-test in comparison to reports of parent-child relationship quality at pre-test was supported. Parent data showed that there were statistically significant differences in both parents' perceived levels of conflict and closeness in the parent-child

relationship. This hypothesis was based on research that found parents commonly reported an improved relationship with their child as an outcome of attending a parenting program (Butler et al., 2020). One explanation for this finding may be that parents were able to learn new skills that helped them engage in more supportive ways with their child, which may have indirectly increased the warmth in their relationship. Warmth in the relationship helps build compassion, which has the potential to impact how a parent responds to situations as they learn new strategies (Hinstsanen et al., 2019). The qualitative data expanded on these findings. All of the parents that agreed to the interview shared ways in which their view of their relationship with their child had changed and improved. Their responses were consistent with the research, and many noted how spending time with their child, one-on-one, with no distractions, played a big role in them feeling more connected. These findings support the idea of including parents and caregivers in child-focused interventions and show how a collaborative approach can impact the parent-child relationship in positive ways.

Feasibility and Acceptability

Feasibility was determined through attendance and retention. Attendance was good overall. No more than two classes were missed by participants in Cohorts 1 and 2. Reasons for a slightly lower attendance in Cohort 2 may have been due to the time of year (e.g., starting a new school year, holidays). After enrollment, only one pair withdrew from Cohort 1, and one pair withdrew from Cohort 2. Following the start of the training, one other pair withdrew from Cohort 2 due to a family emergency during the course.

While retention was strong for the present study, recruitment was difficult. Some of the main challenges for delivering interventions in the ‘real world ’include timing, engagement, and incentive; the perceived cost needs to be less than the rewards. With this study specifically, the cost of time may have been a deterrent to signing up and may have made the study less acceptable.

Overall, five overarching themes answered RQ4 and described the acceptability and feasibility of the intervention. The five overarching themes for acceptability and feasibility were defined as: training need, favorite elements of the training, enhanced understanding of the concepts, self-compassion implemented in daily life, and suggestions for change.

When looking at suggestions for change and elements of the training that may have made it less acceptable to participants, several parent participants found the meeting time

for the training, Saturday mornings, to be difficult to make when combined with other family, school, and life commitments. Though when asked about alternate time options, parents did agree that the weekends were best. Along with that, child participants reported feeling "bored" occasionally, which could be addressed by a shorter class time for the child participants or more breaks in learning. These findings suggest helpful changes for future *Friend in Me* training programs.

In addition to time concerns, both child and parent participants discussed the benefits and challenges of the training being held online. The online training allowed for increased inclusivity of the sample, allowed participants to complete the training from the comfort of their homes, eliminated travel needs, and was more cost-effective overall. However, one of the main challenges with the online platform was burnout. One parent shared how the rise in online learning since the coronavirus pandemic has been difficult for her child; she noted issues with focus and engagement.

Finally, in Cohort 2, due to the small sample size, there was only one female child in the group; her parent mentioned that it was "awkward" for his daughter. In this case, the parent suggested having a larger group; however, he also noted that his daughter "might not have talked" if there had been more children. A larger group would help the study in several ways and is an important piece to keep in mind for future studies.

All in all, the study was found to be both feasible and acceptable by the participants, with critical areas to consider in future research. Those suggestions are discussed more in-depth.

Experiences of the Friend in Me Training

The qualitative data further captured the acceptability of the training by highlighting participants' lived experiences. Overall, two main themes addressed participants' experiences of the *Friend in Me* training. The two overarching themes of participant experience were mutual learning and increased positive perceptions of parent-child relationship quality. These findings are consistent with social learning theory and the extant literature on parent-child interventions. Throughout the training, as parents learned or practiced skills, children had the opportunity to observe their behaviors. Then, consistent with social learning theory, parents started noticing their child imitate the behaviors they were observing and look to them as models for behavior (Bandura, 1977). Moreover, parents also recognized moments where they assumed their child was not paying attention

but then saw their child demonstrate the behavior later in time. These events show evidence that learning can occur in the absence of behavior, which highlights the importance of cognition (Bandura, 1965).

Learning also occurred for the parent participants. Parents noted feeling more cognitively aware of their actions when they knew their children were watching. There was enhanced motivation to model the skills and practices learned so that they could both model the preferred behaviors and help reinforce them in their children. One child referred to this as being "copycats" with his dad. In addition, many children noted that learning together through this training made them feel like they were on a "team" with their parent. This form of learning has the potential to make the information more memorable, as it is tied to a unique context for the parent and the child and holds an emotional connection for both of them.

In conjunction with experiencing mutual learning, child and parent participants developed increased positive perceptions of the parent-child relationship and a greater understanding of each other over the six-week training. The literature suggests that children feel more connected and have increased positive feelings about their relationships with their parents when their parents take time to listen to them, make them a priority by spending time with them, play with them, and create rituals together (Milkie et al., 2010; Milteer et al., 2012). The *Friend in Me* training brought all these components together, as children received scheduled and consistent one-on-one time with their parent, where they engaged in activities, learned, and played together. As a result, many families were able and motivated to continue these practices, and several parents spoke about how they were spending more intentional time with their child outside of the training.

Through the narratives of their experiences, participants indicated that the program was both timely and well-liked by participants. Furthermore, both child and parent participants reported that they found self-compassion, other-compassion, and mindfulness to be applicable and useful in their daily lives and shared that they have been able to use the techniques learned in the course both individually and together during everyday moments and even more so during moments of stress. These are promising findings, as they point to a gap in the resources available to children in this age group and their caregivers.

Additionally, the results demonstrated the value of parents and children buying into these trainings and engaging in them together through a mutual learning process. It is

important to understand how positive role models, such as parents, can impact and encourage desirable behaviors and facilitate change from an early age (Cherry, 2022).

Strengths of the Present Study

There are multiple strengths of this study. First, this study expanded on what is already known about self-compassion, other-compassion, and parent-child relationship quality in childhood by helping to assess the feasibility and acceptability of a program centered on mindful self-compassion for children and their caregivers in middle childhood. To the researcher's knowledge, this is one of the first compassion-based training programs for this age group, which helps to fill a gap in the literature on self-compassion research for this age range (Neff & Germer, 2012).

Additionally, this study explored the training program using a longitudinal design with multiple methods of assessment. Mixed-method study designs are strong because using quantitative and qualitative data in a single study provides stronger inference than using either approach on its own (Wasti et al., 2022). Moreover, the embedded design supplemented the conclusions from the quantitative data and revealed a more comprehensive picture that added depth to the study. Literature on mindfulness and compassion also suggests the importance and need for multi-method and multi-informant assessments in this area of research (Galla, 2016).

Another strength was that the study and the semi-structured interviews were conducted online via Zoom. The online platform allowed the training to consist of a more diverse sample, in terms of geographic location, with people attending from many different states. Also, Zoom interviews have been shown to hold rich therapeutic value, both in the context of being interviewed and in accessing formal health care services, to be more comfortable for participants since they are in their own spaces, and to reduce recruitment costs and extend reach and inclusivity (Oliffe et al., 2021).

Moreover, the study results may ultimately help provide a complementary intervention for children to promote self-compassion, other-compassion, and positive perceptions of the parent-child relationship and offer an innovative approach to understanding how these constructs may work with one another. Feasibility studies are crucial in determining whether a larger controlled intervention study to test for efficacy is justified and in refining the research design and intervention protocol (Wuest et al., 2015).

Finally, the researcher sees the biggest strength of this study to be the support it offers to both children and their caregivers. Finding ways to support parents and help them meet the challenges of their role as a caregiver has been identified as a public health concern in the literature and remains a priority (Butler et al., 2020). Supporting children and their caregivers is a type of social investment with widespread implications. As the research shows, mental health concerns often commence in childhood and can significantly impact all areas of a child's life; consequently, it is crucial to intervene early and provide caregivers and children with strategies and skills that support children's mental health needs (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2021b). Supporting parents through this process will only better enable them to show up for their children and promote healthy development.

Limitations of the Present Study

While this study has many strengths, it is not without limitations. This study involved a small sample, which limited statistical power and the generalizability of the results. Additionally, the measures used in this study demonstrated some issues with reliability. Specifically, reliability was unacceptable for the child self-compassion (SCS-C), child perceptions of parent-child relationship quality (CPRS), and the parent self-compassion (SCS-SF) measures. Additional analyses were conducted to explore potential explanations and solutions to such issues. For instance, wondering if child age may have been a factor, reliability analyses were conducted by separating the responses of younger child participants (age < 9) from older child participants. When these analyses were conducted, the reliability increased but was still unacceptable. As such, quantitative results should be interpreted with caution. Despite the best effort of the researcher to use reliable measures, measures can often be subject to random or systematic measurement error, leading to biased estimates and non-significant findings. Therefore, caution should be taken when looking at the results of this study, as there is the possibility the findings are non-significant, and results were obtained by chance. This impacts the conclusions that can be drawn from this study and would be an important component for future research studies to pay attention to. Moreover, the sample size was too small to draw statistical conclusions confidently. Due to the overall small sample size, the study may be underpowered and may not have had a large enough sample size to answer the research questions of interest.

Furthermore, the current study was also limited by time constraints. Due to the length of the training, recruitment could only be conducted for nine months, which may have contributed to the smaller sample size. Additionally, self-selection bias was possible. Since participation in the semi-structured interview was voluntary, it is possible that the people who chose to be interviewed did not provide a true reflection of the views of the remaining participants. In addition, as seen in the literature, differences in compassion interventions make it difficult to find consistency. Finally, there was a general lack of uniformity in the amount of homework/home practice completed by the participants.

Future research may also consider collecting data using alternate formats. Results of the study may vary if the training, surveys, and interviews were completed in person with more control over the timing and context in which the surveys and interviews were administered. This may also help with the reliability and validity of the study. More research is needed to confirm the study findings and gain a richer understanding of which components of the training are most beneficial to participants.

Clinical Implications

Couple and Family Therapists

Results from this study underscore important clinical implications for family therapy. There is significant research supporting parent participation and engagement in child and family mental health treatments (Haine-Schlagel & Walsh, 2015). Therefore, mental health providers working with children in this age group should consider focusing on increasing parental involvement and participation and may encourage parents to engage in a treatment program or training with their child. Results from this study support that a training program such as the *Friend in Me* training promotes increased connection and positive perceptions of the parent-child relationship, which are associated with better adjustment in children and fewer behavioral problems (Hazel et al., 2014).

Moreover, the research has found that training programs emphasizing positive parent-child interaction skills, emotional awareness, and communication skills while requiring that parents and children interact with the material together during the training to practice are more successful with better parental outcomes (Rossi, 2009). The *Friend in Me* training consists of these three components, and both quantitative and qualitative results of the present study show that parents saw an increase in their positive perceptions of the

parent-child relationship and that both parent and child participants shared narratives of feeling more connected to each other and more like a "team."

Additionally, based on parent participant qualitative responses, a program such as this one also has the potential to increase parental understanding of their child, reduce parental stress, and increase their sense of competence in implementing techniques that may help their child regulate and self-soothe. These are important factors for children. Children who are able to gain a deeper understanding of self-compassion and other-compassion at an early age have been associated with enhanced psychological health as they age into adulthood, with adults who are more self-compassionate demonstrating higher personal initiative, happiness, and optimism, along with lower expressions of depression, anxiety, stress, rumination, perfectionism, and fear of failure (Heffernan et al., 2010; Hollis-Walker & Colosimo, 2011; Neff, 2003a; Neff et al., 2005; Neff et al., 2007). There is also considerable evidence in the literature suggesting that parenting interventions based on the principles of social learning theory have the potential to provide clinical and cost-effective methods to improve the health and well-being of parents and children (Butler et al., 2020).

Therefore, clinicians working with parents and children in this age range should consider family therapy, as opposed to individual treatment, to address the needs of the parent-child system. Additionally, clinicians could benefit from integrating this training into their practice or from taking the findings from this preliminary study and including some of the key concepts and techniques in their sessions.

Future Research

There are several avenues suggested for future research. First, since compassion is conceptualized in different ways, it is crucial to ensure that all future research includes a clear description of the theoretical underpinnings of the developed intervention (Kirby, 2017). The research also encourages including follow-up measures in future research (Bluth et al., 2016). Follow-up assessments are necessary to help determine self- compassion's effectiveness in maintaining long-term outcomes.

Furthermore, in future research, a larger and more diverse sample would improve the quality and accuracy of study results. Additionally, future studies would benefit from being designed as a randomized control trial or from using an active control group, as a control group would help establish the internal validity of the results. Finally, a more

extensive and well-controlled study meant to assess which specific aspects of the *Friend in Me* training are acceptable and effective and to explore how it compares to basic mindfulness training would enhance the findings from the present study.

Conclusion

This study assessed the feasibility, acceptability, and preliminary outcomes of "A Friend in Me: A Self-Compassion Training for Children and their Caregivers." To examine this intervention, the study explored the variables of self-compassion, other-compassion, and parent-child relationship quality at different time points using paired sample t-tests and utilized qualitative semi-structured interviewing to gain a more intricate understanding of participants' experiences of the training. The results highlighted the complexity of the variables through mixed support for the proposed hypotheses. Although not all proposed hypotheses were supported, the importance of interventions focused on compassion and targeted at children in middle childhood was not lost. The present study was a step towards more solutions for a group that is often forgotten in the literature; yet is experiencing a mental health crisis. Supporting children and their caregivers is a social investment with invaluable implications.

APPENDICES

APPENDIX A

HUMAN SUBJECTS APPROVAL LETTER

FLORIDA STATE UNIVERSITY

OFFICE *of the* VICE PRESIDENT *for* RESEARCH

APPROVAL

January 4, 2022

Dear Francesca Otero-Vargas:

On 1/4/2022, the IRB reviewed the following submission:

Type of Review:	Expedited (4) Noninvasive procedures; (5) Data, documents, records, or specimens; (6) Voice, video, digital, or image recordings; (7)(a) Behavioral research
Title:	A Friend in Me: Effectiveness of an Online Mindful Compassion Program for Children
Investigator:	Francesca Otero-Vargas
Submission ID:	STUDY00002697
Study ID:	STUDY00002697
Funding:	None
IND, IDE, or HDE:	None

Documents Reviewed:	• Compassion Scale.pdf, Category: Survey/Questionnaire; • CAMM Measure.pdf, Category: Survey/Questionnaire; • Brief Resilience Scale (BRS) _ Modified for Children 7-12.pdf, Category: Survey/Questionnaire; • KIDSCREEN-10 index_ChildrenAdolescents_sample_UK.pdf, Category: Survey/Questionnaire; • Brief Resilience Scale.pdf, Category: Survey/Questionnaire; • The Compassion Scale (CS) _ Modified for Children 7-12.pdf, Category: Survey/Questionnaire;

	• WHO-5 Well-being Index.pdf, Category: Survey/Questionnaire; • A Friend in Me Curriculum .pdf, Category: Other; • SatisfactionWithLife .pdf, Category: Survey/Questionnaire; • ShortSCS Measure.pdf, Category: Survey/Questionnaire; • Student_s Life Satisfaction Scale (SLSS).pdf, Category: Survey/Questionnaire; • CaringForBlissScale_ForResearchers .pdf, Category: Survey/Questionnaire; • Self-Compassion Scale-Children.pdf, Category: Survey/Questionnaire; • Caring for Bliss Scale (CBS) _ Modified for Children 7-12 .pdf, Category: Survey/Questionnaire; • Semi-Structured Int. Guide.pdf, Category: Survey/Questionnaire; • Caregiver Perception of Child Well-Being.pdf, Category: Survey/Questionnaire; • FFMQ.pdf, Category: Survey/Questionnaire; • A Friend in Me: Assent Form , Category: Consent Form; • A Friend in Me: Consent Form , Category: Consent Form; • A Friend in Me: Consent Form (Revised), Category: Consent Form; • A Friend in Me: IRB October Protocol , Category: IRB Protocol; • A Friend in Me: Recruitment Flyer, Category: Recruitment Materials; • CITI Certificate_Seibert, Category: CITI Training Completion Documentation; • Demographic Questionnaire, Category:

	Survey/Questionnaire; • Participant Confirmation E-mail, Category: Recruitment Materials; • Participant Survey E-mail, Category: Recruitment Materials; • Registration Webpage Description, Category: Recruitment Materials; • Screening Questions, Category: Survey/Questionnaire;

The IRB approved the protocol, effective from 12/17/2021 to 12/16/2022 inclusive.

Before 12/16/2022 or within 30 days of study close, whichever is earlier, you are to submit a completed continuing review and required attachments to request continuing approval or closure.

If continuing review approval is not granted before the expiration date of 12/16/2022, approval of this protocol expires on that date. COVID-19 Information for Research Involving Human Subjects: Note that the U.S. is operating under the national emergency Proclamation 9994 concerning the COVID-19 pandemic and that this national emergency remains in effect until rescinded or terminated by the President of the U.S. (go here for the Proclamation letter). Conditions are dynamic and related policies or guidance evolve accordingly; as applicable, refer to the U.S. Centers for Disease Control and Prevention website specific for universities or refer to our COVID-19 and Human Research Studies web page to learn more about how you should or may protect persons (whether vaccinated or unvaccinated) involved in any of your in-person research activities.

Other Information:
This study meets the definition of a clinical trial as it involves the assignment of one or more human subjects to one or more interventions (procedure, device, or drug, including use of placebo or control) to evaluate the effects of the interventions on biomedical or behavioral health outcomes. Please note that the approved IRB consent form template must be posted by the awardee to a federal website to be disclosed. This document must be posted after the research has been closed and no later than 60 days after the last study visit of any subject.

You are advised that any modification(s) to the protocol for this project must be reviewed and approved by the IRB prior to implementation of the proposed modification(s). Federal regulations require that the Principal Investigator promptly report any new information related to this protocol (see Investigator Manual (HRP-103)).

You are required to submit a Continuing Review at least 60 days before the protocol expiration date of 12/16/2022 to request continuing approval or closure. If the continuing review approval is not granted before the expiration date, approval of this protocol expires on that date.
In conducting this protocol, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system.

Sincerely,
Office for Human Subjects Protection (OHSP)
Florida State University Office of Research
2010 Levy Avenue, Building B Suite 276
Tallahassee, FL 32306-2742
Phone: 850-644-7900
E-mail: humansubjects@fsu.edu
OHSP Web: https://ohsp.fsu.edu

APPENDIX B

INFORMED CONSENT AND ASSENT

Title of the Study: *A Friend in Me: A Mixed Methods Pilot Study of an Online Mindful Self-Compassion Program for Children*

Principal Investigator: Francesca Otero-Vargas, MAMFT, FSU Doctoral Candidate

Co-Investigators: Drs. Lenore McWey, Myriam Rudaz, Gregory Seibert, & Thomas Ledermann

Faculty Advisor: Lenore McWey, Ph.D., FSU Professor

You and your child are being invited to take part in a research study. Please find below information about this research for you to think about before you decide to take part. Ask us if you have any questions about this information or the research before you decide to take part.

What is this study about?
This study examines the Effectiveness of the Online training program, A Friend in Me (FIM), a Mindful Self-Compassion Program for Children. We are specifically interested in examining the effectiveness of this training on individual and relationship well-being. You are one of approximately 128 persons we estimate will take part in this study. Your involvement in the study is expected to last 13 hours over the course of 3 months.

What will happen during this research?
If you agree to be part of this research, your participation will include attending the online 6-week FIM training (1.5 hours per week) with your child and completing a series of three online surveys individually. Both you and your child will take these surveys. The trainings will take place on [date/time]. All participating individuals will attend each training, along with the program developers. Trainings sessions will be conducted using Zoom software and will not be recorded. Any personal recording of the live sessions (audio or video) is prohibited. You and your child will be asked to complete one survey prior to starting the training, at the completion of the course (week 6), and 6 weeks after completing the course. You and your child will also be asked to participate in a voluntary interview after week 6 which will take approximately 30-60 minutes to complete.

Each survey will take approximately 20-30 minutes to complete. Surveys include questions on self and other compassion, mindfulness, resilience, well-being, parent-child relationship quality, life satisfaction, caring for bliss, and caregiver perception of the child participant's well-being. The total time commitment for these surveys over the three months is about 1 – 1.5 hours. The Friend in Me (FIM) training comprises of six 1.5-hour live online sessions once per week over the course of six weeks, 60 minutes of caregiver child participation, 30 minutes of caregiver activities and reflection, and then home practice time at your discretion. The total amount of time spent in training for this course will be 9 hours.

We will tell you about any new information that may affect your willingness to continue to take part in this research.

What will you do to protect my privacy?
The results of the study may be published or presented, but no information that may identify you will ever be provided or released in publications or presentations. We will take steps to protect your privacy and confidentiality. These steps include that all data will be de-identified and stored on a password-protected/encrypted computer to ensure confidentiality. To protect your privacy, Personal Identifiable Information (PII) will not be collected with the exception of the initial study contact information and this consent form. Your identity and the identity of your child will be stored separately from the responses and will not be shared with other researchers or revealed in any publications, presentations, or reports resulting from this study. Research records will be kept confidential to the extent allowed by law and may be reviewed by the FSU Institutional Review Board and other oversight organizations. The personal information and this informed consent will be kept for 3 years after the conclusion of the study, after which time they will be destroyed. Deidentified data will be kept indefinitely. Despite taking steps to protect your privacy or the confidentiality of your identifiable information, we cannot guarantee that your privacy or confidentiality will be protected. For example, if you tell us something that makes us believe that you or others have been or may be physically harmed, we may need to report that information to the appropriate agencies.

Individuals and organizations responsible for conducting or monitoring this research may be permitted access to and inspect the research records. This includes the Florida State University Institutional Review Board (FSU IRB), which reviewed this study.

If identifiers are removed from your identifiable private information that are collected during this research, that de-identified information could be used for future research studies or distributed to another investigator for future research studies without your additional informed consent.

What are the risks of harms or discomforts associated with this research?
The risks of harms or discomforts associated with the research study include a slight risk of experiencing distress in relation to completing questionnaires and the potential loss of confidentiality. If you experience discomfort, there is always the option to take a break or excuse yourself completely from the study without penalty. In addition to the risks of these harms or discomforts, this research may have risks of harms or discomforts that are unknown at this time. If in the future we become aware of any additional harms or discomforts that may affect you, we will tell you.

How might I benefit from this research?
There may be no personal benefit from your participation, but the knowledge received may be of value to society. The investigators, however, may gain insights into the utility of compassion and mindfulness practices, which may inform the development of future trainings to help parents and children manage stress.

What is the compensation for the research?
By participating in this research, you and your partner will receive the Friend in Me training for a

reduced cost.

What will happen if I choose not to participate?
Participation in this research, which includes enrolling in the FIM training and completing three to four surveys, is voluntary. If you decide not to complete the surveys, you and your child are not eligible to enroll in the reduced fee FIM training.

Is my participation voluntary, and can I withdraw?

Your participation in this study is voluntary. You do not have to take part in this study. Your decision whether to participate will not affect your relationship with your FIM trainer, this research team, or FSU. There is no penalty if you do not participate.

You have the right to choose not to participate in FIM training and to completely withdraw from continued participation before the training without penalty.

If you withdraw from the study, the data collected to the point of withdrawal will be retained for potential use.

Who do I talk to if I have questions?

If you have questions, concerns, or have experienced a research-related injury, contact the research team at:

Francesca Otero-Vargas
(850) 329-0604
foterovargas@fsu.edu

Lenore McWey
(850) 644-3217
lmcwey@fsu.edu

The Florida State University Institutional Review Board ("IRB") is overseeing this research. The FSU IRB is a group of people who perform official independent reviews of research studies before studies begin to ensure that the rights and welfare of participants are protected. If you have questions about your rights or wish to speak with someone other than the research team, you may contact:

Florida State University IRB
2010 Levy Drive, Suite 276
Tallahassee, Florida 32306
850-644-7900
humansubjects@fsu.edu

STATEMENT OF CONSENT
I have read and considered the information presented in this form. I confirm that I understand the purpose of the research and the study procedures. I understand that I may ask questions at any

time and can withdraw my participation without prejudice. I have read this consent form. My signature below indicates my willingness to participate in this study.

By clicking “I agree”, providing your first and last name, your e-mail address, your child’s first and last name, and electronically signing below, you are indicating that you are at least 18 years old, act as a caregiver for a child aged 7-12, have read this consent form, and agree to participate in this research study.

INFORMED ASSENT

Title of the Study: *A Friend in Me: A Mixed Methods Pilot Study of an Online Mindful Self-Compassion Program for Children*

Principal Investigator: Francesca Otero-Vargas, MAMFT, FSU Doctoral Candidate

Co-Investigators: Drs. Lenore McWey, Myriam Rudaz, Gregory Seibert, & Thomas Ledermann

Faculty Advisor: Lenore McWey, Ph.D., FSU Professor

What is a research study?

Research studies help us learn new things. We can test new ideas. First, we ask a question. Then we try to find the answer.

This paper talks about our research and the choice that you have to take part in it. We want you to ask us any questions that you have.

Important things to know…

- You get to decide if you want to take part.
- You can say 'No' or you can say 'Yes'.
- No one will be upset if you say 'No'.
- If you say 'Yes', you can always say 'No' later.
- You can say 'No' at any time.
- We would still take good care of you no matter what you decide.

Why are we doing this research?
We are doing this research to find out more about compassion.

What would happen if I join this research?

- Training: We would ask you to participate with your caregiver in an online training.
- Questions: We would ask you to read questions online. Then you would mark your answers to the questions online.
- Talking: A person on the research team would ask you questions over the phone. Then you would say your answers over the phone.

Could bad things happen if I join this research?
Some of the tests might make you uncomfortable or the questions might be hard to answer. We will try to make sure that no bad things happen.

You can say 'no 'to what we ask you to do for the research at any time and we will stop.

Could the research help me?
We think being in this research may help you because you would be in a program that would teach you new skills that you may find helpful.

What else should I know about this research?
If you don't want to be in the study, you don't have to be.

It is also OK to say yes and change your mind later. You can stop being in the research at any time. If you want to stop, please tell your caregiver and they will talk to one of the researchers.

You would not be paid to be in the study.

You can ask questions any time. You can talk to your caregiver or contact the Principal Investigator, Francesca Otero-Vargas. Take the time you need to make your choice.

Statement of Assent:
I have read and thought about the information in this form. I confirm that I understand the purpose of the research and the study procedures. I understand that I may ask questions at any time and can stop being in the study at any time without anything bad happening. I have read this assent form. My signature below indicates my willingness to participate in this study.

By clicking "I agree", typing your first and last name electronically below, you are saying that you agree to participate in this research study.

APPENDIX C

MEASURES

DEMOGRAPHIC INFORMATION

1. What is your age? _____

2. Which of the following best describes your current gender identity (please mark all that apply)?
   - Man
   - Woman
   - Trans man
   - Trans woman
   - Agender
   - Androgyne
   - Demi-gender
   - Genderqueer or gender fluid
   - Questioning or unsure
   - An identity not listed: _____
   - Prefer not to say

3. What is your primary race/ethnicity?
   - Asian/Asian American
   - Black/African American
   - Hispanic/Latinx
   - Native American
   - Pacific Islander
   - White/European-American
   - Bi-racial
   - Multi-racial
   - Prefer not to answer
   - Other: _____

4. What is the highest level of education you have completed?
   - Less than high school
   - High school diploma or equivalent (e.g., GED)
   - Vocational/technical school
   - Associate degree
   - Some college
   - Bachelor's degree
   - Graduate or professional degree (e.g., MA, Ph.D., MD, JD)

5. What is your typical yearly individual income before taxes?
   - $0-$25,000
   - $25,001-$50,000
   - $50,001-$75,000

- $75,001-$100,000
- $100,001-$150,000
- More than $150,000
- Prefer not to answer

6. Which of the following best describes your current employment status?

- Employed-Full Time
- Employed- Part-Time
- Unemployed- Looking for work
- Unemployed- Not looking for work
- Homemaker
- Student
- Retired
- Military
- Unable to work

7. With what religious faith do you identify?

- Agnostic
- Atheist
- Christianity
- Judaism
- Islam
- Buddhism
- Hinduism
- Prefer not to answer
- Other: _____

8. Do you have any prior mindfulness experience?

- Yes, formal experience (i.e., completed a mindfulness-based course, yoga teacher training, meditation retreat)
- Yes, informal experience (i.e., home practice, use of meditation or mindfulness apps, yoga videos)
- No formal or informal experience

9. How many children currently live in the household and what are their ages?

- 1: ____
- 2: ____ & ____
- 3: ____ & ____& ____
- 4: ____& ____& ____& ____
- 5: ____& ____& ____& ____& ____
- 6: ____& ____& ____& ____& ____& ____& ____
- More than 6 children

10. How old is the child participating in this training with you? _____

11. Which of the following best describes your child's current gender identity (please mark all that apply)?

- Man

- Woman
- Trans man
- Trans woman
- Agender
- Androgyne
- Demi-gender
- Genderqueer or gender fluid
- Questioning or unsure
- An identity not listed: _____
- Prefer not to say

12. What is your child's primary race/ethnicity?
    - Asian/Asian American
    - Black/African American
    - Hispanic/Latinx
    - Native American
    - Pacific Islander
    - White/European-American
    - Bi-racial
    - Multi-racial
    - Prefer not to answer
    - Other: _____
13. What is your child's current grade level?
    - Kindergarten
    - First Grade
    - Second Grade
    - Third Grade
    - Fourth Grade
    - Fifth Grade
    - Sixth Grade
    - Seventh Grade

PRE-AND POST-COURSE MEASURES

Self-Compassion Scale-Children (SCS-C)

***** If interested in viewing, please ask for a copy of this measure, as some measures are copyrighted and are not included in the appendix.

Reference:

Sutton, E., Schonert-Reichl, K. A., Wu, A. D., & Lawlor, M. S. (2018). Evaluating the reliability and validity of the self-compassion scale short form adapted for children ages 8–12. *Child Indicators Research*, *11*(4), 1217-1236.

Self-Compassion Scale Short Form (SCS-SF)

How I typically act towards myself in difficult times: Please read each statement carefully before answering. Indicate how often you behave in the stated manner, using the following scale:

Almost never **Almost always**

1 2 3 4 5

1. When I fail at something important to me, I become consumed by feelings of inadequacy.
2. I try to be understanding and patient towards those aspects of my personality I don't like.
3. When something painful happens, I try to take a balanced view of the situation.
4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
5. I try to see my failings as part of the human condition.
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
7. When something upsets me, I try to keep my emotions in balance.
8. When I fail at something that's important to me, I tend to feel alone in my failure
9. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm disapproving and judgmental about my own flaws and inadequacies.
12. I'm intolerant and impatient towards those aspects of my personality I don't like.

SCORING KEY

Self-Kindness Items: 2, 6

Self-Judgment Items (Reverse Scored): 11, 12 Common Humanity Items: 5, 10

Isolation Items (Reverse Scored): 4, 8 Mindfulness Items: 3, 7

Over-identification Items (Reverse Scored): 1, 9

To reverse score items (1=5, 2=4, 3=3, 4=2, 5=1).

To compute a total self-compassion score, first reverse score the negative subscale items - self-judgment, isolation, and over-identification. Then take the mean of each subscale, and compute a total mean (the average of the six subscale means).

Note that these scoring procedures are slightly different than that used in the original scale article (Raes et al., 2011), in which items were totaled rather than averaged. However, it is easier to

interpret the scores of the total mean is used and most researchers currently report total SCS-SF scores on a five-point scale.

Reference:

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy.* 18, 250-255.

The Compassion Scale (CS) – Modified for Children 7-12

Instructions: Please read each statement carefully before answering. Please answer according to what really reflects your experience rather than what you think your experience should be. Indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	2	3	4	5

1. I pay careful attention when other people talk to me about their problems.
2. If I see someone going through a difficult time, I try to be nice toward that person.
3. I do not worry about other people's problems.
4. I realize everyone feels sad sometimes, it is part of being human.
5. I notice when people are upset, even if they don't say anything.
6. I like to be there for others when things are hard.
7. I think little about other people's problems.
8. I think that no one is perfect.
9. I listen when people tell me their problems.
10. I feel bad for the people who are unhappy.
11. I try to stay away from people who are in a lot of pain.
12. I feel that being sad or having a difficult time happens to everyone.
13. When people tell me about their problems, I try to look at the situation in different ways.
14. When others feel sadness, I try to comfort them.
15. I have a hard time connecting with other people when are sad or having a hard time.
16. Even though we are all different, I know that everyone feels pain just like me.

SCORING KEY

Kindness items: 2, 6, 10, 14

Common Humanity items: 4, 8, 12, 16

Mindfulness items: 1, 5, 9, 13

Indifference items (reverse scored): 3, 7, 11, 15

To reverse score items (1=5, 2=4, 3=3, 4=2, 5=1).

Subscale scores are computed by calculating the mean of the four subscale item responses. To compute a total compassion score, reverse score the indifference items then take a grand mean of all items.

When examining subscale scores, higher scores on indifference items indicate *less* compassion before reverse-coding, and *more* compassion after reverse coding. You can choose to report indifference scores with or without reverse-coding, but items must be reverse coded before calculating a total compassion score.

Reference:

Pommier, E., Neff, K. D. & Tóth-Király I. (2019). The development and validation of the Compassion Scale. *Assessment,* 21-39.

The Compassion Scale (CS)

Instructions: Please read each statement carefully before answering. Please answer according to what really reflects your experience rather than what you think your experience should be. Indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	2	3	4	5

1. I pay careful attention when other people talk to me about their troubles.
2. If I see someone going through a difficult time, I try to be caring toward that person.
3. I am unconcerned with other people's problems.
4. I realize everyone feels down sometimes, it is part of being human.
5. I notice when people are upset, even if they don't say anything.
6. I like to be there for others in times of difficulty.
7. I think little about the concerns of others.
8. I feel it's important to recognize that all people have weaknesses and no one's perfect.
9. I listen patiently when people tell me their problems.
10. My heart goes out to people who are unhappy.
11. I try to avoid people who are experiencing a lot of pain.
12. I feel that suffering is just a part of the common human experience.
13. When people tell me about their problems, I try to keep a balanced perspective on the situation. 14. When others feel sadness, I try to comfort them.
15. I can't really connect with other people when they're suffering.
16. Despite my differences with others, I know that everyone feels pain just like me.

SCORING KEY

Kindness items: 2, 6, 10, 14

Common Humanity items: 4, 8, 12, 16

Mindfulness items: 1, 5, 9, 13

Indifference items (reverse scored): 3, 7, 11, 15

To reverse score items (1=5, 2=4, 3=3, 4=2, 5=1).

Subscale scores are computed by calculating the mean of the four subscale item responses. To compute a total compassion score, reverse score the indifference items then take a grand mean of all items.

When examining subscale scores, higher scores on indifference items indicate *less* compassion before reverse-coding, and *more* compassion after reverse coding. You can choose to report indifference scores with or without reverse-coding, but items must be reverse coded before calculating a total compassion score.

Reference:

Pommier, E., Neff, K. D. & Tóth-Király I. (2019). The development and validation of the Compassion Scale. *Assessment,* 21-39.

Child-Parent Relationship Scale (Short Form) – Child Measure

Please reflect on the degree to which each of the following statements currently applies to your relationship with your parent. Using the scale below, circle the appropriate number for each item.

Definitely does not apply	Not really	Neutral, not sure	Applies somewhat	Definitely applies
1	2	3	4	5

1.	I share an affectionate, warm relationship with my caregiver.	1	2	3	4	5
2.	My caregiver and I always seem to be struggling with each other.	1	2	3	4	5
3.	If upset, I seek comfort from my caregiver.	1	2	3	4	5
4.	I am comfortable with physical affection or touch from my caregiver.	1	2	3	4	5
5.	My caregiver values their relationship with me.	1	2	3	4	5
6.	When my caregiver gives me praise, I feel proud of myself.	1	2	3	4	5
7.	I am able to spontaneously share information about myself with my caregiver.	1	2	3	4	5
8.	My caregiver easily becomes angry with me.	1	2	3	4	5
9.	My caregiver is in tune with what I am feeling.	1	2	3	4	5
10.	My caregiver remains angry after disciplining me for doing something I was not supposed to.	1	2	3	4	5
11.	Dealing with my caregiver drains my energy.	1	2	3	4	5
12.	When my caregiver is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
13.	My caregiver's feelings toward me can be unpredictable or change suddenly.	1	2	3	4	5
14.	My caregiver is sneaky or manipulative with me.	1	2	3	4	5
15.	My caregiver makes me feel like I can openly share my feelings and experiences with them.	1	2	3	4	5

Child-Parent Relationship Scale (Short Form) – Parent Measure

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply	Not really	Neutral, not sure	Applies somewhat	Definitely applies
1	2	3	4	5

1.	I share an affectionate, warm relationship with my child.	1	2	3	4	5
2.	My child and I always seem to be struggling with each other.	1	2	3	4	5
3.	If upset, my child will seek comfort from me.	1	2	3	4	5
4.	My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5.	My child values his/her relationship with me.	1	2	3	4	5
6.	When I praise my child, he/she beams with pride.	1	2	3	4	5
7.	My child spontaneously shares information about himself/herself.	1	2	3	4	5
8.	My child easily becomes angry at me.	1	2	3	4	5
9.	It is easy to be in tune with what my child is feeling.	1	2	3	4	5
10.	My child remains angry or is resistant after being disciplined.	1	2	3	4	5
11.	Dealing with my child drains my energy.	1	2	3	4	5
12.	When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
13.	My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
14.	My child is sneaky or manipulative with me.	1	2	3	4	5
15.	My child openly shares his/her feelings and experiences with me.	1	2	3	4	5

Scoring Guide:

Sum the items as noted. Alpha reliability is calculated for each scale based on 714 subjects, ages 4.5 - 5.5 years old.

Conflicts (alpha = .83)

2 seem to be struggling with each other
4 uncomfortable with physical affection
8 easily becomes angry with me
10 remains angry after discipline
11 dealing with my child drains my energy
12 bad mood, long and difficult day
13 feelings can be unpredictable
14 sneaky or manipulative

Closeness (alpha = .72)

1 an affectionate relationship
3 will seek comfort from me if upset
5 values his/her relationship with me
6 praise, beams with pride
7 spontaneously shares information
9 easy to rune in to child's feelings
15 openly shares feelings and experiences

Reference:

Driscoll, K., & Pianta, R. C. (2011). Mothers' and fathers' perceptions of conflict and closeness in parent-child relationships during early childhood. *Journal of Early Childhood and Infant Psychology*, (7), 1-24.

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BIOGRAPHICAL SKETCH

Francesca Otero-Vargas

Curriculum Vitae 2023

EDUCATION

Ph.D. The Florida State University (FSU), Tallahassee, FL 2023
Marriage and Family Therapy
Major Professor: Dr. Lenore McWey Ph.D.

M.A. Appalachian State University (ASU), Boone, NC 2019
Marriage and Family Therapy, Systemic Multicultural Counseling
Advisor: Dr. Kristen Benson, Ph.D.

B.S. The Florida State University (FSU), Tallahassee, FL 2017
Major: Family and Child Sciences
Major: Psychology

INTERN LICENSE AND CERTIFICATIONS

Registered Marriage and Family Therapist Intern, FL	2020 – present
License #: IMT3305	
EEO/Sexual Misconduct: Education & Prevention Training, FSU	2021
Embracing Diversity: Cultivating Respect and Inclusion, FSU	2021
At-Risk for University College Faculty and Staff, FSU	2020
Treating Interpersonal Violence Collaborative Collegiate Clinical Training, FSU	2020
The Gottman Research Institute	2019
A Research-Based Approach to Relationships (Level 1), FSU	
Institutional Review Board Human Subjects Training. FSU	2019
Program for Instructional Excellence (PIE), TA Training, FSU	2019
LGBTQ+ Inclusive Therapy Training, ASU	2017
Institutional Review Board Human Subjects Training, ASU	2017
Online Suicide Prevention Gatekeeper Training, ASU	2017
Allies & Safe Zones 101, FSU	2017
Registered Yoga Teacher – 200 Hour Training, Palm Beach Gardens, FL	2017 – present

AWARDS AND HONORS

College of Health and Human Sciences Dissertation Award, FSU	2022
Anderson-Darling Family Award for Outstanding Teaching Assistant, FSU	2022
Billie J. Collier Graduate Scholarship, FSU	2022
Norejane J. Hendrickson Scholarship Fund, FSU	2021
Academic Leadership Award, FSU	2021
Ruth Dales Scholarship, FSU	2020
Florence Smith McAllister Endowed Fellowship Fund Scholarship, FSU	2020

Adelaide D. Wilson Graduate Fellowship Endowment Fund Scholarship, FSU 2019
Teacher Training Recognition from the Program for Instructional Excellence, FSU 2019
McKnight Doctoral Fellowship 2019 – present
Graduated Summa Cum Laude, ASU 2019
Outstanding Educational Program, ASU 2019
Membership Development Award, ASU 2019
Recipient of the Health Resources & Services Administration Grant, ASU 2018 – 2019
The Graduate Student Government Research Travel Presentation Award, ASU 2019
North Carolina Tuition Scholarship, ASU 2017 – 2018
Graduated Cum Laude, FSU 2017

TEACHING EXPERIENCE

Adjunct Instructor, ASU Spring 2023 – present
Marriage and Family Therapy Graduate Program
HPC5272: Individual and Family Development (Online – Synchronous)
Responsibilities:

- Instructor for 15 students.
- Responsible for developing course material including the course syllabus, lecture material, assignments, and exams.
- Facilitates a discussion-based course via Zoom that integrates current events, multimedia, and theory to further explain course concepts.
- Provides feedback in a timely manner and responds to day-to-day course correspondence.

Instructor of Record, FSU Fall 2020 – Fall 2022
Department of Human Development and Family Science
Responsibilities (sole teaching instruction):

- Responsible for developing course material including the course syllabus, PowerPoint slides, video lectures, discussion boards, application projections, and exams.
- Provided students with lecture material in multiple forms to support diverse learning styles, i.e., weekly recorded lectures, PowerPoint slides, and PDF documents of the course material.
- Engaged students in a theory intensive course and integrating current and various multimedia approaches/instructional technology to enhance pedagogical approach and further explain course concepts.
- Provided feedback in a timely manner and responded to day-to-day course correspondence.

Courses:

- Fall 2022 – FAD4601: Foundations of Counseling (Online – Asynchronous) ($N = 60$)
- Fall 2021 – CHD4537: Parenting (In-Person) ($N = 50$)
- Summer 2021 – FAD2230: Family Relationships, A Lifespan Development Approach (Online – Asynchronous) ($N = 43$)
- Fall 2020 – FAD2230: Family Relationships, A Lifespan Development Approach (Online – Synchronous) ($N = 60$)

Teaching Assistant, FSU Fall 2019 – present

Department of Human Development and Family Science
Responsibilities (partial online instruction under faculty members):

- Assists with grading student assignments and providing detailed feedback to help students progress and improve in the course.
- Aids students in their professional growth by providing guidance in crafting job-oriented profiles, including LinkedIn profiles.
- Available to guest lecture.
- Provides detailed feedback in a timely manner and responds to day-to-day course correspondence in a timely manner.

Courses:

- Spring 2023 – FAD2230: Family Relationships, A Lifespan Development Approach (Online – Asynchronous) (*N* = 248)
- Summer 2022 – FAD3343: Context of Adult Development and Aging (Online – Asynchronous) (*N* = 140)
- Spring 2022 – FAD4932: Pre-Professional Development in Family and Child Science (Online – Asynchronous) (*N* = 66)
- Spring 2021 – FAD3432: Stress and Resilience in Individuals and Families (Online – Asynchronous) (*N* = 66)
- Summer 2020 – FAD4932: Pre-Professional Development in Family and Child Science (Online – Asynchronous) (*N* = 39)
- Fall 2019 – FAD3343: Context of Adult Development and Aging (Online – Asynchronous) (*N* = 191)

CLINICAL EXPERIENCE

Enso Psych Group, Tallahassee, FL 2021 – present
Clinical Therapist, Registered Marriage and Family Therapy Intern
Responsibilities:

- Provides therapy to individuals, couples, and families from a variety of cultural and socioeconomic backgrounds utilizing primarily Narrative Theory while integrating mindfulness skills, meditation, and yoga-based body movements into sessions to promote a more holistic approach to therapy.
- Implements a collaborative and non-blaming therapeutic approach that empowers clients to create a path in life that aligns with their goals and values, fostering authenticity.
- Creates individualized theory-based treatment plans according to client needs and circumstances.
- Maintains thorough records of client sessions and progress using Theranest.
- Receives bi-weekly group supervision from an AAMFT approved supervisor.

Center for Couple and Family Therapy, Tallahassee, FL 2019 – 2021
Clinical Therapist, Registered Marriage and Family Therapy Intern
Responsibilities:

- Provided therapy to individuals, couples, and families from a variety of cultural and socioeconomic backgrounds. Primarily worked with college-age students, couples, and individual adults in the Tallahassee community.

- Cofacilitated groups, including an Intimate Partner Violence support group.
- Integrated mindfulness skills, meditation, and yoga-based body movements into sessions to promote a more holistic approach to therapy.
- Completed theory-based assessments, treatment plans, and clinical notes using the Theramanager system.
- Received weekly group supervision from an AAMFT approved supervisor.

Daymark Recovery Service, Blowing Rock, NC 2018 – 2019
Registered Marriage and Family Therapy Intern
Responsibilities:

- Worked in the Day Treatment program for the Blowing Rock Elementary School.
- Provided individual and co-therapy therapy sessions for clients aged five to ten.
- Facilitated group skills sessions and psychoeducation focused on the use of mindful movements, breathing, and art therapy for clients aged five to ten.
- Actively participated in Child and Family Team Meetings with parents, teachers, administrators, and pertinent agents to provide collaborative care and discuss relevant academic and mental health matters.
- Completed theory-based assessments utilizing primarily CBT and maintained records and clinical notes through the Daymark system.
- Learned to refine the treatment and behavioral plans for clients ages five to ten with various diagnoses, including ODD, ADHD, CD, and PTSD to name a few.
- Received weekly group and individual supervision from an AAMFT approved supervisor.

Appalachian State Marriage and Family Therapy Clinic, Boone, NC 2018 – 2019
Registered Marriage and Family Therapy Intern
Responsibilities:

- Provided individual therapy sessions for clients at the university.
- Maintained accurate and timely records of therapy sessions.
- Conducted phone intakes and referred clients to appropriate resources based on individual needs.
- Managed administrative aspects of the clinic including scheduling client intakes, paperwork, phone and email correspondence, marketing, and daily organization tasks.
- Received weekly group and individual supervision from an AAMFT approved supervisor.

Center for Couple and Family Therapy, Tallahassee, FL 2016 – 2017
Undergraduate Practicum Student
Responsibilities:

- Handled the administrative aspects of the clinic, including conducting phone intakes, scheduling clients, making referrals, and managing payments, along with additional management tasks.
- Aided doctoral students in the Marriage and Family Therapy Program and to the clinical faculty.
- Actively contributed to the case conceptualization and development of evidenced-based treatment plans through observation of live sessions.

SUPERVISORY EXPERIENCE

AAMFT Approved Supervisor Candidate, Tallahassee, FL 2020 – present

- Completed some AAMFT Approved Supervisor Candidacy course requirements.
- Received direction about supervision style under the supervision of course instructor and AAMFT Approved Supervisor.
- Provided weekly clinical supervision to a Ph.D. candidate in the Marriage and Family Therapy program and to a master's level student in the Clinical Mental Health Counseling Art Therapy program.
- Supervision focused on raw data from the trainees' clinical practice which was attained through a combination of written clinical notes, audio and video recordings, and live supervision.

RESEARCH EXPERIENCE

Principle Investigator, FSU 2021 – present

A Friend in Me: A Mixed Methods Feasibility Study of an Online Self-Compassion Intervention for Children and their Caregivers

Supervised by Dr. Lenore McWey, Ph.D., LMFT, AAMFT Approved Supervisor

- Responsible for the management and integrity of the design, conduct, and reporting of the research project.
- Oversees the management, monitoring, and the integrity of all collaborative relationships with faculty members and program stakeholders.
- Analyzes all study data for future publication utilizing SPSS, ATLAS.ti, and Qualtrics software.
- Led the creation of the IRB for the study and promptly responds to all requests for information or materials solicited by the IRB, including the timely submission of the research study for IRB approval.
- Created all recruitment material for the study including the flyer and study webpage.
- Disseminated all study material to participants.

Research Team Lead, ASU 2018 – 2019

Gender Identity Discourse in the Wake of North Carolina HB2

Supervised by Dr. Kristen Benson, Ph.D., LMFT, AAMFT Approved Supervisor

- Conducted outreach to stakeholders.
- Assisted in the development of the IRB application.
- Collaborated with the PI in the development of the research guide and interview questionnaire.
- Assisted in the development of the demographic questionnaire using Qualtrics.
- Helped to facilitate participant recruitment and interviewing.

Graduate Research Assistant, ASU 2018 – 2019

Supervised by Dr. Kristen Benson, Ph.D., LMFT, AAMFT Approved Supervisor

- Completed article searches for research purposes and prepared literature reviews.
- Collaborated in administrative tasks such as completing reports.

- Assisted in editing and preparing manuscripts, presentations, and other materials.
- Helped prepare materials for submission to granting agencies and foundations.
- Organized, maintained, and updated the MFT Program email account and social media content.

Qualitative Coding, ASU 2017 – 2018
Unexpectedly Queer: Families with Trans and Gender Expansive Children
Supervised by Dr. Kristen Benson, Ph.D., LMFT, AAMFT Approved Supervisor

- Learned about different coding styles and received an introduction to qualitative research.
- Assisted in analyzing the data utilizing line by line coding and categorizing to determine themes.

PUBLICATIONS & PRESENTATIONS

Research Presentations

Completed:

Otero-Vargas, F.N. (2023, March). *A friend in me: A mixed methods feasibility study of an online self-compassion intervention for children and their caregivers.* Oral presentation. Dissertation Defense. Tallahassee, FL

Benson, K., **Otero-Vargas, F**., Smith, K., Gray, C., Adams, H., Kessler, J., Randolph, C., & van Eeden-Moorefield, B. (2018, Nov). *Gender identity discourse in the wake of north carolina HB2.* Oral panel presentation. National Council on Family Relations Annual Conference. San Diego, CA.

Accepted (Canceled due to COVID-19):

Otero-Vargas, F. N. (2021, Feb.). *Meaning Making through Communicative Touch in Narrative Couple Therapy.* Oral presentation. McKnight Mid-Year Research & Writing Conference. Tampa, FL.

Jaurequi, M. E., Kimmes, J. G, Seibert, G. S., Pocchio, K.E., **Otero-Vargas, F.N.,** & Tawfiq, D.K. (2020, Nov). *Sleep: The role of relationship satisfaction and mindfulness.* Oral poster presentation for Annual Conference, American Association for Marriage and Family Therapy, Orlando, FL.

Jaurequi, M. E., Kimmes, J. G, Garcia, K., Tawfiq, D.K., Pocchio, K.E., & **Otero-Vargas, F.N.** (2020, Nov). *Mindfulness practices, adult attachment, and relationship conflict.* Oral poster presentation for Annual Conference, American Association for Marriage and Family Therapy, Orlando, FL.

Book Chapters Accepted

Otero-Vargas, F., & Wu, Q. (In Press). Chapter 6: Central and East Asia. In *Women and Sexuality: Global Lives in Focus*. Santa Barbara, CA: ABC-CLIO.

Journal Articles in Review

Otero-Vargas, F. (Under Review). Meaning making through communicative touch in narrative-based couple's therapy

Langlais, M.R.., **Otero-Vargas, F.**, Randall J.A., & Moeller, M.D. (Under Review). It's a match!: Perceived effectiveness of romantic relationship formation using dating applications

Journal Articles in Progress

Otero-Vargas, F. (In Progress). A systematic research synthesis of parenting in Puerto Rican families and child outcomes

Otero-Vargas, F., Selice, L., Mosley, M., Lancaster, M. (In Progress). Clinical Connections: A Framework for Relationally Focused Therapy in a Digital World

Selice, L., **Otero-Vargas, F.**, Roberts, K., & Kimmes, J. (In Progress). Trait mindfulness and commitment: The role of empathy.

PROFESSIONAL EXPERIENCE

Speaker Series, FSU 2022

- Collaborated with the College of Health & Human Sciences to produce a speaker series on relationships.
- Presented on intimacy promoting versus intimacy blocking language in relationships.

Professional Panel Coordinator, FSU 2020

GSAC Stepping Stones: Panel on Professional Development Skills (Online)

- Pitched panel proposal and theme.
- Led a team in contracting featured speakers based off student's reported areas of interest.
- Coordinated with members of the FSU College of Health and Human Sciences to create marketing material for the event.
- Managed deadlines, timing, online meeting set-up, and facilitated questions.

Professional Conference Coordinator, ASU 2018

It's a Family Affair: Trauma, Perinatal Mental Health, and Systemic Therapy in Practice

- Contracted featured speaker based off students' reported areas of interest.
- Obtained Continuing Education Hours for professionals.
- Coordinated with Appalachian State University services to book conference location.
- Managed all aspects of the conference including planning, set-up, registration, fee collection, certifications, and evaluations.

PROFESSIONAL AFFILIATIONS

Apprentice Reviewer, Journal of Marriage and Family Therapy 2019 – present

Professional Student Member, AAMFT 2018 – present
- Member of Margins to Center: Cultural Connections among C/MFTs

Registered Yoga Teacher – 200 Hours, Yoga Alliance 2017 – present
North Carolina Association of Marriage and Family Therapy 2017 – 2019

DEPARTMENT AND PROGRAM LEADERSHIP

President, Graduate Student Advisory Council, FSU 2020 – 2021
Secretary, Graduate Student Advisory Council, FSU 2021
Co-President, Student Association for Marriage and Family Therapy, ASU 2018 – 2019
Student Representative, Student Association for MFT, ASU 2017 – 2018

DEPARTMENT AND PROGRAM SERVICE

Head of Marriage and Family Therapy Social Committee, FSU 2021 – 2022
- Planed and organized program social events.
- Facilitated correspondence between faculty and students.
- Designed and created program merchandise.

Showcase Moderator, FSU 2021
FSU College of Human Sciences 20th Annual Research Showcase
- Announced each presenter.
- Facilitated questions between presenters, audience members, and judges.
- Upheld an organized and timely schedule.

Videographer for MFT Program Interview, FSU 2021
- Shot film and created rough and final cuts to the project.
- Assisted in the marketing of the MFT program to interviewees.

Student Interview Coordinator and MFT Program Representative, FSU 2020
- Facilitated correspondence with perspective students throughout the entire interview process.
- Organized resources, housing, and transportation for interviewees.
- Participated in day-long interview process.

STUDENT ORGANIZATION MEMBERSHIPS

The Fellows Society, FSU 2019 – present
The Graduate Student Advisory Council, FSU 2020 – 2022
The Student Association of Marriage and Family Therapy, ASU 2017 – 2019
The National Society of Collegiate, FSU 2013 – 2017
Phi Eta Sigma Honor Society, FSU 2013 – 2017
Order of Omega Greek Honor Society, FSU 2013 – 2017

CONFERENCES ATTENDED

37th Annual McKnight Fellows Meeting, Tampa, FL 2023
36th Annual McKnight Fellows Meeting, Tampa, FL 2021
The Mindfulness and Relationship Conference (Virtual) 2021

American Association for Marriage and Family Therapy (Virtual)	2020
McKnight Mid-Year Research and Writing Conference, Tampa, FL	2020
35th Annual McKnight Fellows Meeting, Tampa, FL	2019
American Association for Marriage and Family Therapy, Austin, TX	2019
McKnight Doctoral Fellows' Orientation Meeting, Tampa, FL	2019
American Association for Marriage and Family Therapy, Louisville, KY	2018
National Council on Family Relations Annual Conference, San Diego, CA	2018
ASU Student Association of MFT Annual Conference, Boone, NC	2018
North Carolina MFT Annual Conference, Winston Salem, NC	2018
ASU Student Association of MFT Annual Conference, Boone, NC	2017

STUDENT SERVICE

Co-contributor MFT Drip Drop Fitness Social Training, FSU	2023
Team Leader for Panhellenic Recruitment, FSU	2012 – 2016
Logistics Chair for PAVE (Promoting Awareness, Victim Empowerment), FSU	2015
Team Ambassador for Relay for Life, FSU	2015 – 2016
Recruitment Counselor for Panhellenic Recruitment, FSU	2014 – 2016
Charter Member of the Alpha Omicron Pi Fraternity – Alpha Pi Chapter, FSU	2013

OUTSIDE SERVICE

Tom Moore 5K for Huntington's through NCAMFT, Boone, NC	2019
Personal Care Product Drive with W.A.M.Y Community Action, Boone, NC	2018
Volunteer for Voter Registration, Boone, NC	2018
Hospitality House of Northwest North Carolina, Boone, NC	2018
Damayan Garden Project, Community Volunteer, Tallahassee, FL	2017