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PERCEIVED STRESS, SELF-COMPASSION, AND EMOTIONAL VARIANCE IN
PARENTS OF CHILDREN WITH COMMUNICATION DISORDERS:
A FAMILY APPROACH TO SERVICE DELIVERY IN
SPEECH-LANGUAGE PATHOLOGY

Olivia Arnos

60 Pages

The amount of children born with developmental disorders in the United States is on the rise, increasing from 12.8% in 1998 to 15.04% in 2008 (Huang, Chang, Chi & Lai, 2013). Children with developmental disabilities often have chronic conditions that require additional support across their lifetime, ranging in deficits of attention, physical abilities, visual impairments, hearing impairments, learning disabilities, and communication disorders. Research has shown as dependency of a child on caretakers increases, there is an increase in parental stress and a decrease in perceived well-being. Hall and Graff (2011) found parents of children with developmental disorders are less likely to use adaptive behaviors to cope with the child's needs, while Hedov, Annerén, and Wikblad (2000) found parents of children with developmental disorders experience more fatigue, depression and anxiety compared to parents of typically-developing children, all affecting parent's emotional state.

One team member that can help mitigate the effects of parental stress is the child's speech language pathologist. Speech language pathologists (SLPs) counsel caregivers by providing education, guidance, and support about their child's communication disorder diagnosis. Using a family-centered approach, SLPs teach caregivers acceptance, adaptation, and decision-making about their child's communication, feeding or swallowing deficits, keeping in

mind the needs of both the child and family. While related fields such as physical therapy and occupational therapy have studied the relationship between stress and caregiving for an individual with a disability, little is currently known about the relationship between perceived stress and well being of caregivers of children with communication disorders. The purpose of this study was to identify the levels of perceived stress of parents of children with communication disorders, to determine the levels of self-compassion of parents with children with communication disorders, to understand the relationship between levels of perceived stress and self-compassion, to understand if the severity of a child's communication disorder influences the levels of perceived stress and self-compassion in parents, and to establish if the child's age influences the levels of perceived stress and self-compassion in parents.

Using the Perceived Stress Scale (PSS) and Self-Compassion Scale (SCS), twenty-seven participants completed the survey. Results indicated that no relationship existed between child's age and perceived stress or self-compassion scores. Similarly, no relationship existed between the length of time a parent had known of the communication disorder diagnosis and perceived stress levels and self-compassion scores. Yet, when asked to rate the severity of their child's disability, parents who rated their children as more severe had higher perceived stress scores and lower self-compassion scores than parents who rated their child's disability as less severe. Similarly, parents who had high levels of self-compassion had low levels of perceived stress, while parents with high levels of stress had low levels of self-compassion. The findings of this study demonstrate the importance of using self-compassion in therapy to improve emotional well-being of parents of children with communication disorders.

KEYWORDS: Communication, Disorder, Parental stress, Perceived stress, Self-compassion, Speech language pathology

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O.A.

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CHAPTER I: INTRODUCTION

Parenthood is regarded as one of the most rewarding, yet challenging, chapters of a person's life. Parental stress stems from a variety of factors, including responsibility over the child's education, healthcare, financial needs, and emotional health. The stress of being a parent, however, appears to amplify in relation to the child's level of dependency (Huang, Chang, Chi & Lai, 2013). One population that typically relies considerably on caregivers are those with developmental disorders and intellectual impairments. In 2004, Tomanik, Harris and Hawkins found that two-thirds of mothers of children with developmental disabilities experienced higher levels of stress in comparison to parents of typically-developing children. Huang et al., (2013) found that fathers of children with special needs had both poorer physical and mental health compared to fathers of typically-developing children. Collectively, both mothers and fathers also developed more headaches, backaches, joint pain and sleep problems versus parents of non-disabled children (Huang et al., 2013).

Children with developmental disabilities often have chronic conditions that require additional support across their lifetime (Huang et al., 2013). These may include deficits of attention, physical abilities, vision impairment, hearing impairment, learning disabilities, and communication disorders (Huang et al., 2013). And with the number of children born with a developmental disorder on the rise, increasing from 12.8% in 1998 to 15.04% in 2008 (Huang et al., 2013), higher numbers of parents may be feeling the effects of their child's disability than ever before.

Lack of emotional resources for parents of children with disabilities can add to parental stress. Hall and Graff (2011) found parents of children with developmental disorders are less likely to use adaptive behaviors to cope with the child's needs compared to parents of children

without disabilities. Hedov, Annerén, and Wikblad (2000) documented that parents of children with developmental disorders experience more fatigue, depression and anxiety compared to parents of typically-developing children, all of which affect a parent's emotional well-being.

A parent's view, however, has the power to alter the subjective impact of the impairment or disorder. For example, Huang et al. (2013) discovered that parent's perception of the child's condition was found to either evoke or diminish associated stress. Similarly, Bazzano et al. (2015) found that parents who were mindfully aware of their perceptions of the child's disability, versus those who were not, reported lower parental stress, higher psychological well-being, and improved general health.

Parental stress and perceived well-being can affect more than the parent's ability to support the child emotionally; these factors can also influence the ability of parents to care for themselves emotionally. One resource parents should be able to depend on to assist them with cultivating positive emotions is the service-delivery team with which they work. A service-delivery team consists of a group of professionals, typically inclusive of occupational therapy, physical therapy, and speech-language pathology, targeting the child's disability concerns through varying therapeutic approaches. Speech-language pathologists are responsible for a continuum of duties as service-delivery providers. According to the American Speech-Language-Hearing Association (ASHA, 2016), it is within the speech-language pathologist's (SLP) scope of practice to collaborate, screen, assess, treat, and more specifically, counsel patients with communication disorders and their stakeholders, The ASHA (2016) Scope of Practice States:

SLPs counsel by providing education, guidance, and support. Individuals, their families, and their caregivers are counseled regarding acceptance, adaptation, and decision-making about communication, feeding and swallowing, and related disorders. The role of the SLP

in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders (p. 8).

The Scope of Practice (ASHA, 2016) further outlines the activities SLPs engage in regarding persons with communication, feeding, and swallowing disorders, along with their family members. These include:

- 1) Empower the individual and family to make informed decisions related to communication or feeding and swallowing issues,
- 2) educate the individual, family, and related community members about communication or feeding and swallowing disorders,
- 3) provide support or peer-to-peer groups for individuals with disorders and their families,
- 4) provide individuals and families with skills that enable them to become self-advocates,
- 5) discuss, evaluate and address negative emotions and thoughts related to communication or feeding and swallowing disorders and
- 6) refer individuals with disorders to other professionals when counseling needs fall outside of those related to communication and feeding and swallowing (p. 8).

Therefore, an SLP is obligated as a service-delivery provider to counsel patients and caregivers as it pertains to the patient's communication disorder. The forms of counseling an SLP administers can span from parent education, to self-advocacy, working with families to adjust to changes in feeding or swallowing, and counseling through the news that their child has a communication disorder. Yet the importance of parents' emotional health may often be overlooked. If a parent cannot emotionally provide for himself or herself, it is difficult to allocate emotional resources for the patient. Consequently, introducing coping strategies to caregivers is crucial for patient care. Neff and Germer (2013) postulated that practicing kindness to oneself

during difficult times may lower parental stress, improve one's perception of disability, and increase emotional well-being over time. This approach is self-compassion.

Purpose of Investigation

To date, there is a lack of research that examines how parents are influenced by self-compassion when coping with their child's communication disorder. There is no research to date that examines the influence of self-compassion on patients with communication disorders or their stakeholders. A search in Communication Sciences and Disorders databases including ComDisDome, CINAHL, PubMed and JSTOR, with keywords "speech pathology and self-compassion" and "self-compassion and communication disorders" generated no results. Additionally, a search of the keywords "self-compassion" and "self-compassion and speech pathology" on the American Speech-Language-Hearing Association produced no results. The purpose of the current investigation is to research the relationship between self-compassion and parental stress within parents of children with communication disorders. Specifically, this study will address the following five research questions:

- (1) What are the levels of perceived stress of parents with children with communication disorders?
- (2) What are the levels of self-compassion of parents with children with communication disorders?
- (3) Is there a correlation between levels of perceived stress and self-compassion?
- (4) Does the severity of a child's communication disorder influence levels of perceived stress and self-compassion?
- (5) Does the child's age influence levels of perceived stress and self-compassion?

CHAPTER II: REVIEW OF LITERATURE

Self-Compassion

Self-compassion is kindly reflecting on one's thoughts, emotions and behaviors, and is what enables a person to be fully compassionate toward others (Neff, 2016). When a person is compassionate towards another human being, either outwardly or not, he or she is empathetic towards the other person's pain. As Neff (2016) states, there are stages of compassion. First, the individual must recognize that the other person is suffering. If a person is unable to acknowledge another person's troubles, he or she will not be able to provide empathy towards his or her situation. Second, the individual must be emotionally moved by the person's suffering. Compassion is a way of showing another person that one understands what they are experiencing, and want to do something to change the situation for that person. Third, the individual must see a person's setback as a chance to be kind to the person experiencing pain, not pass judgment on the circumstance. And lastly, the individual must be cognizant that mistakes simply make up the human experience, which is one we all bear.

Self-compassion has three fundamental elements: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification (Neff, 2016). Self-kindness versus self-judgment simply means meeting one's frustrations with warm emotions rather than criticism. If a person believes that life suffering is avoidable, he or she is less likely to be accepting of it when it occurs, and in turn feel stressed and emotionally overwhelmed. Humanity versus isolation means that a person is aware that we all suffer in life; pain doesn't happen to one person, but instead it is a part of human nature that connects us all. Mindfulness versus over-identification means being non-judgmental in the present moment and realistic with one's emotions (Neff, 2016). Ignoring negative emotions is just as harmful as ruminating on

them. A person must find a balance between the two to be mindfully aware of emotions as they surface (Neff, 2016). It is believed that when a person is kind to himself or herself, he or she has the emotional intelligence to mitigate problems as they arise. People often look to others for comfort in the face of adversity; yet practicing self-compassion allows individuals to rely on themselves, to reflect on personal attitudes, and forgive themselves as necessary (Neff, 2016).

As stated above, mindfulness is a component of self-compassion and the two are closely related. Jon Kabat-Zinn (2012) defined mindfulness as “an awareness, cultivated by paying attention in a sustained and particular way: on purpose, in the present moment, and non-judgmentally” (p. 1). He explains that it allows one to engage in “systematically regulating our attention and energy, thereby influencing and possibly transforming the quality of our experience, in the service of realizing the full range of our humanity and of our relationships to others and the world” (p. 1). Kabat-Zinn explains that mindfulness has many health benefits in terms of dealing with stress, pain, and illness, and shows changes in both structure and functioning of the brain. Mindfulness, then, is being in tune with one’s experiences and subsequent feelings.

Mindfulness helps one connect the mind with experiences, and self-compassion affect’s how a person cares for him or herself. Self-compassion refers to being “touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering, and to hear oneself with kindness” (Neff, 2003). According to Neff, there is a reciprocal relationship between mindfulness and self-compassion, where they facilitate and enhance each other, and aid in constructing positive well-being.

While self-compassion has its roots in Buddhism, fields outside of religion, including psychology, physical therapy and occupational therapy, have discovered its usefulness in

patients' quality of life (Neff, 2016). As it currently stands in research, self-compassion acts as a protective factor against depression (MacBeth & Gumley, 2012), reduces feelings of isolation (Leary, Tate & Adams, 2007), increases optimistic attitudes and life satisfaction (Hollis- Walker & Colosimo, 2011), creates higher motivation and self-confidence (Neff, Hsieh, & Dejitterat, 2005), correlates with healthy eating habits and physical care (Brooks, Kay-Lambkin, Bowman, & Childs, 2012), and reduces stress when caring for others (Bazzano et al., 2015). Many studies have showcased the value of self-compassion as it pertains to quality of life across the lifespan and its varying circumstances. A representative sample of those is reviewed below.

Physical Health

Current research within health-related fields, such as physical therapy, occupational therapy, psychology and medicine, have been conducted to comprehensively examine the direct effects of self-compassion on one's overall physical health. Many of these studies focus on self-compassion within an individual after he or she experienced a substantial negative life event. Topics that have been studied include self-compassion's role in mitigating negative psychological factors associated with stress, coping mechanisms, self-identity, and body image (Przezdziecki et al., 2013). Other studies have investigated self-compassion's role in assisting individuals with diagnoses of post-traumatic stress disorder, physical disabilities, and breast cancer.

One study that was done with women who have breast cancer was published by Przezdziecki et al. (2013). Cancer's impact on a patient is out of his or her control, and it can have devastating effects both emotionally and physically on the patient and his or her stakeholders. Breast cancer treatment usually involves a combination of chemotherapy, radiation, and hormonal treatments (Przezdziecki et al., 2013). The side effects of these treatments can vary

from hair loss, hormonal changes, early onset of menopause, change in nail color and thickness, the removal of one or both breasts, scar tissue after surgery, uneven breast position, skin discoloration and rashes, weight fluctuation, and energy level (Przedziecki et al., 2013). These changes can undoubtedly alter a woman's self-esteem. A drastic change in physical appearance can change how a woman views her sexuality and self in general, possibly leading to psychological anguish and lower perceived self-worth.

Przedziecki et al. (2013) investigated whether or not self-compassion could reconcile the relationship between body image and distress in women who went through breast cancer treatment. A sample of 279 women from a cancer organization completed The 10 question Body Image Scale (Hopwood, Fletcher, & Ghazal, 2001) to measure distress associated with body image, the 26-item Self-Compassion Scale (Neff, 2003) to measure how often participants practice self-compassion during stressful life events, and the 21 question Depression, Anxiety and Stress Scale (Lovibond & Lovibond, 1995). Results of Przedziecki et al.,'s study showed that the majority of participants reported having poor body image as a result of their cancer treatment, which continued even after treatment ended. However, women who practiced self-compassion had lower levels of reported distress compared to the women who did not practice self-compassion. The researchers' findings therefore aligned with their hypothesis that self-compassion can help increase positive body image in patients after breast cancer treatment, while concurrently lowering psychological distress.

Many patients, similar to those battling cancer, seek out the support of counselors after traumatic events, shifts in health, or when one must struggle accepting a habitual stressor in life. One such case is lifelong chronic illness. Chronic illness may be entirely out of a patient's hands, making it difficult for patients to effectively respond to health-related stress in a positive way.

Yet patients that do may be emotionally more equipped to take on medical challenges. For example, Treharne, Lyons, Booth and Kitas (2007) found patients with arthritis who accepted their diagnosis had higher life satisfaction and lower rated stress; conversely, patients who avoided their diagnosis had higher levels of psychological distress and low levels of acceptance (Voth & Sirois, 2009). To further study the role of self-compassion dealing with chronic illness, Sirois, Molnar and Hirsch (2015) conducted a study to see if patients who practiced self-compassion and who were diagnosed with a chronic illness were more likely to use adaptive coping strategies, less likely to use maladaptive coping strategies, and have lower perceived stress levels versus patients who did not use self-compassion. The results of the study showed that patients who did not practice self-compassion engaged more in maladaptive coping strategies, and had higher rates of perceived stress than patients who actively used self-compassion.

Understanding the role of self-compassion on patient health is valuable to any health-related field. Yet little research explicitly outlines how it can change patient's motivation to be physically healthier in the future. Prospective clinicians who understand self-compassion's influence may be able to incorporate it into patient's desire to live a healthy lifestyle (Magnus, Kowalski, & McHugh, 2010). While many individuals, women in particular, stay active solely to be viewed by society as attractive, external motivation doesn't typically sustain an individual's desire across the lifespan. However, having intrinsic motivation to care for oneself has the ability to do so. Magnus et al. (2010), understanding self-compassion's positive implications, hypothesized that women who are self-compassionate would more likely want to foster an honest desire to care for themselves above external influences, and in turn, self-compassion would act as a buffer against negative views of the self.

Without self-compassion, maintaining an active exercise routine for one's well-being can be extremely challenging. Comparing oneself to others during workouts, being upset when one doesn't achieve health goals, or feeling angry with oneself can inhibit the continuation of exercise regimens (Magnus et al., 2010). Yet self-compassion can take these negatively-charged emotions and alter them. For example, not meeting health goals can simply turn to goal re-engagement; feeling angry with oneself can turn to an opportunity to be kind to oneself.

Magnus et al. (2010) tested self-compassion in physical health contexts. Approximately 250 women were recruited as their sample. A collection of surveys was administered, including those for self-esteem, self-determination, goal orientation, social physique anxiety, obligatory exercise, and self-compassion. The results documented a trend in the data. Self-compassionate participants had higher intrinsic motivation, lower levels of extrinsic motivation, healthy goal orientation, lower social physique anxiety, and lower levels of feeling obligated to exercise that led to guilt (Magnus et al., 2010). In sum, self-compassion not only created a healthy way for individuals to engage in physical activity, but also protected against negative reasons for individuals to stay active that only have a temporary effect. This study may help physical therapists working towards goal achievement in patients, while also allowing them to be compassionate towards themselves when physical barriers are present.

Mental Health/Overall Well-Being

Just as self-compassion fosters a positive sense of physical well-being, it also creates a means for patients to improve their mental health. The quality of care provided by a dietician during therapy can facilitate clients' positive mental health outcomes. In therapy, a clinician's role is to be supportive, mindful, and compassionate towards his or her patients, to create an environment where patients understand it is okay to forgive previous faults, and to assist patients

in working through negative emotions (Germer & Neff, 2013). However, the services provided by a clinician will cease, either when the patient leaves the office, or when the patient is dismissed from therapy. That does not mean that the patient no longer needs support. The role of self-compassion in instances such as these can be paramount to prolonging a patient's psychological well-being.

In 2013, Kristin Neff, a chief researcher of self-compassion, along with Harvard Medical School's Christopher Germer, studied the effects of self-compassion in a series of two studies. To test if mindfulness could increase participants' self-compassion and well-being, they first conducted a pilot study. Over the course of eight weeks, 21 participants went through Mindful Self-Compassion, or MSC, training. MSC is an intensive training program that teaches people to live in the present moment, and how to practice compassion with oneself. The self-compassion scale (Neff, 2003) was administered prior to, and after the training program. Differences in pre and post-test measures indicated that participants' level of self-compassion, life satisfaction and happiness all increased substantially, even six months after the training ended (Neff & Germer, 2013).

Once the pilot study was completed, Neff and Germer (2013) designed a similar study comparing outcomes of treatment group scores to control group scores after completion of the Mindful Self-Compassion program. Similar to the pilot study, Neff and Germer found that participants in the experimental group rated their perceived self-compassion, well-being, and use of mindfulness significantly higher after going through MSC treatment. For example, Neff and Germer found that participants increased their levels of self-compassion by 43%, and had higher life satisfaction one year post-treatment than they did before the study. Since both the pilot study and research study had favorable outcomes, Germer and Neff (2013) conducted a follow-up

study to learn the effects of self-compassion training on a group of patients this time in clinical practice.

Twenty-five participants from the general public were asked to attend the Mindful Self-Compassion training program over the course of eight weeks. The participants were instructed to, practice techniques from the program for 40 minutes each day to maximize the effects of MSC. Germer and Neff (2013) followed one man's journey in particular to describe his transformation across the two months of training. The patient, Brian, was a 52-year-old gentleman who had seen a counselor for approximately 9 years. After experiencing a divorce, failed business, and history of suicidal thoughts, depression and anxiety, Brian often felt worthless and isolated, with many of these feelings dating back to his childhood. Due to these factors, Brian's therapist referred him to the Mindful Self-Compassion Training. Brian described his life as ceaseless distress, feeling regretful from the time he woke up about the past, and constantly worrying about the future. His therapist also noted that he didn't feel he was worthy of being happy.

Throughout the sessions, Brian made a substantial turn-around. As soon as treatment began, he had epiphanies such as: realizing everyone suffers, his own breath could calm him down, and the power of creating positive phrases in his mind could lower his stress. Brian also started to reach out to family members more, stopped being a perfectionist with every detail of his art, and "counted his blessings" (Germer & Neff, 2013, p. 10). When Germer and Neff (2013) interviewed him a year after the training ended, Brian said he no longer needed his antidepressant or anti-anxiety medication, stopped worrying everyday about the future, started to sleep better, and enjoyed working with clients at his job for the first time. While Brian's experience is unique to him, Mindful Self-Compassion Training's contribution to teaching self-

compassion can help soften negative emotions that patients experience outside of the therapy room.

A second study focusing on mental health addressed self-compassion's role in treating patients with post-traumatic stress disorder, or PTSD. According to Thompson and Waltz (2008), PTSD consists of three symptomologies: re-experiencing the traumatic event by reacting to internal or external cues of the event, avoidance, which can consist of neglecting thoughts of the incident or numbing one's emotions to cope with it, and hyperarousal, which can include lack of sleep, being startled easily, having anger-management issues, or experiencing troubles focusing on a specific topic. Self-compassion, on the other hand, helps individuals behave in opposite manners. It brings negative thoughts to light, allows a person to see a negative event as part of human nature, and facilitates a person's ability to comfort himself or herself. Thompson and Waltz hypothesized that severe PTSD symptoms would be related to low levels of self-compassion and high levels of self-criticism.

Thompson and Waltz's (2008) sample consisted of 100 participants who met the diagnostic criteria for PTSD, including traumatic events related to physical injury, deaths of friends or family, and sexual assaults. The participants completed the Self-Compassion Scale (Neff, 2003) to measure their level of self-compassion, as well as the Posttraumatic Stress Diagnostic Scale from the DSM-IV (American Psychiatric Association, 2013) to measure their levels of re-experiencing, avoidance, and hyperarousal. The results of the study were mixed: self-compassion did not correlate with levels of re-experiencing or hyperarousal; however, it did correlate with avoidance behaviors. Scores showed that participants who practiced self-compassion were more likely to let themselves think about their traumatic event and less likely to avoid negative thoughts surrounding it. The authors explained that individuals who are

compassionate towards themselves are less likely to feel threatened by the traumatic event that triggered their PTSD, and are able to confront the emotions and thoughts that underlie their diagnosis.

A fundamental component of mental health is advocating for oneself when help is needed. While self-compassion isn't often studied in conjunction with self-advocacy, both areas can impact a person with disabilities in parallel ways. Stuntzner and Hartley (2015) studied how self-compassion can increase the likelihood that people with disabilities will advocate for themselves, while also preventing these individuals from using self-pity. Self-pity is very different from self-compassion. Self-pity isolates the person, disengaging their experience from the experience of others. Self-compassion, alternatively, takes those experiences as a joint human experience that connects people to one another. Self-compassion lets people with disabilities recognize that life events are sometimes out of their hands, including how others react to their disability, but responding to those events with self-kindness is not.

There are many barriers besides self-pity that can stand in the way of self-advocacy. According to Stuntzner and Hartley (2015), one of the most fundamental barriers is disclosing one's diagnosis. Revealing one's diagnosis and corresponding barriers to unfamiliar peers can lead to social isolation, rejection, or anxiety. Any of these negative reactions can make a person with a disability feel insecure, and unwilling to continually share the diagnosis to others in the future. However, if a person fails to self-advocate, he or she risks not receiving accommodations and modifications at work or school, having others discriminate against them, not receiving proper medical care, or not connecting with others who share similar disability concerns. Similarly, Stuntzner and Hartley state that if people with disabilities do not comfort themselves

emotionally, they may ruminate on negative thoughts, feel less tolerant with their limitations, and judge their situation in a negative way.

Stuntzner and Hartley (2015) found that “self-compassion can empower people to advocate for themselves, while also reinforcing the message that individuals do not need to be rescued and are not victims of the environment” (p. 1). The importance of teaching self-advocacy skills along with self-compassion strategies can help alleviate some of the environmental stress a person with disabilities feels, and therefore can improve one’s quality of life. In sum, combining self-advocacy and self-compassion can psychologically protect people with disabilities in their daily lives.

Professionals’ Well-being

Though self-compassion can be vital to the well-being of patients receiving treatment, it can be equally important for the counselors themselves (Patsiopoulos & Buchanan, 2011). Proper service -delivery must encompass healthy guidance and support, and without having compassion for oneself, compassion for others can be extremely difficult. It reflects the saying you can’t pour from an empty cup; with that, counselors must first learn how to implement self-compassion in their own lives, before teaching these strategies to their clients (Patsiopoulos & Buchanan, 2011).

Patsiopoulos and Buchanan (2011) interviewed 15 therapists about how they practice self-compassion. The importance of this area of research is reflected in one of Patsiopoulos and Buchanan’s participant’s comment, “many of us never really learned how to take the time to care and to nourish ourselves having been trained to believe this would be selfish, or that there is no time for this when there is much else to handle. Nor have most psychologists taken the time to develop compassion for themselves, and compassion for themselves, and compassion for their own wounds” (p. 301).

Patsiopoulos and Buchanan (2011) utilized a series of three interviews, a screener, and two follow-up interviews to gather information from participants regarding their ways of practicing self-compassion. After the interviews were conducted, three main themes were found from the counselors who practiced self-compassion: counselors' stances in session, workplace relational ways of being, and finding that balance through self-care strategies.

Theme one, counselors' stances in session, had the common premise of accepting their own faults and limitations knowing that it's something all humans have. The theme also included admittance, being honest with patients when the counselors don't have the answer to patients' questions, mindfully working in the present moment, taking the time to be patient with themselves, and reminding patients that they, the counselors, too make mistakes but must not judge themselves harshly for it (Patsiopoulos & Buchanan, 2011). The second theme was workplace relational ways of being. The most common answers included being compassionate to their fellow co-workers, being honest with one's mistakes, making their own needs known, and expressing the importance of self-compassion in their own lives.

All of Patsiopoulos and Buchanan's (2011) participants expressed why they felt practicing self-compassion was useful in their profession, the third theme of the study. One woman described it as a necessary part to connect with patients, stating it was a "willingness to be open to the experience of flow of energy between (her)self and another person" (p. 306). Another counselor explained it's a connection between therapist and patient:

it is not something that happens just with me. I hear another's story and so I feel compassion. I learn self-compassion by more or less disclosing to someone else, and then it's this ongoing feedback of compassion (p. 306).

The last interviewee tied it together by stating “self-care means that I deserve to take care of myself and that I want to do something good for myself. The focus is on my well-being, which is the outcome of self-compassion” (p. 305). All of the responses stressed the importance of self-compassion professionally, but emphasized it more as a journey to benevolence with others by first being kind to oneself.

Two fields that fall under the category of professions who use patient-centered therapy are occupational and physical therapy. Both professions work with patients with physical disorders or disabilities, and both target goals that promote long-term patient health. Like the fields of psychology and counseling, occupational therapy and physical therapy also require a humanistic approach, empathizing with patients’ needs and limitations. Training professionals to be self-compassionate, as well as training patients themselves to be self-compassionate, may be crucial in how patients respond to treatment (Stew, 2011). When it comes to the field of health care, specifically those such as occupational therapy and physical therapy, professionals have a high chance of experiencing burnout, feeling emotionally drained, and having a low sense of accomplishment, all of which can in turn affect the type of care provided (Stew, 2011). However, if clinicians can properly administer self-care, they leave room for teaching others how to care for themselves as well.

Stew (2011) published a study in which occupational therapy students were trained to be more mindful of their thoughts, and to care for themselves. Stew also studied the effects of this training on service delivery. Over the course of eight weeks, students were trained on how to be aware of their present being, personally and professionally. The program itself was based in mindfulness training and students were expected to set aside time in their schedule to prioritize their own emotional needs, a theme of self-compassion. A few months post-training, Stew met

with the participants to conduct interviews about their experiences. More so, participants were asked how the training impacted their lives as health care providers.

One major theme that appeared was students' recognition that they often "do" instead of "be," meaning they may be working on the go, without ever stopping to simply be authentic with themselves (Stew, 2011). Clinicians in instances such as these are compassion-fatigued, and cannot provide adequate care for themselves when necessary. Stew went on to add,

when people are confronted with a disability or illness, the most profound level that it affects is the level of identity. In such situations, taking a moment to mindfully explore one's identity is the first step in deepening self-awareness...such exploration can allow therapists to assume greater responsibility for their choices, even under stressful circumstances, and to develop empathy and compassion for others' suffering (p. 273).

Clinicians in occupational therapy will almost always work with patients who have a disability or impairment, and having the ability to be aware of one's own thoughts, behaviors and emotions can then allow the therapist to better empathize with patients' needs.

Parenting

One stakeholder that can play a pivotal role in treatment, regardless of the fields discussed thus far, is a parent. In psychology, a parent may be the first to pick up on cues that his or her child may have a psychological disorder. In counseling, a parent may be the person who takes their child in to meet with a therapist when they feel as though the child's emotional needs demand attention. In physical therapy or occupational therapy, a parent may be expected to maintain and carry over strategies from therapy, being the "at home clinician" if you will, to sustain the child's progress outside of the therapy room. But what is often over looked is the

parent themselves: are parents giving themselves the same level of compassion they would undoubtedly give to their child?

The struggles of a parent can be countless, earth shattering at times, and can even begin as soon as conception. To raise a child is difficult in and of itself, but for many, conceiving a child is the greatest struggle of all. Approximately 1 in 10 couples will struggle with infertility (Burns, Covington & Kempers, 2006). Primary infertility refers to a couple's inability to get pregnant after a one-year span, whereas secondary infertility refers to a couple's inability to get pregnant again after having a previous stressful pregnancy (Burns et al., 2006). Regardless of the infertility type, parents may undergo many similar experiences, including emotional distress, increased medical expenses, feelings of shame, higher levels of stress, depression, and feelings of isolation (Raque-Bogdan & Hoffman, 2015).

One coping strategy that may mitigate these feelings is self-compassion. Self-compassionate individuals understand suffering is a part of being human, treat themselves kindly when a failure occurs, and limit the amount of self-blame in which they participate (Raque-Bogdan & Hoffman, 2015). Given the typical feelings infertile couples face, self-compassion can act as an emotional resource during difficult times. Raque-Bogdan and Hoffman (2015) examined infertility type, fertility-related stress, and the role of self-compassion to adult's general well-being. Their study's aim was two-fold: to understand how fertility-related stress differed depending on primary or secondary infertility type, and to understand how self-compassion affected a person's general well-being during times of infertility.

The study consisted of 172 women, 119 having primary infertility, and 53 having secondary infertility. All participants completed questionnaires about their experiences: questions regarding their reproductive medical history and treatment types, fertility-related stress

using The Fertility Problem Inventory (Newton, Sherrard & Glavac, 1999), questions about their perceived well-being, and the Self-Compassion Scale (Neff, 2003). The results of the study showed that both fertility-related distress and self-compassion were the highest in predicting a woman's perceived well-being, more so than the type of infertility she was experiencing. Self-compassion also mediated the need for being a parent and perceived well-being, as well as reconciling the relationship of perceived well-being and social concerns. Raque-Bogdan and Hoffman (2015) noted that self-compassion allow for problem-focused coping, rather than self-blame, which may explain their findings, as well as self-compassion's ability to create resiliency in women experiencing infertility.

Parental stress can span the parent's life: issues stemming from the first step of parenting, conception, all through child development, can have a profound emotional impact on parents. However, parents of children with special needs appear to have their own set of challenges that separate them from parents of typically-developing children. Autism Spectrum Disorder, or ASD, according to the DSM-V, is a diagnosis "characterized by deficits in social communication, with the presence of restricted, repetitive, and stereotyped interests and behaviors" (American Psychiatric Association, 2013, p. 1). Individuals with Autism demonstrate an impaired ability to use communication appropriately for social exchanges with others, have weak flexibility in changing communication style to match the environment and listener, have poor turn-taking abilities, struggle with figurative language, often have communication breakdowns, and sometimes can be non-verbal (American Psychiatric Association, 2013). The individual often times has a limited range of interests, demonstrates repetitive motor movements, prefers to follow daily routines, may demonstrate behavioral problems such as aggression and temper tantrums, may have delayed toilet-training, and can experience problems with sensory

integration, all of which may exist across the lifespan (American Psychiatric Association, 2013). These factors considered, it is not surprising parents of children with special needs, specifically Autism, have high levels of parental stress. Cappe, Wolff, Bobet, and Adrien (2011) found that parents of autistic children reported lower quality of life, higher levels of depression, and less optimism for their child's future versus parents of typically-developing children.

To understand if self-compassion could help alleviate parental stress in parents of children with Autism, Neff and Faso (2015) conducted a study that tested if self-compassion could predict well-being more than the child's severity level. The authors stated, "because parents devote so much time and energy to caring for their autistic child, self-compassion is thought to create a healthier balance by helping parents to nourish and take emotional care of themselves" (p. 2). Participants included 40 mothers and 11 fathers of children diagnosed with ASD. All of the participants completed an online battery of surveys that assessed Autism symptom severity, life satisfaction, hope, goal reengagement, depression, parenting, and self-compassion. The survey results showed that self-compassionate parents were more emotionally resilient than parents who weren't self-compassionate, had higher life satisfaction, reported being more hopeful for their child's future, predicted more goal reengagement for their children, had lower rates of depression, and predicted overall parent well-being above and beyond the child's symptom severity. These findings may help parents of children with Autism actively cope with the emotional trials that arise from having a child with special needs throughout child development.

Because children with special needs don't follow the typical trajectory of development like their typically-developing peers, it is important to highlight the necessity of self-compassion, especially during periods of episodic grief. Episodic grief, or ongoing loss, is continuous sadness

a caregiver feels at different points of a child's life (Olshansky, 1962). Olshansky was one of the first psychologists to discuss episodic grief in parents of special needs children, and explained that episodic grief can arise at different points in time, usually around crucial periods in the child's development. These crucial periods can include the child learning to walk, turning sixteen, graduating from high school, and other points that emphasize the child's increasing independent (Olshansky, 1962). According to Olshansky, these hallmark times are those in which the discrepancy between the child with disabilities and their typically developing, same-aged peer is most evident, and grief is triggered. Olshansky described episodic grief as a normal, natural reaction the parent experiences, rather than an abnormal psychological reaction. In cases where parents feel the effects of episodic grief, it is evidently important for him or her to practice self-compassion and kindness to help cope with negative emotions that come with understanding their child's unique difficulties.

Conclusion

In summary, this literature review concerning self-compassion points to a cohesive view of its effects on patients, service-delivery providers, and parents. Not only is self-compassion found to create positive emotional regulation, improve mental and physical health, and develop one's perceived well-being, but it also is found to lower the amount of one's negative emotions that lead to destructive views of the self. The studies discussed to this point have displayed the importance of self-compassion when kindness is needed most: in times of distress, shame, anger and isolation.

The SLP works with patients and their stakeholders during what can be exceedingly difficult times such as when a child is born with feeding difficulties, when a parent can't understand his or her child's wants or needs, or when a parent feels guilty that his or her child's

isolation is due to not being able to communicatively connect with world. During these times, parents need support in the form of appropriate counseling. Counseling is within an SLP's scope of practice (American Speech-Language-Hearing Association, 2016) and, according to Holland (2007)

appropriate counseling greatly increases the opportunity for an optimal outcome for clients, whether this involves resolving a specific disorder or maximizing quality of life by means of coping and adjustment techniques (p. 1).

Despite the documented positive effects of self-compassion on coping skills, the fact that many individuals with communication disorders and their stakeholders could benefit from self-compassion training, and SLP's responsibility to counsel patients to help them develop appropriate coping skills, there is no research to date that examines the influence of self-compassion on patients with communication disorders or their stakeholders. A search was conducted within Communication Sciences and Disorders databases including ComDisDome, CINAHL, PubMed and JSTOR, with keywords "speech pathology and self-compassion" and "self-compassion and communication disorders" that generated no results. Additionally, a search of the keywords "self-compassion" and "self-compassion and speech pathology" on the American Speech-Language-Hearing Association website produced no results.

This study, therefore, aims to begin researching the area of self-compassion within parents of children with communication disorders.

CHAPTER III: RESEARCH DESIGN

The purpose of the investigation was to research the relationship of self-compassion and parental stress within parents of children with communication disorders. Specifically, this study addressed the following five research questions:

- (1) What are the levels of perceived stress of parents with children with communication disorders?
- (2) What are the levels of self-compassion of parents with children with communication disorders?
- (3) Is there a correlation between levels of perceived stress and self-compassion?
- (4) Does the severity of a child's communication disorder influence levels of perceived stress and self-compassion?
- (5) Does the child's age influence levels of perceived stress and self-compassion?

Methodology

A survey research methodology was used for the study. Because surveys are inexpensive, are able to be administered to a large sample, and can efficiently collect information in a short period of time (Office of Research Integrity, 2016), it was decided a survey format was the most appropriate instrument to assess the relationship between parental stress and self-compassion. A survey was provided to parents of children with communication disorders who attended SLP clinics and to parent support groups within central Illinois.

Participants

Participants were parents of children with documented communication disorders who attended SLP therapy in clinics or who were members of associations that support SLP intervention. These included Easter Seals, Central Illinois Down Syndrome Organization, and the Eckelmann-Taylor Speech and Hearing Clinic. These facilities and associations are all within central Illinois. The associations were chosen because they actively support enrollment of children with communication disorders varying in ages from 0-21 and recognize the importance of the role of parents in children's intervention.

Twenty-seven parents, 2 males and 25 females, responded to the survey. The age of children ranged from 2-26 years ($M=10.20$, $SD=6.05$). Nineteen participants reported knowing the length of time since learning of their child's communication disorder diagnosis. The range of time known was 1-26 years ($M=7.45$, $SD=6.25$). Participants' mean rating of the severity of their child's communication disorder on a scale of one to ten with ten being the most severe was 6.61 ($SD=2.52$). Fourteen respondents reported that they do not engage in stress-reducing practices, while 13 respondents reported using stress-reducing practices, including breathing exercises, yoga, participating in support groups, exercising, prayer, reading, consumption of drugs or alcohol, and spending time alone.

Materials

A survey (see Appendix A) was created for distribution in both paper and electronic format. The electronic survey was created using the SelectSurveyTM software program provided by Illinois State University. The survey questions were uniform in both survey formats. Specifically, demographic information was collected first. This included parents' gender, child's age, child's communication diagnosis, and parent's perception of child's disability severity rated

on a scale of one (low) to ten (high). Additionally, parents were asked if they had a stress-management practice, and, if so, what it was.

The survey's remaining questions included the PSS (Cohen et al., 1983) and the SCS (Neff, 2003). The authors of these two scales have provided their consent to use these scales for research purposes on their respective websites (see Appendix B). The PSS is the most commonly used scale for measuring one's own perceived stress. It examines the degree in which participants find life situations stressful, as well as how uncontrollable they view life's obstacles (Cohen et al., 1983). According to Cohen et al., (1983), the PSS has a high internal reliability, test-retest reliability, and high construct and predictive validities.

The SCS (Neff, 2003) is a 26-item Likert scale measuring one's self-compassion. The subscales of the SCS include Self-Judgment, Isolation, Over-Identification, Self-Kindness, Common Humanity, and Mindfulness. According to Neff, the SCS had a test-retest reliability of .93 overall. Neff compared the SCS to similar scales and found it to have high construct validity.

Procedure

Institutional Review Board approval was obtained and recruitment emails were sent out to clinic administrators. Once administrators' consent was obtained, surveys were distributed to parents. Prior to completing the survey itself, parents were notified of the purpose of the investigation, the fact that their participation was voluntary, and that all responses were anonymous.

Clinic directors were asked to either email parents whose children attend their clinics a link containing the SelectSurvey™ electronic survey or to distribute hard copies of the surveys and a SASE to parents. Two copies of the hard copy survey were given to each set of parents to

encourage both to respond to the survey. Administrators of associations were asked to do the same with their parents who were members. Whether a parent received the electronic or the paper copy was determined by facility, association, or parent preference. Parents who completed the survey electronically (n=13) clicked on a link provided at the end of the introductory email (see Appendix A) to enter the survey. When they completed the survey, their results were automatically collected and analyzed by SelectSurvey™. The parents who completed a paper copy of the survey (n=14) were given a copy of the survey along with a letter describing the nature of the research (see Appendix A) and a SASE. Parents were asked to return the completed survey to the PI in the provided SASE. All responses were kept anonymous and were collected by the graduate student PI for analysis.

Analysis of Data

Survey responses to the demographic information were analyzed descriptively. Specifically, the number of males and females who completed the survey were tallied, means and standard deviations of children's age were calculated, and the number of children with specific communication diagnoses was tallied. As for stress reduction behaviors, coders noted respondents that engaged in stress-reduction behaviors and those who did not. From there, the graduate student recorded each stress-reduction response into a spreadsheet, observing trends in reported behaviors. The undergraduate research assistant then verified the responses and disagreements were discussed until consensus was achieved.

Responses to the PSS and the SCS on the paper surveys were transcribed onto opscan sheets: the coder transferred the PSS and SCS ratings (i.e., numbers 1-5) on to opscan forms. From there, an undergraduate research assistant student independently verified the responses were filled in correctly. Responses collected electronically were automatically recorded through

Select Survey. PSS and SCS scale scores from the electronic survey and opscan results were exported to SPSS and all statistical analyses were done using SPSS.

The PSS was scored following Cohen, et al.'s (1983) directions. Participants rated each PSS item on a 5-point scale with 0=never, 1=almost never, 2=sometimes, 3=fairly often, and 4=very often. Four PSS items are worded in a positive manner and were reverse-scored. Twenty-one respondents answered all items on the PSS. Their scores on items were totaled. A higher total score indicates higher perceived levels of stress.

The SCS was scored according to Neff's (2016) instructions. All items were rated on a 1 (almost never) to a 5 (almost always) scale. Items on the Self-Judgement, the Isolation, and the Over-Identification subscales were reverse-scored. Mean scores for total SCS were calculated for the respondents (n=20) who completed all SCS items. A higher score indicates greater levels of self-compassionate.

Respondents were divided into two groups based on the age of their child: 10 and under, and above 10. This age was selected as the dividing point for groups because it was the mean age of respondents' children. Independent t-tests with alpha = .05 were calculated with the PSS and the SCS, and the scores of the SCS as dependent variables.

Respondents were also separated into two groups, based upon how long the parent has known the child's diagnosis. The range of years was 1-26, with a mean length of time of 7.45 years. Seven years therefore served as the dividing point for the two groups, short amount of time being less than 7 years, and a long period of time being more than 7 years. Independent t-tests with alpha=0.5 were calculated with the PSS and SCS, with scores of the SCS as dependent variables.

Similarly, respondents were divided into two groups based on reported severity of children's communication disorder: 5 and under, and above 5. This rating was selected as the dividing point for groups because it was the mid-point of the rating scale used. Independent t-tests with $\alpha=.05$ were calculated with the PSS and the SCS, with the scores of the SCS as dependent variables.

A Spearman correlation coefficient was calculated between parents' ratings of severity and the PSS and the SCS. A Spearman correlation coefficient was also calculated between child's age and parents' PSS and SCS scores. Spearman correlation coefficients were calculated because the total number of participants was fewer than 25. Lastly, a Spearman correlation coefficient was calculated between parents' PSS and SCS scores and length of time a parent has known of the child's diagnosis.

CHAPTER IV: RESULTS

Stress-Reduction Practices

Fourteen parents indicated that they practice stress-reducing techniques of their own. Six participants stated using a combination of techniques, such as completing deep breathing exercises, practicing yoga, engaging in prayer, exercising, and confiding in friends or family. One parent indicated that by sending their child to therapy, they felt a decrease in stress as a parent. Two parents stated they used recreational drugs and alcohol to reduce stress. One parent indicated that they practiced gratitude, being thankful for the challenges related to their child's disability. Lastly, three parents indicated that they cared for themselves first, either by making time in their schedule to see friends, or being sure to spend time alone once a week. See Table 2.

Self-Compassion and Perceived-Stress Scores

Of the 27 participants in the study, 20 participants completed the SCS. The mean SCS score was 3.31 (SD=0.82). According to Neff (selfcompassion.org, 2016) scores of 1-2.5 indicate low self-compassion, scores of 2.5-3.5 indicate moderate levels, and 3.5-5.0 indicate high levels.

Twenty-two respondents completed the PSS. The mean score was 18.5 (SD=7.16). According to (Cohen, 1994) the norm for females is 13.7 (SD=6.6) and for males is 12.1 (SD 5.9).

Independent t-tests with age of child as the grouping variable and SCS the dependent variable, indicated that no significant difference existed between groups ($t(18) = -1.12, p = .28$). Similarly, no significant differences were found between parent groups based on child age for the PSS [$t(20) = .94, p = .36$].

Twenty-two respondents reported how long they have known their child's communication disorder diagnosis. Reports indicated a minimum of one year, maximum of twenty-six years ($M = 7.45$, $SD = 6.25$). Independent t-tests with how long since diagnosis as the grouping variable and SCS the dependent variable, indicated that no significant difference existed between groups [$t(18) = -.038$, ($p = .728$)]. Similarly, time since diagnosis as the grouping variable and PSS the dependent variable indicated no significant difference existed between groups [$t(18) = .11$, ($p = .628$)].

Independent t-tests with severity of child's communication disorder as the grouping variable and SCS at the dependent variable indicated that a significant difference existed between groups [$t(18) = 2.15$, $p = .045$]. Parents who rated their child's communication disorder as less severe had higher SCS scores ($M = 3.8$, $SD = .52$) than did those who rated their child's communication disorder as more severe ($M = 3.05$, $SD = .84$). Similarly, a significant difference was found between parent groups based on severity of child's communication disorder for the PSS [$t(20) = 2.19$, $p = .02$]. Parents who rated their child's communication disorder as less severe had lower PSS scores ($M = 13.43$, $SD = 4.99$) than did those who rated their child's communication disorder as more severe ($M = 20.87$, $SD = 6.88$). See Table 1 for means and standard deviations.

Correlation coefficients were calculated using Spearman correlation coefficients between PSS, SCS, severity ratings, time since diagnosis and age of child. Results indicated statistically significant correlations existed between total PSS and SCS scores ($-.835$, $p = .00$), severity rating and total SCS ($-.650$, $p = .004$), and severity and total PSS ($.558$, $p = .01$). However, neither age nor length of time parents knew about diagnosis were found to correlate with severity, total SCS or total PSS.

Independent t-tests with the use of stress-reduction practice as the grouping variable and SCS as the dependent variable indicated a significant difference existed between groups [$t(17) = -2.83, p = .012$]. Parents who use stress-reduction practices had higher SCS scores ($M = 3.71, SD = .68$) than those who did not ($M = 2.79, SD = .71$). When independent t-tests were used with stress-reduction practice as the grouping variable and PSS as the dependent variable, no significant group differences existed [$t(19) = 1.26, p = .223$]. Parents who use stress-reduction practices had similar PSS scores ($M = 16.72, SD = 8.14$) as parents who do not use stress-reduction practices ($M = 20.70, SD = 6.0$). See Table 3 for means and standard deviations.

Independent t-tests with type of stress reduction practice as the grouping variable, and SCS as the dependent variable indicated a significant differences existed between groups [$t(17) = -3.75, p = .002$]. Parents who use positive, internal, stress-reduction practices had higher SCS scores ($M = 3.85, SD = .56$) than those who used negative or no stress-reduction behaviors ($M = 2.76, SD = .68$). When independent t-tests were used with type of stress-reduction practice as the grouping variable, and PSS as the dependent variable, significant differences existed between groups [$t(19) = 3.05, p = .007$]. Parents who use positive stress-reduction behaviors had lower PSS scores ($M = 13.88, SD = 5.71$) than those who use negative or no stress-reduction behaviors ($M = 22.16, SD = 6.45$). See Table 4 for means and standard deviations.

CHAPTER V: SUMMARY AND CONCLUSIONS

Summary of the Study

The purpose of this study was to research the relationship of self-compassion's influence and parental stress within parents of children with communication disorders. Specifically, this study addressed five questions: (1) What are the levels of perceived stress of parents with children with communication disorders? (2) What are the levels of self-compassion of parents with children with communication disorders? (3) Is there a correlation between levels of perceived stress and self-compassion? (4) Does the severity of a child's communication disorder influence levels of perceived stress and self-compassion? (5) Does the child's age influence levels of perceived stress and self-compassion?

Numerous studies have been conducted comparing self-compassion's role in individuals' physical, mental and emotional health, yet no research to date has examined self-compassion's impact within the field of speech pathology, specifically when focusing on parents of children with communication disorders. SLPs use a team approach in therapy, working with the child with a communication disorder and their parents together. In other fields, increased severity of a child's diagnosis has been shown to lead to an increase in parental stress (Cappe et al., 2011). Without appropriate emotional resources, parents are less likely to care for themselves, and in turn, struggle to provide appropriate emotional support to their child (Cappe et al., 2011). Given such findings in other fields, it is important to begin examining the roles parental stress and self-compassion play for parents whose children have communication disorders. By implementing self-compassion into treatment, patients may begin to look at themselves less as someone with a communication disorder and more as someone who deserves kindness. Parents can focus on their child's strengths compared to his or her weaknesses, making time to care for themselves before

providing emotionally for their child. The relationship between parent and caregiver, when incorporating self-compassion, can also improve. Frustration, guilt, and negativity surrounding the disorder can be alleviated when the family understands they are not alone in their struggles.

The current study aimed to begin researching these areas and focused solely on caregivers of children with diagnosed communication disorders, their perceived stress levels of being a parent with such great demands, and the amount of compassion they give themselves when necessary.

In order to assess the relationship between perceived stress in parents and their levels of self-compassion, as well as the dynamics that play an integral role, such as age, stress management practice, severity of disorder, and time since the diagnosis was given, a survey was created. Parents were first asked to identify the child's age, communication disorder diagnosis, and severity of the disorder. Parents were then asked if they used a practice to manage their stress. If participants said yes, they were asked to indicate what their stress-reduction practice is. Next, the parents were asked to complete the PSS and the SCS.

Stress Management Practices of Parents

Twenty-seven respondents replied to yes or no questions asking if they participated in stress-reducing behaviors. Of these, fourteen respondents described the type of stress reducing behaviors they use. Of the fourteen respondents, twelve used internal coping strategies to mitigate parental stress related to their child's communication disorder, and two used externally-focused practices. Internally-focused behaviors, such as breathing exercises and prayer, were categorized as positive behaviors because they required the parent to cope with the effects of the disorder head-on. Externally-focused behaviors, on the other hand, were categorized as negative behaviors because they served as an escape to the problem.

The most common internally-focused responses included breathing exercises, prayer, and practicing gratitude. Deep breathing acts as a physiologic response to stress by decreasing oxygen consumption, decreasing heart rate, and decreasing blood pressure, while increasing theta wave amplitudes. This resets the autonomic nervous system and synchronizes neural elements in the heart, lungs, limbic system and cortex, calming the body (Jerath, Edry, Barnes, & Jerath, 2006). The second stress-reducing behavior is prayer. Prayer is viewed as a relaxation response, in which slowed breathing, reduction in heart rate, a drop in blood pressure, peripheral warming, slower brain wave activity, and lower metabolic rate occur (Jantos & Kiat, 2007).

Another commonly used stress-reduction practice among respondents was practicing gratitude. Research has shown people who practice gratitude daily have an enhanced sense of well-being, greater levels of happiness, higher reports of optimism and satisfaction with their lives, greater progress in attaining life goals, higher frequency of feeling love, and lower reports of stress and depression (Alspach, 2009). There are also social benefits to practicing gratitude, such as building strong, close relationships with others, gravitating toward others who also appreciate life, and feeling a sense of benevolence (Alspach, 2009). As for physical benefits, research has shown practicing gratitude leads to higher levels of enthusiasm and energy, higher rates of exercising, more hours asleep, better quality of sleep, fewer physical pains such as headaches or nausea, and heightened immunity (Alspach, 2009).

Two of the twelve respondents reported using less positive, externally-based behaviors to mitigate parental stress. While the other twelve participants used internal coping strategies, two relied on external supports. These included smoking medical marijuana and consuming alcohol. Regular marijuana use is associated with an increased risk of anxiety and depression, is linked with psychoses including Schizophrenia, and exacerbates stress (Volkow, Baler, Compton &

Weiss, 2014). Data have indicated people who drink alcohol due to stress drink more often than those who drink socially, and when alcohol is used to cope, it is often because they lack other, more adaptive ways of coping (Cooper, Frone, Russell & Mudar, 1995). Moreover, reliance on alcohol to deal with stress may lead to further deterioration in adaptive coping and to increased psychological dependence on alcohol to meet one's emotional needs (Cooper et al., 1995). Marijuana and alcohol are substances that alter one's psychological state, and because they are supports that distract parental stress rather than focus on the stress itself, they were categorized as less positive responses.

Self-Compassion

Results of the t-tests indicated that parents who rated their child's communication disorder severity as low had significantly higher levels of self-compassion than did parents who perceived their child's disability as severe. Parent's perception of the severity of their child's communication diagnosis influenced the level of their self-compassion as revealed in the SCS scores. These findings are consistent with research by Neff and Faso (2015) whose survey of parents of children with Autism showed that self-compassionate parents were more emotionally resilient than parents who weren't self-compassionate. The parents also had lower rates of depression, and higher overall parent well-being above and beyond the child's symptom severity (Neff & Faso, 2015).

The second influence examined was time since diagnosis. Respondents were asked how long they have known their child's communication disorder diagnosis. From there, respondents were separated into two groups, those who had known a shorter time (less than seven years), and those who had known a long time (more than seven years). The amount of time a parent had known of their child's communication disorder diagnosis was found to corresponded with the

child's age in the majority of respondents. It was found that time since diagnosis did not have an effect on parents' SCS scores.

The third influence studied was age. When respondents were separated into two groups based upon age, younger and older, it was found that age did not have an effect on parents' SCS scores. One possible reason for this finding may be tied to episodic grief. Since children with special needs don't follow the typical trajectory of development like their typically-developing peers, grief related to the child's communication disorder is not isolated to one point in time, but rather can reoccur across the child's lifespan. Because episodic grief is a continuation of sadness related, it is not surprising that age did not influence SCS scores.

The last influence studied was the use of stress-reduction behaviors. This was studied in two separate ways. First, participants were separated into two groups, those who practice stress-reduction behaviors, and those who do not. SCS scores were higher in those who practice stress-reduction behaviors compared to parents who do not, showing a positive relationship between stress-reduction behaviors and self-compassion.

The second analysis separated parents into two groups: those who engage in positive stress-reduction behaviors, and those who engage in negative/no stress-reduction behaviors. Scores between groups indicated SCS scores were significantly higher in parents who practice positive stress-reduction behaviors compared to those who use negative/no stress-reduction behaviors.

Perceived Stress Levels

No difference was found between the PSS scores of parents with younger children and those of parents of older children. This finding could also relate to the issue of episodic grief.

Results of t-tests with PSS scores showed that parents who rated their child's communication disorder as more severe had significantly higher levels of perceived stress than parents who rated their child's communication disorder as less severe. These findings supported the work of Cappe et al. (2011) that found parents who have children with severe special needs have high levels of parental stress and lower quality of life compared to parents whose children's needs are not as severe.

Comparing PSS scores of parents who had known of their child's communication disorder diagnosis for a long time to scores of parents who had known of their child's communication disorder diagnosis for a short time, no difference existed in their mean scores. Therefore, time since diagnosis did not have an effect on parents' PSS scores.

The last analysis looked at the relationship between PSS and use of stress-reduction behaviors. Participants were separated into two groups: those who practiced stress-reduction behaviors, and those who do not use stress-reduction behaviors. No significant differences were found in PSS scores across groups. The second analysis categorized parents into two groups: those who engage in positive stress-reduction behaviors, and those who engage in negative/no stress reduction-behaviors. When participants were separated by the type of behavior used, negative and positive behaviors, results showed participants who engage in positive stress-reduction practices had significantly lower PSS scores than those who use negative/no stress-reduction behaviors.

Correlation SCS, PSS, Severity and Age

The findings of the independent t-tests were consistent with the results of the correlation coefficients. Specifically, a negative relationship was found between PSS scores and SCS scores such that the higher the stress levels parents reported, the lower their levels of self-compassion.

Similarly, parents who reported the higher levels of self-compassion had lower PSS scores. There was also a negative relationship between parent rating of communication disorder severity and SCS scores. The greater the rating of the severity of the child's diagnosis, the lower was level of self-compassion. A positive relationship existed, however, between rating of communication disorder severity and PSS scores: the more severe a child's communication disorder was rated, the higher parents' PSS scores were and the less severe a child's disorder was rated, the lower parents' PSS scores were. Again, neither age nor length of time parent had known about the diagnosis were correlated with SCS or PSS scores. Thus, severity of a child's communication disorder appears to be more critical to a parent's perceived stress and level of self-compassion than does age or length of time parents had known of their child's communication disorder diagnosis.

Limitations of Study and Future Directions

A limitation of this study was the sample size. The researcher's goal was to obtain at least 100 parents of children with communication disorders, however, the sample size was approximately a fourth of that proposed. Future research should be duplicated with a larger sample size to determine if the same findings regarding SCS and PSS amongst parents who practice various coping strategies hold true as those found in this study. Researchers should focus on gathering more participants, and exploring different modalities of obtaining survey data. Lastly, future research should study the perspectives of other stakeholders, including siblings of children with communication disorders, as well as the patients themselves.

Conclusion

The current study utilized electronic and paper surveys to explore the relationship between perceived stress levels in parents of children with communication disorders and their

levels of self-compassion. This unique population faces a multitude of stressors that many other parents do not. Typically these parents are met with the financial, emotional and mental barriers for the entirety of their child's life, and without adequate emotional resources to counter such stressors, parents may not be able to emotionally provide care for their child or themselves (Cappe et al., 2011).

The role of parents in therapy is so crucial in the field of speech-language pathology: in order to work effectively as a group, SLPs and parents must collaborate as equal members of a team to improve the child's quality of life. However, when the focus is consistently on the needs of a child, it is easy for parents to overlook their own needs.

Results of the current study indicated an inverse relationship existed between parental stress and self-compassion: when stress increased, self-compassion decreased. Oppositely, when self-compassion increased, perceived stress decreased. It was also found that parental stress and self-compassion were related to parents' perceived severity of their child's communication disorder. As the role of a parent would suggest, it is instinctual to put the needs of one's child first. Yet neglecting the emotional needs of a caregiver affects the parent, the child, and the effectiveness of therapy. When a parent practices positive, internal coping strategies, perceived stress decreases, and self-compassion increases. It is imperative that SLPs therefore fully understand the benefits of self-compassion in therapy to offer to parents.

SLPs should assist parents with understanding self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification, as these elements often go ignored. It is within SLP's scope of practice to counsel patients and their stakeholders, whatever the communication disorder may be; this means being knowledgeable of ways to educate, guide and support individuals throughout their therapeutic journey, from time

of diagnosis, through the dismissal of services. The current study has added to the support of an approach that has unfailingly upheld its effectiveness across time, discipline and in this case, communication disorder diagnosis. That approach is self-compassion.

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10.1037/a0014739

APPENDIX A: RECRUITMENT SCRIPTS AND SURVEY

Recruitment Script accompanying electronic survey

Dear parent,

I am Olivia Arnos, a graduate student in Speech-Language Pathology at ISU. I am working on a research project as part of my graduate program under the supervision of Dr. Ann Beck. We are interested in learning more about the perceived stress levels and levels of self-compassion of parents of children with communication disorders. To help us with this, we ask you to complete a short electronic survey that should take no more than 15 minutes to complete. The only possible risk is that you might feel uncomfortable answering a question. If you do, you do not have to answer that question or you can stop taking the survey at any time. Your participation in this survey is voluntary and there will be no penalty to you for not completing it. All responses will be anonymous. While there is no expected benefit to you by taking this survey, we hope that the information gained will allow us to determine the relationship between parents' perceived stress levels and levels of self-compassion so that we can design programs to help parents manage their stress.

If you have any questions about this study, you can contact me, Olivia Arnos, at omarnos@ilstu.edu or Ann Beck at arbeck@ilstu.edu. For questions about research participants' rights and/or a research related injury or adverse effects, please contact the Research Ethics and Compliance Office at (309) 438-2529 and/or rec@ilstu.edu.

You can enter the survey by clicking on the link below. By clicking on this link, you are giving your informed consent to participate.

Thank you for considering this request,

Olivia Arnos

Recruitment Script accompanying paper copy of survey

Dear parent(s),

I am Olivia Arnos, a graduate student in Speech-Language Pathology at ISU. I am working on a research project as part of my graduate program under the supervision of Dr. Ann Beck. We are interested in learning more about the perceived stress levels and levels of self-compassion of parents of children with communication disorders. To help us with this, we ask you to complete a short survey that should take no more than 15 minutes to complete. The only possible risk is that you might feel uncomfortable answering a question. If you do, you do not have to answer that question or you can stop taking the survey at any time. Your participation in this survey is voluntary and there will be no penalty to you for not completing it. All responses will be anonymous. While there is no expected benefit to you by taking this survey, we hope that the information gained will allow us to determine the relationship between parents' perceived stress levels and levels of self-compassion so that we can design programs to help parents manage their stress.

If you have any questions about this study, you can contact me, Olivia Arnos, at omarnos@ilstu.edu or Ann Beck at arbeck@ilstu.edu. For questions about research participants' rights and/or a research related injury or adverse effects, please contact the Research Ethics and Compliance Office at (309) 438-2529 and/or rec@ilstu.edu.

By completing the survey, you are giving your informed consent to participate in the study.

Thank you for considering this request,

Olivia Arnos

off from the rest of the world.

- _____ 5. I try to be loving towards myself when I'm feeling emotional pain.
- _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- _____ 8. When times are really difficult, I tend to be tough on myself.
- _____ 9. When something upsets me I try to keep my emotions in balance.
- _____ 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 intolerant and impatient towards those aspects of my personality I don't like.
- _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- _____ 14. When something painful happens I try to take a balanced view of the situation.
- _____ 15. I try to see my failings as part of the human condition.
- _____ 16. When I see aspects of myself that I don't like, I get down on myself.
- _____ 17. When I fail at something important to me I try to keep things in perspective.
- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.

- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

Name _____ Date _____

Age _____ Gender (Circle): M F Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?..... 0 1 2 3 4
2. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4
3. In the last month, how often have you felt nervous and “stressed”?0 1 2 3 4
4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4
5. In the last month, how often have you felt that things were going your way?.....0 1 2 3 4
6. In the last month, how often have you found that you could not cope with all the things that you had to do? 0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life?..... 0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things?.....0 1 2 3 4

9. In the last month, how often have you been angered
because of things that were outside of your control?..... 0 1 2 3 4
10. In the last month, how often have you felt difficulties
were piling up so high that you could not overcome them? 0 1 2 3 4

Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress.
Journal of Health and Social Behavior, 24, 386-396.

APPENDIX B: CONSENT FROM AUTHORS TO USE SCS AND PSS

SCS Permission

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. Masters and dissertation students also have my permission to use and publish the Self-Compassion Scale in their theses.

The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.

Associate Professor Educational Psychology Dept.

University of Texas at Austin

e-mail: kneff@austin.utexas.edu

Reference: Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.

Retrieved from <http://self-compassion.org/self-compassion-scales-for-researchers/>

PSS Permission

Please feel free to use the Perceived Stress Scale for your research.

Mind Garden, Inc.
info@mindgarden.com
www.mindgarden.com

The PSS Scale is reprinted with permission of the American Sociological Association, from

Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 386-396.

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APPENDIX C: TABLES

Table C-1

Means and Standard Deviations on the Measure of Self-Compassion and Perceived Stress Scale as a Function of Disability Severity

Severity Group		<i>n</i>	<i>M</i>	<i>SD</i>
Total SCS	Low	7	3.80	.527
	High	13	3.05	.841
Total PSS	Low	7	13.42	1.88
	High	15	20.86	1.77

Table C-2

Themes of Responses to Stress-Reduction Practices

Theme	<i>n</i>
Prayer	3
Exercise	3
Creating Time for Self	3
Talking to Friends/Family	2
Breathing Techniques	2
Yoga	1
Practicing Gratitude	1
Reflecting on Interactions with Child	1
Marijuana Use	1
Consumption of Alcohol	1
Enrolling Child in Therapy	1
Time Management	1

Table C-3

Means and Standard Deviations on the Measure of Self-Compassion and Perceived Stress Scale as a Function of Stress-Reduction Practices Use

Participants Who Use Stress-Reduction Practices			
	<i>n</i>	<i>M</i>	<i>SD</i>
Total SCS	10	3.71	.688
Total PSS	11	16.72	8.14
Participants Who Do Not Use Stress-Reduction Practices			
	<i>n</i>	<i>M</i>	<i>SD</i>
Total SCS	9	2.79	.715
Total PSS	10	20.70	6.00

Table C-4

Means and Standard Deviations on the Measure of Self-Compassion and Perceived Stress Scale as a Function of Stress-Reduction Practices Type

Positive Stress-Reduction Practices	<i>n</i>	<i>M</i>	<i>SD</i>
Total SCS	9	3.85	.562
Total PSS	9	13.88	5.71
<hr/>			
Negative/No Stress-Reduction Practices	<i>n</i>	<i>M</i>	<i>SD</i>
Total SCS	10	2.76	.682
Total PSS	12	22.16	6.45