

Chapter 4

“Possums”: building contextual behavioural science into an innovative evidence-based approach to parenting support in early life

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THE VITAL IMPORTANCE OF PARENTING

Parenting is a core feature of human life. The majority of people become parents, and even more are alloparents, providing significant care in an ongoing relationship with children. The fact that parenting is very demanding for us is a defining feature of our species (Ball, 2009): our children require significant parental care for many years. The human infant is born with the least mature brain of any mammal, most recently theorised as a result of the inability of the gestating mother to continue to meet the metabolic demands of that already large and rapidly growing brain in utero (Dunsworth, Warrener, Deacon, Ellison, and Pontzer, 2011). At birth, the human brain is only one quarter of its adult size, and in the first nine months or so after birth the infant is most accurately conceptualised as an exterogestate foetus.

Human infants are secondarily altricial (Ball, 2009). That is, although we evolved from mammals that are born developmentally mature or precocial, our infants are born developmentally immature or altricial and highly dependent on their parents. Like precocial mammals, we typically give birth to singletons and produce low-fat, high lactose milk necessitating close parental contact and frequent feeding. Our dependency on our parents continues far beyond infancy. Ongoing development within the context of a human family is necessary for an infant to develop into full personhood - to fully develop as a human being with language and self-awareness.

Although parenting is often a great source of satisfaction, it is also challenging. At the point of the transition to parenthood, in particular, the impact of the demanding nature of

parenting can be seen. Estimates of postnatal depression in mothers vary from about 6.1% to 19.2% (Gavin *et al.*, 2005; Reck *et al.*, 2008) with 11.1% of mothers developing postnatal anxiety (Reck *et al.*, 2008). Fathers are not unaffected with as many as 7.8% of new fathers showing signs of postnatal depression (Gawlik *et al.*, 2014). At four weeks after the birth, 38% of parents report sleep problems (Hiscock *et al.*, 2014). In Australia, although most women want to breastfeed, by four months only 39% are able to breastfeed exclusively (Australian Institute of Family Studies, 2011). This makes it vital that we harness the latest in psychological science to fully support parents, from the transition to parenthood and beyond.

Of course, supporting parents is not only justified by the impacts on parents themselves. Parenting quality impacts on many and diverse outcomes from physical health, to intelligence and educational aptitude, to social abilities and emotional competence, to behavioural problems and psychological health (Bowlby, 1988; Eshel, Daelmans, Cabral de Mello, and Martines, 2006; Hart and Risley, 1995). The links between parental mental health and the psychological and development outcomes of children are also well understood (Kingston and Tough, 2014). If we want to improve outcomes for our children, it is logical that we need to lever the parent-child relationship to that end. It particularly makes sense to support new parents at the transition to parenthood ensuring that new parents adapt successfully to their new role, since early life experience in the parent-baby relationship sets many families on particular interpersonal trajectories that affect their child's development life-long (Fogen, King, and Shanker, 2008).

DOMINANT APPROACHES: ACHIEVEMENTS AND PROBLEMS

Within the scientific literature on parenting there are two dominant worldviews: the behavioural and the relational/emotional worldviews (Whittingham, 2015). The behavioural worldview is grounded in operant theory, social learning theory and applied functional analysis. The relational/emotional worldview includes attachment theory, the emotional availability literature and meta-emotion theory. Evidence-based psychological interventions for parents are generally grounded in one of these two worldviews, although some interventions draw from both frameworks. Dominant evidence-based parenting interventions, for the most part, take an educational and skills-deficit approach. Interventions grounded within the behavioral worldview teach parents how to be an effective change agent in the behaviour of their child. Interventions grounded within the relational/emotional worldview teach how to be a sensitive and emotionally available caregiver and how to display parental emotion coaching skills. Parenting interventions from both worldviews are effective in addressing internalising and externalising behaviour in children (Allen, Timmer, and Urquiza, 2014; Patterson, 2005; Sanders, Kirby, Tellegen, and Day, 2014; Wilson, Havighurst, and Harley, 2012).

However, in understanding parenting interventions in the first year of life, it is necessary to state that the dominant behavioural approach to parent-infant sleep, particularly when applied in the first half-year, is not supported by high level evidence, and in fact may worsen outcomes for some families (Douglas and Hill, 2013; Kempler, Sharpe, Miller, and Bartlett, 2015). This dominant approach is grounded in a particular understanding of how operant theory applies to infant sleep (Douglas and Whittingham, 2015). Parents are educated to be-

lieve that “sleep breeds sleep”, and to structure sleep routines into their days through the use of algorithms or estimates of their baby’s sleep need and graphs of sleep cycles. They are asked to delay responses to the baby’s cues or to ignore cues such as crying or sleepiness at the end of feeds, in order to break-down “bad” sleep associations and to teach self-settling in a cot in a low-stimulation environment. Efforts to achieve sleep and self-settling during the day may be prolonged and distressing, but parents are advised that sleep habits set up in very early life will affect sleep and development throughout the rest of childhood, even though long-term positive effects of these early sleep interventions have not been established (Whittingham and Douglas, 2014).

As existing parenting interventions focus on addressing parental knowledge gaps and skills deficits, what is not fully addressed is the psychological function of parental behaviour for the parent. That is, a parent may have sufficient knowledge and skills but nevertheless not practise optimal parenting in a particular situation. For example, a parent may yell at her toddler not because she believes yelling is an effective behaviour change strategy or consistent with sensitive caregiving and not because she lacks the skills necessary to respond differently. Yelling serves the psychological function of reducing her own stress, allowing her to avoid a distressing emotional state. Related to this, the importance of ensuring that parental behaviour is flexible and that verbal rules have not undermined the contextual control of parental caregiving behaviour is not well understood. For example, dominant approaches to parenting in infancy, inspired by the relational/emotional worldview, commonly discuss the importance of cue-based care or parenting in response to the infant’s cues. However, this is often discussed in a formulaic rule-based manner with lists of specific infant behaviours interpreted as having specific, prescribed meanings, e.g. lists of “tired cues”. In fact, parental behaviour is sensitive and responsive when parental caregiving behaviour is under the contextual control of the infant’s cues. That is, like learning to ride bike, it ultimately must be shaped and supported by direct contingencies, not by verbal rule following. Parental sensitivity is flexible and dynamic.

The two dominant worldviews, the behavioural and the relational/emotional worldviews, are not fully synthesized and this remains a significant failing within current literature and clinical practice. There are acknowledged points of tension between the two worldviews. In addition, as is usual with scientific paradigms, both the behavioural and the relational/emotional worldviews include assumptions or common, unexamined ways in which the theoretical frameworks are applied to parenting and these assumptions also create points of tension. For example, the dominant application of the behavioural worldview to parent-infant sleep includes the assumption that increasing the duration that an infant sleeps at night without signalling will improve parental sleep (Douglas and Hill, 2013; Whittingham and Douglas, 2014). However, the relationship between infant signalling and maternal sleep is more complex than this. Maternal sleep efficiency, that is, the length of time it takes for the mother to fall asleep, is essential to understanding potential relationships between infant signalling and maternal sleep (Goyal, Gay, and Lee, 2009; Warren, Howe, Simmens, and Dahl, 2006). Mothers whose infants signal more frequently may nevertheless obtain more sleep than mothers whose infants signal less frequently if both they and their infant easily and efficiently settle back to sleep once woken. This explains why some studies have shown that breastfeeding mothers obtain the best sleep even though their infants also signal more frequently (Doan,

Gay, Kennedy, Newman, and Lee, 2014; Kendall-Tackett, Cong, and Hale, 2011). Further, infants who regularly signal very frequently at night may have undiagnosed feeding problems, (Douglas, 2013) or disruption of the circadian clock (often resulting from unnecessarily long periods of day-time sleep in quiet, dark rooms). That is, very frequent signalling may be reflective of a feeding problem, or a circadian clock problem, not a problem with the baby's capacity to fall sleep. The common, unexamined assumption, that decreasing infant night signalling will result in better parental sleep, clashes with the relational/emotional worldview's emphasis on parental responsiveness, creating confusion within the literature and within clinical interventions.

In addition to problems of synthesis between the dominant theoretical frames within the scientific literature on parenting, there is a lack of synthesis of the parenting literature with other relevant scientific literatures and interdisciplinary frameworks including neuroscience, developmental psychology, lactation science, sleep science and evolutionary anthropology. So, for example, interventions intended to support early parenting in the postnatal period may have little to no input from lactation science, even though infant feeding (whether by breast or bottle) is the main parental care activity in the early months of parenthood and feeding problems, if not addressed early, can have cascade effects. This lack of synthesis is a major limitation of the existing literature and approaches.

A NEW CONTEXTUAL APPROACH

Acceptance and Commitment Therapy (ACT) is a third wave Cognitive Behavioural Therapy (CBT) grounded within a behavioural theory of language and cognition called Relational Frame Theory (RFT) (Hayes, Strosal, and Wilson, 2003). The overall approach is also called Contextual Behavioural Science (CBS). The purpose of ACT is to improve psychological flexibility, the ability to persist or to change in your behaviour, with full awareness of your current experiences and context, in the service of valued ends. Core ingredients of ACT include:

- 1) values or chosen life directions;
- 2) mindfulness or psychological presence in the present moment;
- 3) experiential acceptance or willingness to experience one's own thoughts, feelings, memories and sensations as they arise in life;
- 4) action, or taking workable steps towards valued ends.

Acceptance and Commitment Therapy (ACT) is ideally suited to be the bedrock of a new, contextual approach to parenting and the transition to parenthood. Acceptance and Commitment Therapy, in combination with its underlying theoretical frame of Relational Frame Theory (RFT) can effectively address the psychological function of parenting behaviour for the parent, increasing parental flexibility.

From an ACT/RFT perspective, considering the psychological function of parenting behaviour means considering the psychological costs of human language and complex cognition. Human language and cognition, according to RFT, is underpinned by our ability to relate stimuli arbitrarily and learn through derived relations (Coyne, McHugh, and Martinez,

2011; Hayes *et al.*, 2003). For example, you can learn that the sound “bambino” means the same thing as the sound “baby” even though the sounds “bambino” and “baby” are not physically related. Further, by learning that relation you would also derive, without direct training that the sound “bambino” refers to actual babies. Importantly, relational frames also include the transformation of stimulus functions. The psychologically relevant features of a stimulus are transformed according to the derived relations of that stimulus within a specific context. So, if “baby” is psychologically meaningful for you due to your learning history, the word “bambino” will function psychologically in a similar manner in certain contexts.

This process of derived relational responding underlies language and complex cognition, but it comes with a cost. We are inclined to treat our psychological world, our own cognitions, emotions, sensations and memories, as if it were the real, physical world (Coyne and Wilson, 2004). Our behaviour may become rule-governed, rather than under the contextual control of direct contingencies. At times this leads to unworkable behaviour, a process known as cognitive fusion (Coyne and Wilson, 2004; Hayes *et al.*, 2003). The function of following verbal rules may be naturally occurring consequences described within the rule (tracks) or the function may be socially mediated consequences such as approval (pliance). Tracks are problematic when they are factually inaccurate, unworkable or untestable. An example of a common verbal rule that is factually inaccurate is: “If you don’t teach your child to self-settle as a baby then your child is more likely to have sleeping difficulties later on”. Pliance is problematic when the behaviour necessary to obtain social approval is unworkable for that individual. For example, “good parents never bedshare with their baby” or “good parents don’t feed their baby to sleep” may not be workable for many families. Further, due to the transformation of stimulus functions these rules may be highly psychologically loaded. An expectant mother who learns that “breast is best” is also likely to derive, through existing relational frames (best is the opposite of worst, doing your worst is bad), the dark underside of this rule: “if you use formula then you are a bad mother”. When experiencing cognitive fusion, our behaviour becomes rigid and inflexible, our creativity is limited and our ability to learn from our direct experiences is compromised (Coyne and Wilson, 2004; Murrell, Wilson, LaBorde, Drake, and Rogers, 2009). This is problematic because a flexible, experimental approach to parenting, learning through experience and pattern recognition is vital to long-term resilience (Whittingham and Douglas, 2014).

Our inclination to treat our psychological world, our own cognitions, emotions, sensations and memories, as if it were the real, physical world (Coyne and Wilson, 2004) also means we engage in experiential avoidance. We engage in deliberate efforts to avoid, minimise or control our own experiences (Hayes *et al.*, 2003). However, our psychological world does not operate in the same way as the real, physical world and so experiential avoidance can, paradoxically, increase the frequency of the experience that we are trying to avoid. Attempts at thought suppression may create rebound effects, increasing the frequency of the suppressed thought. Experiential avoidance may also increase suffering in the long-term in other ways. A parent who is attempting to suppress the distressing thought, “I am a bad parent”, is likely to find that the thought is triggered by their own child, perhaps particularly when their child is distressed or in need. Avoiding the distressing thought may therefore lead to avoiding their child or at least not responding to their child’s distress in the loving and responsive way that they would like. Sub-optimal parenting behaviour including lack of parental responsiveness,

intrusiveness, laxness or harsh discipline may occur not because of skill deficits but because it serves the psychological function of experiential avoidance (Coyne *et al.*, 2011; Coyne and Murrell, 2009; Shea and Coyne, 2011; Tiwari *et al.*, 2008). Parents may attempt to control their children's behaviour or even their children's psychological experiences in order to control their own psychological experiences.

Philosophically, contextual behavioural science including ACT and RFT has strong links to evolutionary science. This allows for the synthesis of both the behavioural and the relational/emotional worldviews, from a contextual perspective, within the larger paradigm of evolutionary science. So, although the links between contextual behavioural science and the dominant behavioural paradigm are most clear, contextual behavioural science can also be fully synthesised with the relational/emotional worldview. From a contextual perspective, attachment behaviour is an operant class of behaviours (Mansfield and Cordova, 2007). That is, attachment behaviour refers to any behaviour that is shaped by the function of obtaining proximity to and nurturance from caregivers. Sensitive and responsive caregiving from a contextual perspective occurs when parental caregiving behaviour is under appropriate and appetitive contextual control. That is, sensitive caregiving is under the contextual control of the child's cues and sensitive parents find caregiving reinforcing. We argue that, in applying ACT/RFT to parenting, it is vital that this opportunity for synthesis between the two existing dominant worldviews and between the parenting literature and other relevant scientific literatures is taken up.

ACT AND PARENTING: THE STATE OF THE SCIENCE

To date, three studies have tested the application of ACT to parenting, one within-subjects design study with twenty parents of children with autism spectrum disorders (Blackledge and Hayes, 2006) and two randomised controlled trials with fifty nine families of children with acquired brain injury (Brown, Whittingham, Boyd, McKinlay, and Sofronoff, 2014; Brown, Whittingham, Boyd, McKinlay, and Sofronoff, 2015) and with sixty seven families of children with cerebral palsy (K. Whittingham, Sanders, McKinlay, and Boyd, *in press*; K. Whittingham, Sanders, McKinlay, and Boyd, 2013). Overall, research suggests that ACT makes a useful contribution to parenting intervention.

In the within-subjects design, parents of children with autism spectrum disorders reported significant reductions in experiential avoidance, stress and depressive symptoms following a 14 hour ACT workshop and at follow up three months later (Blackledge and Hayes, 2006).

A 4 hour group ACT intervention was tested in conjunction with the parenting intervention Stepping Stones Triple P (Positive Parenting Program) for families of children with acquired brain injury (Brown *et al.*, 2014; Brown *et al.*, 2015) Stepping Stones Triple P is a variant of Triple P developed for families of children with developmental disabilities. All outcomes were parent-report. Parents receiving the combined Stepping Stones Triple P and ACT intervention reported reductions in child externalising and internalising behaviour, dysfunctional parenting styles, parental psychological symptoms and disagreements between parents. Improvements were shown in parental confidence, family adjustment and psychological flexibility.

The same 4 hour ACT intervention was tested in conjunction with Stepping Stones Triple P for families of children with cerebral palsy (Whittingham *et al.*, in press; Whittingham *et al.*, 2013). In this study a three arm design was used with families randomly allocated to one of three groups: waitlist control, Stepping Stones Triple P and Stepping Stones Triple P combined with ACT. All outcomes were parent-report. Stepping Stones Triple P alone was associated with decreases in child internalising behaviour and in the number of externalising behaviour problems compared to the waitlist group. Stepping Stones Triple P combined with ACT was associated with reductions in the number and intensity of externalising behaviour problems, child hyperactivity, dysfunctional parenting styles, and parental psychological symptoms. In addition, it was associated with gains in child functioning in the area of mobility and child quality of life. The finding that Stepping Stones Triple P alone was associated with a reduction in parent-reported child internalising behaviour, but the combination of Stepping Stones Triple P and ACT was not is surprising. It is difficult to explain how the addition of ACT could undermine the intervention effect of Stepping Stones Triple P on child internalising behaviour. It may be the case that ACT increased parental awareness of child affect, and hence to report child internalising symptoms. Overall, the results of this RCT suggest that ACT has an important contribution to make, above and beyond established parenting intervention.

Exploring wider than ACT in particular, to the third wave in general, there is evidence that mindfulness-based approaches to parenting are effective. In particular, there is evidence that mindfulness-based interventions may lead to reductions in parenting stress (Bazzano *et al.*, 2013; Bogels, Hellemans, van Duersen, Romer, and van der Meulen, 2014; Bogels and Restifo, 2014; Neece, 2014) and psychological symptoms (Bogels *et al.*, 2014; Bogels and Restifo, 2014; Neece, 2014) as well as increases in parental well-being (Bazzano *et al.*, 2013), self-compassion (Bazzano *et al.*, 2013; Benn, Akiva, Arel, and Roeser, 2012) and empathic concern (Benn *et al.*, 2012). In some studies, reductions in the child internalising and externalising symptoms have also been noted following parental participation in a mindfulness intervention (Bogels *et al.*, 2014; Bogels and Restifo, 2014). Parenting interventions that integrate mindfulness and acceptance techniques with other established parenting approaches have also been found to be effective (Coatsworth *et al.*, 2014; Dawe and Harnett, 2007; Dawe, Harnett, Rendalls, and Staiger, 2003). There are some studies that suggest that mindfulness may be a useful intervention in the antenatal period to protect maternal mental health (Dunn, Hanieh, Roberts, and Powrie, 2012; Guardino, Schetter, Bower, Lue, and Smalley, 2014; Vieten and Astin, 2008).

Overall, the research on the application of ACT and related approaches to parenting is positive to date. However, more research needs to be done.

THE “POSSUMS” APPROACH

We are involved in integrating contextual behavioural science and ACT into an innovative and interdisciplinary approach to post-birth care: the “Possums” approach. This clinical approach is grounded within a synthesis of the relevant scientific literature including the theoretical frames of complexity science, evolutionary anthropology, lactation science, medical science, developmental psychology and contextual behavioural science. The synthesis of

all of the relevant literature has led to novel insights and ways of working with challenges in the post-birth period (Douglas, Miller, Bucetti, Hill, and Creedy, 2013; Douglas and Hill, 2013). This has included developing a novel approach to parent-infant sleep (Whittingham and Douglas, 2014).

Within the Possums approach, ACT is integrated into clinical interventions for problems with breastfeeding and bottle-feeding, infant crying and fussing, parent-infant sleep, and perinatal anxiety and depression. Problems of cry-fuss behaviours, feeding and sleep are linked in complex ways with anxiety and depression in new mothers and fathers, (McMahon, Barnett, Kowalenko, Tennant, and Don, 2001), and unsettled infant behaviour also increases that child's risk of developmental problems in later childhood (Hemmi, Wolke, and Schneider, 2011; Santos, Matijasevich, Capilheira, Anselmi, and Barros, 2015). At the moment, parents complain of receiving conflicting and confusing advice for unsettled infant behaviour, resulting in worsened anxiety and increased risk of postnatal depression. This is a result, in part, of the paradigm tension between behavioural and emotional/relational worldviews, and also from a widespread failure to identify common contributing infant feeding problems (Douglas, 2013). The Possums approach integrates ACT strategies into evidence-based and holistic clinical interventions, with the aim of promoting vital living, mindfulness, and parenting according to values in early life.

This innovative new approach is being developed in partnership with the not-for-profit organisation Possums, a health promotion charity in Australia, and it is currently implemented clinically at The Possums Clinic in Brisbane, Australia. The Possums Clinic is a multidisciplinary team with all staff trained in the overall Possums approach including basic training in the application of ACT in early life. ACT is integrated into the operations of the clinic in a holistic and preventive way, rather than only becoming relevant when there are maternal mental health concerns.

"POSSUMS" IN ACTION

Case 1. Mary and John present with four week old Amy, who is back-arching and crying at the breast, and refusing to feed. In addition to breastfeeding, Mary has been pumping and giving Amy expressed breast milk or sometimes infant formula in a bottle a number of times a day. Mary dreads trying to breastfeed now, and is relieved that John is able to help with the bottle. The nights are terrible, because Amy is waking every hour or so. They've been trying to teach her self-settle, by putting her down in her cot drowsy but awake, but she often screams for a couple of hours.

Case 2. Ellie and Damien present with eight month old Sebastien, who is waking every one to two hours during the night, and "hardly sleeps" during the day. Although he always has a one to two hour sleep mid-morning, Ellie can spend up to forty minutes trying to get him to sleep at later nap-times during the day, and then he only sleeps for twenty. Apart from the first sleep of the day, she can never "get him into a second sleep cycle." At night he sleeps in



a cot in their room, but Damien thinks it is time Sebastien went into his own room and they began “responsive settling,” because Ellie is so exhausted.

In Case 1, we use the Possums five domain approach to post-birth care to organise what is a complex consultation or number of consultations. These domains are: the fundamental considerations of baby’s health; mother’s health – physical, social, emotional; and the three neurobehavioral domains of feeds, sensory, and sleep) (Douglas *et al.*, 2013).

Baby Amy has developed a negative association with the breast, in the context of previously unidentified fit and hold problems. Once we are certain that the baby is otherwise well, we provide intervention for the immediate clinical breastfeeding problems, also introducing some simple ACT strategies such as defusion (*i.e.* undermining fusion) and mindfulness to help Mary manage the anxious feelings that inevitably arise if a baby is not feeding and fussing at the breast. Clinical breastfeeding assistance is integrated with assistance across the domains of sensory and sleep. Similarly, in Case 2, we identify and manage underlying problems, in this case, disruption of the circadian clock, which exacerbate night-waking, and inform parents about the healthy function of the circadian clock and the sleep homeostat (the need for sleep that builds during periods of wakefulness). We integrate ACT in order to help parents navigate the difficult thoughts and feelings that so typically arise during the exhausting first year of their baby’s life (Whittingham and Douglas, 2014). If parents think it is time for the baby to learn something new in the night, we explore how they might do that, in a way that aligns with their values. In the rest of this section, we’ll consider particular aspects of ACT that we integrate into perinatal consultations.

Values clarification

Values clarification plays an important role in increasing flexible experimentation, undermining cognitive fusion and bringing joy into the parent-child relationship. Values may be clarified in consultation with simple questions such as “What kind of parent do you want to be?” Parents are often clear about their desire to be a connected and loving parent. However, rule following, both pliance and inaccurate tracks, can decrease sensitivity to context, producing rigid, uncreative and joyless parenting. This may especially be the case for parents experiencing challenges as parental attention narrowly focuses on “the problem”. In tandem with correcting inaccurate tracks, reconnecting parents to their values can help parents to regain flexibility. For example, we could say to Ellie and Damien: “I want you to imagine yourself 20 or 30 years in the future. Little Sebastien has been sleeping through the night independently for many years and you are regularly getting a really good night’s sleep yourself. In this future time, looking back on today, what will you want these early months to have meant to you and to Sebastien?” Values clarification is used as a springboard to expand attention beyond the current problem to the grand task of parenting itself. We say: “Don’t parent to your problems, parent from your values”.

Mindfulness

Mindfulness is deeply integrated into the Possums approach. In addition to providing clinical intervention for breastfeeding problems, we invite Mary to try practising mindfulness

and acceptance during feeds. In addition to removing those obstacles to healthy function of the biological sleep regulators (the circadian clock and the sleep homeostat), which disrupt parent-infant sleep, we offer Ellie and Damien mindfulness exercises for breathing, falling asleep, mindfulness of emotions and mindfulness of everyday parenting activities including changing baby's nappy. Mindfulness can improve sleep efficiency by short-circuiting ruminative and anxious thinking which interferes with sleep.

Experiential acceptance

We explore the relationship between experiential acceptance and sleep by contemplating the sleep paradox. We might say the following to Ellie and Damien:

“I'm going to ask you to perform several different behaviours and every time I ask you to do something I want you to do what I've asked pretty much straight away and we'll see what we notice. Is that okay? Alright, let's start. First of all – put your hands in the air. Easy? Now, clap your hands. Easy? Sure, not that hard, is it? Now, go to sleep. Easy? Did you manage it? Okay, so here's the first thing that we need to understand about sleep: unlike moving your arms or your legs, going to sleep isn't fully under your conscious control. You can't just choose to go to sleep when you want to. Now, let's try that again but this time I want you to imagine that I'm not just asking you I'm commanding you at gunpoint. If you don't do what I'm telling you to do you're in a whole lot of trouble. Alright – let's start. Put your hands in the air. If I had a gun and I was commanding you to do that, could you? Now, clap your hands. Again, if I had a gun and I was commanding you, could you? Now, go to sleep. Did you manage it? Could you go to sleep, at gun-point, if your life depended on it? Going to sleep, in that situation, would be almost impossible. So here's the second thing that we need to understand about sleep: not only is sleep not under our conscious control it actually cannot be forced. In fact, the more that we feel anxious and stressed, the more that we care about falling asleep straight away, the harder we try to fall asleep, the less likely sleep becomes. This is true for parents and it is true for babies”.

Flexible experimentation

We are conscious of the fact that rule-governed behaviour can become problematic and that contemporary parents are exposed to a multitude of contradictory and confusing parenting rules. We encourage flexible experimentation. Consistent with ACT, the clinician aims to position herself as a fellow traveller not as the expert. Whilst the clinician is a source of information for parents to consider and experiment with, the parent is always acknowledged as the expert on their own baby and family situation. We might say to Mary, John, Ellie and Damien, “Let life with your baby be as easy and enjoyable as possible; doing what works for you and your child, even if that is changing from day to day and week to week”.

Meaningful living

Parents are encouraged to focus on building a rich, meaningful and rewarding life for themselves and to live life fully, with baby accompanying them. In addition to protecting parental mental health, this is also the easiest way to ensure that baby receives a rich sensory diet. This rich sensory diet is crucial to early neurodevelopment and a lack of sensory satiation (which might, for example, arise from efforts to teach self-settling) can paradoxically create cry/fuss difficulties (Douglas and Hill, 2013).

IMPLICATIONS FOR HEALTH PROFESSIONALS

ACT can be successfully integrated into consultations by a variety of health professionals, in supporting early parenting. Health professionals can:

- clarify parenting values by asking parents what kind of parent they want to be and what brings them joy as a parent.
- Support parental mindfulness in their interactions with their infant. Parents may begin regular, formal mindfulness practise or simply be conscious of being fully present with their children on a regular basis. Health professionals can integrate mindfulness into consultations by guiding parental attention to the lived experience of the present moment and to baby as she or he is in the present moment.
- Be conscious of the dangers of rule-governed parenting behaviour. Is the parent behaving rigidly and inflexibly? Health professionals can support flexible experimentation and position themselves as a fellow traveller rather than as the expert.
- Consider the psychological function of parenting behaviour for the parent. Does the parent lack the necessary skills or is their behaviour serving a psychological function for them? For example, is the function of the parental behaviour experiential avoidance?
- Support experiential acceptance in parents. This can be achieved through experiential exercises and metaphors readily available within the ACT literature or through specifically developed exercises such as the sleep paradox. In addition, experiential acceptance can be supported during conversation by the clinician demonstrating their own acceptance for the parent's thoughts, feelings and memories as thoughts, feelings and memories.
- Support parents in living rich, meaningful and fulfilling lives, including in their role as parents.
- Be aware of the confusing and conflicting advice that parents receive. The conflict and the controversies within the parenting literature are largely created by a lack of synthesis between the dominant behavioural and relational/emotional worldviews and a lack of synthesis between the parenting literature and the wider relevant scientific literature. Be aware of this situation and of the gaps within your own knowledge.

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