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Original Research

Comparison of Self-Compassion, Distress Tolerance and Psychological Flexibility in Parents of Normal and Disabled students

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Abstract:

Introduction: Given the importance of distress tolerance in parents of disabled children, the present study aims to compare self-compassion, distress tolerance, and psychological flexibility in parents of normal and disabled students.

Research method: This study is an applied and comparative causal research in terms of methodology, comparing two groups of mothers with ordinary and disabled elementary students in terms of the variables of self-compassion, distress tolerance, and psychological flexibility. It also uses a quantitative approach in order to collect the research data. The research population consisted of the families with disabled and healthy children in the city of Joyn, out of which 50 families were randomly selected for each group. For the group of mothers with disabled children, the families who were members of the Welfare Organization of this city were considered. Standard research questionnaires were used as the research tool, including Reyes's self-compassion questionnaire, Simmons's distress tolerance scale, and Dennis's cognitive flexibility inventory (CFI).

Findings: The research results indicated that the variables of self-compassion, distress tolerance and psychological flexibility are different between the parents of ordinary and disabled students.

Keywords: distress tolerance, ordinary and disabled students, psychological flexibility, Self-compassion

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Introduction:

Exceptional and disabled children exist throughout the world, and as the world population increases, the population of this group increases as well. Considering the growing population of these people and the fact that these children and their families have special needs, special attempts must be taken in order to understand the causes of these disabilities and prevent the birth of these children [1]. On the other hand, considering their physical movement limitations or mental disabilities, taking care of these children requires a separate discussion, as the associated damages and costs are a challenging problem for their parents, especially their mothers, which in turn exposes them to various psychological damages and decreased tolerance [2]. Although all members of the family are damaged in such a situation, the parents, and specially mothers, are more exposed to psychological problems, because due to their traditional role as "caregivers", they assume more responsibilities towards their disabled children [3]. It is assumed that problems related to caring for a troubled child put parents at risk of developing mental health problems. As a result of the birth of a premature child, the parents show intensive emotional reactions, including the fear of facing the child's death or disability and feelings of inadequacy and discomfort. This issue and issues like this can affect many variables related to mental health in families. One of these variables that seems to require more investigation in families with disabled children is "self-compassion" [4].

Self-compassion is defined as being kind to yourself in cases of perceived inadequacy, failure, or general suffering. The authors in [5] suggested three main components for self-compassion: 1) self-kindness; 2) common humanity; and 3) mindfulness [6]. Self-kindness involves being kind to yourself in the face of personal pain and shortcomings, rather than ignoring them or self-harming with self-criticism. Common humanity involves the fact that personal suffering and failure are part of the common human experience. Mindfulness requires a balanced approach to one's negative emotions so that his/her emotions are neither suppressed nor exaggerated. In this way, negative thoughts and feelings are clearly observed and brought into the awareness of the conscious mind [7]. A sense of self-compassion in parents with a disabled child helps to accept the existing conditions and their disabled child and preserve their mental health.

Another variable related to families with disabled children that has received less attention by researchers is "distress tolerance". This variable has a multidimensional nature and is influenced by several dimensions, including the ability to tolerate, evaluate and accept the emotional state, emotional regulation by the individual, the level of absorption by negative emotions, and the amount of its contribution to the occurrence of dysfunction. [8]. According to various studies, low distress tolerance is closely correlated with a wide range of disorders, e.g. self-harming behaviors [9], major depressive disorder, and severe impulsive behaviors [10]. Moreover, another variable that is compared among families with disabled and ordinary children in this study is "psychological flexibility" [11]. Psychological flexibility refers to the ability to be open-minded, focus on the present, and adjust behavior as the situation changes. In other words,

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psychological flexibility makes it possible for a person to be able to make a correct diagnosis in different situations and perform behaviors that help improve the situation. Therefore, this variable is a multifaceted attribute involving cognitive, behavioral, and emotional aspects, being manifested in many areas of life. It is also a dynamic attribute that is manifested in one's interaction with the environment [12]. The birth of a disabled child as a crisis can have a profound effect on family relationships and actions. Families who have open, effective, and permanent communications and are flexible in their roles can adapt well to address such crises [13]. It has been widely accepted that parents with disabled children have less physical and mental health compared to parents with ordinary children. In particular, mothers of these children, due to being much more involved with their disabled children, are more exposed to damages than their fathers. In our society, parents with disabled children not only do not receive the right support, but they are put under additional pressure from the society and different cultures, and others also feel sorry for them. On the other hand, the economic costs of a disabled child are also heavy for some parents [14]. Considering that the variables of self-compassion, distress tolerance, and psychological flexibility seem to be particularly important in a family with a disabled child, and on the other hand, they have not been carefully examined scientifically in previous studies, the present study was conducted with the aim of evaluating and comparing these variables in parents with ordinary and disabled students. The main question of our research is whether there is a difference between self-compassion, distress tolerance, and psychological flexibility in parents of odinary and disabled students.

Research method:

This study is an applied and comparative causal research in terms of methodology, comparing two groups of mothers with ordinary and disabled elementary students in terms of the variables of self-compassion, distress tolerance, and psychological flexibility. The research population consisted of all the parents of ordinary and disabled children in the city of Joyn. The parents who were referring to the Niayesh Center of Joyn city were considered as the parents of disabled children (60 people), and the parents of students studying in Joyn elementary schools were used as the parents of ordinary students. The available sampling method was used to select people, according to which first all the people who wanted to participate in the research were registered, out of whom those who had the conditions and possibility to participate in the research (such as reading and writing literacy) we selected. The research inclusion criteria included: 1) mothers with mentally disabled children under care in centers for the mentally disabled, 2) the mothers aged between 19-35, 3) at least one of the variables of self-compassion, distress tolerance, and psychological flexibility in the mothers was above average, 4) having at least a diploma education, 5) not participating in psychological courses in the last 2 months, and 6) not taking psychiatric drugs; and the research exclusion criteria included: refusing to complete the questionnaire and completing the questionnaire improperly. The research tools included:

Self-Compassion Questionnaire: Developed by Reyes et al. [15], this self-report scale has 26 items and measures the positive and negative aspects of the three main dimensions of self-

compassion, i.e. self-kindness (5 items) versus self-judgment (5 items), common humanity (4 items) versus isolation (4 items), and mindfulness (4 items) versus over-identification (4 items). The questions were designed based on a 5-point Likert scale ranged from almost never to almost always. The average score of these 6 components (including reverse scores) gives the self-compassion score. To obtain the overall score of self-compassion, its negative subscales (self-judgment, isolation, and over-identification) should be scored inversely. The questionnaire components included self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. In Shahbazi's et al. research [16], a 12-item short form, with six subscales and two items each, developed by Reyes et al. (2011), was used to measure self-compassion. In Shahbazi' et al. research (2014), the alpha coefficient for the overall score of the scale was 0.91. Moreover, Cronbach's alpha coefficients for the subscales of self-kindness, self-judgment, common human experiences, isolation, mindfulness, and over-identification were 0.83, 0.87, 0.91, 0.88, 0.92, and 0.77, respectively. The concurrent and convergent validities of the questionnaire were also reported as favorable. In this research, the reliability of the questionnaire was declared as 0.89 and its validity was also confirmed by different professors.

Distress Tolerance Scale: This scale is a self-measurement index of emotional distress tolerance that was developed by Simons and Gaher in 2005 [17]. It has 15 items and four subscales, i.e. emotional distress tolerance, absorption by negative emotions, mental estimation of distress, and adjustment of efforts to relieve distress. The questions were scored based on a 5-point Likert scale, ranging from completely agree to completely disagree. A question in this scale was reversely scored. A score of 45 is the cut-off point of the questionnaire. Scores higher than 45 indicate high distress tolerance and scores less than 45 indicate low distress tolerance. The validity and reliability levels of the scale were also determined and mentioned in its file. The reliability and validity of this questionnaire has been confirmed by Alavi [18] in Iranian society. Its reliability was obtained by Cronbach's alpha coefficient (0.92).

Cognitive flexibility inventory (CFI): This questionnaire was developed by Dennis and Vander Wal [19] in 2010 and consists of 20 questions. It is used to evaluate a person's progress in clinical and non-clinical work as well as in developing flexible thinking in the cognitive-behavioral treatment of depression and other mental illnesses. In Iran, the researchers in [20] have obtained three subscales for this questionnaire: alternatives, control, and alternatives for human behavior. In Dennis and Vander Wal (2010), the concurrent validity of this questionnaire with the Beck Depression Inventory (BDI-II) was -0.39 and its convergent validity with Martin and Robin's cognitive flexibility scale was 0.75. In Iran, Soltani et al. (2012) reported the retest coefficient of the whole scale as 0.71 and Cronbach's alpha coefficients as 0.90. Cronbach's alpha of the data of this questionnaire was found to be 0.75 in Fazli's et al. [21] study. In the current research, Cronbach's alpha for the subscales of alternatives, control, and alternatives for human behavior was obtained as 0.72, 0.55, and 0.57, respectively.

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This study was implemented using a questionnaire. Due to the restrictions of the Corona era, the questionnaires were uploaded using the website and the link was sent to the people in the virtual space, and in some cases it was distributed in person.

Table 1. Descriptive characteristics of the change of the subscales of the research variables by separating the two groups.

	Variable	Group	Mean	SD
Self-compassion	Self-kindness	Ordinary	6.19	2.4
		Disabled	7.17	9.3
	Self-judgment	Ordinary	8.15	5.3
		Disabled	9.18	7.3
	Common humanity	Ordinary	1.18	5.4
		Disabled	4.16	9.3
	Isolation	Ordinary	6.11	4.3
		Disabled	7.12	5.3
	Mindfulness	Ordinary	8.14	7.3
		Disabled	9.11	1.3
	Identification	Ordinary	8.15	7.3
		Disabled	4.15	6.3
Distress tolerance	Emotional distress tolerance	Ordinary	4.11	2.3
		Disabled	8.9	1.3
	Absorption by negative emotions	Ordinary	6.12	8.3
		Disabled	4.13	9.3
	Mental estimation of distress	Ordinary	5.13	5.3
		Disabled	7.13	6.3
	Adjustment of efforts to relieve distress	Ordinary	5.10	7.2
		Disabled	8.8	3.2
Psychological flexibility	Alternatives	Ordinary	9.45	8.11
		Disabled	7.41	7.9
	Control	Ordinary	4.27	4.7
		Disabled	3.24	3.7
	Alternatives for human behavior	Ordinary	5.8	7.1
		Disabled	3.6	5.1

Table 2. Checking the normality of data distribution.

	Variable	Kolmogorov-Smirnov z-value	p-value
Self-compassion	Self-kindness	1.278	0.076
	Self-judgment	0.365	0.999
	Common humanity	0.73	0.66
	Isolation	0.116	0.24
	Mindfulness	0.145	0.21
	Identification	0.07	0.2
Distress tolerance	Emotional distress tolerance	0.125	0.23
	Absorption by negative emotions	0.548	0.795
	Mental estimation of distress	0.115	0.2
	Adjustment of efforts to relieve distress	0.07	0.2
Psychological flexibility	Alternatives	0.177	0.05
	Control	0.115	0.2
	Alternatives for human behavior	0.07	0.2

Table 3. Levene's test to check the homogeneity of the variance of the scores of the research variables.

Variable	F	Significance level
Self-kindness	4.9	0.028
Self-judgment	0.085	0.771
Common humanity	0.31	0.57
Isolation	0.03	0.88
Mindfulness	1.9	0.16
Identification	10.3	0.002
Emotional distress tolerance	5.1	0.025
Absorption by negative emotions	0.89	0.29
Mental estimation of distress	12.1	0.001
Adjustment of efforts to relieve distress	2.07	0.15
Alternatives	2.1	0.14
Control	0.23	0.09
Alternatives for human behavior	0.62	0.73

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Moreover, the results of Levene's test are listed in Table 3 to check the homogeneity of the variances of the research variables. As can be seen, the homogeneity of the variance of the evaluation scores is significant ($p<0.05$).

Table 4. Comparing the level of self-compassion in parents of ordinary and disabled students.

Variable	Mean difference	SD difference	DF	T statistic	Significance level
Self-kindness	1.9	0.3	98	5.6	0.001
Self-judgment	-3.1	-0.2	98	9.13	0.001
Common humanity	1.7	0.6	98	4/4	0.001
Isolation	-1.1	-0.1	98	3.8	0.001
Mindfulness	2.9	0.6	98	7.6	0.001
Identification	0.4	0.1	98	1.4	0.074

As can be seen in Table 4, as the values of the significance level of self-compassion and its subscales are less than 0.05, it can be said that with a confidence level of 0.95, self-compassion is different in parents of ordinary and disabled students.

Table 5. Comparing the level of distress tolerance in parents of ordinary and disabled students.

Variable	Mean difference	SD difference	DF	T statistic	Significance level
Emotional distress tolerance	1.6	0.1	98	4.7	0.001
Absorption by negative emotions	-0.8	-0.1	98	-3.3	0.009
Mental estimation of distress	0.2	-0.1	98	1.5	0.41
Adjustment of efforts to relieve distress	1.7	0.4	98	5.1	0.001

As can be seen in Table 5, the values of the significance level of distress tolerance and its subscales are less than 0.05. Thus, with a confidence level of 0.95, it can be said that distress tolerance is different in parents of ordinary and disabled students.

Table 6. Comparing the level of psychological flexibility in parents of ordinary and disabled students.

Variable	Mean difference	SD difference	DF	T statistic	Significance level
Alternatives	4.2	2.1	98	13.5	0.001
Control	3.1	0.1	98	10.8	0.001
Alternatives for human behavior	2.2	0.2	98	7.4	0.001

As can be seen in Table 6, the values of the significance level of psychological flexibility and its subscales are less than 0.05, so with a confidence level of 0.95, it can be said that psychological flexibility is different in parents of ordinary and disabled students.

Discussion and conclusion:

Self-compassion is different in parents of ordinary and disabled students. According to the results of this study, there is a significant difference between the parents of ordinary and disabled students in terms of the subscales of self-compassion ($P<0.05$). The results of this study are consistent with those obtained by the researchers in [22-23] and not consistent with the results in [24]. In explaining these results, it can be said that self-compassion acts as a buffer against the effects of negative events. Individuals with high self-compassion judge themselves more kindly, accept negative events of their life more easily, and their self-evaluations and reactions are more accurate and based on their actual performance, as self-judgment in these people tends neither towards an exaggerated self-criticism nor towards a self-defensive inflation [25]. Accordingly, an individual with self-compassion feels care for him/herself when experiencing stressful events, gains awareness, has a non-judgmental attitude towards his/her inadequacy and failures (in this research, having a disabled child), and accepts the fact that his/her experiences are part of common human experiences [26]. Distress tolerance is different in parents of ordinary and disabled students. The results of this study indicate that there is a difference between the parents of ordinary and disabled students in terms of distress tolerance subscales ($P<0.05$). The results of this research are consistent with those in [27-28]. In explaining these results, based on Zemestani's et al. [29] opinion, it can be said that having a disabled child causes a lot of stress and pressure on the parents, and the pressure factors affecting the parents include: financial problems, e.g. medical expenses, emotional problems in the family, excessive and extreme care, rejecting children, devoting little time to other family members, sacrificing other children, blaming parents, increased tension and family conflicts, problems and issues in family relationships, stressful factors caused by family social life, and increased incidence of psychological disorders such as anxiety and depression in parents with disabled children.

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Therefore, taking care of a disabled child puts a lot of psychological pressure on the parents, and when the parents face their disabled child, due to the constant maintenance and the need to provide special conditions for the development of these children, they experience severe stress and pressure as well as decreased physical and mental health. As these parents are not able to control their child's disability and the pressures on their lives and consider the pressures to be permanent, their degree of distress tolerance decreases [30]. Psychological flexibility is different in parents of ordinary and disabled students. The results of this study indicate that there is a difference between the parents of normal and disabled students in the subscales of psychological flexibility ($P<0.05$). The results of this research are in line with those in [31-32]. In explaining this finding, it can be said that flexibility plays an important role in engaging in health-related behaviors [33]. According to the results of Zhang's et al. research [34], individuals with higher cognitive flexibility are able to act better in stressful situations, and if they are not able to change the source of stress, they behave flexible and consider other alternatives. Parents with disabled children show less cognitive flexibility because they endure more stress than parents with ordinary children. Since parents with ordinary children have a higher level of flexibility compared to parents with disabled children, they better cope with life problems and do not give up on problems; these parents feel secure in their family relationships and are satisfied with the progress their children have made; their children become more compatible and do greater efforts to learn and adapt to the outside world [35].

Research Limitations: The current study had limitations. For example, the research is limited to the city of Joyn, which makes it difficult to generalize the results to other regions. Also, lack of control of socio-economic variables was another limitation of the research.

Suggestions for Future Research: It is suggested to conduct other researches in different cities and different statistical population so that the possibility of generalizing the findings to other cities and other people will not be limited. Also, future research is suggested to consider other variables (e.g. children with ADHDA/hyperactivity disorder, autism, etc.) as independent variables, examine their effects on self-compassion, distress tolerance, and psychological flexibility, and compared their results with the results of the present study. Considering the low level of self-compassion, distress tolerance. and psychological flexibility among parents with disabled children, psychological treatments such as compassion therapy and mindfulness therapy should be used for these parents.

Conflict of Interest

The authors declare that this work is the result of an independent research and does not have any conflict of interest with other organizations and individuals.

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