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EVALUATION OF THE EFFECT OF COMPASSION-CENTERED EDUCATION OF MOTHERS ON REDUCING ANXIETY OF CHILDREN AGED 4-6 YEARS

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ABSTRACT

The aim of this study was to evaluate the effect of compassion-centered education of mothers on reducing anxiety in children aged 4-6 years. The research method was a quasi-experimental, pre-test, post-test and follow-up with the experimental and control group. The research population included all mothers with preschool children in Isfahan in 2018. Using a convenient sampling method, 30 mothers who had a child with anxiety symptoms were selected and randomly divided into two experimental and control groups (each group included 15 subjects). The experimental group received compassion-centered education for 12 sessions in group, 90 minutes per session, and the control group did not receive any interventions. Demographic information questionnaire and Spence et al Children's Anxiety Scale were used as the research tools. Data were analyzed using repeated measures analysis of variance. The results revealed a significant difference among the pre-test, post-test and follow-up scores in anxiety, and the mean scores in the post-test and follow-up stages showed reduction compared with the mean score in pre-test stage and the scores in these groups showed significant changes compared to control group ($p < 0.05$). These results were closer to the posttest in the one-month follow-up. In general, it was found that compassion-centered education of mothers was effective on reducing the children's anxiety, because mental health of parents and the quality of their relationship can affect the quality of their children's life.

Keywords: *Mental health, Compassion-centered education of mothers, Anxiety, Children.*

INTRODUCTION

Anxiety is a very unpleasant and often vague feeling of concern, which is often associated with symptoms of the autonomic system, including chest tightness, palpitations, sweating, headache, stomach ache, and restlessness characterized by inability to sit or stand (Kaplan and Saduk, 2007). Anxiety is a state with strong negative emotions and symptoms of physical stress in which the child predicts the danger or misery of the future (Lotfifar et al., 2013). Anxious and distressed mother will have an anxious child, and the anxious father may also educate an anxious child (Noorbala et al., 2013). In other words, in this state, the child models his parents. Anxious children are often rejected, defeated, and insecure (Sharifi Daramadi and Moradi, 2012). The most common reaction to mental pressure is anxiety. Anxiety disorders are one of the most common psychiatric disorders in the United States and many other populations that have been studied. In addition, studies have always shown that these disorders cause many problems and complications, and major parts of health care services are allocated for them, and they cause many dysfunctions in people. Recent studies have also shown that chronic

anxiety disorder can increase the mortality associated with the complications of primary hypertension. Thus, psychiatric clinics and other professionals should be able to diagnose and treat the anxiety disorder quickly and accurately (Clark and Beck, 2014). Compassion-centered therapy is the third generation of cognitive-behavioral therapies whose goal is to stimulate a social mentality that is around the desire to develop self-compassion and to use a compassionate mind approach (Gilbert, 2009). A compassion-centered education approach has been developed to help individuals grow emotional-based experiences of relaxation for self-relaxation. In others words, they aim to improve the positive emotions and adjust the emotions that are based on depression, anxiety, lack of self-esteem and anger and other unfavorable states.

Therefore, all stages of treatment, educations, exercises, and techniques of compassion-centered therapy target the activation of the relaxation system, so that they are always available and help for adjusting emotions that are based on depression, anxiety, anger, and lack of self-esteem. The framework considered by the therapist is examined through two mental sets. These two sets are: 1-Understanding the suffering / interaction 2-relief / prevention of suffering (Gilbert, 2014). Ghadampour and Mansouri (2018) examined "the effectiveness of compassion-centered therapy on increasing the level of optimism and self-esteem among students with generalized anxiety disorder". The results of this study showed that compassion-centered therapy is an important factor in increasing the optimism and self-compassion of the people with generalized anxiety disorder. Ismaeli et al. (2018) investigated the "effectiveness of acceptance and commitment-based therapy with a focus on compassion on social anxiety in adolescent girls." The results showed the effectiveness of acceptance and commitment based therapy with a focus on compassion on social anxiety in adolescent girls. Manzari Tavakoli (2016) examined the effectiveness of group compassion-centered education on anxiety and depression among students of Baft Islamic Azad University. The results of covariance analysis indicated that the implementation of compassion-centered education intervention can lead to a significant reduction in anxiety and depression in male and female students participating in the present study compared to the control group. Proeve, Anton and Kenny (2018) conducted a research with the aim of investigating the effectiveness of mindfulness-based cognitive therapy on shamefulness, self-compassion and psychological distress in anxious and depressed patients. The research results showed that shamefulness and external shame have a significant and positive relationship with coldness. Moreover, external shame showed a positive and significant relationship with stress and depression symptoms. Mindfulness-based cognitive therapy increased self-compassion and reduced personal coldness, shamefulness, and rumination, anxiety, and stress symptoms. This research evaluated the effectiveness of compassion-centered education of mothers on reducing anxiety in preschool children.

METHODOLOGY

The method of this study was quasi-experimental and pre-test, post-test and follow-up with a control group. The research population included all mothers with preschool children in Isfahan in 2018. Using a convenient sampling method, 30 mothers who had a child with anxiety symptoms were selected and randomly assigned to two groups of experimental and



control (each group included 15 subjects). The research inclusion criteria included having preschool child with anxiety symptoms, lack of other mental and physical problem that can lead to difficulty during the intervention, having depression in mothers and not having other emotional disorders diagnosed by the psychiatrist, and non-using psychiatric drugs in mothers. The research exclusion criteria also included non- synchrony of two disorders in children, absence in more than 2 sessions, and not giving complete answer to the questionnaire's questions. The demographic information of the questionnaire included children's information, including gender, age, and so on. Preschool Anxiety Scale: It is completed by parents and has been prepared based on anxiety disorders' list of the fourth diagnostic and statistical system of mental disorders. It has 28 items assessing the separation anxiety disorder, generalized anxiety disorder, social anxiety disorder, social phobia (as a specific disorder), and obsessive-compulsive disorder in children aged 2 to 5 years. Total score of anxiety is calculated through the sum of these six sub-scales. After 28 items, there is an open question about the child's experience of the harmful events that no score is given to it, but if the child experienced such an event, it would be followed with 5 other items that target the symptoms of post-traumatic disorders. The score of these 5 items is not counted in the total score and is only given for the clinical attention to this disorder. Unlike other parental rating scales, such as Child Behavior Checklist (CBCL, Achenbach and Rescorla, 2002), and the strengths and difficulties' questionnaire, which do not examine anxiety specifically and consider the child anxiety as a part of general problems (Such as internalization problems that include emotional problems and depression), this scale examines most of anxiety problems focusing on anxiety problems. Psychometric evaluations of this scale have had positive results. The internal consistency of the sub-scales, the correlation between the results obtained from parents, and test-retest correlations indicate the reliability of the test, and factor analysis and correlation with other previous tools such as Child Behavioral Checklist and comparison of the results of the group of children with anxiety disorders and normal children confirms the scale validity. The reliability of this questionnaire was obtained 0.71, 0.70, 0.68, 0.65, 0.57, and 0.65 for generalized anxiety dimension, social phobia dimension, obsessive-compulsive disorder dimension, physical harms dimension, separation anxiety disorder, and the total anxiety scale, respectively. The procedure of research implementation was in this way that the mothers first answered the Preschool Anxiety Scale. The experimental group received compassion-centered education's theoretical foundations and principles (Ranjbar and Nouri, 2016) for 12 sessions, two sessions per week, and 90 minutes per session. The control group did not receive any treatment. Immediately after completing the education, the questionnaires were taken from experimental and control groups. Before the implementation of the project, the objectives and method of conducting the research were described for the participants and their consent was taken. A summary of each session is presented in Table 1.



Table 1. Compassion-centered educational program

| Sessions | Description of sessions |
|-----------|--|
| Session 1 | An introduction to compassion-centered treatment The members and therapist acquaintance with each other, stating the expectations of members from each other, describing the rules of group, establishing a therapeutic relationship and listening to the narratives of patients and empathy of |

| | |
|-----------|---|
| | members with each other, a brief explanation of emotions, a brief explanation of the compassion-centered approach (especially discussion on mindfulness and compassion), educating and performing the mindfulness breathing exercises. |
| Session 2 | <p>Three-ring model</p> <p>Think of the times when you were in a threat ring and feel threatened. These threats can be physical, but they are often social (based on communication with others), or based on psychology (based on the thoughts we have had). Now think of a situation that has come to you recently and activated your threat system.</p> <p>What was your body feeling?</p> <p>What reactions occurred when you felt threatened?</p> <p>What kinds of emotions did you experience when you felt threatened?</p> <p>What kind of thoughts did you have?</p> |
| Session 3 | <p>An introduction to compassion</p> <p>-Review of past session</p> <p>What is compassion?</p> <p>-Introduction of compassionate mind approach (attention, thinking and reasoning, imagination, motivation, behavior and emotion) / plotting exercise chart</p> <p>Think of the times when you feel threatened or angry. Imagine that an event has disturbed you or made you feel insecure or threatened.</p> |
| Session 4 | <p>Bothersome brain</p> <p>-Introduction of the old and new brain</p> <p>-Introducing negative and threatening emotions (anger, anxiety and fear) from the point of view of the three-ring system and the old and new brain</p> <p>-Treatment: Working with three-ring model- relaxing breathing</p> |
| Session 5 | <p>Spectrum of emotions</p> <p>- Examining some emotions like depression, anxiety and anger from a compassionate mind</p> <p>- Discovery of different parts of an emotion and practice in this regard</p> <p>-Reviewing homework, receiving feedback and discussion</p> |
| Session 6 | <p>Learning to change the patterns of troublesome patterns</p> <p>-Examining past patterns and old and new brain reactions facing with problems and barriers</p> <p>-Information of compassion components</p> <p>-Examining a recent emotion regarding compassion factors</p> |
| Session 7 | <p>Working with emotional habits</p> <p>-Introducing compassion skills</p> <p>-Compassionate thinking and behavior</p> <p>-Practicing to create secure space</p> |
| Session 8 | <p>Blaming thinking and behavior / compassionate thinking and behavior</p> <p>-Reminding compassion skills and explaining the role of compassion in guiding thinking and reactions</p> <p>-Practice of self-criticizing and its causes and consequences</p> <p>- Learning compassionate thoughts and behaviors against the critic ones</p> |



| | |
|------------|--|
| | -Examining the types of reactions against failures and barriers (critic and compassionate styles) |
| Session 9 | Integration of changes in a compassionate structure practice: Creation of an ideal self-compassion First, breathe with a relaxed rhythm and compassionate demonstrations. Imagine a safe place, sounds, feeling and landscapes. Remind yourself that this is your safe place, and being in it is amazing for you; here is the place you like. Meet your kind image in it. What is the form of an ideal image of a caring person? In what ways, do you like others speak with you? What other features do you like in this image? What kind of relationship do you like with the compassionate image? |
| Session 10 | Fear of self-compassion Identifying the inhibitory thoughts of self-compassion and working on them |
| Session 11 | Developing compassion to others The process of empathy The process of forgiveness |
| Session 12 | Developing compassion to others Practice having empathy to others Practice having forgiveness to others Positive growth and helping others |

The obtained data were analyzed in two levels of descriptive and inferential statistics. In the descriptive section, indices such as mean, standard deviation and percentage of frequency were used. In the inferential section, repeated measures' analysis of variance was used and statistical calculations were performed using SPSS, version 22, software.

Ethical considerations

1. Introducing yourself to the participants and a brief explanation of the objective of the study, the way of cooperating, the advantages and disadvantages of participating in the study, the goal of completing the questionnaire
2. Taking the consent of participants to complete the questionnaire
3. Ensuring the participants on the privacy and confidentiality of information
4. Ensuring the participants that have complete freedom to leave the research at any stage
5. Ensuring the participants that the data will be analyzed, reported, and published with observing unanimousness principles

RESULTS

The demographic variables of this study included gender, age, number of children, maternal age and maternal education. They are presented in Table 2.

Table 2. Frequency distribution of gender, age, number of children, maternal age and maternal education

| Variables and their levels | | f | % | Total |
|----------------------------|--------|----|----|-------|
| Gender | male | 15 | 50 | 30 |
| | female | 15 | 50 | |



| | | | | |
|--------------------|---------------------------|----|------|----|
| Child age | 4 years | 2 | 7.6 | 30 |
| | 5 years | 14 | 7.46 | |
| | 6 years | 12 | 40 | |
| | 7 years and older | 2 | 7.6 | |
| Number of children | 1 | 16 | 3.53 | 30 |
| | 2 | 8 | 7.26 | |
| | 3 | 2 | 7.6 | |
| | 4 and more | 4 | 3.13 | |
| Maternal age | 19-24 years | 10 | 3.33 | 30 |
| | 25-30 years | 7 | 3.23 | |
| | 31-36 years | 6 | 20 | |
| | 37-41 years | 5 | 7.16 | |
| | 42 years and older | 2 | 7.6 | |
| Maternal education | Diploma and under diploma | 3 | 10 | 30 |
| | Associate | 11 | 7.36 | |
| | Bachelor | 8 | 7.26 | |
| | Master and higher | 7 | 3.23 | |
| | Not reported | 1 | 3.3 | |

Table 3 presents the number, mean and standard deviation of anxiety scores in the control and experimental groups.

Table 3: Mean and standard deviation of anxiety scores

| Indicator | Group membership | n | pretest | | Posttest | | Follow up | |
|----------------------|------------------|----|---------|------|----------|------|-----------|------|
| | | | mean | SD | mean | SD | mean | SD |
| Generalized anxiety | Experiment group | 15 | 13.10 | 13.2 | 20.9 | 36.2 | 27.9 | 37.2 |
| | Control group | 15 | 47.10 | 48.3 | 53.10 | 44.3 | 60.10 | 41.3 |
| Social phobia | Experiment group | 15 | 93.11 | 08.3 | 93.9 | 47.3 | 10 | 40.3 |
| | Control group | 15 | 33.11 | 57.3 | 20.11 | 62.3 | 07.11 | 86.3 |
| Obsessive-Compulsive | Experiment group | 15 | 53.10 | 94.3 | 40.8 | 13.4 | 40.8 | 13.4 |
| | Control group | 15 | 13.10 | 96.3 | 07.10 | 28.4 | 07.10 | 28.4 |
| Physical harms | Experiment group | 15 | 07.14 | 61.3 | 93.11 | 09.4 | 13.12 | 96.3 |
| | Control group | 15 | 47.13 | 37.4 | 20.13 | 57.4 | 33.13 | 37.4 |
| Separation anxiety | Experiment group | 15 | 87.10 | 41.2 | 27.9 | 68.2 | 40.9 | 53.2 |
| | Control group | 15 | 27.10 | 91.2 | 20.10 | 98.2 | 20.10 | 98.2 |
| Total anxiety score | Experiment group | 15 | 53.57 | 09.6 | 81.44 | 08.7 | 20.49 | 05.7 |
| | Control group | 15 | 67.55 | 74.8 | 20.55 | 93.8 | 27.55 | 89.8 |

Shapiro-Wilk test was used to assess the normal distribution of scores of dependent variables in the groups and Levine test was used to assess the equality of variances. Table 4 presents the results of the assumption of normality of data and equality of variances. The results of Table 4 showed that the assumption of the normality of means in anxiety scores was confirmed in three stages of pretest, posttest and follow up, and the results could be generalized to whole

population ($P > 0.05$). The Levine test results showed that the F value in anxiety was not significant. As a result, it can be stated that the variance of the two groups was equal in the above-mentioned variables and there was no statistically significant difference between them, so there was no limitation in terms of using parametric test. As a result, the equality of variances was confirmed. Given the equality of covariance of compassion-centered education on the main variables, the results of the Box's M test showed that the level of significance was higher than 0.05, so the assumption of equality of covariance test was accepted.

Table 4. Results of Shapiro-Wilk, Levine, and Box's M tests

| indicator | test | Variable | statistic | F | Box's M value | Degree of freedom | Degree of freedom 1 | Degree of freedom 2 | Significance |
|-----------|--------------|-----------|-----------|------|---------------|-------------------|---------------------|---------------------|--------------|
| Anxiety | Shapiro Wilk | posttest | 95.0 | - | - | 30 | - | - | 28.0 |
| | | posttest | 97.0 | - | - | 30 | - | - | 67.0 |
| | | Follow up | 97.0 | - | - | 30 | - | - | 65.0 |
| | Levine | posttest | 95.0 | 58.1 | - | 30 | 1 | 28 | 21.0 |
| | | posttest | 97.0 | 77.0 | - | 30 | 1 | 28 | 38.0 |
| | | Follow up | 97.0 | 79.0 | - | 30 | 1 | 28 | 37.0 |
| | Box' M | | | 88.3 | 42.26 | - | 6 | 30.5680 | 001.0 |



The results of Mauchly's Test of Sphericity have been presented in Table 5 and the results of multivariate analysis are shown in Table 6.

Table 5. Results of Mauchly's Test of Sphericity

| Indicator | Intragroup effect | Mauchly's value | Chi-square | Degree of freedom | Significance |
|----------------------|-------------------|-----------------|------------|-------------------|--------------|
| Generalized anxiety | Measurement time | 16.0 | 18.49 | 2 | 001.0 |
| Social phobia | Measurement time | 16.0 | 13.49 | 2 | 001.0 |
| Obsessive-Compulsive | Measurement time | 001.0 | 15.49 | 2 | 001.0 |
| Physical harm | Measurement time | 33.0 | 91.29 | 2 | 001.0 |
| Isolation anxiety | Measurement time | 13.0 | 60.54 | 2 | 001.0 |

Examining the results of the Mauchly's Test of Sphericity also rejected the Sphericity condition that stated multivariate statistics do not require observing Sphericity with $p=0.001$. Thus, Greenhouse-Geisser test was used for testing the generalized anxiety, social phobia, physical harm, and isolation anxiety scores in 3 times of measurements. The results of this test also confirmed the effectiveness of compassion-centered education of mothers on children's anxiety ($p < 0.05$).

Table 6. Multivariate analysis results

| Indicator | | test | Statistic | F | Degree of freedom | significance | squared Eta | Statistical power |
|----------------------|--------------|--------------|-----------|-------|-------------------|--------------|-------------|-------------------|
| Generalized anxiety | Test time | Wilks Lambda | 70.0 | 56.5 | 2 | 001.0 | 29.0 | 81.0 |
| | Time * group | Wilks Lambda | 74.0 | 60.4 | 2 | 019.0 | 25.0 | 73.0 |
| Social phobia | Test time | Wilks Lambda | 58.0 | 63.9 | 2 | 001.0 | 41.0 | 96.0 |
| | Time * group | Wilks Lambda | 55.0 | 97.10 | 2 | 001.0 | 44.0 | 98.0 |
| Obsessive-Compulsive | Test time | Wilks Lambda | 52.0 | 99.24 | 1 | 001.0 | 47.0 | 99.0 |
| | Time * group | Wilks Lambda | 55.0 | 05.22 | 1 | 001.0 | 44.0 | 99.0 |
| Physical harm | Test time | Wilks Lambda | 49.0 | 61.13 | 2 | 001.0 | 50.0 | 99.0 |
| | Time * group | Wilks Lambda | 57.0 | 19.10 | 2 | 001.0 | 43.0 | 97.0 |
| Isolation anxiety | Test time | Wilks Lambda | 63.0 | 707 | 2 | 001.0 | 36.0 | 92.0 |
| | Time * group | Wilks Lambda | 67.0 | 53.6 | 2 | 005.0 | 32.0 | 87.0 |

The results of repeated measures analysis of variance (Table 7) showed that there was a significant difference between the three times of pretest, posttest and follow-up in scores of anxiety components (generalized anxiety, social phobia, Obsessive-Compulsive, physical harm, isolation anxiety) ($p < 0.005$). There was also a significant interaction between the scores (pre-test, post-test and follow-up) and groups in anxiety components ($p < 0.05$). These results suggested the effectiveness of compassion-centered education of mothers in improving children's anxiety. Therefore, comparative tests showed that the level of anxiety in the experimental group decreased in the posttest and follow up stages compared to the pretest stage, and the scores in the experimental group had significant changes compared to those in the control group ($p < 0.05$). Statistical power above 0.70 also indicated the significance of these effects (Table 7).

Table 7: Results of repeated measures analysis of variance for three times of anxiety measurement

| Indicator | | Sum of squares | Degree of freedom | Mean of squares | F | significance | Eta | Statistical power |
|---------------------|------------------|----------------|-------------------|-----------------|-------|--------------|------|-------------------|
| Generalized anxiety | Measurement time | 26.3 | 08.1 | 003.3 | 97.4 | 031.0 | 15.0 | 60.0 |
| | Time * group | 5 | 08.1 | 59.4 | 60.7 | 008.0 | 21.0 | 78.0 |
| social phobia | Measurement | 48.23 | 08.1 | 58.21 | 87.15 | 001.0 | 36.0 | 97.0 |

| | time | | | | | | | |
|-----------------------------|------------------|-------|------|-------|-------|-------|------|------|
| | Time * group | 75.15 | 08.1 | 47.14 | 65.10 | 002.0 | 27.0 | 90.0 |
| Obsessive-Compulsive | Measurement time | 20.24 | 1 | 20.24 | 99.24 | 001.0 | 47.0 | 99.0 |
| | Time * group | 35.21 | 1 | 35.21 | 05.22 | 001.0 | 44.0 | 99.0 |
| Physical harm | Measurement time | 35.25 | 19.1 | 16.21 | 51.25 | 001.0 | 47.0 | 1 |
| | Time * group | 82.16 | 19.1 | 04.14 | 93.16 | 001.0 | 37.0 | 99.0 |
| Isolation anxiety | Measurement time | 86.12 | 07.1 | 01.12 | 23.15 | 001.0 | 35.0 | 97.0 |
| | Time * group | 82.10 | 07.1 | 10.10 | 81.12 | 001.0 | 31.0 | 94.0 |

DISCUSSION AND CONCLUSION

The aim of this study was to evaluate the effectiveness of compassion-centered education of mothers on anxiety in preschool children. Van Dam et al. (2011) showed that self-compassion was a strong and important predictor of mental health that can be a vital component for MBIs in anxiety and depression topics. Macbeth and Jiomeli (2012) showed that there was a significant and reverse relationship between self-compassion and depression, anxiety and stress. Petcharat and Liehr (2017) showed that self-compassion education helped parents to experience increased consciousness along with mindfulness and improved mental health and accepted their children better. Their children also had less behavioral problems and had a positive relationship with their parents. Gouveia et al (2016) showed that higher scores of opposite mindfulness and self-compassion were associated with higher scores of parental mindfulness, lower scores of parental stress, higher scores of authoritarian parenting, and lower scores of permissive parenting style. These results were inconsistent with those of research conducted by Powley et al (2010) who showed that self-compassion is difficult in people diagnosed with depression and anxiety and psychological disorders had negative effect on their abilities on self-compassion. In explaining the results of the current study, it can be stated that the intervention of self-compassion education in mothers of these children led to the termination of old behavior pattern and onset of new behavior, since it empowered their mental dimensions. It also made these mothers identify their way of thinking and behavior towards themselves and helped the mothers of these children make their cognition, emotions and reactions more flexible and enhance their kindness towards their child and family. Gilbert (2005) stated that self-compassion as a form of self-communication can increase one's satisfaction in various dimensions. This satisfaction made mothers more flexible when coping with their problems and helped them to have a clearer vision of the challenges. In general, it can be stated that the protocol of self-compassion education of mothers focused on increasing self-help and peace of mind in different situations of life. In this type of education, as mothers could overcome some of their problems by performing appropriate practices such as imagining a safe place and imagining a friendly place, they could construct and reconstruct themselves against the challenges.



It can be also stated that the mothers who were criticized or blamed by others in their interpersonal relationships found more opportunity for compensation and strengthen self-compassion in in social, family and psychological relationships, as mothers' knowledge of kindness increased. With individual compassion, kindness towards themselves during periods of suffering, hopelessness or failure, and avoiding strictness towards themselves during discomfort or observing unfavorable aspects of individual personality individual (self-criticism and low judgment), self-compassion education in mothers of 4-6 years of old children helped them reduce the interpersonal disturbances by developing intimacy and empathy. Self-compassion education in mothers led to responding to feelings and sense of attachment, security, mutual trust and forgiveness in family relations. Providing appropriate education (experience of gaining kindness from others), due to the familiarity of mothers with the system of security and relaxation, caused mothers to reduce interpersonal disturbances by creating intimate and empathy in their lives. Finally, it can be stated that in the self-compassion education of mothers, they became familiar with the skills of attention, reasoning, kindness feelings and behavior (Gilbert, 2009), so the isolation and avoidance from others during the discomfort periods discontinued and increased the effort toward the development of personal perspective with self-awareness and mindfulness. These issues led mothers of children to make much effort to create altruism and the feeling of loneliness resulting from disruption in relations to decrease. Therefore, compassion-centered education of mothers can lead to a more intimate relationship with the child, family members and individuals by looking at the clear side of the issues and interpersonal problems. Generally, it can be stated that compassion-centered education of mothers reduced anxiety in children aged 4-6 years.

Moreover, the results of repeated measures analysis of variance showed the effectiveness of compassion-centered education of mothers in improving the anxiety of children. The results of the Mauchly's Test of Sphericity confirmed the effectiveness of compassion-centered education of mothers on children's anxiety ($p < 0.05$). The researcher did not find a similar study to examine the effect of compassion-centered education of mothers on the anxiety of 4-6 year old children. However, the results of this study were in line with those of the research conducted by Besaknejad et al. (2012) who showed that experimental interventions were effective in reducing the types of anxiety disorders in anxious preschool children and one-month follow up in the experimental group indicated that therapeutic intervention can maintain its intervention effect over time. Noorbala et al. (2013) showed that compassion-centered therapy is effective in reducing depression and anxiety in patients. Additionally, people with higher level of self-compassion obtained more benefit from this intervention, and their rumination decreased and low self-compassion led to an increase in the rumination of individuals during this intervention. In a study on patients diagnosed with depression, anxiety and stress disorders that completed the self-reporting scale, Gilbert et al. (2014) found that these disorders were negatively associated with self-compassion behavior. In explaining this result, it can be stated that compassion-centered education of mothers improved the self-compassion that is in the form of focused inner feeling or state of stability associated with organized attention, thinking, behavior, and feeling. Development of self-focus can balance the primary emotional systems and direct them and enhance the mothers' cognition. It leads to the termination of the old



behavior patterns and the onset of new behavioral patterns and it make people to be more flexible and kind.

Gilbert (2005) stated that self-compassion as a form of self-communication can increase one's satisfaction in various dimensions. This satisfaction made mothers more flexible in coping with their problems and have a clearer vision of the challenges. In general, it can be stated that the self-compassion education of mothers of 4-6 year old increased self-help and relaxation in different situations of life and the mothers could overcome their service conditions by performing appropriate practices. As a result, it can be stated that compassion-centered education reduced the anxiety of children. Thus, it can be stated that compassion grows when a person gains insight on the nature of suffering, capacities, and value of compassion and has an opportunity for practice and obtain confidence on its performing (Gilbert, 2014, quoted by Ranjbar and Nuri, 2016). In fact, conditions at home activated their threat system. When a person feels threatened, he feels physical stress and if it lasts for longer period, it will turn to suffering, digestive problems, headache, and even sleep disorder. Such a person will find few options and it will be difficult for him to ask help from others, adopt a defensive strategy and might feel isolation and anxiety. Compassion towards self and others makes the threat system balanced. In this situation, one experiences negative emotions but he is not defeated and he feels ensured that he is able to cope with negative emotions. As a result, he experiences physical relaxation and finds more options and various ways to cope with difficult situations. When people gain insight into the threat and security system, the brain relaxing system is strengthened and negative feelings decrease and positive feelings increase. Therefore, the mother will have a better interaction with the child and does not transfer her negative emotions to the child and she will have a child with mental health that can control her anger. As a result, it can be stated that compassion-centered education can reduce mothers' anxiety in children aged 4-6 years.

This study, as many other studies, had some limitations, including:

1. As this study was conducted on mothers with a 4-6 year old child, we should treat with caution in generalization of the results to other age groups.
2. The convenient sampling method makes it necessary to conduct further studies to make a definitive conclusion on the hypotheses
3. Due to the conditions of the child and the mother, the longer follow up was not possible.

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