



Helping the Parents: Parental Perceptions of Well-Being When Implementing Child Sleep Interventions

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Abstract

Few qualitative studies on parental perceptions of sleep interventions have been conducted, and little is known about parents' subjective well-being in this context. This study explored parental experiences of subjective well-being when implementing child sleep interventions. Ten parents who approached a sleep consultancy for assistance with their children's sleep problems participated in this qualitative study. Data was collected through in-depth interviews and results were analysed thematically. Three key themes were identified: (1) parents as experts, (2) sleep interventions as a team effort, and (3) improvements in well-being are multifaceted. Findings indicate that parental well-being during sleep interventions may be influenced by their knowledge and beliefs, and participants highlighted a need for additional support, including peer support. Parent's perceptions of subjective well-being in the context of behavioural sleep interventions may influence program adherence and completion. Parents may experience improvements in well-being after the intervention, attributable to enhanced routine, child well-being and improved sleep. The findings from this study may assist practitioners to develop more tailored interventions, subsequently minimizing parental distress during intervention implementation.

Keywords Child sleep interventions · Qualitative · Subjective well-being · Parents · Experiences

Highlights

- This qualitative study explored parental experiences of subjective well-being when implementing child sleep interventions.
- Parental experiences of subjective well-being during interventions may be influenced by parents' knowledge and beliefs.
- Parents desire more information and support when implementing sleep interventions, especially in community settings.
- Facets other than child sleep may influence perceived improvements in parental well-being after interventions.
- Implications for practice include developing sleep interventions with parents as active contributors.

Introduction

Adult sleep patterns differ substantially from those of infants and young children. Adults require approximately seven hours of sleep (Watson et al., 2015), whereas frequent night waking is common during early childhood (Galland et al., 2012; Huang et al., 2016). Up to 30% of children under the age of five experience sleep problems (Paavonen

et al., 2020). While parameters for defining child sleep problems have been suggested (Paavonen et al., 2020), researchers have often defined sleep problems as parent-reported long sleep onset latency, frequent night-wakings and short consolidated night-time sleep (Field, 2017). Parental definitions of sleep problems are highly subjective and depend, amongst others, on sociocultural expectations, parental knowledge of child sleep, attitudes towards sleep, and practical requirements (Honaker et al., 2021; Whittall et al., 2021). Because of its subjective nature, child sleep may therefore be considered problematic if, for whatever personal and practical reasons, parents experience it as such.

Due to the differences in child and adult sleep patterns, parental sleep may be disrupted. Poor sleep is associated with various negative outcomes, including parental

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depression and anxiety (Okun et al., 2018) and compromised functional efficiency (Hiscock & Fisher, 2015). Poor sleep may therefore deleteriously impact parental well-being. To improve their children's sleep, and thus potentially their own sleep and well-being, parents may choose to implement behavioural sleep interventions, colloquially termed sleep training. While there are several types of sleep interventions, the present study focused on two strategies commonly used by sleep consultancies: graduated extinction and extinction with parental presence. The first requires delayed parental response to their child's signals (calls or cries). The length of the delay often depends on parental preference and child age (Thomas et al., 2014) but can range between one to 25 minutes (Honaker et al., 2018). Extinction with parental presence requires a phased decrease of parental presence at bedtime. Parents gradually decrease the length of time spent in the room over consecutive nights or weeks until the child can fall asleep unaided (Galland & Mitchell, 2010).

Behavioural sleep interventions have received widespread attention in the literature (Whittall et al., 2021), yet parental perceptions of these interventions have received little consideration (Tse & Hall, 2008). Additionally, parents' perceived well-being in the context of sleep interventions has largely been ignored. While sleep interventions are recommended for practice by the American Academy of Sleep Medicine (Morgenthaler et al., 2006), they are not highly endorsed in community settings (Honaker et al., 2021; Loutzenhiser et al., 2014). Recommendations for sleep interventions may also not align with parents' personal or cultural family practices, contributing to the complexities of treatment for child sleep problems. Additionally, parents often find implementing sleep interventions stressful, are hesitant to implement it (Blunden et al., 2022) and report lower efficacy rates outside of research settings (Loutzenhiser et al., 2014). Examining parental perceptions of well-being within this context may elucidate these experiences and enable practitioners to develop tailored interventions that are endorsed by parents.

The efficacy of child sleep interventions has been established (Hall et al., 2015; Rafihi-Ferreira et al., 2019) and secondary outcomes include improvement on facets of parental well-being such as parenting stress (Field, 2017) and depression (Hall et al., 2017). However, there is a dearth of literature exploring parents' subjective experiences of implementing these interventions. Existing qualitative studies suggest that parents find it stressful (Blunden & Baills, 2013; Tse & Hall, 2008), predominantly related to ignoring children's cries (Blunden et al., 2016).

The stressful nature of sleep interventions may influence parental subjective well-being (SWB), especially when parents are vulnerable from prolonged poor sleep. Yet, there is a paucity of research exploring parental SWB in the

context of sleep interventions. For purposes of this study, SWB was defined utilising Diener's (1984) tripartite model, where SWB is comprised of three components: life satisfaction, positive affect, and negative affect (Diener, 1984; Diener et al., 2018). Life satisfaction is an evaluative judgement based on the subjective assessment of an individual's circumstances (Diener et al., 1985), and may include cognitive appraisals of life as a whole, or specific domains such as parenthood or romantic relationships (Diener et al., 2018). The affective components include the presence of positive affect, and low negative affect, and relate to emotional responses to life experiences or events (Diener et al., 2002), such as parenting a child with sleep problems. Additionally, couple satisfaction (as a domain of life satisfaction), and depression and perceived stress (as indicators of the absence of well-being) were explored as dimensions of SWB.

SWB is associated with improved health-related outcomes (Diener et al., 2018), and both individual and family functioning are influenced by well-being (Nomaguchi & Milkie, 2020). Understanding parental SWB may offer insights into the emotional and evaluative aspects of their experiences. Therefore, it is important to consider factors that may contribute to parental experiences during sleep interventions, as these may potentially influence program adherence and success, enabling the development of more tailored interventions. While improvements in parental well-being following interventions have been quantified, parental perceptions of SWB remain underexplored. Identifying features that shape their experiences, and thus influence adherence and success, is crucial. This study consequently aimed to explore parents' perceptions of SWB within the context of sleep intervention implementation to inform the development of more targeted interventions. The research question was: 'what are parental experiences of subjective well-being when implementing sleep interventions for children with perceived sleep problems?'

Method

Research Approach

This qualitative study was part of a larger multiphase, mixed-method project aimed at investigating the SWB of parents implementing sleep interventions for young children (Muller et al., 2022; Muller & Guse, 2024). The study consisted of three phases: quantitatively determining parental well-being before (phase 1) and after (phase 2) the intervention, and qualitatively exploring well-being after the intervention (phase 3). Analysis of qualitative data revealed themes linked to different timeframes, with participants reflecting on well-being in the context of infant sleep

Table 1 Description of Interview Participants

Participant	Gender	Age (years)	Ethnicity	Age of child(ren), (months)
P1	Female	34	White	6
P2	Female	30	White	8
P3 ^a	Female	32	White	8
P4 ^a	Female	36	White	3
P5	Female	41	White	3
P6	Female	31	White	8
P7	Female	36	White	5
P8 ^a	Female	31	White	12
P9	Male	43	White	5
P10 ^a	Male	31	Coloured	12

^aParents of twins

problems before the intervention, and well-being during and after the intervention. This study reanalysed responses related to well-being during and after the intervention to gain deeper insights, and the qualitative findings from this analysis are discussed here.

Participants and Procedure

Parents who voluntarily approached a sleep consultancy in South Africa participated in the study. Data from eight females and two males, with ages ranging between 30 and 43 years were analysed for the present study. The majority (9) were White, while one identified as Coloured (mixed ancestry, an official South African census term). The participants' children's ages ranged between three to 12 months, four participants had twins, and seven parents were first-time parents. Table 1 provides their demographic information and pseudonyms.

A combination of nested and snowball sampling was employed. Using nested sampling, where participants for semi-structured interviews were identified from survey participants (Schatz, 2012), mothers from phase 2 of the larger project consented to be interviewed. No fathers had opted to participate in the quantitative study and thus snowball sampling (Handcock & Gile, 2011) was employed. Mothers from phase 2 were asked to identify fathers (their partners) that may be willing to participate, and two fathers consented. One father (P10) was the partner of a mother also interviewed (P8). The first author conducted nine telephonic interviews and one virtual interview, in English, approximately three weeks after completion of the intervention. Interviews occurred at a time suitable for the participants, with consent to record audio, and lasted between 20 and 60 minutes. Questions were open-ended and referred to participants' general experience regarding the intervention and their well-being. Parents were asked to

reflect on their experiences of the intervention overall, as well as perceived well-being during and after the intervention.

Participants had to be in a committed relationship (in order to explore experiences of couple satisfaction as a domain of life satisfaction), with children of at least three months old, and were excluded if their children presented with medical or neurological conditions that influenced sleep (to avoid potential confounding influences on parental well-being as a result of managing more complex sleep problems). Parents of children under one year were provided with an extinction with parental presence program. Based on parental preference, parents of children one year and older were provided with either graduated extinction or extinction with parental presence.

Trained and experienced sleep consultants, who were supervised by the regional director of the Association for Professional Sleep Consultants, assisted parents during the intervention process. Each family was assigned a sleep consultant in their region who met with the parents on a virtual platform for an individual session of approximately two hours. Some consultants may therefore have supported more than one family. These sessions took place within a few days of implementing the intervention. Thereafter, consultants were available telephonically for two to three weeks from the start of the intervention. Parents could contact the sleep consultant at any time to receive feedback and guidance. Parents were also encouraged to send WhatsApp voice notes of their child's cries if they were distressed and needed assistance related to when to respond. If parents did not contact them during the day, the consultants would check in with the parents the next morning to ascertain progress and provide support or guidance where necessary.

Ethical Considerations

The Research Ethics Committee of the Faculty of Humanities at the University of Pretoria approved this study (HUM051/0619). A participant information letter detailing the nature of the research was presented to parents who voluntarily approached the sleep consultancy. Participants were informed that they could withdraw from the study at any time with no consequences, and that the services offered by the sleep consultancy would not be affected by participation, refusal to participate, or withdrawal from participation. Informed consent was obtained before interviews commenced.

Data Analysis

We used a reflexive thematic analysis approach, where themes were developed from the data without attempting to

impose a previously determined coding frame or analytic preconceptions (Braun & Clarke, 2006; 2019). The analysis was conducted according to the six phases outlined by Braun & Clarke (2006; 2019) as follows: 1) familiarisation with data; 2) initial coding; 3) identifying themes; 4) reviewing themes; 5) defining and naming themes; and 6) writing the report.

To enhance the quality of the study, the first author transcribed the interview recordings verbatim and checked the transcripts against the recordings for accuracy. The first author coded the entire dataset. To enhance confirmability, the co-author independently coded two interviews, and an external academic proficient in qualitative analysis separately coded three randomly selected interviews. Confirmability was further enhanced through reflexive journaling by the first author during the coding process. Codes that were highlighted by the external scholar were incorporated in all the interviews. The authors then met to discuss the codes and decided on themes, which were further refined and agreed upon during the writing process. To ensure a rich and nuanced perspective and to add to the quality of the findings through transferability, negative case analysis was utilised and instances where participants' experiences differed from or did not support the prevailing perception of a theme were included.

Reflexivity Statement

As the authors are women and mothers, it was important to be ethically mindful of how personal experiences might influence findings during data collection and analysis. The first author is a mother of twins, currently in middle childhood, but who experienced sleep problems during infancy. She did not use sleep interventions but acknowledge the impact poor sleep had on her family's well-being, which informs her interest in interventions to improve child sleep. The second author is a mother of an adult child who did not experience sleep problems during infancy. She is also a licensed psychologist who developed a particular interest in supporting maternal well-being during the peripartum period. Using reflexivity, the potential influence of these experiences and beliefs was managed through a reflexive journal on the part of the first author, and frequent discussions between both authors, also including childless colleagues, to allow opportunities to identify and challenge preconceptions.

Findings

Following analysis, three broad themes were identified, with various sub-themes: (1) parents as experts, (2) sleep interventions as a team effort, and (3) improvements in subjective well-being are multifaceted.

Theme One: Parents as Experts

Theme one related to the understanding that parents are the experts of their own children and parental behaviour is informed by their knowledge, beliefs and expectations during an intervention. This theme consisted of four sub-themes: knowledge is power; parents know best; managing child sleep; and age does not matter.

Subtheme 1.1: knowledge is power

A prominent subtheme related to how broader knowledge of the intervention process and outcomes influenced parental experiences. The findings suggest that parental subjective well-being during the intervention may be influenced by parental knowledge and beliefs. Specifically, where parents lacked knowledge on the process of the interventions, and potential outcomes and safety, lacked understanding of their children's experiences, or their expectations were not addressed, they perceived decreased well-being. The present study confirms findings of prior literature regarding parental experiences of sleep interventions as stressful, largely due to enduring their children's cries (Loutzenhiser et al., 2014; Tse & Hall, 2008). The findings further suggest that parents initially experience negative emotions such as guilt and fear not only due to changing their responsiveness to their child(ren) as required by the intervention, but also lack of knowledge of the intervention procedure and potential consequences, sleep consultants ignoring parental expertise, and beliefs regarding child readiness for the intervention. A lack of knowledge often resulted in perceived stress. Some participants initially perceived decreased subjective well-being due to fears of potential negative consequences for the child, and how the child experienced the intervention. For instance, Participant 2 experienced stress because she wondered if she would "scar this child for life?", while Participant 8 felt that her twins "wouldn't understand" why she was suddenly changing her responsiveness at bedtime and therefore experienced "guilt" and "sadness."

Contrary to these experiences, when parents had more education on sleep interventions they had more positive experiences, as exemplified by Participant 5: "I read like some studies about how, you know attachment isn't affected by it and I was just very happy with any academic results I could find on it didn't point to any kind of lasting harm," and thus found the intervention to be "quite a pleasant experience" overall (P5). However, two parents felt that they were unprepared for the amount of crying, which negatively influenced their well-being. Participant 8 mentioned that she "didn't know it would involve so much crying," and as a result experienced the intervention as "quite traumatic," whereas Participant 10 found it to be

“hell” because “the way it was proposed to us originally, I don’t think it was necessarily the most forthcoming.” Decreasing responsiveness at bedtime appeared to increase parental stress, although for most participants only for the first few nights. Participant 4 reported that, “the whole crying thing, not that they cry themselves out but you need to leave them a bit and it, it was stressful but literally it passed quickly so it’s fine”. Similarly, Participant 5 felt that “it was a stressful first night but it was short lived.”

Subtheme 1.2: parents know best

Some parents occasionally deviated from the intervention program because they felt they had a better understanding of what their children required or was appropriate in the moment based on the child’s cues, specifically as it related to the needs of the child(ren), such as understanding a specific cry indicating acute distress. For instance, Participant 1 responded sooner to cries than advised in the intervention because “it’s especially about turning her on the side [when she cries]. I get the idea it’s necessary.” Where parental expertise was ignored, it resulted in increased perceived stress, as experienced by Participant 6: “I just couldn’t face another night of seeing or dealing with my distressed baby and then not being able to give him what he wants which was the dummy.” Similarly, Participant 8 perceived herself as a “bad mother” during the intervention for not responding when she felt it was needed.

Subtheme 1.3: managing child sleep

The sleep interventions appeared to have improved parents’ understanding of and confidence in managing their children’s sleep, with parents gaining knowledge of child sleep requirements. For instance, Participant 2 stated that “the best part for us was... learning that he was supposed to be in bed by seven,” while Participant 9 said “you don’t think 15 minutes makes a difference but with her it does...she was just a bit too over tired...which then made it harder for her to sleep.” This knowledge appeared to have influenced their confidence. For instance, Participant 3 felt more “comfortable” because “it might just be they are having a bad dream, or they’re just not comfortable in that position, and I know they will figure it out.”

Subtheme 1.4: age does not matter

Interestingly, parental experiences of well-being and the intervention itself were not influenced by the age of the child during the intervention, but rather their belief in the readiness of their child for the intervention. For instance, Participant 5 felt that it was easier because at three months old her child had not “formed bad habits yet,” and therefore

she “adjusted quite quickly,” while Participant 1 waited for six months because “I want my child to be able to understand a little bit,” and felt that her child “did incredibly well,” yet Participant 8 felt that at 12 months her children were “so young that they don’t understand,” and therefore experienced the intervention as “traumatic.”

Theme Two: Sleep Interventions as a Team Effort

Theme two related to affective parental experiences of the sleep intervention as shaped by the level of support received, and consisted of two subthemes: sleep consultant support, and partner and peer support.

Subtheme 2.1: sleep consultant support

During the intervention intensive support was provided from sleep consultants. While several parents deemed this as helpful, and as a result knew “I wasn’t alone” (P3), some parents nevertheless required more support. Participant 8 felt that while the consultant was “always there” to “guide” her, she still wanted “someone to manage the parent’s emotions better.” Participant 6 expressed a similar desire: “I wish someone had said, listen, this is what is happening with baby but this is also what is happening with you.”

Subtheme 2.2: partner and peer support

Despite the consistent availability of consultants, and, in some cases, the presence of partner support, some participants expressed a desire for additional emotional support, indicating a possible decrease in the affective component of subjective well-being during the intervention. Four mothers expressed a desire for emotional support from extended family or peers, regardless of whether partner support was present or absent. Both participant 7, who was “definitely the driver” of the intervention, and Participant 5, whose partner was “one hundred percent committed with me,” said they would have liked to speak to other couples or new parents, while Participant 8 felt that it would have been helpful to have someone “validate how you are feeling.”

Several participants perceived support from a partner as important, and that teamwork made the experience “easier” (P9). Where partner support was deemed insufficient or lacking it influenced the overall experience of the intervention. For instance, Participant 7 felt it was “probably one of the hardest things I’ve ever had to do,” while Participant 8 did not continue with the full intervention with one of her twins (although daytime routines and dietary changes were maintained and her partner, P10, continued with the other twin).

Theme Three: Improvements in Subjective Well-being are Multifaceted

Theme three related to perceived changes in subjective well-being as measured in this study, as a consequence of multiple interrelated elements resulting from the intervention, and consisted of three subthemes: improvements in routine, perceived child well-being, and improved sleep.

Subtheme 3.1: improvements in routine

The improvements in routine appeared to have led to changes in the participants' daily life, increasing free time and predictability, which in turn improved subjective well-being. For instance, Participant 8 felt that her mood had improved because "the routine has been good for everyone." Additionally, some participants felt they had more time with their partners. Participant 9 explained it succinctly as follows:

"You know your routine's working which means you're stressing less, which means you should be more positive, which means your outlook on life is better, which means you probably have a better relationship with your partner. I mean it just, like it all adds up, right?"

Subtheme 3.2: perceived child well-being

Some participants valued the improvements in their children's well-being due to enhanced child sleep and acknowledged the indirect improvements to their own and the family's well-being. Participant 1 related, "Her mood has improved dramatically because she is no longer overtired, so that is why the general mood has improved in the house because we no longer have a little girl who screams and moans all day long." It was apparent that child well-being and improved child sleep were important contributors to parental subjective well-being. Participant 9 shared, "I think you know when your kid's happy and sleeping... then you're just all in a better state."

Subtheme 3.3: improvements in sleep

Every participant stated that sleep improved as a direct result of their child's improved sleep. Many participants felt that they were more satisfied with life because of the improved sleep, as exemplified in the comment by Participant 9: "Life's better because we're all sleeping more." Participants related more positive emotions generally: "Happiness is back" (P6), as well as towards their children: "I'm happy and I'm, you know much more loving towards

my child" (P5). Participants also perceived fewer negative emotions in general: "I was just angry. And that this is no longer the case" (P1), as well as towards partners: "Because I now have more sleep and we both have more sleep as a result I think there's just less general irritability" (P5), and children: "I don't get angry with them as quick as what I used to" (P3). Some participants also perceived improvements in perceived stress: "I was stress free" (P2), and mood: "I don't feel so depressed anymore" (P3) and felt less "overwhelmed" and more "present" (P6), as a result of more sleep. Finally, some mothers experienced improved perceptions of their own parenting, such as Participant 3: "I feel like I am a better mom because I sleep and because they sleep ... my whole life has just been completely changed because of it."

Discussion

We aimed to explore parental experiences of SWB within the context of sleep interventions to inform the development of more tailored interventions. Findings from this study suggest that parents may experience enhanced life satisfaction, improved affect, reduced stress, and improved mood following sleep interventions. However, it is important to recognize that some aspects of well-being, particularly stress and negative affect, were reported to increase during the intervention. Most participants indicated that these changes were short-lived, with noticeable improvements after the intervention.

Although the stressful nature of sleep interventions is well-documented, Reuter et al. (2020) noted that few studies address the reasons why these interventions are difficult to implement. In the present study, a lack of knowledge of the intervention outcomes led some participants to perceive a decline in well-being related to fears about potential consequences of the intervention. Prior literature has highlighted parental concerns regarding attachment (Etherton et al., 2016), potential harm (Blunden & Dawson, 2020), and their children's experiences during the intervention (Loutzenhiser et al., 2014). These fears may be influenced by some academic literature and popular media which advocate against extinction-based sleep interventions (e.g., Etherton et al., 2016) and often spread misinformation (Whittall et al., 2021).

Our findings suggest that educating parents prior to implementing the interventions may reduce stress, as those parents who educated themselves reported less distress. However, it remains important to inform parents of the expected duration and likelihood of crying during the intervention, without extenuation. It is inherently difficult to modify a child's sleep because it requires deviating from a familiar pattern of behaviour, and children express negative

emotions and discomfort through cries (Chóliz et al., 2012). Therefore, crying during a sleep intervention is anticipated. If parents express concerns about managing their child's cries, practitioners should consider more responsive interventions. By managing expectations around crying and offering alternatives when necessary, the perceived decreases in well-being during interventions may be mitigated.

Our findings offer additional insight into potential factors contributing to non-adherence in sleep intervention programs. Parents may deviate from the intervention due to their belief that they better understand their children's needs. This may explain why efficacy rates in community samples tend to be lower than in controlled research settings (Loutzenhiser et al., 2014). In our study, parents reported less stress when they relied on their own expertise regarding their children's needs. This highlights the importance of sufficiently involving parents in program development, particularly in relation to subjective well-being, by accounting for their knowledge of their children. However, potential delays in improved child sleep should be weighed against parents' well-being during the intervention, and perhaps parents should make the final choice.

Few studies on sleep interventions have included infants younger than six months (Reuter et al., 2020), despite early implementation within community settings (Kahn et al., 2023). The use of sleep interventions for young infants remains debated (see Blunden et al., 2022; Crichton & Symon, 2016). Additionally, parental cognitions influence the development of child sleep problems and the implementation of interventions (Kahn et al., 2020; Knappe et al., 2020). The findings of the present study suggest that parental beliefs regarding a child's readiness for intervention, rather than age, may influence parental perceptions, and consequently the implementation and outcomes of sleep interventions. This should therefore be considered before recommending sleep interventions.

Support during the intervention was an important factor in perceived subjective well-being and program completion. Consistent with the appreciation for the daily consultant availability in this study, Tse and Hall (2008) reported that participants relied considerably on research staff for support. This indicates that parents may require more support than what researchers and sleep consultants typically provide in both research and community settings. However, Loutzenhiser et al. (2014) asserted that support is not the sole responsibility of consultants. In community settings, partners and peers could offer support, and this should be encouraged. By creating additional platforms for parental support, sleep consultancies could provide the necessary additional assistance, as social support is associated with enhanced well-being (Battulga et al., 2021).

Finally, participants attributed improvements in subjective well-being to enhanced routines, better sleep, improved child well-being, and greater confidence in managing sleep. A more structured routine allowed parents more free time for relaxation, aligning with research linking increased free time to improved well-being (Offer, 2016). Additionally, perceived improvements in child well-being, attributed to better sleep and routines, further contributed to perceived parental subjective well-being. This supports previous research associating parental and child well-being (Nomaguchi & Milkie, 2020), as well as family routines and family well-being (Mindell & Williamson, 2018). Given the association between sleep duration variability and subjective well-being (Lemola et al., 2013), it is unsurprising that improvements in parental sleep positively influenced perceived subjective well-being. Sleep interventions should therefore address both daytime and nighttime routines and sleep practices, as the multifaceted nature of improvements in parental subjective well-being requires a comprehensive approach beyond merely adjusting parental responsiveness to children at bedtime.

Practical Implications

These findings have important implications for the development of sleep interventions. First, parents should be educated about the safety of sleep interventions before implementation to support their well-being throughout the process. Consultants should also acknowledge parental insights into their children's needs when developing interventions to ensure programmes are tailored to parental beliefs and preferences. In addition, consultants should manage parental expectations about the likely duration and intensity of infant crying, without extenuation. Parental beliefs about their child's readiness for sleep interventions should be considered before recommending such interventions, and where required, more responsive interventions should be recommended. Additional support during interventions should be advised, particularly through partners and peers, and support platforms should be offered when partner support is unavailable. Finally, sleep interventions should incorporate modifications to both daytime and nighttime routines and sleep practices to ensure a comprehensive approach to improving individual and family well-being.

Limitations

A limitation of this study was the relatively homogenous sample in terms of gender, ethnicity, and nationality. Future research should focus on more diverse populations to determine whether experiences of well-being differ across various groups. Another limitation of this study is that we did not collect data on parental education, which may influence

parenting practices. Future studies should take parental education levels into account to better understand its potential impact on the outcomes of sleep interventions. Additionally, all parents in this study reported some level of success with the intervention, thus it is important to explore perceptions of well-being in parents for whom the intervention was not successful. Lastly, the level of support provided by sleep consultants in this study may not reflect typical practice in other settings. Future studies should investigate the impact of partner and peer support on parental well-being during sleep interventions and examine whether the improvements in subjective well-being observed in this study are also found in samples receiving less support.

Conclusion

Few studies have qualitatively explored parental experiences of behavioural sleep interventions, and perceptions of well-being during and after such interventions are poorly understood. Our findings suggest that parental subjective well-being during sleep interventions may be influenced by parental knowledge and beliefs. Knowledge of sleep intervention outcomes, as well as insight into their children's needs, are important contributors to well-being during the intervention. If parental beliefs have not been considered, parents may experience a decrease in well-being during the intervention. Furthermore, while support from consultants and partners may promote well-being during sleep interventions, parents may require additional support beyond current provisions, and peer support should be explored. Despite the inherent difficulties of implementing sleep interventions, parents may perceive improvements in their subjective well-being, particularly life satisfaction and affect, due to improved routine, child well-being, and sleep.

Data availability

The data that support the results of this study are available from the corresponding author upon reasonable request.

Code availability

The code that support the results of this study are available from the corresponding author upon reasonable request.

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versions of the manuscript. All authors read and approved the final manuscript.

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Compliance with ethical standards

Conflict of Interest The authors declare no competing interest.

Ethics Approval The Research Ethics Committee of the Faculty of Humanities at the University of Pretoria approved the study (HUM051/0619).

Consent to Participate Informed consent was obtained from all individual participants included in the study.

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