Working with Caregivers to Mitigate Automatic Responses in Families Using Mindfulness Techniques in a Parent Discussion Group

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Working with Caregivers to Mitigate Automatic Responses in Families Using Mindfulness Techniques in a Parent Discussion Group

by

Amy Korkemeier-Howard

A Thesis
Submitted to the Graduate Faculty of St. Cloud State University in Partial Fulfillment of the Requirements for the Degree Masters of Science in Child and Family Studies

August, 2018

Thesis Committee:
Jane Minnema, Chairperson
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Abstract

The purpose of this thesis was to find effective mitigation strategies for common negative caregiver-child “automated” response patterns for families with high to average risk factors. The participants in this study included a convenience sample of 13 caregivers of preschoolers. This exploratory intervention research study used mixed methods to describe parental automated responses to their children's behavior through self-report. Both quantitative and qualitative data were collected through demographic surveys that included open and closed items, pre- and post-study questionnaires, participant attendance and participation recordings, participant self-reporting in their home setting, field notes of self-reported progress in the caregiver discussion group, and an audio recorded semi-structured group discussion. Staged interventions requiring attendance included pre-study instruction, field discussions, and the final group interview; which were also designed as the means to acquire mindfulness skills as well as offered the benefits of group field discussion supports from peers and the parent educator. Study features included in-home daily Mindfulness Journaling and Action Plan Script practices.

Overall, the results of the study showed that either full or partial participation in study interventions offered perceived benefits in understanding of 1) child and adult development/behavior, 2) the workings of emotional regulation/dysregulation and 3) in-turn practical implementation of mindfulness techniques to aid in reducing automatic responses between caregivers and their children. Participants reported the increased identification of triggering events and related thoughts, feelings, and physical responses, the creation of new mental scripts, as well as the selection of mindful calming techniques to offset triggered reactions. This study adds to the current literature in the area of enlisting caregivers as change agents in rewriting automatic response patterns through the use of mindfulness techniques learned in a discussion group with the guidance of a parent educator and peer supports, which resulted in a perceived reduction of negative effects between caregivers and the children in their care.
Acknowledgements

I would like to take this opportunity to express my gratitude to those who have helped make this opportunity possible for me. Starting way back when I was a senior in high school, the Dobihal Family opened their home to me and encouraged me to go to college, eventually sending me off with a suitcase, a bike, and a bus ticket. Here I am, still going to college. Many thanks for the encouragement and generosity you showed me and my family. It was life changing.

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member of my committee. I appreciate the support, guidance and insight all of you have provided me.
Dedication

This thesis is dedicated to my husband Dylan, and my daughter Cloey. May we be a calm, loving presence for each other and with all whom we share the earth.

“We don’t have to run from lions, but we are stuck with the instinct.”

-Ratey & Hagerman
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Key Terms

Automaticity—Automatized patterns of thinking, feeling, and acting that are resistant to change and are mindless; performed with little deliberate attention to what is occurring in the present moment (Dumas, 2005, p. 780).

Mindfulness—Paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally (Kabat-Zinn, 1994, p. 4).


Core Capacities—Planning, focus, self-control, awareness and flexibility, which fall under the “self-regulation” umbrella. (Center on the Developing Child at Harvard University, 2016, p. 5).

Executive function—Made up of inhibitory control, working memory, and mental flexibility (Center on the Developing Child at Harvard University, 2016, p. 5).

Fight or Flight Response—(automatic self-regulation) Rapid impulse-directed, important for urgent situations (Center on the Developing Child at Harvard University, 2016, p. 10).

Intentional Self-Regulation—Conscious, planful, proactive and inhibits automatic responses. (Center on the Developing Child at Harvard University, 2016, p. 5).

Mistaken Behaviors—The understanding that children are at the beginning of a lifelong learning process and that along the way mistakes will be made (Gartrell, 2004, pp. 6-7).

Resiliency—The mental ability to cope with adversity, to persevere and adapt when things go awry (Pearson & Kordich Hall, 2006, p. 3).
Trigger—An event that causes an automatic response (Center on the Developing Child at Harvard University, 2016, p. 7).
Chapter 1: Introduction

Overview

A child’s developing understanding and emotional recognition are based on parents’ beliefs about emotions and emotion socialization skills (Castro, Halberstadt, Lozada, & Craig, 2014). In this way, children can begin to understand, regulate, and control emotions based on caregiver interactions, co-regulation assistance, and modeling (Farrant, Divine, Maybery, & Fletcher, 2011; Gartrell, 2004; Swain, Lorberbaum, Kose, & Strathearn, 2007).

A parent’s emotional response to their children’s behaviors along with their desire to guide social-emotional development ‘appropriately’ are of great concern to families. As a parent educator, I often hear caregivers question if they are “doing it right,” stating that they run out of patience for behaviors that “push their buttons.” Interestingly, information regarding children’s growing emotional capacities frequently associate with the “other half of the equation;” the effects of parents’ emotional regulation or dysregulation in response to the child’s emotional state (Siegel & Bryson, 2012). There is corroborating evidence that these automated or ingrained non-thinking ways of acting and reacting happen with relatively little awareness (Jobe-Shields, Moreland, Hanson, & Dumas, 2015), are relationship-specific (Dumas, 2005), and can be rewired with planning and practiced effort (Center on the Developing Child at Harvard University, 2016; Linehan & Wilks, 2015; Siegel & Bryson, 2012).

Statement of Problem

General findings in the research base for this area of parent-child interactions point to the importance of healthy parent-child relationships, which are created through loving, supportive, give-and-take interactions (Mercer, 2015). Everyday interactions between parents and children
can be difficult to manage, often adding onto other outside factors such as disabilities (parent or child’s), health conditions, loss of work, or other stress-evoking situations. Unhealthy interactions and a pattern of heightened stress in the home can impact the developing brain and a child’s future success (Siegel & Bryson, 2012). Unfortunately, in some families, parents have a lowered stress tolerance because of risk factors due to exposure to adverse childhood experiences (ACEs). While not limited to, some examples of ACEs include abuse, neglect, divorce, or other impactful events, which may lead to elevated negative automatic responses in the body and the brain (Center on the Developing Child at Harvard University, 2016). The combination of current and past life factors can contribute to difficulties as one parents one’s own children which in turn create ingrained ways of responding (Center on the Developing Child at Harvard University, 2016). These automated stress responses, if not mitigated in some way, can lead to less productive, or even destructive, ways of thinking and acting, which can ultimately be passed to their children as abuse or mis-modeled behaviors. In this way, the cycle of automaticity of response to children is continued from one generation to the next generation (Bernier, Carlson, & Whipple, 2010; Center on the Developing Child at Harvard University, 2016).

**Importance of Study**

Research has indicated that “automaticity of response” becomes an intergenerational issue showing effects not only on a single family; but classrooms, communities, and society as a whole (Center on the Developing Child at Harvard University, 2016). Combining this understanding with the belief that most families look for better, more effective ways of parenting through difficulty confirms the importance of engaging caregivers as key ‘change agents’ in this parent-child dynamic.
Studies of Behavioral Parent Training (BPT) programs (Fettig, Schultz, & Sreckovic, 2015; Mah & Johnston, 2008; Shanley & Niece, 2010), as well as findings from mindfulness (Dumas, 2005; Linehan & Wilks, 2015; Singh et al., 2010), and resiliency of thinking trainings (Farrant et al., 2011; Pearson & Kordich Hall, 2006), have shown varying degrees of effectiveness in mitigation of automated behaviors. Some of the training programs focus on either parent skills or child skills in isolation, with minimal or moderate success at combating automatic responses and improving children’s behaviors (Mah & Johnston, 2008).

Research calls for an integrated learning/training approach for families, based on child and caregiver overall needs in mind (Fettig et al., 2015). Ideally, emotional, mindfulness, and behavioral education would be offered in combination (Dumas, 2005). Parents would practice specifically designed pre-planned assistive tasks so they can remain calm while thoughtfully connecting with their child during stressful dysregulated times (Dumas, 2005; Fettig et al., 2015). It is important that a child’s “mistaken behaviors” (Gartrell, 2004, p. 6) or “lagging skills” (Greene, 1999, p.19) be viewed as a product of a child’s developmental stage. An effective and supportive model for adult learning occurs when “real” learning situations with immediate or specific feedback based on the needs and skill/s being practiced are created (Fettig et al., 2015; Mah & Johnston, 2008; Shanley & Niece, 2010). In addition to gaining new skills, families can find great benefit from learning in group environments with peer support and discussions guided by a parent educator (Campbell & Palm, 2004; Curran, 1989; Walker, Anderson & Brown, 2012). This model of adult learning is particularly helpful for those caregivers with heightened risk factors (National Academies of Science, Engineering and Medicine, 2016).
Purpose and Research Questions

This study purports to find causal factors and effective mitigation strategies for negative parent-child “automated” response patterns, which can lead to ineffective attachment practices, thereby negatively impacting a child’s social-emotional development, executive function capacities, self-regulation abilities, and overall health (Center on the Developing Child at Harvard University, 2016). Finding these response patterns a common concern for parents with high as well as average risk factors, exploration of the research question will benefit all families. With this understanding as the first element of an integrated approach, this study will explore the question: When parents learn mindfulness techniques in a parent education class, does implementation of these practices mitigate automated responses to their child/ren at home?

Conceptual Model

According to Minuchin (1985), a family therapist, system theory identified parents and children as components of a family, claiming they equally contribute to the regulation patterns of the family. In analyzing the concept of a family as a social system, each person or relationship creates an independent yet interdependent subsystem, which can in turn affect other subsystems in the family unit such as grandparent-child, parent-child, or siblings (Minuchin, 1985). If one subgroup of the family has ineffective patterns of dealing with emotional regulation, possibly as a result of previous interactions in other subsystems, it can affect the entire family unit and perpetuate across generations (Cross & Barnes, 2014).

This perspective supports the idea that each individual should be understood in context, one element of a whole, when working to change patterns of behavior (Minuchin, 1985). System theory insight brings to practice the importance of working with parents as one way to improve
children’s negative emotional and behavioral responses by way of teaching parents adaptive patterns in order to offset the cyclical nature of socially learned patterns (Minuchin, 1985).

**Conclusion**

Research supports that an integrated, scaffolded approach, based on evidence-based strategies, may fill any gaps that mindfulness or behavioral training programs create when training components are offered in isolation (Dumas, 2005). This small-scale study will offer insight into a heuristic-based (Eisenberg, Cumberland & Spinrad, 1998; Hoza, Johnston, Pillow, & Ascough, 2006), more open-ended (Mah & Johnston, 2008) treatment model that aims to offset the cycle of automatic responses between parents and their children. To achieve this program goal, caregivers will learn to replace automatic responses with alternative thinking and acting habits. These caregiver habits are deliberately designed responses combined with peer support and personal reflection on planned practice activities (Linehan & Wilks, 2015). This research study intends to target caregivers’ personal and inter-relational physical and emotional workings that are at play in parent-child relationships.

There are many programs and practices that attend to parent and child learning perspectives. Programmatic content seeks to connect all families, from those with multiple risk factors to those struggling to support typical “mistaken behaviors” (Gartrell, 2004, p. 6) or “lagging skills” (Greene, 1999, p. 19), to typical child/adult developmental information, body-brain responses to stress insights, resiliency of thought training, executive function awareness, scripted practices, and facilitated social “teaming” of efforts. The overarching aim of these programs is to serve long-term healthy family and community goals. These evidenced-based
programs and practices are discussed further in the following literature review, Chapter 2 of this thesis.
Chapter 2: Literature Review

Overview

The following chapter outlines research findings focused on essential understandings and practices necessary to support families as they combat “automated thinking and response patterns.” Automatic patterns of thinking and interacting as described by the Center on the Developing Child at Harvard University (2016) are developed early in life. If parents retrain their ineffective responses and in turn model appropriately for their children, these ways of thinking and acting will be less likely to be perpetuated (Center on the Developing Child at Harvard University, 2016). Social competence training begins early in life and takes much time and practice to become a developed “skill.” Misguided social “practices” at home can influence school and future work relations as these responses become ingrained neural pathways that, once habitualized, are changeable but less easily than if positively ingrained early in life (Dumas, 2005).

In an effort to address automatic responses between caregivers and their children, I turned to family systems theory and current research findings to aid my comprehension of the dynamics at play that need to be understood before a purposeful “intervention” or training could be attempted. Thus, integral components reviewed in this literature review included parent-child attachment and social-emotional development, intergenerational effects/automatic responses/building “core capacities,” emotional and physiological responses to stress in the body and brain, adult teaching-learning practices, and lastly, empirically verified internal and external-state interventions that support healthy caregiver-child relationships that address ineffective “automatic” caregiver-child interactions.
Parent-Child Attachment and Social-Emotional Development

Social-emotional regulation is a developing skill in young children that Swain et al. (2007) believe evolves over time through practice, with guided assistance and modeling from family members and peers. Emotional understanding develops through deepening attachment relationships between parents and children during infancy and beyond. Hugs and kisses turn to tears and tantrums as the need for safety and behavioral limits increase, creating new and challenging dynamics at each stage of development for families to address. Castro et al. (2014) supported a parent’s ability to recognize their child’s emotions and the child’s ability to recognize their parent’s emotions. These findings, as well as the positive correlation with parent labeling socialization behavior, suggested that supporting a parent’s ability to recognize and understand children’s emotions is as important as helping the child directly.

The attachment-theory-based techniques shared by Gartrell (2004) focused on the importance of how social-emotional skills are taught/modelled in early childhood. He encourages teachers and families to reassess their personal perspective of children’s challenging behaviors sometimes labeled “misbehaviors”, asserting these occurrences are best viewed as opportunities to teach and model conflict resolution strategies (p. 6). These “mistaken behaviors” (p. 6), when used as teaching tools, can help “children learn from their mistakes rather than disciplining them for the mistakes they make” (p. 65).

The concept of patience with children’s behaviors, viewed by many as a depletable resource, is debunked, with claims that a less judgmental understanding of child development is necessary (Weber, 1987). Socially appropriate behaviors and physiological control of their
bodies and thoughts are growing through guided practice with teacher or parent assistance in problem solving.

Parents often question what practices best support a child’s growing self-esteem as they work through these important stages in social development with their children. Gartrell emphasized using crisis management strategies when a child is too upset for conflict management to achieve long-term gains. Simply putting into action respectful guidance steps using the “describe, express, direct sequence” (Gartrell, 2004, pp. 144-149), at the right time can lead a child to enhanced self-regulation and social competence. When a child may have gone past that point of using words to express feelings or solve problems, calming techniques are offered without separation before further conflict management may be considered. The adult uses descriptive emotion language to acknowledge what they see the child experiencing. Connecting in this way, by giving words to the emotions the child is displaying, helps dissipate the intense reactions. To further ease the stress of the moment, adults can guide the calming process by offering and modeling deep breaths or other techniques.

Some children may need to actually be removed from the offending area or person in order to regain emotional control. Removal from the area or calming in place is not used as a punishment, but as a way to allow the child time and space to regain composure with the expectation that problem solving will come later. The adult may stay near the child, remaining quiet; not to be seen as a reward for inappropriate behavior, but as a way to connect with the child and to aid in moving to the next step. Gartrell (2004) asserted this time of emotional upset is not a time to try to problem-solve. A young child’s emotions may override any expectations or preferences for alternative behavior; adding that adults, even with years more experience, may
still struggle to talk through emotional upset. Making a deliberate choice to connect and understand behaviors serves not only children but people of all ages and capacities.

For some families, healthy attachment is compromised for a variety of reasons. Mercer (2015) conducted a meta-analysis of Circle of Security (COS) components, which is an intervention aimed at supporting attachment relationships between children and parents. COS was developed specifically for those relationships that may require mental health support to negate negative child outcomes. This meta-analysis determined that the overall effectiveness of the intervention was weakly supported by research findings, suggesting that “commercialism” (p. 390) of the program was a concern since studies were not independently verified. The COS intervention uses the caregiver attachment/exploration “graphic” and “shark music” concepts, which support caregivers’ understanding of the need for “sensitivity and responsiveness” to their children. It is important to note that the COS intervention was deemed “user-friendly” and effective overall. Mixed findings support the importance of using empirically verified parent training programs to achieve the best outcomes for families while asserting that some aspects of the program may still offer effective tools. Thus, continued review and refinement are necessary so as not to lose important components of programming found beneficial to families.

**Intergenerational Effects/Automatic Responses/
Building “Core Capacities”**

The interrelation between parents and their children has been described in more contemporary times by Kuczynski in *The Handbook of Dynamics in Parent-Child Relations* (2003) as a bidirectional relationship where each is an equal give-and-take partner, versus separate, individually developing components. This systems theory perspective drives current
understanding of how family systems operate in the home and how learned patterns of behavior may go beyond into interactions with peers (Cross & Barnes, 2014).

To more deeply understand this concept, I used insights from neuroscience and psychology research from the Center on the Developing Child at Harvard University (2016), which released a collaborative paper highlighting the importance of building “core capacities” (p. 5) in executive function, self-regulation, and attention in children and adults through increased understanding of automated thinking patterns and responses. The authors note the strain of poverty, adversity (unstable, unsafe environments), and stressors create an “overbalance of automatic responses” (p. 7) to perceived threats, depleting our energy, and “place heavy demands” (p. 7) on our regulatory systems.

Safe environments and responsive caregivers in the early years set a child up for the greatest potential executive functioning, whereas early traumatic exposures can create automatic rapid “fight or flight” (p. 10) responses in the brain to perceived stresses that compromise[s] one’s ability to self-regulate or control impulses. This becomes a physically hardwired way of thinking and acting. Sometimes dysregulation is an automated response to previous or current life-stresses which requires specific action steps for modification (Siegel & Bryson, 2012). Retraining efforts are difficult as our brains connect new responses to past experiences, which are very ingrained pathways. Research has shown the cycle of dysfunctional impulsive-reactive behavior, when interrupted through social and individual supports, can create a new long-term trajectory. These newly created trajectories have also been shown to benefit families for generations (Center on the Developing Child at Harvard University, 2016).
Modifying regulation responses begins with understanding how we work as a system; strong executive functions (resisting impulsive behavior, holding information for brief periods, adjusting to demands and perspectives) lead to increased attention and balanced self-regulation. Modifications in these areas require an inner dialog (identifying triggers, regulation of thoughts and feelings, goal management through problem-solving) and constant adjusting so one can work past impulsive responses and toward long-term gains for themselves and their children (Center on the Developing Child at Harvard University, 2016). Growth in capacities is possible at all ages, but preferably beginning in the early years.

**Emotional and Physiological Responses to Stress in the Brain**

Siegel and Bryson (2012) suggested “parenting with the brain in mind” (p. 4). Insights included a focus on the instinctive ways emotional reactions and physical responses affect the developing brain and the dynamics of the parent-child relationship. Responses in the body and brain to emotions or perceived stress may temporarily override one’s thinking, causing dysregulation. Parents and children may benefit when they learn simplified explanations of the physiological response to emotions. Parents are encouraged to reframe difficult times as teaching times. Clearly defined guidance processes highlighting body-brain concepts can aid parents in not only understanding the why of behavior, but what steps to follow to connect children with their own self-regulation practices. Key strategies include breaking down the workings of the left and right brain, explaining why the logical and emotional sides of the brain can become out of “balance” and creating dysregulation of thought and behaviors (Siegel & Bryson, 2012, p. 18). Integration practices for the more primitive brain—the “downstairs brain” (instinctive reactions like fight-or-flight thinking) and the “upstairs brain” (decision making, insight, empathy and
morality)—are supported through stories and mindful activities and practices (pp. 52-53). As parents and children gain awareness of the cause of their body-brain responses, they can begin practicing making choices that offer greater control over reactions to stress and emotions. A parent’s ability to model these practices is integral to a child’s success.

**Adult/Child Development and Learning**

Adult/parent development and child development are happening simultaneously in families. Life span development, using a systems approach, suggested the importance of studying interwoven relationships at different stages as a possible window into better understandings of life-cycle needs of family members (Minuchin, 1985). Under this premise, adults have different learning needs at various times in their lives. It is imperative to analyze the research to ensure proper design of the adult learning/coaching experiences as it relates to the successful design and implementation of study components and will inevitably affect study outcomes.

Transformative learning theory of adult learning is described by Mezirow (1997, p. 5) as simply understanding that to teach adults, one must aid in changing their “frame of reference” built from past “experiences-associations, concepts, values, feelings, and conditioned responses.” A teacher/facilitator of adult learning keeps content “learner-centered,” challenging adults to work past their comfortable way of thinking and feeling, encouraging internal reflection, and using peer discussion and problem-solving as a way to connect new information to their current perspectives (Mezirow, 1997). Mezirow (1997) promoted using group problem-solving teaching methods, where the learners take over the leadership of learning; such as “group projects, role play, case studies, and simulations” (p. 10). Meeting the learner where they are at in their
understanding and connecting their learning or problems with others in the group opens the door to greater problem-solving and peer support (Cox, 2015; Mezirow, 1997). Concept maps, explored by Biniecki and Conceicao (2015), and other individual methods (metaphor analysis, life history, critical incidents) also work to assist the adult learner in engaging with new concepts while changing perspectives and ultimately creating new frames of reference (Mezirow, 1997).

In analyzing adult learning through group facilitated practices in an Early Childhood Family Education (ECFE) setting, Walker et al. (2012) quantified caretakers’ perceived changes in parenting and improved understanding of the changes in their child’s development based on participation in the ECFE classes. Results showed families reported increased benefit and improved changes overall in the 33 small to large school district programs that were surveyed.

In addition to group leaders understanding “why and how” to coach adult learners in defining their needs in the learning process, Curran (1989) emphasized that the “when” is characterized by predictable stages of group development. The assertion is there is a general build-up of comfort and characteristics that are identifiable and consistent in cohesive and higher performing groups. The group leader must be proficient at structuring this best-case learning environment and nuanced in guiding the group through the progression in order to aid in creating optimal participant connection and learning situations. Based on Curran’s (1989) group theory, it is important to have awareness of this dynamic when group interactions are used as a study intervention component, as structuring the timing of the process, based on a group’s current “stage,” may affect overall outcomes.

The 5 Stages include:

Stage 1: Forming–Getting acquainted with each other and sharing of basic information;
Stage 2: Norming–Goals are set and participants share expectations, and group rules may be created to ensure a sense of inclusion and safety;

Stage 3: Storming–Generally, comfortable for participants to freely share, which may lend itself to sharing differences, and to important learning/growth opportunities;

Stage 4: Performing–(Preferred teaching/learning stage) Group members rely on each other for problem-solving and support. Deeper emotional topics can be more comfortably addressed;


Internal State Training/Practices–Mindfulness-Based, Resiliency, and Automated Thinking Trainings

This section will review studies using intervention or training practices specifically designed to modify caregiver and/or child thoughts and behaviors with the aim of creating emotional self-regulation outcomes. Many of the studies seek further investigation to improve next steps in research.

Mindfulness, described by Kabott-Zinn (1994), is an awareness of our mind and its workings, brought forth through self-observations that help us pay attention to the present moment non-judgmentally. He inferred present moment thinking is a way to combat automatic thinking. Awareness of thoughts can give us control over our perceptions and our actions, offering a deeper look at what fears or insecurities create our thoughts. This insight is studied in various forms such as resiliency of thought labelled as “growth mindset or a fixed mindset” (Dweck, 2006). Overall, findings of mindfulness practices point to positive outcomes, thus encouraging this type of training as a good fit for enhancing parent-child interactions.
A short-term 5-day study by Tang et al. (2007) used integrative body-mind training (IBMT; or integrative meditation) with the aim to increase attention and related self-regulation in participants. Originating in China in the early ‘90s, this training has been found effective in a wide age range of people; including those inexperienced in meditation practices.

This study intervention began with a brief instructional period of the method called ‘mind-setting’ with the goal to induce a cognitive or emotional set that would influence training. The method stresses a state of restful alertness that allows a high degree of awareness of body, breathing, and external instructions from an audio recording. Thought control is not stressed as an element of the training but is reached by “posture and relaxation, body-mind harmony, and balance with the help of a coach” (p. 17152). After the initial group training there were 5 days of training for 20 minutes each day with coaching supports. The control group used a Western type of relaxation training with no coaching assistance.

Results showed changes in stress responses as measured pre- and post-study between the 40 college-age experimental and 40 college-age control group participants, with significantly reduced levels of stress-related cortisol, increased levels of immunoreactivity, and improved scores on the Attention Network Test (ANT) in areas of alertness, orienting, and conflict. This study suggested that even short-term use of a coached integrative meditation practice can offer significant benefits in stress reduction and related effects.

Dumas (2005) called for empirical investigation of mindfulness-based parent training programs (MBPT). She suggested combining Behavioral Parent Training (BPT) strategies, currently the most used intervention for families, with mindful practices to create an “integrated model” (p. 779) that, when used individually, leaves gaps in knowledge. Dumas found BPT
techniques analyzed in a meta-analysis of 26 studies resulted in more positive outcomes for children whose parents participated than for those that did not. The remaining families found the “operant” (p. 779) model of conditioning their children, with reinforcement and punishment, did not combat the deeply ingrained or “mindless” (p. 779) ways of thinking/acting, thus leading the researcher to suggest a supplemental Mindfulness-Based Cognitive Therapy (MBCT) model of parent training.

Proposed mindful practices teach listening, distancing, and Motivated Action Planning (MAPs). Mindfulness training focused on the concept of creating new habits and ways of interacting through structured role-playing practice, visualization, and discussions between parents and their children. A key concept of mindfulness is to retrain oneself to be non-judgmental instead of thinking things are either good or bad. Acceptance of each other’s “needs and preferences” (p. 784) was supported by setting personal thoughts and emotions aside temporarily.

In the report, *Parenting Matters: Supporting Parents of Children Ages 0-8* (National Academies of Science, Engineering and Medicine, 2016), it was pointed out that one’s understanding of the benefits of parenting practices or having a want to change a behavior does not necessarily “translate into the use of such practices” (p. 9). This awareness is foundational to an additional element to consider in combating automaticity, Motivated Action Plans (MAPs). Specific behavior goals with action steps addressing the when, where, and how are reinforced through practiced role playing and visualizations. This form of addressing the problem assisted parents in retraining their response before it happens, which purports to allow them more energy in the moment to follow through. Mah and Johnston (2008, p. 230) suggested that when parents
design their procedures, it ensures the “motivator for acceptability of treatment.” Problematic scenarios rehearsed ahead of time, as a way to offset the current automatic responses, have been found effective in “programmatic studies” (Dumas, 2005, p. 787). By breaking the parent-child emotionally reactive cycle, this in turn reduces the need for planning in the moment and aids in a fast, positive parent response, versus the typical triggered set of events.

A mother’s facilitation and modeling of empathy and perspective-taking were shown to be successful in supporting children’s cognitive empathy as well as helped grow their perspective-taking practices (Farrant et al., 2011). The researchers argued that along with perspective-taking comes the ability to be more responsive to cues about others’ thoughts and feelings as well bringing out aspects of sympathy, thus resulting in prosocial behaviors.

Another study using mindfulness concepts, the The RIRO Resiliency Guidebook (Pearson & Kordich Hall, 2006), an evidence-based skills training program, was designed to promote resilience and “thinking habits” (p. 12) in young children through teaching the importance of adult modeling of resilient thinking and behaviors. As part of a multi-stage research study, the researchers used Dr. Andrew Shatte’s original materials (developed for use with children 8 years and older), from the Penn Resilience Program at the University of Pennsylvania for the basis of the guidebook design.

In Stage One of the research study, modifications were made and pilot-tested by trained early childhood educators (ECEs) who worked with children 6 years and under in four childcare centers in Ontario. The researchers believed that indirect modeling for young children would increase their “resilient thinking skills” or ability to “bounce back” (p. 53). They also wanted to determine how early in development resiliency activities could effectively be introduced.
The ECEs reported learning not only to ask children about their feelings, but moreover their “thinking” (p. 54). They also added that reflecting on their own thinking style/habits and other resiliency strategies was extremely important when communicating with children and caregivers in the program. Children were observed using the resiliency strategies with their peers, most effectively by children over 4 years, as well as controlling impulses and emotions. Parents attended resiliency information sessions and completed surveys 6 weeks later to review the effectiveness of the training and to gage interest in further training/resources.

Positive results of the pilot tests and parent feedback led to Stage Two in the research and funding for the actual development of the *RIRO Resiliency Guidebook* (Pearson & Kordich Hall, 2006), trainings for more than 350 ECEs and other child-serving professionals, and online materials. Stage Two assessments and interviews found effective results; 100% of professionals stated they would recommend the training (p. 58). This guidebook and related resources supported the claim that teacher and parent modeling of resilient thinking can enhance a child’s ability to develop regulatory controls, especially as a prevention tool to combat automated or less healthy learned responses.

Crossover effects of parent and caregiver modeling of resiliency and mindfulness of thought were noted by Singh et al. (2010) in a small-scale mindfulness study. Trainings were provided to three caregivers who took care of severely disabled individuals. Assessment measures were taken at 8 weeks of training and again 16 weeks after training and then assessed to determine if the effects of these trainings at work generalized to interactions at home. Training session topics included pre-training, knowing your mind, appreciating oneness of everything, being in the present moment, beginner’s mind, being the activity, and review/wrap-up. Each
participant also had reading assignments from a selected mindfulness book. Results were affirmative, showing that the effects of mindfulness trainings positively influenced those in their care as well as simultaneously reducing non-compliance in their home situations. Interestingly, mindfulness-based practices work to change the way one thinks about or perceives one’s thoughts. Study participants reported that they more easily stopped their automatic responses and used practices they learned in their training. Children, spouses, and family members also reported noticing these changes. The researchers’ hypothesis was correct in asserting that mindfulness training would have cross-over effects on other areas of the participants’ lives.

To further support Linehan and Wilks (2015) Dialectical Behavioral Therapy (DBT), a cognitive behavioral therapy with key mindful-based practices, has been used as a standalone training in various non-clinical settings for dealing with issues such as ADHD as well as to support resiliency in school, home, and work settings. This approach was used without the therapy component, which was previously used for people with more specific mental health diagnoses. This skills training component offers specific “change skills” in the areas of interpersonal effectiveness and emotional regulation as well as “acceptance skills” based on mindfulness and distress tolerance teachings (Linehan & Wilks, 2015, p. 103). The initial component aimed to help one tolerate stress versus falling into one’s past impulsive ways of reacting and then replace old habits with new ways of thinking and responding. During program inception, Linehan worked to balance research and theory, stating that the model was based on a biosocial theory of BPD, which is a disorder of the emotional regulation system (Linehan & Wilks, 2015). More currently, DBT’s skills component is a worthwhile consideration for other
professionals working with adults, children, and families as a way to support development of emotional regulation skills, or ways to combat dysregulation.

**External State Trainings/Practices—Behavioral Parent Training (BPT), or Cognitive Behavioral Parent Treatment (CBPT)**

In regards to parent and child externalizing behaviors, identifying preemptive behavior change components is essential in reducing automatic responses. The following section is a compilation of studies that offer various treatment specifics and highlight positive effects.

Caregivers enrolled in the Parenting our Children to Excellence (PACE), a preventive parenting program study (Jobe-Shields et al., 2015) aimed at reducing parent-child automaticity, showed positive findings. These findings demonstrated that problematic back and forth automatic responses can be combated in a parent training group format. Researchers purported that the preschool years are possibly a time when children’s behavioral control and coping skills are less evidenced, aligning with parent-child automaticity of behaviors, and are thus a time parents may look for support in the form of parent training.

The purpose of the study was threefold: to better understand characteristics of how a child’s coping and behavior at home and school were linked to automaticity between parents and children; to determine if a parent-child high level of automaticity were associated with high rates of attendance in PACE program; and lastly to see if the rate of automaticity changed in relation to attendance in the program. Eight weeks of sessions covered bringing out the best in children, setting clear limits, helping children behave well at home and beyond, importance of sleep, encouraging children’s early thinking skills, developing children’s self-esteem, helping children do well in school, anticipating challenges, and seeking support.
Initial baseline reports of child coping skills from parents and teachers showed higher parent-child automaticity is associated with lower social competence (more aggressive behaviors); for anxiety/withdrawal in children, parent stress was a significant predictor. Counter to hypotheses and important to note for the purpose of this study, those who reported higher levels of parent-child automaticity actually attended more sessions, leading to a greater decrease of behaviors at the end of the training for those families. Findings supported the importance of parent-training intervention for parent-child automatic behaviors, which as reported carry over to school settings that in turn affect a child’s social competence. Also, it is suggested that in combating these automated response patterns early, relationships between parents and children may be influenced positively in other interactions.

Three suggestions to improve this program were to test for automaticity at the time of sign-up to verify whether families have elevated automatic patterns and will thus be more apt to attend all eight sessions; including children in training measures to observe for added benefit; and adding elements of mindfulness and observational validation methods.

A comparative review of seven studies by Mah and Johnston (2008) analyzed whether improving parent behaviors through Behavioral Parent Treatment (BPT) or Cognitive Behavioral Parent Treatment (CBPT) would yield a reduction in children’s behavior problems. The techniques were found to be effective but not necessarily long-term or generalizable for all families. Difficult to modify “parent characteristics” (i.e., psychopathology, life stress) and “demographic characteristics” (i.e., single parents, low income, or maternal age) are not the only factors that were found to hinder treatment effectiveness (p. 225). After reviewing the study outcomes, the researchers suggested that parents’ initial perceptions play into their acceptance
and engagement in the treatment plans. With the use of Hoza et al.’s (2006) heuristic model (p. 225), the authors search for ideas to make BPT more effective by finding the ‘right fit’ as perceived by the parent participant. Parents that viewed treatments as “credible,” meaningful, and beneficial to them, as well as feel the rigor of the program matches their abilities and preferred ease of use, will be more engaged, which leads to better end results (p. 225). As a way to enhance this beginning ‘buy-in,’ it is suggested to use up-front strategies to provide process specifics and identify expected treatment results. This study also highlighted the importance of structuring treatments with parents’ immediate needs and abilities in mind, suggesting that connecting them to training concepts prior to the start of the “training” will set the stage and ultimately increase the chances for successful implementation. These trainings have been found viable in effectively improving parenting behaviors, in turn off-setting children’s externalizing problems and additionally creating positive effects in other areas of family functioning (Mah & Johnston, 2008).

Further, Shanley and Niece (2010) found Parent-Child Interaction Therapy (PCIT), a BPT technique with immediate parent-child feedback, to be an effective way to enhance parenting skills quickly. A convenience sample from a Midwestern community consisted of 60 mothers with children ages 2 to 7 years old. These mothers were placed into either coached or non-coached groups to observe for an increase in positive parenting practices. As participants played with their children, coached groups (CG) received modeling, reinforcement, and correction in real time from trained therapists who watched from behind the scenes, offering verbal supports via an ear-piece.
The researchers hoped to increase “low frequency parenting skills” (labeled and unlabeled praise for child prosocial behaviors, reflection on appropriate verbalizations, or behavior description of acceptable behaviors). These parenting skills were assessed by coding interactions in an initial 15-minute observation of the parent and child (p. 284). This research activity was followed by a 25-minute play interaction where researchers coded parents to increase their use of the lowest frequency skills. Other parents’ skills were reinforced by providing phrases verbatim for the parent to say to the child, while praising the parents’ efforts. The amount of coaching increased or decreased depending on the observed use of targeted skills. During the second session, mothers received 15 minutes of coaching during parent-child play sessions, followed by a 25-minute observation. With some limitations, researchers found this training method to be more effective in increasing parenting skills than in-office role playing and “delayed feedback” through video review. More research is needed in a long-term clinical setting to realize the true impact.

Fettig et al. (2015), examined Functional Assessment (FA)-based parent intervention from the Positive Behavior Support (PBS) highlighted individuality of design based on the specific needs of the parents. The research study proposed to answer these questions: 1) To what extent does coaching affect parents’ implementation of the FA strategies, and 2) to what extent does level of parent implementation of function-based strategies reduce children’s challenging behaviors? Guided coaching was used for parent-identified key stress-inducing behaviors that their children displayed. One of the purposes of this study was to add to the parent-coaching intervention literature that increased implementation and overall intervention validity.
Before coaching began, child behavior was assessed with a written Child Behavior Checklist (CBCL). Then, a “functional assessment” was implemented that began with 3 in-home observations to gather baseline data during identified problem times. Next, the researchers worked with the parent to determine the “function” of their child’s challenging behavior and to create an intervention plan. Lastly, they used FA-based strategies to train the parent to improve parent-child interactions using replacement behavior strategies. The “trainings stage” consisted of a discussion of social-emotional development and challenging behaviors, review of child’s data/observations, possible strategies for different behavior functions, prevention strategies, current skills, and new responses to challenging behaviors. Next, the “intervention stage” consisted of observations until both parent and child behaviors were thought to be stable. The in-home “coaching phase” followed during the identified problem time and assisted parents to process the observations, give positive feedback, and model next step strategies. If all strategies were followed for 2 consecutive sessions and behaviors were consistent, the “withdrawal phase” began, when parents were left for 2 weeks to continue with the behavior plan independently.

To establish reliability; videotaped observations, trainings, and coaching sessions were coded for improvements in child behavior, which was the dependent variable. To determine fidelity of implementation, checklists were created to verify that the training steps and coaching procedures were completed for each participant. Each parent was also observed to complete the video recordings. Lastly, parents filled out an end-of-study questionnaire, offering opinions about the training methods and the perceived training effectiveness.

Results at the end of the coaching period showed parents were able to implement the strategies at a level of 100%. In reviewing for behavior change in the children, it was noted that
the largest change was between the training and coaching stages, which showed that when parents were consistent in implementing the strategies, challenging behaviors decreased. The coaching supports seemed to be a key point in supporting parents’ strategies implementation. Suggestions to make this type of training more feasible long-term included offering parents self-monitored checklists or online coaching supports.

Findings from the literature support using a multi-stage approach for the purpose of this study. Stage One of the intervention facilitated in a collaborative parent-educator/peer coaching group setting during its “performing” phase (Curran, 1989) would include pre-training (Mah & Johnston, 2008) in child and adult development, behavior coaching (Fettig et al., 2015), mindfulness techniques, and guided practice identifying and reducing internal physical responses to stress, specifically in the areas of thoughts and emotion as highlighted in previous sections. During Stage Two, individually selected practices, based on the caregivers’ personal needs, would take place at home coinciding with further collaborative coaching.

Conclusion

This literature review pulls together some of the key ideas that were highlighted in the overview to this chapter. The aim was to gather information to identify the best way to support caregiver-child interactions, ultimately finding effective strategies to reduce the automatic responses between family members. Studies indicate integrated mindfulness and behavioral training approaches (Dumas, 2005, Farrant et al., 2011; Pearson & Kordich Hall, 2006; Singh et al., 2010) similar to the caregiver-child interventions I have staged may be more effective than if each component were done individually. Group feedback along with participant-specific supports from a skilled facilitator have shown to be important factors when designing trainings
and thus are additional components implemented in this study (Curran, 1989; Jobe-Shields et al., 2015; Walker et al., 2012). The instruments used in reviewed studies were similar to those that I created for use in my study (Biniecki & Conceicao, 2015; Dumas, 2005; Fettig et al., 2015; Linehan & Wilks, 2015), allowing for personalized practices and accountability.

In Chapter 3, I discuss my research design, participants, setting, data collection strategies, study procedures, and data analysis based on this staged-approach aimed at reducing automatic responses between parents and children supported by facilitated structured support.
Chapter 3: Method

Opening

Current research is calling for further review of integrated mind-behavior training approaches to offset the “automated responses” between caregivers and their children (Dumas, 2005; Farrant et al., 2011; Fettig et al., 2015; Jobe-Shields et al., 2015). For instance, studies of Behavioral Parent Training (BPT) programs (Fettig et al., 2015; Mah & Johnston, 2008), as well as findings from mindfulness (Dumas, 2005, Singh et al., 2010) and resiliency of thinking trainings (Farrant et al., 2011), have shown evidence in varying degrees of automated behavior mitigation. Some of the training programs focus on parent skills or children’s skills singley, with minimal or moderate success at combating automatic responses and improving children’s behaviors (Mah & Johnston, 2008). As an initial component of an integrated approach, the purpose of the current study is to explore how parental responses to their children changes when parents learn and implement mindfulness techniques at home. This exploratory study will add to the growing literature in the areas of caregiver perceptions and behavior training when caregivers self-report as the primary data collection strategy.

Research Design

This exploratory intervention research study used mixed methods to describe parental automated responses to their children's behavior through parent report.

Research Question

The research question for the present study was:

*When caregivers learn mindfulness techniques in a parent education class, how does implementation of these practices help mitigate automated responses to their child/ren at home?*
Participants and Setting

This convenience sample involved caregivers (n=13) of preschoolers between the ages of 3 and 5 years who were enrolled in an Early Childhood Program that is located in a rural Central Minnesota community. The preschoolers whose families participated in the study attended the program for 2 days a week for 3-hour sessions. This program was comprised of a Head Start program and a community-based collaborative class. Caregiver attendance was required at the second class session every week for the full school year from September to May, with one and half hours of the 3-hour session devoted to a caregiver discussion time. Field discussions were held in a separate “parent discussion room” at the beginning of the class session prior to caregivers spending interaction time with their children in the classroom.

Data Collection Strategies and Instruments

I used multiple sources of data collection to complete this exploratory intervention research study. These sources of data provided both quantitative and qualitative data through demographic surveys that included open and closed items, participant self-reporting in their home setting, my field notes taken during participant self-reported progress discussions in the parent discussion group, participant attendance recording, pre- and post-study questionnaires that contained open-ended items, and audio recorded semi-structured group discussion.

To collect these quantitative and qualitative data, I used the follow researcher-developed, data collection instruments:
Instruments for data collection:

- Demographic Survey—a form requesting participant information including; age, sex, race, income level, employment information, education level, number/age of children, and marital status;
- Focus Discussion Field Note Form—a form used by the parent educator to record participant comments during weekly discussion check-ins;
- Caregiver Mindfulness Practices- Pre-Study/Post-Study Questionnaire—a 7-question pre-assessment & post-assessment of caregiver mindfulness measured with a 5-point Likert scale (Note: The Post-Study Questionnaire was also used as a take-home version.);
- Semi-structured Interview Session Script—Parent Educator created/facilitated questions and probes used during the recorded final group interview;
- Semi-Structured Take-Home Interview Questions & Take-Home Post-Study Questionnaire—Parent Educator created questions and probes used during the recorded final group interview placed on a fill-in form & a copy of the Post-Study Questionnaire for those not able to attend the final interview in person;
- Participant Attendance for Instruction and Journal Participation Form—a form to record weekly attendance and Mindfulness Journal participation;
- Participant Demographic Survey Findings Sheet—a form used as an overview of demographic findings that were recorded;
● Pre- and Post-Caregiver Mindfulness Questionnaire Findings Sheet—a form used as an overview of pre-survey and post-survey findings that were recorded

(See Appendix B for copies of these data collection instruments.)

In addition to the data collection instruments for this research study, I used a variety of participant materials to enhance participants’ understanding of their study participation expectations. These study materials included:

**Intervention materials:**

● Mindfulness Concept Mapping Form—form where participants identify their thought cycles (“old way” and replacement “new way” thinking process);

● Folders with reference materials to support mindfulness practices (See Reference List for full listing.);

● Mindfulness Daily Journal and Action Plan Script Forms—6 forms completed weekly & reviewed daily during treatment phase by participants; identifying emotions, physical reactions, thoughts/replacement thoughts, and selected replacement mindfulness actions. (See Appendix C for copies of these study materials.)

**Research Study Procedures**

Pre-study instruction, study data collection, and post-study interview sessions ran ten weeks in duration from mid-winter into spring session, 2017. Timing of the study was structured late in the school year based on Cambell and Palm’s (2004) “Conceptual Framework, Part 1 Models for Understanding Group Dynamics,” which theorizes that the “life cycle” of a parent group would be at the highest level of development, Stage 4 “performing,” when the facilitation
of discussion would support deeper emotional collaboration and self-disclosure and group members become comfortable sharing and problem-solving to reach goals with group member support (p. 4).

Weekly attendance and overall participation in study components were recorded in the Caregiver Participant Attendance for Instruction Sheet and used for data analysis. Please note that all participants in the discussion group received information about, and were trained in, mindfulness techniques, even if individuals chose not to participate in the study. They also participated in all study field discussions and the final semi-formal group interview, if in attendance. Confidentiality was maintained by assigning a number and/or letter for each participant family linking them to their preschooler.

This research study was divided into 10 weeks of data collection procedures. Table 1 presents the instructional methods used in each week of data collection. (See References List for a listing of instructional resources.) A more detailed narrative description of the instructional instruments follows this table to provide a better understanding of the research study procedures.
Table 1

**Instructional Methods**

| Week 1- Pre-study | -Discussion of thought- feelings- trigger cycles  
| | -Physical effects (fight or flight) responses to thoughts and feelings  
| | -Watch video- “Emotion & the brain” |
| Week 2-Pre-study | -Reviewed thought- feelings- trigger cycles  
| | -Discuss Adverse Childhood Experiences (ACES) research and how it affects “triggered” responses  
| | -Discussion & activity calming techniques through the senses (Examples shared)  
| | -The basis for the study discussed  
| | -People signed paperwork to participate in the study (Consent Form, Demographic Form, Pre-study Questionnaire).  
| | -Reminder: Study to start the next class. |
| Week 3-Last Pre-study Instruction (Journaling began) | -Study review & journal questions (Record field notes)  
| | -Reviewed calming techniques (for adults & children)  
| | -Mindfulness video clip & activity  
| | -Review mindfulness techniques and practice as a group  
| | -Mindfulness study reference folders handed out  
| | -Hand out journaling sheets & completed a practice entry as a group for Day #1 of journaling & script |
| Week 4 | -Introductions (new attendees)  
| | -Study review & journal questions (Record field notes)  
| | -A-B-C Thought video & review discussion of thinking traps |
| Week 5 | -Study review & journal questions (Record field notes)  
| | -Activity: Paper throw away or put in your pocket. (Control thoughts review)  
| | -Attention “Gorilla” video  
| | -Emotional regulation TSG objective review (child development progression)  
| | -Shared Apps- “Stop-Breathe-Think” & “Breathe, Think, Do with Sesame Street” for mindfulness practice |
| Week 6 | -Study review & journal questions (Record field notes)  
| | -Review & continue discussion on emotional regulation  
| | -Validation, gratitude, pause-redo practice |
| Week 7 | No school |
| Week 8 (Last week of study/journaling) | No discussion (Special Person Invitational) |
| Week 9 | -Study review & journal questions (Record final field notes)  
| | -Handout- reminding everyone about group interview next week.  
| | -Non-related discussion topic: co-parenting/divorce/sibling rivalry |
| Week 10 | -Semi-formal Group Interview/ End-of-Study Questionnaire |
At the study onset and as available for all or partial components of the study, participants were asked to sign a consent form agreeing to participate in the data collection procedures. Those choosing to participate completed a demographic survey as well as a Pre- and/or Post-Study Caregiver Mindfulness Questionnaire. They also agreed to recordings of field notes during the study session discussions and audiotaping of the final semi-formal group interview. (See Appendix B and C for study-related forms.)

This 10-week study followed both my research study implementation schedule and the previously determined school year calendar of events. Weeks one and two included pre-study instruction that provided foundational knowledge of the mind-body connection to emotional and behavioral responses including effects of adverse childhood experiences (ACEs) on automaticity of thought and emotional responses, processes of physiological mirroring of emotions in the brain and emotional reactivity in the body, and calming and mindfulness techniques. Weeks three through six included co-occurring instruction and study launch (mindfulness clarifications/support and resiliency of thought insights). Week seven was a non-school week. Week eight was a non-discussion week as previously scheduled per the school calendar for a special person invitational event, where the children spent time doing activities in classroom with their guest. Week nine included an end-of-study check-in of final field notes prior to a discussion of a non-related topic, and then during the Week ten session, the final semi-formal group interview took place.

Once the pre-study weeks were implemented, Week three of the intervention program was the first day of data collection. Everyone in attendance, which included non-study participants, received study folders that contained participant resources. These folders included
mindfulness resource information and examples of how to implement a variety of mindful regulatory practices as well as Mindfulness Journal/Action Plan Script forms. (See Reference List for study folder resources.) Those participants who were not present received the study folder and forms during the next session that they attended.

During week three, participants were offered concept maps to use as a systematic way of identifying thoughts, feelings, and behaviors that match a “negative trigger” that invoked emotional responses. The responses could be brought on by a caregiver-child interaction or situations where caregivers found that they became easily dysregulated. The “concept mapping” sheets were used as a guide to identify and “rewrite” an alternative mindful “script.” These data were entered into a Mindfulness Action Plan, the first form of data collection. Participants planned to follow these scripts when the “trigger” event occurred the next time. Then, the participants focused on a specified common trigger for each week of the study. They worked to control their thoughts, emotions, and responses, recording their practice in the Mindfulness Journal study forms. Example Mindfulness Journal entries and Mindfulness Action Plan Scripts were modeled on the first day of the study. During these modeling activities, the participants provided feedback to show the projected intervention best-results process (Dumas, 2005; Mah & Johnston, 2008). Journal entries were to be completed daily or as frequently as possible.

Research study criteria consisted of 3 to 7 days a week of participant journal entries during Weeks three through eight of the ten weeks identified as the study phase in Figure 1, Study Timeline/Participant Sign-up.

The Mindfulness Action Plan Scripts were to be created weekly and reviewed daily at a consistent time or during an intentional moment during the day. Participant-selected mindfulness
practices were also to be practiced as part of the Mindfulness Action Plan Script as a way to extend mindful practices for individual caregiver growth. Mindfulness examples were offered in the Study Folder and practiced as a group prior to study onset. I offered email or individual conversational support for all participants, whether they attended a session or not.

During the 6-week study intervention period, caregivers incrementally identified thoughts, feelings, and negative mental scripts while working to implement replacement mindfulness strategies. Participants tracked their progress of these implementations on daily Mindfulness Journals and Action Plan Script Forms. These forms were collected weekly to inform the need for further instruction/clarifications on intervention practices as well as to assess the degree of participation. Participants submitted completed journal forms any time they were in attendance.

Five caregiver field discussions took place as part of the once-a-week, one-and-a-half hour caregiver discussion time. Weekly caregiver field discussion sessions began with a brief focused “check-in” where I collected field notes in real-time on a “Focused Field Note Form.” Participation was voluntary. Following this “check in” activity, I loosely guided this time through facilitation questions based on the past week’s discussion review based on, but not limited to, study components. Participants shared intervention stories, including examples of their joys and challenges as well as growth and understanding of the child-rearing processes and integration of emotional regulation and mindfulness practices. Session time was also used to clarify “mindfulness” and other applications related to the study, including personal use. Throughout the study, participants provided insight and supportive coaching to their peers. This
study procedure discussion was a “check in,” which occurred each week of the intervention. I served both as parent education facilitator and researcher for the purposes of this research study.

In an effort to reach maximum participation, I sent home an information sheet in the children’s backpacks two days prior to the final semi-formal group interview to remind caregivers to turn in any outstanding journal sheets and encourage them to join in the end-of-study Semi-formal Group Interview during the next upcoming caregiver discussion time. The End-of Study Questionnaire was also to be completed at that time.

As a final step in Week 10, participants in attendance completed the Post-Study Questionnaire and were asked to partake in an audio-recorded Semi-Formal Group Interview, where they responded to semi-structured interview questions and follow-up probes. Participation was encouraged but voluntary, based on each participant’s relationship to the questions asked. Study participants not in attendance received a letter requesting their input via a take-home, fill-in-the-blank version of the Semi-Formal Group Interview questions and the Post-Study Questionnaire. (See Appendix D and E for a copy of the letters sent home.)

**Data Analysis**

For quantitative data analysis, I used descriptive statistics to describe the demographic data for this research study. Variables also included participants’ degree of participation as measured by their session attendance and frequency of participation during “check in” field discussions, as well as completion of Mindfulness Journal and Action Plan Scripts. The Pre- and Post-Study” Caregiver Mindfulness Questionnaire” findings were reviewed for percentage of participation and participant response ratings. The narrative data from the field notes and the
semi-formal interview audio-tape transcripts were analyzed using a content analysis to determine themes of findings.

Chapter 4 contains a review of the Results from the data collection for this research project. The purpose of these findings is to understand participants’ integration of mindfulness practices and their reported effects that combatted automated responses between caregivers and their children.
Chapter 4: Results

Chapter 4 will present the findings from this research study. The findings are organized into two main sections. The first is Quantitative Results, which includes Participant Demographic Results, Participant Attendance and Participation for Pre & Co-study Instruction and Field Notes, and Pre-Study and Post-Study Caregiver Mindfulness Questionnaire Results. The second section highlights participants’ reporting of personal findings in the Qualitative Results section, which is separated into three primary themes of findings.

Quantitative Results

Participant demographic results. There were 13 participants in this research study. In total, there were 17 members of the weekly caregiver discussion group, with children/grandchildren attending the 2-day preschool program. Four of the caregivers, all of whom were grandparents, remained a part of group field discussions as is required in the program but chose not to complete the study data collection activities. See Figure 1 for the study timeline and participant sign-up specifics.

Figure 1. Study timeline/participant sign-up.
The participants in the study (n = 13) consisted of three males (23%) and ten (77%) females. Of the participants, three were couples who attended either together or individually. Participants signed on to the study (completed the Consent Form, Demographic Form, and Pre-Study Questionnaire) at various times, based on their attendance/comfort: Week one of pre-study instruction, 39% (n = 5) of the sample signed up for the study during discussion group; Week two of pre-study instruction, 7% (n = 1) of the sample signed on; Week three study begins, 24% (n = 3) signed paperwork; Week eight final week of journaling, 15% (n = 2) officially signed on, and Week ten/group interview day, 15% (n = 2) signed paperwork to offer interview details.

The age range of participants was broken down into 15% (n = 2) under 25 years, 39% (n = 5) were between 26 to 34 years, and the largest number or 46% (n = 6) identified between 35 to 45 years. The youngest participant was 23 years old and the oldest was 44 years old. All participants identified themselves as Caucasian, and 7% (n = 1) as Caucasian-native. Annual household incomes were identified as 39% (n = 5) under $30,000, 39% (n = 5) at $30,000 to $50,000, 15% (n = 2) at $50,000 plus, and 7% (n = 1) left this survey item blank. Education experience was categorized by high school/GED with 7% (n = 1) identifying, and the remaining 93% (n = 12) of participants as having had some college experience, with 23% (n = 3) currently taking college classes either part- or full-time. Employment status was broken down into 39% (n = 5) identifying as homemaker, 54% (n = 7) had full/part-time work, and 7% (n = 1) listed at full-time student status. See Table 2 for Participant Demographic Breakdown.
Table 2

**Participant Demographic Breakdown**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Participant (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>77</td>
</tr>
<tr>
<td><strong>Age (Range 23 to 44)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>26 to 34</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>35 to 45</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>12</td>
<td>93</td>
</tr>
<tr>
<td>Caucasian/Native</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Income Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $30,000</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>$30-$50,000</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>$50,000 plus</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Left blank</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS/GED</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Some College (Current student)</td>
<td>12 (3 of 12)</td>
<td>93 (25% of 93%)</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>Part/full-time</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Student (full-time)</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>
Each participant cared for a varied number of children with a minimum of one child to a maximum of seven children. For the sample of participants in this research study, 7% (n = 1) of the sample cared for one child, 46% (n = 6) of the sample cared for two to three children, 32% (n = 4) of the sample cared for four to six children, and 15% (n = 2) of the sample cared for seven children. The ages of children in their care varied from infant to 25 years old.

Relationships between caregivers and children in their care included birth mother/father, non-birth mother/father or non-birth caretaker-role, step-parent, or foster parent. Four participants had multiple caregiving relationships, including birth/step-parent and birth/foster parent roles.

Table 3 shows the breakdown of number and ages of children and relationships by caregiver role. In total there were 47 children in the care of the 13 study participants, with 28% of the children (n = 3) accounted for twice as both caretakers (three couples with seven, four, and two children) participated in the study. Of those children whose caretakers participated in this study, the largest majority of children (n = 24) or 51%, were between the ages of birth and 5e years, followed by 32% of the children (n = 15) between the ages of 6 and 11 years, and 17% of the children (n = 8) between 12 and 17 years. The greatest number of caregivers were identified as a birth parents, who cared for 72% of the participating children (n = 34). Following, non-birth caretaking participants cared for 11% of the children (n = 5), step-parents cared for 13% of the children (n = 6), and foster parents cared for 4% of the children (n = 2).
Table 3

**Breakdown of Number/Ages of Children/Relationships by Caregiver Role**

<table>
<thead>
<tr>
<th>Child age</th>
<th>Birth Parent</th>
<th>Non-birth Caretaker-role</th>
<th>Step-Parent</th>
<th>Foster-Parent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth - 5</td>
<td>21 (62%)</td>
<td>3 (60%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>24 (51%)</td>
</tr>
<tr>
<td>6-11</td>
<td>7 (21%)</td>
<td>2 (40%)</td>
<td>4 (67%)</td>
<td>2 (100%)</td>
<td>15 (32%)</td>
</tr>
<tr>
<td>12-17</td>
<td>6 (17%)</td>
<td>0 (0%)</td>
<td>2 (33%)</td>
<td>0 (0%)</td>
<td>8 (17%)</td>
</tr>
<tr>
<td>Total</td>
<td>34 (17%)</td>
<td>5 (6%)</td>
<td>6 (33%)</td>
<td>2 (100%)</td>
<td>47 (100%)</td>
</tr>
</tbody>
</table>

**Participant attendance and participation for pre/ co-study instruction/field discussions and group interview.** Of the eight study days that included in-person participation (pre-study/co-occurring study instruction and field discussions, and the semi-formal group interview), attendance was broken down into 7% (n = 1) of participants who attended no days but whose attending partner brought home study information when in attendance, 7% (n = 1) who attended 2 days, 15% (n = 2) who attended 3 days, 15% (n = 2) who attended 4 days, 23% (n = 3) who attended 5 days, and 23% (n = 3), the group with highest attendance, who attended 6 days. See Table 4 for overall participant study attendance and individual participant breakdown (dates in attendance and number/percentage of days in attendance).
### Table 4

**Participant Overall Attendance for Pre/Co-Study Instruction/Field Discussions and Group Interview**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Wk 1 Pre-In. Date: 3/9/17</th>
<th>Wk 2 Pre-In. Date: 3/16/17</th>
<th>Wk 3 Pre-In./J1 Date: 3/23-17</th>
<th>Wk 4 J2 Date: 3/30-17</th>
<th>Wk 5 J3 Date: 4/6-17</th>
<th>Wk 6 J4 Date: 4/13-17</th>
<th>Wk 7 J5 Date: 4/20-17</th>
<th>Wk 8 J6 Date: 4/27-17</th>
<th>Wk 9 Date: 5-4-17</th>
<th>Wk 10 Date: 5-11-17</th>
<th>Days in Attendance (Total=8)</th>
<th>Days in Attendance</th>
<th>Final Field Discuss.</th>
<th>Group Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>X</td>
<td></td>
<td>Begin *Journaling</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>8a</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>8b</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9</td>
<td>*gma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>X</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10b</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

X = In attendance / *= Caregiver in attendance in place of study participant

Staged intervention features of this study requiring attendance included pre-study instruction, field discussions, and the final group interview. With the understanding of the importance of attendance to acquire mindfulness skills as well as to experience the benefits of group field discussion supports from peers and the facilitation of conversation by the parent educator, I compared the demographic breakouts to search for any significant connections that might highlight high/low attendance. In reviewing the results, high attendance seemed to correlate to a higher economic level, with two participants who identified in the $50,000 plus range attending a mean number of 6 of the 8 days possible, (n = 5) participants with income $30-
$50,000 attending a mean number of 3.8 days, and lastly, five participants with income under $30,000 attending a mean number of 3.2 days. See Table 5 for parent group attendance by participant demographics.

Table 5

*Parent Group Attendance by Participant Demographics*

<table>
<thead>
<tr>
<th>Participant Demographics</th>
<th>n</th>
<th>Mean number of days in attendance (8 possible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>2</td>
<td>4.5</td>
</tr>
<tr>
<td>26 to 34</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>35 to 45</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>5</td>
<td>3.8</td>
</tr>
<tr>
<td>Part/full time</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>FT Student</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>4.1</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>3.67</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian/Native</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Caucasian</td>
<td>12</td>
<td>3.92</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS/GED</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Some college</td>
<td>12</td>
<td>3.92</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $30,000</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>$30-50,000</td>
<td>5</td>
<td>3.8</td>
</tr>
<tr>
<td>$50,000 plus</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

It should be noted that the need for flexible support to meet the varying needs of study participants became apparent based on participant comments and the researcher’s observations. Thoughtful adjustments were made to study components with concerted efforts to maintain the integrity of study outcomes. Adaptations included offering a take-home version of the end of study questionnaire and the final interview questions in addition to the prepared take-home Mindfulness support folder already in use, which aimed to serve this support function. The goal was to get as much information as possible to study participants so they would have informed
practice interventions for home use and would be comfortable joining in discussions to share personal use of the study concepts.

**Pre-study and post-study caregiver mindfulness questionnaire results.** Of the 13 participants in the study, 38% (n = 5) completed both a Pre and Post-Study Caregiver Mindfulness Questionnaire. Of the remaining participants 31% (n = 4) completed a pre-study questionnaire only, and 31% (n = 4) completed a post-study questionnaire only. Of the five who completed both a pre and post-study questionnaire, 15% of the members (n = 2) completed a take-home version, as they were not able to be in attendance on Week 10 when the questionnaire was administered with the group. Others not in attendance were also offered this option but did not return the form. Findings were included in analysis only if participants completed both the pre and post-questionnaires. See Table 6 for a breakout of participant completion of Pre-Study & Post-Study Mindfulness Questionnaire.

Table 6

*Participant Completion of Pre-Study and Post-Study Mindfulness Questionnaire*

<table>
<thead>
<tr>
<th>Completion of Pre/Post-study Mindfulness Questionnaire</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-study Only</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Post-study Only</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Both pre/post study In-Person</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Take Home</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Combined Total</td>
<td>5</td>
<td>38</td>
</tr>
</tbody>
</table>
Caregiver responses were measured on a one-to-five rating on a Likert-type scale with 1–never, 2–rarely, 3–sometimes, 4–often, and 5–almost always. Results for (n = 5) participants who completed both pre- and post-surveys are broken down by question as follows:

**#1 I am aware of my thoughts about my child’s behaviors before I react.** Three participants had a pre-rating of 3 (sometimes), with one with a post-rating remaining at 3; two increased post-study to 4 (often). Two participants had a pre-rating at 4 (often) and increased post-study to 5 (almost always).

**#2 I label feelings when I notice my emotions.** One participant had a pre-rating of 1 (never), with a post-rating increasing to 4 (often); one participant had a pre-rating of 2 (rarely) with a post-rating increasing to 4 (often). Two participants had a pre-rating of 4 (often) and remained at 4 post-study. One participant had a pre-rating of 5 (almost always) pre-study and remained at 5 post-study.

**#3 I validate (acknowledge) my child’s feelings when s/he is upset.** One participant had a pre-rating of 3 (sometimes), with a post-study rating increasing to 5 (almost always). Two participants had a pre-rating of 4 (often) with one post-study remaining the same and one increasing to 5 (almost always). Two participants had a pre-rating of 5 (almost always), one remained at a 5 post-rating, and interestingly one reduced their post-rating to a 4 (often).

**#4 I label my child’s feelings when s/he is upset.** One participant had a pre-rating of 3 (sometimes) with a post-study rating of 5 (almost always). Two participants had a pre-rating of 4 (often), one with a post-study rating remaining the same and the other’s increasing to a 5 (almost always). Two participants had a pre-rating of 5 and remained at a 5 post-study.
#5 I can identify ‘trigger’ events that lead to heightened stress responses in my body.

One participant had a pre-rating of 3 (sometimes) with a post-study rating of 4 (often). The remaining four participants rated their pre-study abilities to identify “trigger” events at a 4 (often), with three of them remaining at a 4 and one increasing their post-study rating to a 5 (almost always).

#6 I have effective ways of calming myself when I become upset.

Three participants had a pre-rating of 3 (sometimes) with one having a post-study rating remaining at 3, one increasing to a 4 (often), and one increasing to a post-rating of 5 (almost always). One participant had a pre and post-study rating of 4, and one of 5.

#7 I am able to slow down my reactions to prevent parenting my children harshly.

Three participants had a pre-rating of 3 (sometimes) with one having a post-study rating remaining at 3 and two increasing to a post-rating of 5 (almost always). One participant had a pre- and post-study rating of 4, and one of 5.

Figure 2 shows the mean score for the caregiver’s perceived changes for each item before and after study completion for the five participants who completed both pre- and post-study questionnaires. Each comparison showed a perceivable improvement in use of mindfulness-related components with the largest improvement being “label own emotions” (one full degree of agreement), next being “slow response to prevent harsh discipline,” “awareness of thought,” and “label child’s feelings” (all with .8 change). Taken all together, these findings suggested that assisting caregivers in using mindfulness techniques supported caregiver awareness and behavior changes that reduced automatic responses between caretakers and the children in their care.
Figure 2. Caregiver changes with use of mindfulness practices.

**Mindfulness journal and action plan script findings.** Mindfulness Journal and Action Plan Script practices, another staged feature of this study, required an individual-led at-home intervention. Of the 13 participants, 15% (n = 2) completed all six journals (18 and 21 total daily entries), 7% (n = 1) turned in five journals (26 total daily entries), 7% (n = 1) completed two journals (14 total daily entries) and was not in attendance for the remainder of the year, and 38% (n = 5) did only one week of journaling (1, 2, 4, 4, and 5 total daily entries), and lastly, the remaining 31% (n = 4) did not complete any journals. Furthermore, of the (n = 13) participants completing journals, only 31% (n = 4) completed action plan scripts in varying quantities. One script per week was part of the 6-week journal design; 23% (n = 3) completed two scripts with
only 15% (n = 2) completing one script. See Table 7 for Mindfulness Journal/ Mindfulness Action Plan Script participation breakdown.

**Table 7**

*Mindfulness Journal/Mindfulness Action Plan Script Participation*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Total # Journals (6 possible)</th>
<th>Total # Journal Entries (6 X 7=42 possible)</th>
<th>Total # Action Plan Scripts (6 possible)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
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<td>2</td>
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<td>5</td>
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<tr>
<td>8a</td>
<td>1</td>
<td>16.5</td>
<td>2</td>
</tr>
<tr>
<td>8b</td>
<td>1</td>
<td>16.5</td>
<td>4</td>
</tr>
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<td>0</td>
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<td>10a</td>
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<td>16.5</td>
<td>4</td>
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<td>1</td>
<td>16.5</td>
<td>5</td>
</tr>
<tr>
<td>11a</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11b</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Participants used the practice journals to keep personal practice notes identifying trigger events, thought identifications, feeling identification, physical responses, calming/mindfulness technique used and perceived effectiveness, and amount of mindfulness practice they completed daily/weekly. Scripts were pre-planned and practiced to offset perspective trigger events. Thematic findings from journal notes and script practices were the basis for participants’ comments shared in field discussions. The journals were an instrument some used very
consistently, while others were not as comfortable with the paperwork aspect of the study. These participants preferred to process and share their findings in the group setting. See Table 8 for parent group journals and script participation by participant demographics and the following Qualitative Section for further participant details on themes of findings.

Table 8

*Participant Journals/Script Participation by Participant Demographics*

<table>
<thead>
<tr>
<th>Participant Demographics</th>
<th>n</th>
<th>Mean Number of Journals (6 possible)</th>
<th>Mean Number of Entries (42 possible)</th>
<th>Mean Number of Scripts (6 possible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>2</td>
<td>1</td>
<td>4.5</td>
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</tr>
<tr>
<td>26 to 34</td>
<td>5</td>
<td>2.4</td>
<td>9.2</td>
<td>0.8</td>
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<tr>
<td>35 to 45</td>
<td>6</td>
<td>1.67</td>
<td>6.67</td>
<td>.33</td>
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<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>5</td>
<td>2.2</td>
<td>9.4</td>
<td>.6</td>
</tr>
<tr>
<td>Part/full time</td>
<td>7</td>
<td>1.85</td>
<td>6.85</td>
<td>.43</td>
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<tr>
<td>FT Student</td>
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<td>0</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Female</td>
<td>10</td>
<td>2.2</td>
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<tr>
<td>Caucasian/Native</td>
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<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Caucasian</td>
<td>12</td>
<td>1.92</td>
<td>7.83</td>
<td>.5</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS/GED</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Some college</td>
<td>12</td>
<td>1.92</td>
<td>7.58</td>
<td>0.5</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $30,000</td>
<td>5</td>
<td>0.6</td>
<td>1.4</td>
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<td>1.4</td>
<td>7</td>
<td>0.4</td>
</tr>
<tr>
<td>$50,000 plus</td>
<td>2</td>
<td>6</td>
<td>19.5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Integrated at-home practices of mindfulness components through journaling and developed scripts aimed to increase benefits of this study’s intervention. Thus, it is important to determine what extenuating factors to consider when reviewing aspects of this intervention’s effectiveness. In comparing the demographic breakouts for rates of participation in the journaling and script processes, the strongest indicator for increased participation was again income level with two participants identifying in the $50,000 plus range. These participants completed six of
six possible journals with 19.5 entries and 1.5 scripts. Yet, there was a wide variation between
the next group of five participants, who identified an income of $30,000 to $50,000. This
subgroup of participants completed 1.4 journals with 7 entries and .04 scripts. Lastly, five
participants with an income under $30,000 completed 0.06 journals with 1.4 entries and 0 scripts.
With the small sample size, these findings would need to be reviewed further to verify reliability
of findings. It may also be important to alter the journaling/script process to increase participant
participation.

**Semi-formal group interview participation.** During session ten, 53.8% of participants
(n = 7) were in attendance for the last steps of the study, the semi-formal group interview. Of the
46% (n = 6) not in attendance, 33% (n = 2) completed and returned the Semi-Formal Group
Interview Questions. These data were included in the final findings along with data from the
other participants for a total participation of 69.2% (n = 9). See Table 9 for the attendance
breakdown for the semi-formal group interview.

Table 9

*Attendance for Semi-Formal Group Interview*

<table>
<thead>
<tr>
<th>Attendance for Semi-Formal Group Interview</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not in attendance/ non-take home interview</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Semi-formal group interview</td>
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<td></td>
</tr>
<tr>
<td>In-Person</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Take Home</td>
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<td>15</td>
</tr>
<tr>
<td>Combined Total</td>
<td>9</td>
<td>69</td>
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Qualitative Results

In this section of Chapter 4, I will address the qualitative results from the participants’ reported findings that were shared in the parent discussion group setting. The following portion of the chapter recounts caretaker perceptions and study concept implementations through individual inferences, as well as the influences that sharing mindfulness practices at home had on family members and peer study participants.

In reviewing study participants’ responses in field discussion notes and dictated data from the semi-formal group interview recordings (including handwritten responses returned from the take home Semi-Formal Group Questions), a Mindfulness Awareness & Practices Continuum has been created as a representation of the general mindfulness integration process from “More Triggered Events” to “Less Triggered Events” shared by participants. Caregivers interacted with continuum components individually with much fluidity. Some appeared to follow the process in full progression, others only partially, some in order, and others interacted with concepts as they related to their own lives with less structure. (See Figure 3, Mindfulness Awareness & Practices Continuum.) The continuum identifies three color-coded Primary Themes; each is broken down further into two subcategories.
Primary Theme #1: Participants became aware of adult and child development through their Parent Education Study Group discussions. Primary Theme #1 emerged to demonstrate participants’ awareness of adult and child development and the varying “conditions” and effects they have on perceptions, mood, and interactions. This Primary Theme #1 is broken
into 2 Subcategories that: 1) Highlight key first-step understandings caregivers identified as they began integration and implementation of study concepts; and 2) identify triggering events and related thoughts, feelings, and physical responses, then creating new mental scripts as well as selection of mindful calming techniques to offset these triggered reactions.

- **Personal state–caregiver & child development.** The Caregiver & Child Development Subcategory was defined simply by a participant, “They change and we change. It’s hard to know when you’re doing a great job. As soon as you get to perfection, they change into something else. It can be annoying.” Caregivers shared their observations regarding “typical” child development as well as their own development and how this growth process required thoughtful understanding as well as created parallel challenges to emotional regulation.

Many participants expressed their concerns with wanting to do things “right” to ensure their children were developing “normally.” Self-doubt was mentioned by both male and female participants, as well as mindfulness methods they employed to remind themselves they were on the right track. A mom shared how she uses a mindful daily affirmation reassuring herself, “You’re enough for your kids.” With a second mother adding her mantra is, “They are going to be normal. They are normal. And every day is a good day.” Lastly, a participant who recently moved into a father-like position and aimed to gain caregiving confidence, seeing the benefits of ‘mindful parenting’ offered, “Three years ago I had no dad experience at all. I have really been working on applying it (study components). I want to be the best I can.”

Common childhood developmental challenges specified by caretakers included children’s lack of listening, sibling rivalry, emotional reactions to limits and changes in routine, and various changes in mood, especially emotional dysregulation episodes. One mother pointed out how her
view of her child’s emotional development had evolved, “I have a better understanding from the study that kids are human, and they can be allowed to be crabby sometimes, too.” Another mom offered an additional comment indicating growth in “child development” awareness when she detailed how her son was generally socially proficient when playing with a single friend at playdates. However, there was a particular instance when multiple friends were over to visit and he became emotionally overwhelmed. She determined he did not have the skills to balance all of their needs or to regulate his emotions with the stress of trying to keep all of his friends entertained and happy. She was able to spot that his distress was due to an age-appropriate challenge while developing social skills and then used study components (mindfulness and calming strategies) to identify ways to help him and the other children, as well as herself, work through the “big” emotional responses.

Participants shared a general understanding that in order for children to develop emotional and social proficiencies, lots of practice, awareness, support, and consistency from parents is required. Even with this awareness many offered stories of how their children innately test limits during their development. One mom exemplified her understanding of this progression of development with recent behaviors of her son, “Dude, you weren’t doing this last week. We finally fixed ‘that’ and re-assert the lines again, and now you start to push other lines.” Participant awareness of age-appropriate “lagging skills” and co-occurring development was important foundational knowledge for the study.

- **Personal state–caregiver & child condition.** The Caregiver & Child Condition Subcategory reflects the various aspects of personal states family members may be in at any given time and the resulting interplay of emotions. Comments and observations regarding
reactions based on caregiver and child conditions highlighted the complex dynamic between family members and the co-occurring effects they had on each other’s ability to regulate. The challenge to identify and modify one’s “condition” was detailed by one mother who suffers from depression, “I’m working to keep things small, but it’s hard for me.” Participants report that what is a problem one day may not be the next day, depending on caregiver or child mood, sleep, schedules, food intake, and so on. Awareness of the shared condition and the interplay of responses between family members is the basis for integration of study practices.

Children also reportedly came to understand how an adult’s “condition” can affect their actions and behaviors. For example, one mom stated that her children began asking her if she was hungry as a trained response when she was having a “crabby” time. She joked that they became aware of her “hangry” condition, as she had discussed and modeled taking a snack break to combat negative moods based on this factor.

During field discussions, participants acknowledged that young children frequently do not have an awareness of their own condition. Caregivers reported that they learned to assess the best way to aid children in finding situation-specific solutions that resonated with each child’s individual needs in the moment. A caregiver offered an example regarding her child having big emotional responses to everyday things after attending preschool (2 days a week). Using study mindfulness practices to self-calm as these events occurred, she was able to make deliberate observations of her child’s behaviors and came to identify the cause as over-stimulation from all of the activities and interactions with friends, teachers, and other adults in the class. Noticing the pattern of his condition and reoccurring triggering responses, she adjusted the after-school routine, offering a half-hour relaxation time and a snack for the child and herself. She asserted
this change was key in preventing otherwise impending “condition-related” conflicts, affording the pattern was interrupted due to her ability to detach through calming.

Modeling and sharing of insights/practices during field discussions influenced other participants’ behaviors as well. As a result of hearing the after-school relaxation suggestion, another mom decided to offer some down time after preschool for her child to play for a few minutes prior to running to pick up his sibling from school, as he too had been reacting in a similar way. She concurred that offering this down time allowed her son to regroup as well, reducing the amount of crying and whining (dysregulation) and that in turn she no longer struggles to stay regulated herself at those times.

**Primary Theme #2: Participants understood their triggers to learn how to implement and model mindfulness practices.** Primary Theme #2 emerged with Subcategory Themes that include Triggers—Understood and Triggers—Personal Awareness, which identified participants’ shifts in understanding the progression of awareness of thoughts and emotional states that led to “trigger events,” on to regulation practices, and finally to integrated deliberate approaches. Themes extend into caregivers’ ability to transfer these insights to their child/ren’s triggered states as well as their growing capacity to implement mindful practices and modeling concepts to ease or prevent trigger episodes with their children.

- **Triggers understood.** The Triggers Understood Subcategory relays caregivers’ growing awareness of their own “triggers” brought on by their condition, thoughts, interactions with, and behaviors of their children, or other situations. The progression from understanding caregiver and child development and conditions, to what a “trigger event” was and why it happened, to identifying their own and those of their children was evidenced in experiences
shared. Caregiver-identified “triggers” involving their children during the study phase included being interrupted, children not listening, children taking a long time to do things, mealtime battles, whining, not following limits (bedtime, etc.), challenging behaviors after school, dysregulated behaviors, sibling violence, and teen behaviors.

As participants gained awareness of the interplay between thoughts and emotions, they gained capacity in separating the patterns of emotional responses between themselves and their children. Caregivers shared that not only were their “triggered” effects created by their child’s state, but their own effects to their children’s emotional states were real and could cause negative reactions as well. One mom notes, “When I become anxious, the kids become reactive and upset.” It was also reported that co-caregivers would become drawn into the emotional upset. The challenges of implementing the mindfulness repair processes to change one’s emotional “condition” were evident in the comment, “It got easier as you went along, but it was hard for me to look at myself and think about how I was reacting and how it affected them.”

When caregivers were more in control of their emotional responses, the progress was clear, “Because I stay calmer, he doesn’t seem to feed off of my negative emotions anymore.” The in-the-moment control could have lasting effects on the whole day, reported one mom, “We learned to handle it better so we have a good day the rest of the day. Learning to pick your battles. We’re making the little things or little moments that are trigger events into happier things, so they don’t become such a big deal.”

Understanding of the body-brain response to “trigger event” stressors was helpful with interactions with their children, as well as in co-caregiving partnerships and beyond. One participant stated that the pre-study instruction on adverse childhood conditions (ACEs) and their
effects on emotional triggering positively impacted her and her partner’s growing competence in supportive co-parenting efforts. Learning that past ingrained experiences (with physical effects) can last even into adulthood was a key understanding that is reflected in this comment, “He is less triggered now when I get triggered and shut down, because he understands that it is a coping mechanism for me.” Now they work from the understanding that she needs support in those “triggered” moments because of her history, since her triggered responses are very difficult to regulate through. She practices the study steps and chooses mindful techniques to self-calm.

Participant insights into triggered events highlighted that co-caregiving many times requires tag-teaming efforts when one caregiver is having a hard time, as they will not be able to connect with the child’s needs when they need to tend to their own calming process. She went on to emphasize, “Now I’m ok with him saying, ‘I can see you need a break…’”, finding it helps her.

- **Triggers–Personal Awareness.** The *Triggers–Personal Awareness Subcategory* reflects progress participants shared relating to owning their own thoughts and emotional reactions and their growing awareness of physical reactions to triggering events. Personal accounts of techniques implemented to calm themselves in a “triggered event” or to reduce the occurrence of triggering highlight continuum components.

  “Realizing what is a trigger for me, I am starting to feel more calm,” states one parent; relaying how the understanding and identifying the “triggering” process in the body and brain was calming in itself. Another caregiver supported this statement, “I realize after I don’t use it (calming/mindfulness), that I should have. I am better then. I become more aware of what to do next time.” A participant associated additional benefits with the practice, “Now I am getting better at redirecting versus reacting.”
Physical reactions to “triggered events” shared during discussions included tension and an urge to yell or “roar,” red ears and face, feeling hot, surprise at how much of a physical response he noticed in his whole body that he never noticed before, the urge to say “no,” a feeling of needing to be like a “drill instructor,” and having to be in control like, “I’m the boss.”

As a way to offset triggered moments that became more apparent during the study phase, families shared ways they increased their “calm factor” in order to prevent reactive episodes. One mom explained how in her home they controlled their internal condition through exercise. Dad walks after work, and she waits until the family is asleep, then takes time for herself to walk. She has found this time has been immensely important for her to process events of the day and to keep a “mindful” perspective. She noted, on days neither she nor her husband were able to get their walks, it could create harder days. Also adding, “My husband is less triggered by our son’s whining after he has had his ‘calm-down’ time after work. Now he is more able to tell him how he is feeling.” Similarly, two other families shared the need of their co-caregivers (one non-study participant and one study participant), who also required a “calm-down” break after work when they get home; it can be challenging when they have been home with the kids all day, but in the end they have come to realize it is important to implement. One participant explained her understanding of her husband’s needs, “He needs to decompress after work. He doesn’t want to be overwhelmed with everything that has happened during the day, or referee right away. He needs to calm down after his day.”

A family-issued calming technique that lessens the effects of “triggering” with their children and also aids in coupleship repair was explained, “We allow for calm down time before
we address an issue.” Calm down times were described as being employed in multiple homes by parents and children.

Going beyond the home, the use of calming techniques was also an asset in work relations. One male caregiver recounts that he normally “gives the cold shoulder for a long time” when he gets upset but instead “took time to cool down and talked it through, and even apologized.” Exemplifying integral components of study outcomes, participants describe the process of slowing down or totally interrupting the cycle of triggered thoughts to prevent the ensuing emotions and physical responses by recognizing the need to self-calm as well as identifying what “self-calming” techniques worked for them. Interestingly, other non-familial triggers were also noted to be improved as a result of study components. Another father shared his long-time trigger, “Driving is an example of when I could get triggered. I am now able to think through it and calm down, especially when it’s a situation I can’t change. But I can change my state of mind.” These examples show how the use of mindfulness practices may aid participants in making changes that positively affect whole-life functioning.

Caregivers shared stories of their children’s triggered events, highlighting connection and calming methods as a way to help their children cultivate emotional awareness and ownership of their own or shared calming experiences. Frequently caregivers referred to their growing awareness of how often one’s condition played into the reactive states. Routine and pre-alerting children to any impending changes, planned-in down time, offering some control in decision making, and including snacks to prevent mood swings were used as preventative measures. The use of a timer to guide the calming process was found an effective tool with children.
Validation of their child’s feelings was also a common approach caregivers began using to reduce the amount of time children spent “triggered” and upset. One caregiver shared, “To validate her feelings, regardless if I thought they were ‘good’ or ‘bad,’ has been really helpful in not as many challenging days at my house.” A caregiver insight included, “I now use validation instead of blowing up, which once I saw the pattern, just made things worse.” Another caregiver purported, “It’s all about recognizing, validation, and getting to problem-solving.” Validation can also be used to increase the probability of children following limits, “I understand you want this, and I will talk with you when your voice sounds like mine.” Others also include hugs and physical contact with validating statements to help their children recover from emotional upset.

Validation allowed caregivers a strategy to connect with their child’s emotions by labeling them, in turn helping them to not “take on” their child’s dysregulated emotions. “I am more calm and I validate my kids’ feelings instead of getting upset with their feelings.” This labeling of emotion works with interactions with ‘all’ family members; notes one participant, “I don’t react as fast as I used to. I think before I talk. I let the kids know how I understand where they are coming from and it has even helped with my husband. I validate his feelings and we understand each other.”

One father added how he began using validation practices to calm situations at work, “I think validation is even more important than the rest of it,” referring to how quickly using this method helped those involved recover. He also shared how he works with an adult relative who frequently “triggered” him and how uncharacteristically, “I validated, apologized, and gave her a hug, which worked, and we both felt better.” Now this father hopes to reconnect with his older children, as he explained his ‘quick-to-anger’ response patterns had put a strain on the
relationships. Practice with study components offered him a renewed confidence in regulatory and triggering responses.

Caregivers also noted the degree of attachment to their children increased through validation, “My son is a very emotional child and when frustrated, he cries. Now when he cries over ‘nothing’ I say, ‘I can see you are frustrated.’ It helps immensely!” One participant reflected, “I wish my parents had this information! My mom used to yell all the time and my feelings were never validated, which felt like I couldn’t share anything with her.”

Mindfulness techniques, also described as calming techniques, became normalized as ‘what you do when you’re upset’ in many of the participants’ homes. “I think kids need timeouts. Not because they are in trouble, but time to breathe or read.” Practices used to support children’s calming were often individually tailored to each child, frequently with caregiver involvement, identifying how the child would like to self-calm. “I ask the kids what they want to do to work through their upset. ‘Do you need deep breathing? The volcano picture? To trace your hand?’” A father described how he assisted his son and benefitted as well, “I can get my son to count. So, if I tell him we need to take a break, let’s count. I can get him to stop where the situation is and count. And then we are both breathing and calming down.”

Caregivers observed that some children needed to connect through talking after school (preschool as well as older children), while others preferred to be alone to destress in their room. During triggering events, one caregiver found that she needed to be present for her school-aged son, “to assist in calming down.” With her new awareness of body-brain responses she started taking more the time to do so, even if she didn’t want to, as she found if she didn’t, the event would be more drawn out. Other children liked to be cuddled and touched to connect for
calming, while some participants emphasized touching their child when upset worked against their child’s calming preference.

An example of a child following their parent’s lead in identifying his trigger included a story about a boy who often became upset when playing with his sister. Mom had been encouraging him to notice when he was getting upset and then to stop, take a deep breath, and to talk about it. She stated, “If his sister steals a toy he will more frequently stop reacting in an upset way, instead think about how he can handle the situation. He prevents a fight every time he can control his thoughts and emotions.”

A few participants were still working on the understanding that self-regulation is a developing skill in the process of being learned, not something that can be punished out of a child. As one mom (who had minimal attendance and did not practice with journal/scripts) identified during field discussion, if her children do not calm down, she grounds them from their “special things.” Interestingly, some group members agreed while others proceeded to offer alternative suggestions. As the conversation evolved, with the encouragement and guidance of the parent educator, most caregivers either had their perceptions of the need for calming time for kids reinforced or gained an understanding for the first time of the importance of “calming” as a positive and necessary time. “I find myself calling it ‘calm down’ time now. I don’t call them ‘timeouts’ any more. I use them too. They really help.”

Theme #3: Participants integrated mindfulness practices and techniques into everyday life and their long-term mindfulness plans. Primary Theme #3 unfolded with Subcategory Themes including Mindfulness—Techniques and Practices & Mindfulness—Moving Forward, which reflected various inferences and practices caregivers employed as they gained
understanding of mindfulness and calming techniques deemed useful in their own lives. Caregivers also shared examples of how their children and others have learned and benefitted from their modeling and implementation of study practices, as well as how they plan to continue using mindfulness in the future.

- Mindfulness–Techniques & practices. Mindfulness–Techniques & Practices Subcategory spotlights the myriad of mindfulness integration strategies shared throughout the study. Some items have previously been touched on throughout the findings section as supports described in the Personal State and Triggers Primary Theme components on the Mindfulness Awareness and Practices Continuum.

Participants applied the following mindfulness techniques:

breathing practices, smile though it, label “old thought” and replace with “new thought” (study journal/script component), plan for it (by visualization in advance), visualize putting the problem in a box to review later when calm or have time to process, visualize to control thoughts (study journal component), stop and think or push ‘pause,’ try not to judge “good vs bad” as it “just is,” laugh to lighten the mood, choose not to react to the feeling, compromise, self-talk (study script component), problem-solve next steps, express emotion versus internalize, talk about needs, talk to someone, reframe thoughts, change state-of-mind, gratitudes-focus, hug or physically connect, notice physical state (study component), try to just “be in the moment,” and count to calm.

The use of “self-talk and planning” as practiced in the Mindfulness Scripts and Journal practices is described in this participant comment, “I sit down and do an overview of what the main power struggle times or issues are (getting dressed, breakfast, naptime, dad coming home).
Then I talk to myself about, ‘How am I going to handle this in advance?’ Having a mindful pre-plan. Then don’t overreact. I seem to be in a better mood.” The ‘reducing the importance’ technique was also exemplified in a comment shared by a participant, “I remind myself there’s nothing that he does that’s so wrong. It could be worse. I just don’t realize how good I have it. There’s nothing wrong.”

The importance of the mindfulness technique “staying in the moment without judgement” was also an essential insight gained, as reflected in the remark, “I just try thinking about each moment. Otherwise, it extends into the next moment and keeps going.” This awareness was supported by another’s related reflection, “I’m getting better at letting go of things. Realizing that in five minutes, or five days, from now this isn’t going to be a big deal. This is not going to affect their entire life, how they are acting right now.” Additionally, one mom reports using a “push pause” strategy to step back and look at situations more effectively at work and is now working on transferring it to home, where she is finding a successful reception from her family members.

Lastly, an increase in the mindfulness focus on “gratitude” reportedly aided caregivers in recognizing what their children were doing ‘right.’ “Then they are doing less wrong.” This comment was followed by another caregiver statement, “Yes, then the kids learn what you want.” One mom said she was using the mindfulness technique of keeping a “journal” with “three gratitudes daily” to help her do just that, stay positive and appreciate her children.

Increased gratitude for their children was mentioned numerous times during the final group interview as an outcome of learning mindfulness practices. One participant, who had relatively low attendance (two sessions and reviewed Mindfulness folder contents independently)
and completed no practice journal entries or scripts, was adamant about the benefits of mindfulness practices to her renewed parenting outlook as shared during the group interview.

“I think I am more grateful for being a stay-at-home mom than I ever have been since being a stay-at-home mom. It’s overwhelming, so when I can handle myself a little more, I am way more grateful to stay home and watch them every single day and how they change. It’s way nicer. Now I don’t want to go back to work. And when I told my kids I might go back to work, they were sad. Now it’s fun! I use a lot of the breathing practices for them as well as myself. It really works. Even my husband is trying.”

It is important to note, three of the study participants had previously used or were currently implementing mindfulness practices in a variety of forms. Only one of the participants identified as using mindfulness practices daily prior to implementation of the study. These practices included meditation, documentation of three gratitudes each day in a Gratitude Journal, and practicing mindfulness concepts. Unfortunately, this caregiver and her child stopped attending classes partway through the study with no indication as to why.

Another participant stated she believed that implementation of the mindfulness concepts seemed easier for her co-caregiver (also a study participant), as he has had previous experience and practice. He stated that he feels, “The use of mindfulness is a good thing and is helpful with children”. Lastly, a participant details how she learned about mindfulness approximately four years prior, applied it a lot back then, but fell out of habit. She admits, “When I’m applying it, it is much easier than not applying it; then I’m not thinking it through or being in the moment.”
Mindfulness—means to me. The *Mindfulness—Means to Me Subcategory* illuminates positive outcomes caregivers relayed as a result of practicing mindfulness components as well as proposed use moving forward. One parent declared, “I enjoyed the study a lot. It has helped me in every aspect of my everyday life. I try to use this with everything, not just my kids.” Another stated, “I loved this. I notice whenever I was triggered I would kind of go into autopilot with my responses. Realizing this helped me to become more mindful and helped me control my responses better.”

Other participants had honest feedback about the challenges faced at the study onset. “It was overwhelming to begin with, to sit down and go through all of these papers and see all of the things I didn’t do during my day, but mindful people do. I realized it was kind of big, but not. It doesn’t take up a huge part of my day to do it (be mindful). And now that I understand it, it is so helpful.”

One of the questions during the final semi-formal group interview offered participants an opportunity to share their final perspective of what “mindfulness” means to them. An overarching theme of personal awareness emerged, specifically individual responsibility in a particular moment and the importance of accountability for how one responds to a situation. One participant stated, “It helps you realize that you can control your triggers and how you react to them. Especially when it comes to your children.” Along this same vein, another participant added, “Mindfulness is where you are in a situation and you fully take responsibility for how you feel and look at the situation, so you have control over your reactions.”

Participants also offered examples of the joy they felt as they became comfortable practicing mindfulness concepts. “It was weird practicing it and having something work the first
time, instead of ten times later, and not having to raise my voice or get upset. Just taking it in and letting it work was the most momentous moment of my day.” Emotional control was observed by participants through the act of “letting go.” As one caregiver recounts, “Being present in the moment and not with what happened previously, or not worrying about what may happen. Reacting based off of that moment and not based on how I might have felt about what happened a little bit ago...not holding on to that.”

Participants shared much evidence of the benefits of mindfulness practices learned in a caregiver discussion group with the support of other caregivers, including increased confidence as well as shared effects to their children, other group members, co-caregivers and other non-study participants. Examples of modeling effects to others in relation to the study participant have been included throughout the “Thematic Findings” section. In addition to those comments, one participant said her husband was taking the strategies he was learning from her and using them at work as well. Others shared stories of how their children were now encouraging use of calming techniques with them, “Mom, can you talk in your calm voice?” And other family members, “I watched my daughter take a deep breath when her brother was interrupting her while she was talking to me. She said, ‘(Brother’s name), I know you are really excited to talk to mom right now, but I’m having my time.’” Families shared how they were many times implementing a variety of these techniques, in the moment, together.

At study completion, participants agreed overall that a primary takeaway was an awareness of the big picture of emotional regulation and the role it plays in healthy relationships, beginning with identifying/ managing thoughts and feelings and their association with ensuing physical reactions and finally managing responses. Mindfulness concepts offered alternatives to
the previous emotional over-reacting. In summary, one participant stated, “I just remember it’s going to happen and instead I try not to worry about it, and just realize it. Things are just going to happen.” This is a major understanding of mindfulness awareness; being in the moment without judgement.

**Conclusion**

In this exploratory intervention research study, using mixed methods, I found the following quantitative results. Caregivers identified a notable perceived improvement in the use of mindfulness related components at study’s end. Study features included in-home daily Mindfulness Journaling and Action Plan Script practices, which reflected relatively low participation by the majority of participants. By contrast, in-person attendance for group field discussions and the final interview were more promising with 61% of the participants (n = 8) attending half or more of the sessions. In comparing demographic data, higher income levels were a notable characteristic that seemed to influence attendance and participation.

For the qualitative portion of my findings, I have identified three Super Themes; **Personal State, Triggers, and Mindfulness** in brief, as components that made up a Mindfulness Awareness and Practices Continuum that modeled the process of integration of study concepts. These study components included identifying triggering events and related thoughts, feelings, and physical responses and creating new mental scripts, as well as the selection of mindful calming techniques to offset these triggered reactions. Combined, these findings suggested that assisting caregivers in using mindfulness techniques provided support in reducing the number of characteristics that created automatic responses between caretakers and the children in their care. In Chapter 5, I
discuss future implications for the use of mindfulness techniques in a caregiver discussion group along with some limitations of this study.
Chapter 5: Discussion

Overview

Children learn how to relate to others in social and emotional ways based on interactions with, and observations of, caregivers (Farrant et al., 2011; Gartrell, 2004; Swain et al., 2007). Assisting children with their developing skills can be rewarding as well as frustrating for those who care for them. Emotional and behavioral responses to perceived negative behaviors cause internal physiological (body and brain) responses, heightening difficulties for caregivers to attend at times when children could benefit and learn through empathizing and modeling of regulatory capacities (Gartrell, 2004; Siegel & Bryson, 2012). This way of responding between caregivers and children becomes automatic and difficult to adapt once habitualized (Jobe-Shields et al., 2015). A variety of parent behavioral trainings have been employed to combat negative behaviors and are effective to some degree (Fettig et al., 2015; Mah & Johnston, 2008; Shanley & Niece, 2010; Shanley & Niece, 2010), as well as findings from mindfulness practices (Dumas, 2005; Linehan & Wilks, 2015; Singh et al., 2010) and resiliency of thinking trainings (Farrant et al., 2011; Pearson & Kordich Hall, 2006).

Summary of Findings and Conclusions

The primary purpose of the present study was to determine if caregivers’ use of mindfulness techniques, learned in a parent education class and practiced at home, was an effective way to mitigate automated triggering responses between caregivers and their children. The participants in this study included a convenience sample of caregivers (n=13) of preschoolers between the ages of 3 and 5 years who were enrolled in a collaborative Early Childhood and Head Start Program located in a rural Central Minnesota community. Data
collection for this exploratory intervention research study used mixed methods to describe parental automated responses to their children's behavior through parent report. Both quantitative and qualitative data were collected through demographic surveys that included open and closed items, pre- and post-study questionnaires, participant attendance and participation recordings, participant self-reporting in their home setting, field notes taken of self-reported progress in the parent discussion group, and an audio recorded semi-structured group discussion.

Overall, the results of the study showed that either full or partial participation in study interventions offered perceived benefits in understanding of: 1) child and adult development and behavior, 2) the workings of emotional regulation/dysregulation, and 3) in-turn practical implementation of mindfulness techniques to aid in reducing automatic responses between caregivers and their children. Figure 3, Mindfulness Awareness & Practices Continuum, is a representation of the components and general process of mindfulness integration from “More Triggered Events” to “Less Triggered Events” shared by participants (see Chapter 4, page 58).

I will now go further into the specific implications these study interpretations and applications have for Parent Education, with an emphasis on more detailed findings from my research study.

Applications for the Field of Parent Education

Key study highlights and applications to Parent Education include:

- **Best ways to support caregiver-child interactions.** If parents can implement simplified and flexible information in their own lives, they work well from a “learn and then practice format.” Pre-study offerings of solid developmental concepts relayed ‘what’ child and adult development actually is. More specifically, content addressed how adults’ past experiences
(stressors) may affect present (thoughts and emotions) perceptions. Next, essential in participant understanding and buy-in, content also addressed ‘why’ this past experience matters, especially in social-emotional development, and ‘how’ the study components aimed to assist parents in improving connections with their children. The implication in this area for Parent Education is promising for the following reasons.

- First, male and female participants reported being more connected with their children.
- Second, participants accomplished these caregiver-child connections by being able to slow down their reactions and thus validate their feelings.
- Third, caregivers were able to step back and look at the big picture versus immediately reacting.
- Fourth, caregivers engaged in hugging or touching their children for emotional support versus sending them away, creating a support system.
- Finally, during upset times, caregivers practiced techniques such as breathing and counting together with their children, and so on, thus assisting with and modeling important regulatory skills.

Caregivers self-reported enjoying parenting much more and having more fun with their children. Apparently, the benefits of building strong attachments in dysregulated times in the short term are immediate confidence builders for caregivers and their children while their trajectory of long-term effects appears encouraging.

- **Effective strategies that reduced the automatic responses between family members.** In a parent discussion group caregivers were taught mindfulness techniques by
identifying triggering events and related thoughts, feelings, and physical responses, and then practiced creating new mental scripts as well as selected calming techniques to offset these triggered reactions. They first implemented concepts individually and, in turn, modeled these concepts for their children and co-caregivers at home and their peers in parent education group discussions. Children, in short order, exercised similar strategies, some using the techniques with or without assistance. Practical results influenced others in the home as well as in the discussion group to join in using the techniques, once they saw these practices to be both comfortable and helpful at home. Some even self-reported using these concepts beyond their homes in their work settings. These findings verify how supporting parent development can further increase children’s potential practices and subsequent outcomes. These practices may be an effective way to offset intergenerational effects of negative “automatic responses” by replacing them with alternative positive “automatic responses.” It is even possible to hope that these improved caregiver-child relationships can foster a “pay-it-forward” influence in the community at large.

- **Integrated and staged mindfulness and behavioral training approaches.**

Caregivers admitted that knowing what to do to guide their children’s behavior is different from being able to do so in the moment. By using mindfulness techniques, participants learned that current study interventions, when paired with deeper understanding of child development and body/brain responses to perceived stress, enabled them to slow down their own emotional responses. This process allowed for the validation of children’s feelings and calming in the moment for themselves and their children alike. At times, these interventions resolved potential conflicts before they could occur. Implications for families are important as the majority of
parents identified their largest caregiving concern was not being able to stay calm during unsettling parenting interactions.

- **Caregiver-child interventions provided in my Parent Education classes were more effective than if each intervention training component were considered individually.**

This study, guided by a trained parent educator in an early childhood setting, was staged as a best-case time in the group’s formation to support positive results in giving and receiving information among participants. A collaborative history in small group processing had also built trusting relationships between the facilitator and group members. Of further benefit to study outcomes was the use of a convenience sample, which included participants familiar and comfortable with one another. It brought the group to a complex level of sharing and support for one another that included their children and family situations.

Integrated interventions were introduced based on findings from my literature review. A stacked in-depth collection of operations aimed to reduce triggering effects were examined and discussed as a group prior to their implementation. Parent education discussion groups often times offer this type of layering of information and practice approach, thus it was an ideal place for this type of investigation.

- **Group feedback and participant-specific support from a skilled facilitator.** The researcher, also a parent educator, had existing relationships with participants and knew their specific situations, which made them comfortable enough to buy in to the research study. First, participants agreed to try a new way of dealing with big emotions using researched-based practices in the setting where these big emotions were typically experienced. Secondly, the preset learning atmosphere was one in which participants understood that personalized assistance
would be offered from pre-instruction learning and throughout all phases of the study. As participants practiced implementing the study interventions, suggestions and adjustments for using study components were readily implemented. Field discussions were a time that participants processed and shared information from their week while receiving research-based input. The parent educator helped bring a higher level of learning through comfortable guided conversations, while shepherding group members through the process with constant awareness of participants’ individual needs. Outside of the parent discussion group, the parent educator offered an open-ended, as needed policy for email, telephone, and personal one-on-one support.

Participants also received support in group discussions by sharing joys and other “big learning” stories that occurred during their mindfulness practices implementation. Hearing suggestions and stories from other participants encouraged some participants to incorporate a variety of techniques into their own daily lives. This occurrence verified the importance of peer modeling and one-to-one support to acquire skills. As a reliability check on the participant self-reported experiences in the peer group setting, participant journal entries and post-study questionnaires indicated similar findings. Participants reported great benefit from using mindfulness techniques and thought other caregivers would benefit as well.

**Study Findings Confirm Previous Literature**

This research study modeled a layered approach, combining suggestions and outcomes referenced in the previous the literature review as a way to combat automatic triggering responses between caretakers and their children. Findings confirmed previous peer-reviewed research that used an integrated learning/training approach for families that was based on a
child’s and family’s overall needs (Fettig et al., 2015). This type of training format was viewed as a first step in engaging participant involvement.

As in Dumas (2005), ideally, emotional, mindfulness, and behavioral education would be offered in combination as this is an area that the participants in my study expressed the greatest concern and requested help most frequently. Parents would practice specifically designed, carefully planned assistive tasks to remain calm while thoughtfully connecting with their child during stressful, dysregulated times (Dumas, 2005; Fettig et al., 2015) as a way to begin to reprogram responses or even prevent dysregulation. Attributing these “mistaken behaviors” (Gartrell, 2004, p. 6) or “lagging skills” (Greene, 1999, p. 19) as a product of a child’s developmental stage is easier said than practiced, so creating “real” learning situations with immediate or specific feedback based on the skill/s being practiced created an effective and supportive model for adult learning (Mah & Johnston, 2008; Fettig et al., 2015; Shanley & Niece, 2010). This research study also confirmed that a comfortable setting with peers and a trained parent educator demonstrating sensitivity to parents’ perceptions of usefulness fostered acceptance and engagement in the study treatments (Campbell & Palm, 2004, Hoza et al., 2006).

Again, overall, study outcomes supported the literature, specifically in the importance of assessing participants’ personal needs and abilities. For example, one mother stated that writing and reading were going to be tough for her, so I offered to verbally take down her journal information or to write a brief overview of her findings weekly when she came to class. We did do this one time, but due to illness and car issues, she missed many of the class sessions. Participant ability in other capacities confirmed the need for flexibility based on needs.
Overall, there was also a low level of participation by the majority of participants in completion of Mindfulness Journals and Action Plan Scripts. However, those who did participate reportedly found benefits between the practices and their identified growth in “mindfulness.” In addition, participants self-reported that they were able to translate these skills into positive results with their children. Finally, participants reported noticing patterns of child behavior and in turn a reduction of their own “triggered” responses. Awareness and practice offered a new calmness during unsettling interactions, which was transferred to similar challenging times. In-turn, new ways of thinking and acting were developed.

It may be suggested that as participants became more comfortable with the process, the need to continue to create the “scripts” became less necessary in order to practice the concepts. Other participants had a variety of reasons for inconsistent participation, which included too time consuming, discomfort in writing pre-scripted interventions due to a previously disclosed medical condition, the illness of either themselves and/or their children, or too many work responsibilities.

The folder of mindfulness resource materials for this study was deemed a helpful asset by participants. One participant who was not able to attend many sessions was guided through the basic components of mindfulness interventions through this secondary method. She did not turn in any journals or scripts but learned enough in the two group field discussions to implement some of the practices at home. Her mother, when attending in her place, praised the way her daughter was practicing breathing with the children. The study participant herself stated that mindfulness interventions have made her a better mother and helped her appreciate her children.
Additions to the Literature Base

The results of the current study confirmed prior findings in the research base and add to the current literature base in the area of using mindfulness to combat the automatic responses between caregivers and their children. Mindfulness concepts learned in a facilitated parent education setting appeared to have a positive effect on caregivers’ attitudes, perceptions, modeling, and relations with their children. Through the use of a variety of interactive measurement methods (pre-post-study surveys, field note discussions, journal entries/action plan scripts, and a group interview), caregivers were able to process and practice the study concepts. There are a variety of research studies that use components similar to this study, but none are based in an early childhood setting. Because of this specific setting, the particular supports of continuous parent educator assistance and peer group cohorts allowed for modeling of study concepts that could be implemented during real-time caregiver-child interactions as well.

Study findings were reviewed for any indication of unique triggering based on relationships, which could include but are not limited to birth, non-birth, step, or foster parent. No pattern in the findings was indicated. There was also no mention that mindfulness was more or less effective based on the number of children a participant cared for. Rather, mindfulness concepts were just helpful in reducing triggering events overall. The majority of fathers and mothers alike were aware of their dominant trigger-evoking event. It is interesting to note, at study onset, that results of the pre-study questionnaire indicated participants identified “labeling their emotions” as the lowest-rated mindfulness skill. After mindfulness practices were implemented, this was an area with the greatest amount of participant growth. Participants’
awareness of their emotions and related internal reactions was a projected aim of the study and was confirmed as an important factor in resolving reactivity.

Finally, all families, regardless of age, number of children, marital status, economic status, and education level would benefit from using mindfulness concepts to reduce the automatic ways of thinking and acting that come with triggering events in close familial relationships. Given these results, I believe that it would be wise for this intervention training to be taught in schools at all levels. By beginning in early childhood, such trainings as in this study could be offered where parents are also involved in learning mindfulness components with support of a trained parent educator with peer supports. Again, research has indicated that supportive, caring caregiver-child relationships reduce abuse and long-term effects of less desirable parenting patterns. In turn, improved family functioning can potentially save costs to state and national governments.

To summarize, the current study added to the mindfulness literature by offering pre-study instruction and co-study instruction. Using a heuristic-style caregiver-selected journaling/script practice, support and modeling of study components with a parent discussion group, and guidance of a trained parent educator, this study confirmed previously published literature as well as adding to the current literature base.

**Study Limitations**

I have identified a variety of limitations in this current research design. A key limitation known prior to study onset was the likelihood of a low study participant number. In addition to a limited number of participants, the data collection strategies for this research project relied on participant self-report. While participants’ self-reporting can be a rich and useful form of data
collection, participants’ own perceptions must be assumed to be sometimes either biased or inconsistent. Finally, I assumed attendance would be inconsistent but found that it was probably unpreventable due to participant “shared co-caregiver duties” in this study setting. Participant attendance for pre-study learning as well as participation in field discussions and other study components was inconsistent for some families, which created reduced validity and reliability in study findings. Participants’ reasons for non-attendance included overlapping work schedule, child enrolled in the program after the study start-date, shared responsibility for attendance between family members, delivery of baby, recovery after baby’s birth, conflicting meeting scheduled, doctor appointments, surgery for child, participant or child illness, and car problems.

It was important to follow patterns in non-attendance to see if a clear and easy fix could be suggested. (Modification concepts to aid in improving attendance are shared in the “Next Steps in Research” section.)

In reflecting on the variations in participant “mindfulness” practices, it appeared more time may be beneficial for pre-study instruction to instill “mindfulness” concepts as a full group prior to practicing individually. Even though benefits were shown for many, a more in-depth modeling of various mindfulness techniques may have been beneficial to assist participants in acquiring a more integrated practice of the components. More integrated practices would also increase study validity and reliability so that the findings could be assumed to be more trustworthy and consistent. Since interpersonal support was helpful and deemed integral in modeling study concepts during the parent education group, perhaps providing participants with a “study-buddy” would aid in accountability and support during non-discussion days. (Further adaptations are listed in the “Next Steps in Research” section.)
I could only conduct a comprehensive comparison of the results for the five participants who completed both pre- and post-study questionnaires (3 in-person and 2 take-home). Findings represented only 38.5% of the total participants. As reported and may be expected, these participants were also predominantly from those who had higher rates of attendance and completed more journal entries/scripts.

Data collection was broad, which afforded much latitude for participants’ personal preferences and perspectives. Yet, specific participant data via an end-of-study survey to ascertain what was beneficial or what needed changing was not complete. End-of-study evaluation data would have augmented this study’s additions to the literature. For example, did those who journaled or used the scripts find that these practices helped them gain increased awareness of emotional dysregulation and improve their skills? Additionally, few participants completed journal and action plan scripts, which was a limitation to the study. Even though concepts appeared to be practiced without documentation, this aspect of the study was not thoroughly implemented by the majority of participants. It would have also been helpful to learn specific reasons as to why journaling and action plan scripts were not used. Were these data collection instruments too time consuming? It may also be important to alter the journaling and script process to increase participant participation. Perhaps an on-line journal or in discussion group action plan script planning component would be a better option for some participants.

Lastly, neither an analyst-checking nor a member-checking were completed for this study as there was not time or resources at the end of the study, which coincided with the end of the school year. The researcher is aware of the need for either one or both of these data analysis procedures as either procedure would have supported my findings. Then, I could say more
confidently that my narrative findings are both trustworthy and consistent. The “Next Steps in Research” section includes more suggestions to improve this research study.

**Next Steps in Research**

There are a variety of next steps to be explored for this research topic. First, it is important to expand the current research design to incorporate a larger sample of participants in Parent Education Class Discussion Groups. It is also necessary to take steps to increase consistency of attendance and participation of group members. I would suggest surveying perspective participants as to their preferred way to interact with study components and allow for a variety of modifications based on the group’s specific needs. Optional methods could include adding all materials, notes, discussions, video clips, and slides to an online classroom where participants unable to attend in-person could choose to ‘catch up’ or view information with a co-caregiver at home. Another option would be to offer a ‘video feed in real-time’ (Skype-like) with the discussion group, in the case of family illness or other barriers to attending the group discussions in person. This would allow an alternative ‘attendance’ format. If unavailable to ‘attend’ in this way, an online dialog box could be set up where absent participants could add in their related ‘field note comments’ after watching online videos of the discussion from any given session. These adaptations could balance out the tag-teaming effects of co-caregiver participant attendance and would also afford non-study participant co-caregivers access to information more intentionally. This could be especially true for fathers, who often are not able to participate because of work schedules but would like to be included.

Additionally, in reviewing the study demographics, it is important to note that of the 17 caregivers in the parent discussion group, 23% who identified as grandparents (n = 4) were legal
caregivers for the attending preschoolers and chose not to sign up for the study. Since this is a growing population of caregivers, finding appealing methods to encourage participation in this contemporary emotional regulation approach is an important focus for future research with added benefits for families. Assessing personal needs and preferred methods of interacting with intervention concepts would be beneficial for this population as well.

In an effort to improve study elements to ensure the highest degree of integration, I would suggest adapting the current design into a multi-phased study. To streamline the mindfulness process for participants, the study could begin with the pre-study instruction; it could continue with a mindfulness-only short-term training phase similar to the 5-day, 20 min. model used in Tang et al. (2007); finally, it could end with integration of script and journaling practices. Research showed results may be more effective if deliberately researched training methods are used with a mindfulness-trained instructor, again as reported in Tang et al. (2007). This study modification could aid caregivers in fully integrating the act of slowing down to retrain their regulatory systems prior to adding other at-home practices. Further research may identify training effectiveness. For instance, random control trials using skill components alone could aid in identifying which skills are effective for which problem areas and for whom they work best.

Conclusion

To conclude this thesis project, I would suggest that we consider the following “big ideas.” For instance, the ultimate goal of this program of research could be to add this form of emotional regulation supports to the Parent Education Framework, which the Minnesota statewide standards for parent educators, as well as to the standards for all teachers from early childhood through grade 12. More specifically, these practices could be a part of the college
curriculum for parent educators, early childhood teachers, and beyond. As future teachers in pre-service training programs, students could learn how to support emotional regulation development in children and parents so that these practices can be incorporated into the general population.

In summary, this study’s findings support the use of mindfulness practices, as evidenced by descriptive statistics and caregiver self-report, as a direct way to reduce automatic triggering between caregivers and their children. This research will help other early childhood parent educators by confirming the importance of using researched-based information, as this research study did. While no set script was prescribed for each individual, this flexibility seemed to be a useful component that should be considered and further researched. Findings also indicated learning, practicing, and discussing these concepts in a parent education class with the support of peers and a parent educator offered a safe place for caregivers to explore and gain confidence in developing mindfulness skills. Lastly, this study added a broad baseline of mindfulness interventions with resulting positive impacts for caregiver and child relations to the field of Parent Education. Such enhanced parenting skills bring hope for future parents and children alike in mitigating automatic emotional responses that, in turn, promote healthier parent-child relationships.
References


Other References

Folder Resources


**Instructional-Methods Resources**

| Week 1- Pre-study | -Discussion of thought- feelings- trigger cycles  
| | -Share: Anxiety Curve Illustration  
| | https://www.5pointscale.com/more_sweet_scale.htm Retrieved 3-11-18  
| | -The Cycle of Anger. 2016 Therapist Aid LLC Retrieved 3-1-17, from https://www.therapistaid.com/therapy-worksheet/cycle-of-anger  
| | -Physical effects (fight or flight) responses to thoughts and feelings Watch video- “Emotion & the Brain” Retrieved 3-1-17 https://www.youtube.com/watch?v=xNY0AAUtH3g  

| Week 2-Pre-study | Reviewed thought- feelings- trigger cycles  
| | -Discuss Adverse Childhood Experiences (ACES) research and how it affects “triggered” responses CDC Website https://www.cdc.gov/violenceprevention/acestudy/index.html |
Week 3 - Last Pre-study Instruction/ Journaling began

- Watched Video - “MIrroring by David Eagleman” Retrieved 3-7-17
  https://www.youtube.com/watch?time_continue=14&v=H6Tabh2Z5PI&disable_polymer=true
- Discussion & activity calming techniques through the senses (Examples shared)
  https://www.youtube.com/watch?v=KhfkYzUwYFk (Brain Breaks)
  Resource for Parents: www.gonoodle.com (explored website together).
- What is Mindfulness?
  Ideapod 15 Things Mindful People Do Differently. The Power of Ideas
  January 17 3-1-17, from https://ideapod.com/15-things-mindful-people-differently-can-get-started/
- The basis for the study discussed
- People signed paperwork to participate in the study (Consent Form, Demographic Form, Pre-study Questionnaire).
- Reminder: Study to start the next class.

Week 4

- Introductions (new attendees)
- Study review & journal questions (Record field notes)
- Reviewed calming techniques (for adults & children)
- Mindfulness video clip TEXx Christopher Willard (Author of “Growing up Mindful”)
  https://www.youtube.com/watch?v=Pj8sXZ25n2Q
- Review mindfulness techniques and practice as a group (breathing/eating/movement activities)
- Mindfulness study reference folders handed out.
- Handout journaling sheets & completed a practice entry as a group for Day #1 of journaling & script.
  Review (in folders)
  Mindfulness Skills, 2015 Therapist Aid LLC. Retrieved 3-1-17, from https://www.therapistaid.com/worksheets/dbt-mindfulness-skills.pdf
- A-B-C Model video (Supports the mindfulness process)
  https://www.youtube.com/watch?v=7HfkImKm_3M from http://www.reachinginreachingout.com/
  Thinking trap discussion and personal examples sharing.
  A-B-C Model, 2013 Therapist Aid LLC. Retrieved 3-1-17, from https://www.therapistaid.com/worksheets/abc-model-for-rebt.pdf
  Distress Tolerance Skills, 2015 Therapist Aid LLC. Retrieved
| Week 5                      | -Study review & journal questions (Record field notes)  
|                           | -Activity: Paper throw away or put in your pocket. (control thoughts review)  
|                           | -Attention “Gorilla” video “Test Your Awareness”  
|                           | https://www.youtube.com/watch?v=UfA3ivLK_tE  
|                           | -Emotional Regulation TSG objective review (child development progression)  
|                           | -Shared Stop-Breathe-Think App & “Breathe, Think, Do with Sesame Street” Apps for mindfulness practice: Look at and practice as a group (View on-line)-  
|                           | https://www.stopbreathethink.com/ and  
|                           | https://www.youtube.com/watch?v=yu0YEii4FkQ |
| Week 6                      | -Study review & journal questions (Record field notes)  
|                           | -Review & continue discussion on emotional regulation  
|                           | -Validation, gratitude, pause-redo practice  
|                           | Video-Just Breathe by Julie and Josh Salzman (Walcrest Films)  
|                           | https://www.youtube.com/watch?v=RVA2N6tX2cg |
| Week 7                      | No school |
| Week 8                      | No discussion (Special Person Invitational)  
| (Last week of journaling)   | |
| Week 9                      | Study review & journal questions (Record final field notes)  
|                           | -Handout reminding everyone about group interview next week.  
|                           | -Non-related discussion topic: co-parenting/divorce/sibling rivalry |
| Week 10                     | Semi-formal Group interview/ End of Study Questionnaire |
Appendix A: Consent to Participate

You are invited to participate in a research study about using mindfulness techniques to reduce automatic responses in families.

If you agree to be part of the research study, you will be asked to:

➢ Complete a demographic survey.
➢ Complete a “Pre-study Caregiver Mindfulness Questionnaire”
➢ Create a “mindfulness plan” and take brief “journal” notes 4-7 times a week to document elements used and perceived effectiveness, for the duration of the 6 week study.
➢ Turn in journal notes weekly.
➢ Participate in focused discussion check-ins; sharing as you feel comfortable, updates on the implementation of mindfulness techniques.
➢ Complete a “Post-study Caregiver Mindfulness Questionnaire”
➢ Participate in an audio-taped semi-structured group interview, answering questions regarding mindfulness treatments, as you feel comfortable.

Proposed benefits of the research include: improved awareness and implementation of mindfulness practices (calming and distancing of thought process) in response to your child’s perceived challenging behaviors, which aim to reduce negative automatic responses to your child/ren. No risks or discomforts are foreseen.

By signing below I agree to participate in the research study and all components.

● I am participating voluntarily.
● I give permission for my weekly focused-discussion check-in comments to be hand-recorded by the researcher and used for study findings.
● I give permission for my participation in the end of study semi-structured interview to be tape-recorded.
● I understand I can withdraw from the study, without repercussion, at any time whether before it starts or while I am participating.
● I understand that I can withdraw permission to use the collected data within 2 weeks of the end of study semi-structured interview, in which my portion of all materials will be deleted.

● I understand that confidentiality will be ensured in the write-up to protect my identity. (Data will be reported and presented in group form or with no more than two descriptors presented together.)

● I understand that excerpts from journal entries, semi-structured interview tape-recordings and parent-meeting field notes may be quoted in the thesis and subsequent publication.

● After the completion of the semi-formal interview, I understand I may receive a copy of the transcribed interview. In marking an (X) here I am indicating I would like to receive a copy of the transcript for review. ________

If you have questions about this research study, you may contact Amy Korkemeier-Howard @ 763-389-6192 or Dr. Jane Minnema @ jeminnema@stcloudstate.edu. Results of the study can be requested from the researcher or obtained after publication at the St. Cloud State University Repository.

Your signature indicates that you are at least 18 years of age, you have read the information provided above, and you have consent to participate.

Signature __________________________________________ Date ____________________
Appendix B: Instrument Materials

B.1. Participant Demographic Survey

Participant Demographic Questionnaire

All responses are confidential. There will be no connection to your name or identifying information.

1. Age: ________

2. Sex (circle): Male       Female

3. Race/Ethnicity (circle):
   - White/Caucasian
   - Black/African American
   - American Indian
   - Multiracial
   - Other _______________________________________________

4. Annual household income before taxes (circle):
   - Under $30,000
   - $30,000-$50,000
   - $50,000-$70,000
   - $70,000-$100,000
   - $100,000+

5. Are you currently (circle):
   - Married
   - Not married
   - Separated or divorced
   - Living together in a marriage-like relationship
   - Widowed

6. Children
   a) Number of children ______________________________________________________
   b) Age(s) _________________________________________________________________
   c) Relationship to child/ren (birth-parent, foster-child, stepchild, grandparent, other)
      ______________________________________________________________________
7. What is the highest grade or year of school you completed? (Circle)

- Less than high school
- High school graduate or GED
- Some college, associate degree, or vocational/technical/business school
- Bachelor degree
- Master’s Degree or higher

9. Do you have a job outside the home? (Circle)

- Employed (full or part)
- Homemaker
- Student
- Retired
- Unable to work

Name________________________________________________ Date________________
## B.2. Focus Discussion Field Note Form

### Focus Discussion Field Note Form

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<tr>
<th>Participant</th>
<th>Comments:</th>
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<tbody>
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<td>(See attached blank sheets for extended commentary.)</td>
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B.3. Caregiver Mindfulness Questionnaire (Pre-Study)
Pre-Study Caregiver Mindfulness Questionnaire

Name: ____________________________________________ Date:________________

Please circle the number and corresponding answer that reflects your response.
Add comments as desired. (Note: All responses are confidential.)

1. I am aware of my thoughts about my child’s behaviors before I react.

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<tr>
<th></th>
<th>1 Never</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
<th>4 Often</th>
<th>5 Almost Always</th>
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Comments:

2. I label my feelings when I notice my emotions.

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<th>1 Never</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
<th>4 Often</th>
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Comments:

3. I validate (acknowledge) my child’s feelings when s/he is upset.

<table>
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<tr>
<th></th>
<th>1 Never</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
<th>4 Often</th>
<th>5 Almost Always</th>
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Comments:

4. I label my child’s feelings when s/he is upset.

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<th>1 Never</th>
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<th>4 Often</th>
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Comments:

5. I can identify “trigger” events that lead to heightened stress responses in my body.

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<th>1 Never</th>
<th>2 Rarely</th>
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Comments:
6. I have effective ways of calming myself when I become upset.

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<th>1 Never</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
<th>4 Often</th>
<th>5 Almost Always</th>
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</table>

Comments:

7. I am able to slow down my reactions to prevent parenting my children harshly.

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Comments:
**B.4. Caregiver Mindfulness Questionnaire (Post-Study & Take-home)**

**Post-Study Caregiver Mindfulness Questionnaire**

Name: ____________________________________________ Date:_____________

*Please circle the number and corresponding answer that reflects your response. Add comments as desired. (Note: All responses are confidential.)*

1. I am aware of my thoughts about my child’s behaviors before I react.

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<th>1 Never</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
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<th>5 Almost Always</th>
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Comments:

2. I label my feelings when I notice my emotions.

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<th>1 Never</th>
<th>2 Rarely</th>
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Comments:

3. I validate (acknowledge) my child’s feelings when s/he is upset.

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<th>1 Never</th>
<th>2 Rarely</th>
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Comments:

4. I label my child’s feelings when s/he is upset.

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<th>2 Rarely</th>
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<th>5 Almost Always</th>
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Comments:

5. I can identify “trigger” events that lead to heightened stress responses in my body.

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<th>3 Sometimes</th>
<th>4 Often</th>
<th>5 Almost Always</th>
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Comments:
6. I have effective ways of calming myself when I become upset.

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Comments:

7. I am able to slow down my reactions to prevent parenting my children harshly.

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Comments:
B.5. Semi-Formal Interview Protocol (Script & Interview)
Semi-Formal Group Interview Protocol
(Script & Interview Questions)

Date:____________________

Study Title: Working with Caregivers to Mitigate Automatic Responses in Families Using Mindfulness Techniques in a Parent Discussion Group

Greeting and interview confidentiality:

➔ Hello Everyone. Thanks to all of you for coming today and for participating in the six week study.

➔ Today we will complete the final step in the study. I will be audio recording this “group interview” and will then be making a “transcript” of the discussion.

➔ You may recall, when the transcript of today’s discussion is typed up all of your personal information will be kept confidential, with no identifying names and no more than 2 descriptive phrases put together at one time. As stated in the consent form you signed at the beginning of the study, you are welcome to receive a copy of the transcript if you wish. You can suggest edits or make clarifications at that time. Reminder- If you did not put an X on your consent form denoting you would like to review the transcript, you can let me know today if you wish to do so, and I will make a note to get you a copy.

Interview process:

➔ This will be a semi-formal group interview. Which means I will ask pre-written questions and you can all answer and discuss them as a group. Very similar to what we normally do in our parent discussion time. I want you to feel comfortable during the discussion, so please make sure you take care of any needs you have as they arise.

➔ I look forward to hearing all comments relating to how the last 6 weeks have gone for you. Please share any/all comments or suggestions you think might be helpful to others in the group and/or myself.
Let’s get started with the first question-

What does “mindfulness” mean to you?

**Probe:** During the 6 week study we focused on observing our thoughts, feelings and physical responses in the moment, without judging them, as part of this process. Tell us how that went for you?

**Prompt:** How do you view “mindfulness” now, compared to before you took part in this study?

How has this project changed the way you parent?

**Probe:** Relate a story or incident that stands out in your mind.

**Prompt:** If you haven’t mentioned if yet, have these techniques had an effect on how your co-parent parents as a result of observing/learning from you? Please share a story or incident.

How do you use the new mindfulness techniques in your general day-to-day life?

**Probe:** Can you share specific times and practices through examples?

**Prompt:** What hurdles remain for you being able to practicing the techniques?

How would other people or parents benefit from this information?

**Prompt:** What techniques, if any, have you found yourself sharing with others?

The next step I would hope for would be modeling of mindfulness for/with your child. Have you noticed your child using similar practices since you have been practicing the techniques?

**Probe:** If so can you describe how? When?

**Prompt:** What do you see as your next steps with “mindfulness”?
Are there any other comments? Or does anyone have any further questions for me?

I want to again thank all of you for your time and sharing your experiences with myself, others in class, as well as allowing your information to help others through the study.

End of Study Take-Home Interview

Please take a minute to answer the following questions. The group interview has passed, however your input would still be appreciated as part of the final data collection.

Name: ___________________________ Date:______________________

Study Title: Working with Caregivers to Mitigate Automatic Responses in Families Using Mindfulness Techniques in a Parent Discussion Group

➔ You may recall, when the transcript of this document is typed up, all of your personal information will be kept confidential, with no identifying names and no more than 2 descriptive phrases put together at one time. As stated in the consent form you signed at the beginning of the study, you are welcome to receive a copy of the transcript if you wish. You can suggest edits or make clarifications at that time. Reminder- If you did not put an X on your consent form denoting you would like to review the the transcript, you can let me know today if you wish to do so, and I will make a note to get you a copy.

➔ I look forward to hearing all comments relating to how the last 6 weeks have gone for you. Please share any/all comments or suggestions you think might be helpful to others in the group and/or myself.

Questions:

Note: (You may use additional writing material if need more space for your answers.)

1. What does “mindfulness” mean to you?
   During the 6 week study we focused on observing our thoughts, feelings and physical responses in the moment, without judging them, as part of this process. Tell us how that went for you?
   How do you view “mindfulness” now, compared to before you took part in this study?
2. How has this project changed the way you parent?
Relate a story or incident that stands out in your mind.
If you haven't mentioned if yet, have these techniques had an effect on how your co-parent parents as a result of observing/learning from you? Please share a story or incident.

3. How do you use the new mindfulness techniques in your general day-to-day life?
Can you share specific times and practices through examples?
What hurdles remain for you being able to practicing the techniques?

4. How would other people or parents benefit from this information?
What techniques, if any, have you found yourself sharing with others?

5. The next step I would hope for would be modeling of mindfulness for/with your child.
Have you noticed your child using similar practices since you have been practicing the techniques?

If so can you describe how? When?
What do you see as your next steps with “mindfulness”?

Any other comments? If you have any questions please let me know.
I want to again thank you for your time and for sharing your experiences with myself, others in class, as well as allowing your information to help others.
### B.7. Participant Attendance for Instruction & Journal Participation Form

**Caregiver Participant Attendance for Instruction (Includes instruction highlights) & Journal Collection Checklist** (See Master for details.)

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<th>Wk 4-J</th>
<th>Wk 5-J</th>
<th>Wk 6-J</th>
<th>Wk 7-J</th>
<th>Wk 8-J</th>
<th>Wk 9</th>
<th>Wk 10</th>
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<th>NO DISCUSSION (Sabbath/observed days)</th>
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B.8. Participant Demographic Survey Findings Sheet

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<th>Household Income</th>
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### B.9. Pre & Post-Study Caregiver Mindfulness Questionnaire Findings Sheet

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<th>#1 Post</th>
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<th>#2 Post</th>
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<th>#3 Post</th>
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Appendix C: Intervention Materials

C.1. Mindfulness Concept Mapping Form

Reprogram "Automatic Responses"
Trigger Event:

OLD WAY
OLD Thought
"I think..."

NEW WAY
Wise Mind
Emotions (Regulated)
Reaction (Balanced)
Thoughts (Logical)

OLD Emotion
"I feel..."

OLD Physical Response...

OLD Reaction

Mind Mapping
C.2. Mindfulness Daily Journal Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Trigger Event</th>
<th>Identify Thought</th>
<th>Physical Response</th>
<th>Feeling ID</th>
<th>Calming Tech. (In the moment)</th>
<th>Describe Effectiveness</th>
<th>Mindfulness Practiced Today</th>
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<td>Thur.</td>
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C.3. Mindfulness Action Plan Script Form

MY MINDFULNESS ACTION PLAN SCRIPT

STEP #1 - IN THE MOMENT (Run through this)
When the identified "trigger event" happens I will...
1. Notice my thoughts:
   i am thinking...
   AND reframe to my replacement thought response
   i will change my thought to: ____________________________
2. Notice emotions & physical responses in my body:
   AND identify the emotion name ____________________________
   AND identify what happens in my body ____________________________
   I will say: "I am feeling..."
3. Practice a calming technique to control my emotions/physical reactions:
   I will:
4. I want to calmly say:
   Replacement response: ____________________________

VISUALIZATION PRACTICE

STEP #2 - AT A CALM TIME (Planned practice in order to improve new thinking and acting habits.)
I will mentally "practice" this action plan script _______ time/s each day,
   (when) ____________________________ and (where) ____________________________.
I will "practice" the ____________________________ mindfulness technique,
   (when) ____________________________ and (where) ____________________________.

Write in MINDFULNESS PRACTICE/s below (see lists) you will use to improve emotional regulation this week.

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<tr>
<th>OLD WAY-Thought</th>
<th>NEW WAY-Thought</th>
<th>Calming Technique/s-</th>
<th>Mindfulness Practice/s-</th>
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<td>IN THE MOMENT</td>
<td>AT A CALM TIME</td>
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Appendix D: Reminder Letter Sent Home Prior to the Semi-formal Group Interview

***MARK YOUR CALENDAR***

END OF STUDY - GROUP INTERVIEW
(This week) Thursday, May 11, 2017

Hello Gang,
It’s that time already! The study is over and I want to thank each of you for your participation and candid sharing throughout our time working to change “automatic” response habits through the use of mindfulness and mental scripts with our families.

This Thursday is the final and a very important step of the Mindfulness Study (filling out the short end of study survey and taking part in the “group interview”). This will help me document what you’ve learned, implemented and to see how things are going at the completion of the study.

Those of you who have not yet signed on to the study, I would still like to include your thoughts as well during the final "group interview" we will do this week.

If you haven’t already:
Please bring in ALL "journal sheets" (blank, partially filled in, or completed) for my records.

Thank you,
Amy Korkemeier-Howard

True Mindfulness…..
Appendix E: Follow-up Letter Sent with End-of-Study Take-home Interview Questions

(Date)
Hello ______________,

The study is over and I want to thank you for your participation and candid sharing throughout our time working to change “automatic” response habits through the use of mindfulness and mental scripts with your family.

Last Thursday we had the “group interview”. Many people shared stories of what was working and if/how they may continue to use the information from the study.

I am sending these forms home hoping you might complete them and send or bring them back for my records. I would like to include your comments and end of study information in the mix.

Note: If you haven’t already, please put ALL "journal sheets" (blank, partially filled in, or completed) in this envelope also for my records.

Again, thank you for your time and input.
Amy Korkemeier-Howard
Appendix F: IRB Approval

Institutional Review Board (IRB)
720 4th Avenue South AS 210, St. Cloud, MN 56301-4498

IRB PROTOCOL DETERMINATION:
Expedited Review-1

Name: Amy Korkemeier-Howard
Address: USA
Email: amy.korkemeier-howard@sd1477.org

Project Title: Working with Caregivers to Mitigate Automatic Responses in Families Using Mindfulness Techniques in a Parent Discussion Group
Advisor: Dr. Jane Minnema

The Institutional Review Board has reviewed your protocol to conduct research involving human subjects. Your project has been APPROVED.

Please note the following important information concerning IRB projects:
- The principal investigator assumes the responsibilities for the protection of participants in this project. Any adverse events must be reported to the IRB as soon as possible (e.g., research-related injuries, harmful outcomes, significant withdrawal of subject population, etc.).
- For expedited or full board review, the principal investigator must submit a Continuing Review/Final Report form in advance of the expiration date indicated on this letter to report conclusion of the research or request an extension.
- Expedited review only requires the submission of a Continuing Review/Final Report form in advance of the expiration date indicated in this letter if an extension of time is needed.
- Approved consent forms display the official IRB stamp which documents approval and expiration dates. If a renewal is requested and approved, new consent forms will be officially stamped and reflect the new approval and expiration dates.
- The principal investigator must seek approval for any changes to the study (e.g., research design, consent process, survey/interview instruments, funding source, etc.). The IRB reserves the right to review the research at any time.

If you need further assistance, feel free to contact the IRB at 320-308-3260 or email ri@stcloudstate.edu and please reference the SCSU IRB number when corresponding.

IRB Institutional Official:

[Signature]

Dr. Latha Ramakrishnan
Interim Associate Provost for Research
Dean of Graduate Studies

OFFICE USE ONLY

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<th>1st Year Expiration Date:</th>
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