Parental Mindfulness and Stress as an Influence on Clinically Referred Children’s Emotional Competence

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PARENTAL MINDFULNESS AND STRESS AS AN INFLUENCE ON
CLINICALLY REFERRED CHILDREN’S EMOTIONAL COMPETENCE

by

AHMAD BAIYASI

HONORS THESIS

Submitted to the Honors Program

in partial fulfillment of a

Bachelor of Science Degree

Wayne State University

Detroit, Michigan

May, 2018
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Abstract

Children acquire the skills of emotional competence in a variety of contexts, and demonstrate through their behavior the skills evident of emotional competence. Such skills include a sense of well-being, adaptive resilience in the face of stressful circumstances, and the ability to manage their own emotions (Saarni, 2000). Mindfulness, a relatively new construct in the study of human development, is nonjudgmentally paying attention to relevant aspects of our experiences, including our own emotions and thoughts (Ludwig & Kabat-Zinn, 2008). Stress is emotional or mental strain resulting from adverse or very demanding life circumstances, such as our living environment (Lunney, 2006). The current study undertaken at Wayne State University in the Laboratory of Emotional Development collected data from local, clinically referred children on a number of individual and environmental parameters, some of which are family stress, parental mindfulness, and children’s emotional competence. My thesis examines the relationship between the first two parameters and their correlation with the third.
Emotional Competence

Emotional competence is the set of skills that children use to “respond emotionally, yet simultaneously and strategically apply their knowledge about emotions and their expression to relationships with others, so that they can negotiate interpersonal exchanges and regulate their emotional experiences” (Denham, Mitchell-Copeland, Strandberg, Auerbach, & Blair, 1997). Several skills of emotional competence include using the vocabulary of emotion; discerning one’s own and others’ emotional states; coping with aversive and distressing emotions; and empathetic involvement in others’ emotions (Saarni, 2000). Parental socialization is a major factor in the development of their children’s’ emotional competence. Their contingent reactions to emotion, emotional displays, and teaching about emotions are highly salient to their children. Children learn much from their parents concerning the appropriate expressions of emotions, the nature of emotional expressions and situations, and possible reactions to other’s positive and negative emotions. Emotional competence in young children is crucial for both concurrent and later mental health and well-being and provides a foundation for children’s functioning in future school and peer contacts. (Denham, Ferrier, Howarth, Herndon, & Bassett, 2016). A failure to acquire an age-appropriate level of emotional competence can potentially constrain and hinder the development of a range of cognitive, emotional, and social skills (Blandon, Calkins, & Keane, 2010). Research suggests that deficits in emotional regulation are linked to greater levels of behavior problems and difficulty with peers, while greater capacities for emotional regulation are associated with better social skills (Denham, & Mitchell-Copeland, et al, 1997).
Environmental Stress

Urban Detroit and its surrounding areas of low socioeconomic status can be very stressful to its child residents and their families. Stress occurs when an individual is exposed to challenging, often negative events in their proximal environment. These challenging events, or stressors, test the adaptive capacities of individuals, especially during the period of childhood and adolescence. Constant exposure to stress, as in dealing with the living conditions of Detroit, is problematic, and can actually lead to the proliferation of stress, as stressed individuals can become the source of stress for other persons. This is when one stressor can lead to or beget the existence of other stressors (Miller, & Bennett, 2016). For example, a highly stressed child can act in ways that create stress for other children and adults. Children living in areas such as Detroit are much more likely to encounter hazards and violence in the environment, and uncontrollable and threatening life events (McKelvey, Whiteside-Mansell, Bradley, Casey, Conners-Burrow, & Barrett, 2011). The urban environment puts forth a unique challenge to families living within its boundaries, with its myriad of threats and strains, like constant relocation, safety concerns, and low income hassles. The American Psychological Association separates stress into three categories according to their time course: acute, episodic, and chronic. The chronic stress faced by an individual within an urban context, such as inadequate social services like good transportation, or being chronically in poverty due to a lack of income-producing jobs, can have more of an effect on mental and physical health than less frequent life event stressors (Miller & Bennett, 2016).

The most common expression of internalizing symptoms of urban youth in low income areas is somatization. This occurs when psychological concerns are converted into physical ones, due to high exposures to stress (Reynolds, O'Koon, Papademetriou, Szychgiel, & Grant, 2001).
Furthermore, children in areas of low socioeconomic status are more likely to develop emotional problems (Wood, 2003). The longer a family is exposed to poverty and its negative side effects, the more adverse these emotional problems are. Finally, these families tend to display higher levels of cortisol and inflammation, physiological markers of stress on the body, due to their constant, stressful environment (Daughters, Gorka, Matusiewicz, & Anderson, 2013).

**Parental Mindfulness**

Parenting behaviors have developmental outcomes on children. Parents who interact with their kids in a mindful manner are performing their acts of parenting with awareness and acceptance of their emotions and thoughts; in other words, they are doing mindful parenting. Mindfulness is paying attention to current experiences (Ludwig, & Kabat-Zinn, 2008). It may further be defined as a state of attention to present experiences and events, not affected by cognitive discernment or speech (Corthorn & Milicic, 2016). It is being open, receptive, and free of judgment. Several researchers have observed significant negative associations between mindful parenting, and depression, anxiety, and general stress. Bishop and his associates indicated that currently, mindfulness is used as an instrument to enhance acceptance and awareness of current situations, and as a tool to teach skills that aid in reducing harmful behavior and maladaptive cognitive processes (Bishop et al., 2004).

Previous research done on the effects of parental mindfulness indicate improved emotional regulation in young adults, decreased aggressive behavior, lowered internalizing and externalizing symptoms, and overall decreased levels of stress (De Bruin et al.; 2014). Incorporating mindfulness into parenting enables parents to shift their awareness into the present moment, which further allows better self-regulation of emotions and moment to moment decision making. Consequently, this can lead to parents having better relationships with their
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children and avoiding maladaptive, automatic reactions when children do not meet parental expectations (Corthorn & Milicic, 2016). This study investigated the impact of parental mindfulness and stress on clinically referred children’s emotional competence.

**Goals/Hypothesis of this study**

Previous studies related to the topic of this project, have not looked at clinically referred, urban children in lower socioeconomic areas. This study will include both urban children in or near surrounding Detroit, as well as suburban children in Metro Detroit, in order to include a more representative sample from the population of urban children. Also, despite studies displaying the high rates of stress on urban children who receive services in outpatient clinics (Miller, & Bennett, 2016; Reynolds, & O’Koon, et al, 2001), little has been done to analyze the effects of stress on the emotional competence of children living in stressful urban settings. In addition, little has been done to analyze the mediating effects of parental mindfulness when it comes to stress and emotional competence.

This study will analyze the effects of parental mindfulness as an influence on the effects of stress on children’s emotional competence. The findings of this study will potentially improve outpatient care for urban children. Parental mindfulness is a relatively new concept, that if shown to influence children’s emotional competence, will broaden the scope of treatment and services provided to both children and parents. In addition to addressing the environmental stress commonly encountered by urban families, the reactions of parents would therefore hold higher importance in assessing treatment for children. Focusing on children in underrepresented, urban populations rather than middle class, less stressful life environments, will increase the external validity of this study as well.

**Study Aims**
Stress, Parental Mindfulness, and Children’s Emotional Competence

There were two central questions for this project to answer:

1) Does stress affect the emotional competence of clinically referred children?

2) Does parent mindfulness impact their children’s stress, such that parent mindfulness softens the effects of children’s stress by increasing children’s emotional competence?
Method

Participants

Participants were recruited from the Wayne State University Psychology Training Clinic, The Children’s Center of Detroit, and the Detroit Medical Center Children’s Hospital. Participants who have had services with any of the above locations were contacted through a phone call made in the lab and/or clinic. The families contacted reside in urban and suburban locations, with the majority of families being of low socioeconomic status. The sample was primarily African American in ethnicity. Qualifying children participants fulfilled the following criteria: 1) the child being ages 8 to 12 years old (inclusive), 2) a primary caregiver of the participating child who would be being willing to participate during the study, and 3) both caregiver and child being native English speakers. Participants were excluded from the study if: 1) they have a documented intellectual disability, 2) a diagnosis of autism spectrum disorder, or 3) documented symptoms of psychosis. Further participants only seen within the last three years will be contacted.

Instruments

This study employed the use of several instruments to measure a number of constructs, three of which were the central measures incorporated into this project. This thesis will focus on the three measures involved in the hypothesis of this thesis; stress, parental mindfulness, and emotional competence.
Stress, Parental Mindfulness, and Children’s Emotional Competence

**Measures**

**Table 1.**

Instruments and representative items included in this project

<table>
<thead>
<tr>
<th>Measure (respondent)</th>
<th>Example Items</th>
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</table>
| Five-Facet Mindfulness Questionnaire (FFMQ) (parent rates self) | “I perceive my feelings and emotions without having to react to them.”  
“I watch my feelings without getting lost in them.” |
| Interpersonal Mindfulness in Parenting Scale (IMPS) (parent rates self) | “I am aware of how my moods affect the way I treat my child”  
“I notice how changes in my child’s mood affect my mood” |
| DANVA2- CP-emotion recognition (child assessed with stimuli) | “I’m going out of the room now, but I’ll be back later.” |
| Emotion Regulation Checklist (ERC) (parent rates child) | “Is easily frustrated”  
“Is a cheerful child”  
“Is able to delay gratification” |
| Stress Index (child rates self) | In the last year:  
“Did a family member die”  
“Did you change where you went to school” |

**Stress.** The Stress Index is a self-report measure that will be used to assess child stress (Attar, Guerra, & Tolan, 1994). This questionnaire consists of 16, Yes or No questions that pertain to experience of stressful events in the last year. Each question will be read out loud by a researcher. The Stress Index was created for use with urban, low-income children, and breaks down into three subscales: Life Transition, Circumscribed Events, and Exposure to Violence. Reliability of this measure will be assessed with the current sample using Cronbach’s alpha.
Parental Mindfulness. Dispositional Parental Mindfulness, or mindfulness of the individual without any formal training, will be measured using the Five-Facet Mindfulness Questionnaire. This 39 question self-report assesses five facets of mindfulness: observing, describing, acting with awareness, non-judging, and non-reactivity. Each facet of the five-facet model has shown good construct, convergent, and divergent validity and reliability (Christopher et al., 2012). The Interpersonal Mindfulness in Parenting Scale (IMPS) is a 10 question self-report that measures mindfulness skills as they pertain specifically to parenting interactions. This form uses a 1 through 5 Likert rating scale to assess awareness, non-judgment, and non-reactivity. The IMPS has been found to have overall, concurrent, and discriminant validity (Duncan, 2007; Coatsworth, Duncan, Greenberg, & Nix, 2010; De Bruin et al.; 2014). Reliability of both mindfulness measures will be assessed with the current sample using Cronbach’s alpha.

Emotional Competence. The DANVA2-CP is a computerized task that provides a measure of emotional recognition, a component of emotional competence (Rothman & Nowicki, 2004). This activity is comprised of two sections. First, the children view a series of facial images, then they complete a section where they listen to a series of voices making the statement “I’m going out of the room now, but I’ll be back later.” Within each section the children are asked to identify the emotion being expressed immediately after the stimulus is presented (given a choice between happy, sad, angry, or fearful). Construct validity and reliability within a child population has been demonstrated for this instrument (Nowicki & Duke, 1994). Cronbach’s alpha will be reported as an assessment of the reliability of this measure with the current population.

The other instrument assessing emotional competence is the Emotion Regulation Checklist (ERC), which will be completed by a parent of each participating child. This
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assessments measure overall emotion regulation along with two subscales: emotion regulation (intensity, valence, plasticity, and situational appropriateness) and lability/negativity. This task consists of 24 questions on a Likert scale from 1 to 4. Reliability and construct validity have been established for the Emotion Regulation Checklist for children of similar ages (6-12) as those participating in this study (Shields & Cicchetti, 1997).

Table 2.

Descriptive statistics and reliability estimates of measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress Index</td>
<td>4.73</td>
<td>3.02</td>
<td>.73</td>
</tr>
<tr>
<td>DANVA Faces</td>
<td>4.70</td>
<td>2.17</td>
<td>.40</td>
</tr>
<tr>
<td>DANVA Voices</td>
<td>7.82</td>
<td>4.21</td>
<td>.46</td>
</tr>
<tr>
<td>Emotion Regulation Checklist</td>
<td>65.69</td>
<td>11.06</td>
<td>.87</td>
</tr>
<tr>
<td>FFMQ- Five Factor Total</td>
<td>138.65</td>
<td>20.25</td>
<td>.88</td>
</tr>
</tbody>
</table>

Note. Reliability = Cronbach’s α.
Stress Index(SI), and Diagnostic Analysis of Nonverbal Accuracy 2-Child Paralanguage- Faces (DANVA2-CP-F), Diagnostic Analysis of Nonverbal Accuracy 2-Child Paralanguage- Voices (DANVA2-CP-V), Emotion Regulation Checklist (ERC), and Five-Facet Mindfulness Questionnaire (FFMQ)

Procedure

Research assistants noted down the addresses and contact information of previously seen potential participants at the three urban clinics, recording the information onto a spreadsheet for record keeping. Qualifying families were sent letters notifying them of the current study, its intended purposes and the general procedures of the study, inviting their participation. Follow up
calls took place two weeks after the letters were sent, and a research assistant read off a script notifying them of the study. Interested families were scheduled and compensated with a forty dollar Meijer gift card after the completion of the study. The caregiver completed his or her part of the study in a separate room, and the child participate in activities with a research assistant in a separate room. The study was a one time, one-hour visit that took place at the Wayne State Psychology Clinic or at the clinic where the child had previously been in treatment. Project sessions were held in a private space at each particular location where a recruited child had received treatment.

At the beginning of the appointment, consent from the caregiver accompanying the child was obtained, along with assent from his or her child. While the child began his or her brief assessment with a researcher, the parent was then taken to a nearby room to complete the self-report forms with another research assistant. The project protocol was followed, in accordance with the Wayne State University Institutional Review Board. Following the completion of adult and child data collection, parents were given the chance to make any comments or raise questions or concerns about the project. Compensation was given as a token of appreciation for taking the time to come participate in the research study. Compensation for completing the study included a $40 gift card to Meijer stores, and compensation for parking.

The data for this study were gathered during a one-time visit for each child and parent pair, directly from each guardian and child, representing a cross-sectional design. All parents or guardians signed a release form, and each child participant gave their assent to participate. No child participated only on the consent of their parent or guardian; children's assent was required. The research assistants reviewed each participant’s record and medical chart, upon consent given in the form of a signature by the guardian, of a release form, in order to document age,
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race/ethnicity, gender, and psychiatric diagnoses. Other demographic data collected from chart review included family and household structure; income, and family history of mental illness. Medical charts were reviewed for information about when a participating child started treatment, how long the child had been in treatment, and the type of treatment the child was receiving.

Hypotheses

1. Using the previously gathered data from this project, I expected that stress would affect the emotional competence of children such that higher stress would be related to lower emotional competence in the children.

2. Related to the first hypothesis I also expected that parent mindfulness would affect children’s emotional competence, such that higher parental mindfulness would result in higher emotional competence among their children. Specifically, I expected that parental mindfulness would interact with children’s emotional competence, such that if parent mindfulness raised children’s emotional competence, this would decrease the effects of stress on children.
Results

Stress and Child Emotional Competence

Regarding the hypothesis that stress influences the emotional competence of clinically referred children as represented by a negative correlation, no significant findings were obtained. A Pearson product-moment correlation coefficient was computed to assess the relationship between child stress and the emotional competence of clinically referred children. There was a non-significant negative correlation between the two variables ($r = -0.044, p = 0.81$) with the Emotion Regulation Checklist used as a measure of emotional competence. A non-significant relationship was also found when looking at the relationship of child stress with the DANVA faces emotion recognition task ($r = -0.042, p = 0.82$) and the DANVA voices emotion recognition task ($r = 0.193, p = 0.29$). Overall, a significant correlation was not found between child stress and any measure of emotional competence. Otherwise put, childhood stress was not significantly correlated with emotional competency; there was no indication that high stress in childhood was associated with lower levels of emotional competence.

Dispositional Parental Mindfulness, Stress, and Child Emotional Competence

To test the hypothesis that children’s emotional competence is a function of multiple factors, and more specifically whether their guardian’s mindfulness moderates the relationship between child stress and child emotional competence, a hierarchical multiple regression analysis was conducted. To avoid potentially problematic high multicollinearity with the interaction term, the two independent variables were centered and an interaction term between child stress and guardian mindfulness was created. Parental mindfulness and child stress were entered in the first step as independent
variables and accounted for a significant amount of variance in child emotional competence as measured by the ERC total score, $R^2 = .202$, $F(2, 30) = 3.791, p = .034$. Next, the interaction term between child stress and guardian mindfulness was added to the regression model, which accounted for a non-significant proportion of the variance in child emotional competence as measured by the ERC total score, $F(3, 29) = 2.48, p = .08, \Delta R^2 = .002$. Model Summary shows no significant $R^2$ Change for the interaction term above and beyond what is accounted for by the initial block. This model is not a statistically significant predictor of emotion regulation as measured by the ERC total score.

The same process was run for the DANVA faces and DANVA voices emotion recognition tasks. For both, parental mindfulness and child stress were entered in the first step as independent variables and accounted for a non-significant amount of variance in child emotional competence as measured by the DANVA faces total error score, $R^2 = .005, F(2, 30) = .076, p = .93$ and the DANVA voices total error score $R^2 = .042, F(2, 30) = .66, p = .53$. Next, the interaction term between child stress and guardian mindfulness was added to the regression model, which accounted for a non-significant proportion of the variance in child emotional competence as measured by the DANVA faces total error score, $F(3, 29) = .61, p = .62, \Delta R^2 = .054$ and the DANVA voices total error score $F(3, 29) = .66, p = .58, \Delta R^2 = .022$. The Model Summary for both analyses run showed no significant $R^2$ Change for the interaction term above and beyond what was accounted for by the initial block. Neither model was a statistically significant predictor of emotional competence as measured by the DANVA faces or DANVA voices total error score.
Discussion

It was a major surprise that none of the hypotheses were significant. In order to think about why this surprising finding was obtained, I examined the measures again. In spite of the fact that the measures of emotional competence chosen for this project have been used in many studies with reported satisfactory reliability, two of the instruments used to measure the emotional competence parameters were unreliable in our participants. Results indicate (see Table 2) that DANVA faces and DANVA voice tests were non-reliable tests of emotional competence. Furthermore, results indicate there was no significant relationship between child stress and emotional competence. There were also no significant relationships between the joint variables stress and parental mindfulness on the emotional competence of children. This study unfortunately did not confirm the hypothesis that stress will decrease the emotional competence of children or that parental mindfulness would influence the negative effects of stress on children’s emotional competence. These hypotheses may be true, but the limitations of the variables, particularly the DANVA measures, made it impossible to fairly test the hypotheses. It is highly likely that the lack of reliability in the emotional competence measures caused the null results that were obtained.

Other Limitations

Possible additional limitations beyond those noted above include the fact that some children had pre-existing mental health problems, and those were not being treated at the time of the study, which may have hindered children’s ability to answer questions in this project. Furthermore, parents may have viewed the questionnaires as tedious and lengthy, which could have resulted in incorrectly answered questions regarding the stress of the family and the parental mindfulness of the parent. In addition, the sample size of \( n = 33 \), although composed of
individuals who varied in socioeconomic status, was too small to accurately represent the population of interest and to ensure adequate statistical power for the study. Moreover, the field of mindfulness, especially mindful parenting, lacks sufficient prior research on the topic, which made it difficult to draw parallels from this study’s results to older studies. The DANVA 1 and 2 proved unreliable methods for measuring emotional competence, at least among the children included in this project. Furthermore, self-reported data is difficult to verify when stressful events from the past are to be reported. Children’s memories are not well developed at the start of middle childhood, particularly for events that are more than a few days into the past, however there are rapid increases in memory in middle childhood (Weinert & Schneider, 1994). Therefore, a further unexplored question whether age affected the results of the study, as children of 5 different years of age (8 -12) were included. With only 33 participants, age related effects could not be analyzed meaningfully. Selective memory, the introspective inability to provide accurate answers about one’s self, and positive and negative response bias are all possible when administering self-report tests.

**Future Recommendations**

What can be done differently for future studies, and for the extension of the current study, is to make sure that children with mental health problems, if they are the target participants, are currently seeking treatment in order to alleviate the mental distress of the child, and to prevent inaccurate answering during the study. The parent questionnaires could be analyzed to see if they could be shortened, or breaks could be administered when parents take them in order to prevent testing fatigue or boredom. A larger sample size, one that proportionally represents the age range and demographic characteristics of the sample population, would increase external validity of the results. Using measures that are internally reliable and valid for the targeted participants would
ensure accurately measured responses. Self-report measures that included reversed scoring items and did not depend on children’s conceptions of historical events, would help to ensure less biased answers. For adults, the need to ensure confidentiality by leaving the room when questions are being answered must be balanced by a concern for whether questions are clearly understood. Ensuring anonymity and truthful answering are important; the conditions currently used in this study should continue to be used in future studies, but also compared to similar projects that chose a different view of researcher presence during question answering. Finally, over time more studies will expand the knowledge base on parental mindfulness, which should be conducive to analyzing this lab’s current concerns for the reliability of mindfulness measures.
Appendices
Below are instruments used to measure stress, child emotional competence, and parental mindfulness.

**Stress Index**
(and Subscales Noted by T, C, or V)

**During the last year:**
1. Did your family move to a new home or apartment? (T)
2. Did your family’s property get wrecked or damaged due to fire burglary, or other disaster? (C)
3. Has anyone in your family gotten married? (T)
4. Has your family had a new baby come into the family? (T)
5. Has anyone moved out of your home? (T)
6. Did a family member die? (C)
7. Did another close relative or friend die? (C)
8. Has a family member become seriously ill, injured badly, and/or had to stay at the hospital? (C)
9. Has a family member been robbed or attacked? (V)
10. Has someone else you know, other than a member of your family, gotten beaten, shot, or really hurt by others? (V)
11. Have you seen anyone beaten, shot, or really hurt by someone? (V)
12. Did you change where you went to school? (T)
13. Have you seen or been around people shooting guns? (V)
14. Did you have to go live in a foster home? (T)
15. Have you been afraid to go outside and play, or have your parents made you stay inside because of gangs or drugs in your neighborhood? (V)
16. Have you had to hide someplace because of shootings in your neighborhood? (V)

*Note: T = Life Transitions; C = Circumscribed Events; V = Exposure to Violence.*
# Emotion Regulation Checklist

Anne Shields & Dante Cicchetti, 1995

Please tick the box that applies most to this child. Please answer every question as best you can.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is a cheerful child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Exhibits wide mood swings (child’s emotional state is difficult to anticipate because s/he moves quickly from positive to negative moods)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Responds positively to neutral or friendly approaches by adults.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Transitions well from one activity to another; does not become anxious, angry, distressed or overly excited when moving from one activity to another.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Can recover quickly from episodes of upset or distress (e.g. does not pout or remain sullen, anxious or sad after emotionally distressing events)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Is easily frustrated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Responds positively to neutral or friendly approaches by peers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Is prone to angry outbursts / tantrums easily</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>Is able to delay gratification (wait for good things)</td>
<td></td>
<td></td>
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<tr>
<td>10.</td>
<td>Takes pleasure in the distress of others (e.g. laughs when another person gets hurt or punished; enjoy teasing others)</td>
<td></td>
<td></td>
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<tr>
<td>11.</td>
<td>Can modulate excitement in emotionally arousing situations (e.g. does not get ‘carried away’ in high-energy situations, or overly excited in inappropriate contexts.</td>
<td></td>
<td></td>
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<tr>
<td>12.</td>
<td>Is whiny or clingy with adults.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Is prone to disruptive outbursts of energy and exuberance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Responds angrily to limit-setting by adults.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Can say when s/he is feeling sad, angry or mad, fearful or afraid.</td>
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<tr>
<td>16.</td>
<td>Seems sad or listless.</td>
<td></td>
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<tr>
<td>17.</td>
<td>Seems overly exuberant when attempting to engage other in play.</td>
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<tr>
<td>18.</td>
<td>Displays flat affect (expression is vacant and inexpressive; child seems emotionally absent)</td>
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<tr>
<td>19.</td>
<td>Responds negatively to neutral or friendly approaches by peers (e.g. may speak in an angry tone of voice or respond fearfully)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Never</td>
<td>Sometimes</td>
<td>Often</td>
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<tr>
<td>20.</td>
<td>Is impulsive.</td>
<td></td>
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<tr>
<td>21.</td>
<td>Is empathic towards others; shows concern when others are upset or distressed.</td>
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<td></td>
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<tr>
<td>22.</td>
<td>Displays exuberance that others find intrusive or disruptive.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Displays appropriate negative emotions (anger, fear, frustration, distress) in response to hostile, aggressive or intrusive acts by peers.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>24.</td>
<td>Displays negative emotions when attempting to engage others in play.</td>
<td></td>
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</tbody>
</table>
Five Facet Mindfulness Questionnaire (FFMQ)
Ruth A. Baer, Ph.D.
University of Kentucky

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

<table>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>never or very rarely true</td>
<td>rarely true</td>
<td>sometimes true</td>
<td>often true</td>
<td>very often or always true</td>
</tr>
</tbody>
</table>

1. When I’m walking, I deliberately notice the sensations of my body moving.
2. I’m good at finding words to describe my feelings.
3. I criticize myself for having irrational or inappropriate emotions.
4. I perceive my feelings and emotions without having to react to them.
5. When I do things, my mind wanders off and I’m easily distracted.
6. When I take a shower or bath, I stay alert to the sensations of water on my body.
7. I can easily put my beliefs, opinions, and expectations into words.
8. I don’t pay attention to what I’m doing because I’m daydreaming, worrying, or otherwise distracted.
9. I watch my feelings without getting lost in them.
10. I tell myself I shouldn’t be feeling the way I’m feeling.
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
12. It’s hard for me to find the words to describe what I’m thinking.
13. I am easily distracted.
14. I believe some of my thoughts are abnormal or bad and I shouldn’t think that way.
15. I pay attention to sensations, such as the wind in my hair or sun on my face.
16. I have trouble thinking of the right words to express how I feel about things.
17. I make judgments about whether my thoughts are good or bad.
18. I find it difficult to stay focused on what’s happening in the present.
19. When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it.
20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21. In difficult situations, I can pause without immediately reacting.
Stress, Parental Mindfulness, and Children’s Emotional Competence

FFMQ p. 2

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td><strong>never or very rarely true</strong></td>
<td><strong>rarely true</strong></td>
<td><strong>sometimes true</strong></td>
<td><strong>often true</strong></td>
<td><strong>very often or always true</strong></td>
</tr>
</tbody>
</table>

_____ 22. When I have a sensation in my body, it’s difficult for me to describe it because I can’t find the right words.

_____ 23. It seems I am “running on automatic” without much awareness of what I’m doing.

_____ 24. When I have distressing thoughts or images, I feel calm soon after.

_____ 25. I tell myself that I shouldn’t be thinking the way I’m thinking.

_____ 26. I notice the smells and aromas of things.

_____ 27. Even when I’m feeling terribly upset, I can find a way to put it into words.

_____ 28. I rush through activities without being really attentive to them.

_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.

_____ 30. I think some of my emotions are bad or inappropriate and I shouldn’t feel them.

_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

_____ 32. My natural tendency is to put my experiences into words.

_____ 33. When I have distressing thoughts or images, I just notice them and let them go.

_____ 34. I do jobs or tasks automatically without being aware of what I’m doing.

_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____ 36. I pay attention to how my emotions affect my thoughts and behavior.

_____ 37. I can usually describe how I feel at the moment in considerable detail.

_____ 38. I find myself doing things without paying attention.

_____ 39. I disapprove of myself when I have irrational ideas.
FFMQ Scoring instructions

For all items marked “R” the scoring must be reversed. Change 1 to 5, 2 to 4, 4 to 2, and 5 to 1 (3 stays unchanged). Then sum the scores for each subscale.

Observing
1, 6, 11, 15, 20, 26, 31, 36

Describing
2, 7, 12R, 16R, 22R, 27, 32, 37

Acting with awareness

Nonjudging of inner experience

Nonreactivity to inner experience
4, 9, 19, 21, 24, 29,
**Interpersonal Mindfulness in Parenting (IEM-P) scale**

**Instructions:** The following statements describe different ways that parents interact with their children on a daily basis. Please tell me whether you think the statement is “Never True,” “Rarely True,” “Sometimes True,” “Often True,” or “Always True” for you. Remember, there are no right or wrong answers and please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each statement separately from every other statement.

<table>
<thead>
<tr>
<th></th>
<th>Never True</th>
<th>Rarely True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find myself listening to my child with one ear because I am busy doing or thinking about something else at the same time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. When I’m upset with my child, I notice how I am feeling before I take action.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I notice how changes in my child’s mood affect my mood.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I listen carefully to my child’s ideas, even when I disagree with them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I often react too quickly to what my child says or does.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I am aware of how my moods affect the way I treat my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Even when it makes me uncomfortable, I allow my child to express his/her feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. When I am upset with my child, I calmly tell him/her how I am feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I rush through activities with my child without being really attentive to him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have difficulty accepting my child’s growing independence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Scoring information (hypothesized subscales):

**Awareness & Present-Centered Attention**
1. I find myself listening to my child with one ear, because I am busy doing or thinking about something else at the same time.*
3. I notice how changes in my child’s mood affect my mood.
6. I am aware of how my moods affect the way I treat my child.
9. I rush through activities with my child without being really attentive to him/her.*

**Non-judgment**
4. I listen carefully to my child’s ideas, even when I disagree with them.
7. Even when it makes me uncomfortable, I allow my child to express his/her feelings.
10. I have difficulty accepting my child’s growing independence.*

**Non-reactivity**
2. When I’m upset with my child, I notice how I am feeling before I take action.
5. I often react too quickly to what my child says or does.*
8. When I am upset with my child, I calmly tell him/her how I am feeling.

*Items with an * are reverse-scored*
Research Participant Recruitment Script

Title of Study: The Impact of Stress, Trauma, and Parenting on Psychosocial Outcomes of Children Participating in Mental Health Services

Principal Investigator (PI): Nicholas Seivert, MA
Department of Psychology, Wayne State University

1) What does this study involve?

This study is a research project that is seeking to collect data from children participating in mental health services and their families. We are looking for children for children between the ages of 8-12 years and one of their parents to participate.

2) What is the topic of the research?

In this research study, we are looking at children in mental health treatment and the impact of their experience of psychological stress and trauma on their emotions, social skills, and behavior. We are also looking at how parenting could play a role in affecting these outcomes.

3) What is the time commitment?

Participation in the study should take about one hour. It will take place at the site where your family participates in mental health services (either The Children’s Center or the WSU Psychology Clinic).

4) What are the basic procedures?

Parents will complete a background questionnaire and a series of psychological measures. The psychological measures will include reports of your child’s background, emotions, and behavior. There will also be measures in which parents will report on their own background, emotions, and behavior. The child will engage in research tasks separately with research staff to find out about their verbal skills as well as their background, emotions, and behavior.

5) Is this study voluntary?

This study is completely voluntary. Families do not have to participate if they do not want to. Participation or refusal to participate will in no way affect your clinical services. Each family that participates will be given a $20 gift card to Meijer.

6) Would you and your family like to participate?
If yes, research staff will arrange a time for the family to come in to the site where they receive clinical services (either WSU Psychology Clinic or The Children’s Center) to participate in 1-hour data collection session.

Behavioral Research Informed Consent

Title of Study: The Impact of Stress, Trauma, and Parenting on Psychosocial Outcomes of Children Participating in Mental Health Services

Principal Investigator (PI): Nicholas Seivert, MA
5057 Woodward Ave, 7th Floor
Department of Psychology, Wayne State University
Detroit, MI 48202
313-577-2840

Funding Source: Department of Psychology and The Graduate School, Wayne State University

When we say “you” in this consent form, we mean you and your child; “we” means the researchers and other staff.

Purpose

You are being asked to be in a research study about the impact of stress and trauma on children’s mental development because your child participates in mental health services and is between the ages of 8-12 years. This study is being conducted at Wayne State University and The Children’s Center of Wayne County. The estimated number of study participants to be enrolled at Wayne State University is about 85 families (85 children + 85 parents = 170 total participants). Please read this form and ask any questions you may have before agreeing to be in the study.

In this research study, we are looking at children in mental health treatment and the impact of their experience of psychological stress and trauma on their emotions, social skills, and behavior. We are also looking at how parenting could play a role in affecting these outcomes. Parenting factors include parent’s history of experienced trauma, positive parenting behavior, and parent mindfulness, or parent’s ability to generally be aware of themselves and their surroundings.

Study Procedures

If you agree to take part in this research study, you will be asked to complete a series of surveys and questionnaires about you and your child. Your child will complete a series of tasks with research staff in a separate room. Participation will include a single session lasting approximately one hour. The location will be at Wayne State University (WSU) Psychology Clinic or The Children Center, wherever your child receives clinical services. First, you will be asked to sign a release form so that researchers are able to access your child’s record at the study site. Following this, you will complete a background questionnaire and a series of psychological measures. The psychological measures will include reports of your child’s symptoms, history of psychological stress and trauma, mindfulness (awareness of themselves and their surroundings), behavior
Stress, Parental Mindfulness, and Children’s Emotional Competence

provides, social skills, and emotional control. There will also be measures in which you will report on your own history and behavior, including your experience of psychological trauma, mindfulness, and parenting confidence. Your child will engage in research tasks separately with research staff, including a measure of vocabulary, experienced stress, perception of self-worth, and ability to identify emotions in others. You and your child are not obligated to complete all study tasks if you agree to participate. Each family will be assigned a participant number that will be associated with all of the information you provide. You and your child’s names will be recorded separately and not associated with any of the information you give provide. There will be password protected master list of research participants’ names and their associated numbers that will be kept separate from the provided information.

Benefits

As a participant in this research study, there will be no direct benefit for you; however, information from this study may benefit other people in the future.

Risks

By taking part in this study, you may experience the following risks: emotional risks, such as feelings of sadness or anxiety, particularly as it relates to disclosure of experienced psychological stress and trauma as well as reporting on behavior problems. This risk for and level of discomfort is not greater than what you may have experienced through participation in mental health services.

The following information must be released/reported to the appropriate authorities if at any time during the study there is concern that:

- child abuse or neglect has possibly occurred,
- you disclose illegal criminal activities, illegal substance abuse or violence.

If new, unreported instances of child abuse or neglect are discovered during the course of the study, researchers are obligated to report this information to Michigan Child Protective Services, which could result in legal action towards the alleged perpetrator.

If any of the above described study risk events occur, your primary clinician at WSU Psychology Clinic or The Children Center will be alerted in-person by research staff.

There may also be risks involved from taking part in this study that are not known to researchers at this time.

Study Costs

Participation in this study will be of no cost to you.

Compensation

For taking part in this research study, you will be paid for your time and inconvenience up to $20 in Meijer gift cards. For completion of the parent portion of the study, you will receive a $10 Meijer gift card. For completion of the child portion of the study, you will receive a $10 Meijer gift card.
gift card. If you are not a U.S. citizen and/or not a U.S. taxpayer, 30% of the compensation will be withheld by Wayne State University. Please inform research staff if this is the case for you.

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code name or number. Information that identifies you personally will not be released without your written permission. However, the study sponsor, the Institutional Review Board (IRB) at Wayne State University, or federal agencies with appropriate regulatory oversight [e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.] may review your records.

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study, you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study.

Questions

If you have any questions about this study now or in the future, you may contact Nicholas Seivert or one of his research team members at the following phone number 313-577-2840. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call the Wayne State Research Subject Advocate at (313) 577-1628 to discuss problems, obtain information, or offer input.
Consent to Participate in a Research Study

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

______________________________   _____________
Signature of participant / Legally authorized representative *       Date

______________________________   _____________
Printed name of participant / Legally authorized representative *       Time

______________________________   _____________
Signature of witness**       Date

______________________________   _____________
Printed of witness**       Time

______________________________   _____________
Signature of person obtaining consent       Date

______________________________   _____________
Printed name of person obtaining consent       Time

**Use when participant has had this consent form read to them (i.e., illiterate, legally blind, translated into foreign language).

______________________________   _____________
Signature of translator       Date

______________________________   _____________
Printed name of translator       Time

Continue to HIPAA Authorization on next page
A federal regulation, known as the “Health Insurance Portability and Accountability Act (HIPAA)” gives you certain rights concerning the use and disclosure (sharing with others) of your Protected Health Information (PHI). This regulation provides safeguards for the privacy and security of your information. Your permission (authorization) is required for the use and sharing of any protected health information collected as part of this research study. If you are not willing to sign this authorization to use and/or disclose your PHI by the research team, you will not be eligible to take part in this research study.

The principal investigator (PI) and his research team will use your medical records and information created or collected as part of this research study. Your PHI is important for the PI and his research team in order to collect information about you during the study, to be able to contact you if needed, and to provide treatments to you during the study, if required. The PI may send out your study related health information to the sponsor or other entities involved in this study.

Your medical records, which may contain information that directly identifies you, may be reviewed by representatives from groups identified below. The purpose of these reviews is to assure the study is being conducted properly, that data is being obtained correctly or for other uses authorized by law. These reviews occur at the study site or in the PI’s research office and can take place anytime during the study or after the study has ended.

The PHI that will be “USED” for this research includes the following: name, address (city, state and zip code), phone number, elements of dates, diagnostic information, and medical record number.

The PHI that will be “DISCLOSED” or shared with others for this research includes the following: none.

Your study information may be used or shared with the following people or groups:
- The PI, co-investigators, and key personnel of WSU associated with the research project
- WSU’s Institutional Review Boards (IRB)
- Other collaborating academic research institutions, which include: WSU Psychology Clinic, The Children’s Center of Wayne County
- Federal agencies with appropriate regulatory oversight (e.g., FDA, OHRP, OCR, etc.) may review your records.

Once your information has been released according to this Authorization, it could be released again and may no longer be protected by the HIPAA regulations.

This Authorization does not expire. The research team may need to correct it or provide missing information about you even after the study has ended, and your medical records may be needed to assist in this process.
During your participation in this study you will have access to your medical record and any study information that is part of that record. The PI is not required to release research information that is not part of your medical record.

You may withdraw (take back) your permission for the use and disclosure of your PHI for this research at any time, by writing to the PI at the address on the first page of this form. Even if you withdraw your permission, the PI for the research project may still use your PHI that was collected prior to your written request if that information is necessary to the study. If you withdraw your permission for use of your PHI, you will also be withdrawn from the research project. Withdrawing your authorization will not affect the health care that will be provided by the Detroit Medical Center and/or the WSU School of Medicine Practice Plans.
Stress, Parental Mindfulness, and Children’s Emotional Competence

References


doi:http://dx.doi.org.proxy.lib.wayne.edu/10.1017/S0954579409990307


Stress, Parental Mindfulness, and Children’s Emotional Competence


doi:http://dx.doi.org.proxy.lib.wayne.edu/10.1007/s10802-013-9713-4


doi:http://dx.doi.org.proxy.lib.wayne.edu/10.1080/0305764X.2016.1146659


doi:http://dx.doi.org.proxy.lib.wayne.edu/10.1023/A:1024426431247


Stress, Parental Mindfulness, and Children’s Emotional Competence


Acknowledgements

I would like to thank the people and organizations who have supported me in the completion of my honors thesis. These are the Wayne State Psychology Clinic, and the Children’s Center, where the participants in my thesis were recruited. My gratitude goes to my Principal Investigator Amber Sepsey, and my Principal Investigator Nick Sievert, who conceived of the larger project from which data for my thesis came, along with my co-lab members, who helped with collecting and preparing data from the participants in this project. I also thank my professor and head of the Emotional Developmental Lab, Dr. Rita Casey, who has put in a tremendous amount of effort in helping me finish my thesis.
Autobiographical Statement

I was born in East Lansing, but moved to California at the age of three. The son of a couple of Syrian immigrants, my collectivized family heavily focused on education. My high school courses introduced me to both psychology and other ‘hard’ sciences like biology and chemistry. I excelled in courses that seemed to me applicable in real world experiences. I began volunteering my senior year of high school in Loma Linda Medical Center of Murrieta. There, I worked the care-cart, handing out magazines and books to patients, and engaged in light-hearted discussions. Their expressions of joy at the pleasure of having nice conversations with a stranger rekindled my interest in service; I decided to merge my interest in psychology and science, and to pursue medicine. One year later, I found myself back in Michigan, as a student of the MedStart program. This program gave me early ties to the Medical School at Wayne State, where we participated in clinical simulations and informative seminars. I found myself part of Detroit’s resurgence, and I plan on staying in Michigan to help bridge the gap between physicians and patients in such an underserved area. Majoring in psychology has helped me connect with patients on a more personal, intimate level, and will help me develop the doctor-patient relationship that is so crucial to providing excellent, quality care.