Informal mindfulness practices : a new approach to the prevention and treatment of parental burnout

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Highlights

- The first study to assess the effectiveness of informal mindfulness programme for parental burnout prevention and treatment.
- Compared to the control group there was a significant reduction of parental burnout within the intervention group, with a large effect size.
- Informal mindfulness practices showed beneficial outcomes among the parents suffering from parental burnout or at risk of parental burnout.

Abstract

The present study assessed the effectiveness of informal mindfulness practice among parents in terms of parental burnout prevention and treatment. The objective was to test the new approach of informal mindfulness practice, the FOVEA programme, implemented in daily activities rather than based on formal meditations. Indeed, traditional mindfulness programmes require a 45-minute daily meditation practice which can be difficult to include in parents' tight schedules, and even more for the parents suffering from or at risk of parental burnout. In contrast, the FOVEA programme was designed to enhance the awareness of the present moment in ecological context mainly using the five senses and awareness of breath and body sensations. We tested the hypothesis that compared to the waitlist control group parents participating in the programme would present a greater reduction of parental burnout scores following the intervention. The results revealed a statistically significant large effect of FOVEA intervention on parental burnout severity. There was a statistically significant decrease in parental burnout symptoms between T1 and T2 within the intervention group and no statistically significant difference in parental burnout within the waitlist control group. Thus, informal mindfulness practice seems to effectively prevent and reduce parental burnout.

Introduction

Mindfulness skills reflect the capacity of deliberately orientating the attention toward the present moment with openness and a non-judgemental attitude, and without over-identifying with one's thoughts and emotions [1]. Mindfulness is considered also as metacognitive skill of being aware of one's awareness [2]. Mindfulness skills can be developed through mindfulness meditation practices, or through interventions combining mindfulness meditation with some informal practices (e.g., mindful walking). In this study, we present a new informal approach to mindfulness training based on ecological experiencing, observation, and integration of one's physical sensations, thoughts, and feelings in ongoing activities rather than through a formalised meditation practice. We proposed FOVEA programme (Flexibility, Open monitoring, based on the Vittoz method, to enhance Experiential Awareness) [3] for the prevention and reduction of parental burnout.

Parental burnout is a context specific syndrome which can develop as a consequence of the exposure to chronic parenting stress[4]. It is characterised by four groups of symptoms: (a) physical and emotional exhaustion in parental role; (b) emotional distancing form a child; (c) lack of satisfaction and accomplishment as a parent; (d) and the perception of not being a good parent anymore[5]. Parental burnout is a growing concern due to its prevalence[6,7] and deleterious consequences on family well-being which affect the parent, the couple, and the children (i.e., increased suicidal ideation, conflicts, violence, child neglect and abuse) [8]. Thus, to impede these negative consequences parental burnout should not only be effectively treated but also prevented.

Like professional burnout, parental burnout results from a chronic disproportion between stress-alleviating factors (e.g., social support, emotional competencies, self-compassion)[9,10] and stress-enhancing factors (e.g., lack of emotional and material support, individualism, poor emotional skills, perfectionism and high parenting standards)[6,11–13]. Indeed,

the results of a large-scale international study across 42 countries (N = 17409) showed that the higher prevalence of parental burnout in Western countries was linearly related to cultural individualism [6]. These findings suggest that both individualism and socially prescribed and self-oriented perfectionism can contribute to the development of parental burnout through the intensification of parental investment at the expense of parents' own needs and well-being, growing social pressure on parents, and the isolation of parents. Moreover, both self-oriented and socially prescribed perfectionism has been shown to be associated with worries, obsessive ruminations, and maladaptive stress responses[14].

Conversely, mindfulness practice was shown to mediate the link between perfectionism and depressive symptoms as well as to decrease the pressure to be perfect and to be excessively invested[15]. Evidence showed that both mindfulness trait and practice significantly predicted the lower scores of parental burnout through the increased self-compassion and decreased abstract ruminations[9]. Indeed, both mindfulness and self-compassion were found to underlie parenting self-efficacy, resilience [16], and satisfying family relationships [17]. Moreover, mindfulness-based interventions were found to significantly reduce parental burnout symptoms both among the parents of chronically ill children [18], and the parents from the general population [19]. These findings suggest that developing mindfulness skills in parents can significantly contribute to the prevention and reduction of parental burnout.

Mindfulness-based programmes (e.g., mindfulness-based stress reduction, MBSR and mindfulness-based cognitive therapy, MBCT) have shown their effectiveness in the reduction of stress, anxiety, pain, and depressive symptoms in both clinical and subclinical populations [20,21]. MBSR and MBCT are group-based 8-week interventions aiming to develop mindfulness skills through both formal meditation practices (e.g., sited meditations with a focus on a breath or physical sensations), and informal practices (e.g., mindful walking and mindful eating) during weekly 2h sessions and through daily 45-minutes personal practice between the sessions

[22,23]. In contrast to the informal practices which are applicable to a wide-range of everyday activities, the formal meditation practices require high motivation and self-discipline, especially in terms of regular between-session practice [3]. For this reason, in some contexts (e.g., parents who have very tight schedules or who raise their child alone) informal practices might be easier to integrate in daily activities than formal meditations [3].

Evidence showed the effectiveness of a mindfulness group intervention based only on brief and informal practices integrated in everyday activities (e.g., using breath and the senses of touch, smell, hearing, taste, and vision to maintain the attention focused on the present moment) in terms of stress and negative affect reduction and increase in life satisfaction among the adults from the general population [3]. The informal practices consisted of intentionally according a non-judgement attention toward ongoing activities. The advantage of this kind of practices is that they do not require adding ant specific tasks and that they are focused only of experiencing the present moment. Therefore, in contrast to formal practices which can be demotivating for individuals with perfectionist traits[15] there is less risk to experience the sense of *failure* during informal practices. In addition, formal mindfulness practices require regular practice in order to observe its benefits. In contrast, informal practices seem to immediately improve participants' well-being as they enhance the state of presence during satisfying and pleasant daily experiences [3].

The present study aimed to evaluate the effectiveness of the FOVEA intervention among parents for the prevention and reduction of parental burnout. The present study focused on testing our main hypothesis: compared to the waitlist control group parents participating in the FOVEA programme would present a greater reduction of parental burnout scores following the intervention.

Methods

Participants

Participants were recruited via announcements on social media and through community-based organisations working with parents and children. The inclusion criteria for participating in the study were: (a) to be a parent of at least one child living in the same household at the moment of the study, (b) being over 18 years old, and (c) having accepted an informed consent for participation in the study. According to the power analysis calculated with G* Power software, the required sample size was 54 participants. We determined a medium effect size (f = .25) with 95% power for repeated measures ANOVA based on previous interventional studies [19,24].

In total, 30 parents (90% of mothers) participated in the study. The mean age of participants was 37 years old (*SD* = 4.05), and the median number of children was 2 (*M* = 1.77, *SD* = .82). Participants did not receive any financial incentive for their participation in the study and they participated in the FOVEA intervention for free.

Procedure

The study received approval from the French national ethical committee board (N°: 19.02.06.44810) and was preregistered on the Open Science Framework: https://osf.io/f5c7b/?view_only=22472fb65a344e7cb52e948d2b39e0ff.

Before participating in the study, parents were invited to participate in a meeting where they were informed about the study objective and protocol, as well as about the right to withdraw from the study at any moment. In addition, all participants received a written information sheet and signed the informed consent.

Parents who were available to attend one of the proposed FOVEA groups could immediately assign to the intervention group. The waiting-list control group was proposed to the parents who expressed their interest to participate in one of the subsequent intervention groups but who were not available to participate immediately because of the schedule proposed.

New FOVEA groups were proposed every 8-weeks. Therefore, participants from the waiting-list control group were invited to participate in the intervention group after T2 measures.

Because of the ethical implications associated with parental burnout (i.e., increased rates of child abuse and neglect, suicidal risk) we chose to include all parents that could be available at the time of the FOVEA groups rather than operating a random allocation to experimental and control groups. This enabled the immediate assignment to the intervention of all parents willing and able to attend the intervention. Random allocation would result in the exclusion of the participants form the waiting-list control group before the start of the intervention. Likewise, it is possible that parents who were available to attend the intervention at the moment of signing in for the study but would have been assigned to the control group would not be available to attend the intervention 8 weeks later. As such, from a clinical and ethical perspective fewer parents would have received the intervention if the study had been randomised. Participants from our study were not followed by a doctor and did not receive any other treatment.

Participants from both groups responded to pre-test and post-test measures via an online questionnaire before the beginning and directly after the 8-week intervention. In total four FOVEA groups were proposed. The number of participants in each group varied from 6 to 10. Due to the outbreak of the COVID-19 pandemic and the social distancing policy the study was postponed and therefore the required sample size was not reached. The study flowchart is presented in *Figure 1*.

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Intervention

The FOVEA parenting programme was adapted from the original FOVEA protocol [3] to the context of parental stress and burnout based on the guidelines for parental burnout treatment [25]. The intervention consisted of eight 2-hour sessions delivered once a week by trained FOVEA

instructors with more than two years of professional experience.

The FOVEA programme is based on informal mindfulness practices issued from the Vittoz approach aiming to enhance the awareness of the present moment mainly using the five senses and awareness of body sensations. The brief and simple practices integrated into everyday experiences (e.g., using the breath and the sense of touch, smell, hearing, taste, and vision to maintain the attention focused on the present moment) contribute to the improvement of the state of presence through the development of a caring attention to oneself, to others and to the environment. FOVEA practices are also likely to enhance emotional skills and well-being through the processes of psychological flexibility, openness to experience, non-judgemental attitude, and attentional training [3]. The intervention protocol is described in *Table 1*.

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Measures

Participants responded to the measure of parental burnout and the demographic survey evaluating age, gender, number of children, child's current or past diagnosis of chronic illness or developmental problem, family and professional situation, and the education level.

Parental burnout

Parental burnout symptoms were measured with the *Parental Burnout Assessment* (PBA)[5] measuring four dimensions of parental burnout: (a) physical and emotional exhaustion, (b) emotional distance with a child, (c) feeling of fed-up in parental role, (d) the contrast in perception of how the parent used to be and how they perceive themselves as a parent at the moment. PBA is a 23-item scale assessed on a 7-point Likert scale from 0 (never) to 6 (everyday). Roskam et al., (2018)[5] proposed five cut-off scores to assess the risk and severity of parental burnout: (1) scores below 30 are considered as no risk of parental burnout, (2) scores between 30 and 45 are considered as a low risk of parental burnout, (3) scores between 46 and

60 are considered as a moderate risk, (4) scores between 61 and 75 represents a high risk of parental burnout, and (5) scores above 75 are considered as severe parental burnout. In our sample, the total scale presented an excellent internal consistency with a Cronbach's α =.98 at T1, α = .99 at T2.

Statistical Analyses

We examined the differences between participants from the FOVEA and control groups. We applied one-way ANOVA to examine the differences in age between the groups and χ^2 tests for independence to examine the differences on categorical and discrete variables such as: gender, family situation, professional occupation, education level, and number of children. The prevalence of parental burnout in both groups was calculated using five cut-off scores as recommended by Roskam et al., (2018). We performed preliminary analyses to assess the normality of the data distribution (Shapiro-Wilk test) and the homogeneity of variances (Levene's test) of each variable. Considering that parental burnout scores do not follow a normal distribution in the general population[5,6] we performed non-parametric Mann-Whitney U-test for independent samples to evaluate whether FOVEA and control groups statistically differed on PBA scores at T1.

To test our main hypothesis that compared to the control group parents participating in FOVEA programme would present lower scores of parental burnout we applied repeated measures ANOVA. Data and materials from this study are available under request from the first author.

Results

The results of a one-way ANOVA ($F(1, 28) = .285$, $p = .60$) showed that there was no statistically significant difference in mean age between participants from FOVEA group (M = 37.5, SD = 4.03) and control group (M = 36.7, SD = 4.17). There was no statistically significant

difference between the two group in terms of gender ($\chi^2(1) = 3.33$, $p = .07$), number of children ($\chi^2(3) = 3.03$, $p = .39$), education level ($\chi^2(3) = 3.06$, $p = .38$), professional situation ($\chi^2(2) = 1.31$, $p = .52$), and family situation ($\chi^2(1) = 1.03$, $p = .31$). Regarding the number of children, 43.3% of participants had one child, 40% of participants had two children, 13.3% had three children, and 3.3% had four children or more under 18 years old living at home. In addition, 13.3% of parents reported the child's current diagnosis of chronic illness or developmental problem, 3.3% of parents reported a past child's diagnosis, and 83.3% of parents reported no child's diagnosis of chronic illness or developmental disorder. The prevalence of parental burnout determined on the basis of PBA scores above 75 was of 33.3% in FOVEA group, and 26.6% in a control group. *Table 2* presents the demographic characteristics of participants.

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The preliminary analyses showed that as expected the parental burnout variable did not follow the normal distribution with Shapiro-Wilks $p = .04$ and the Leven's test showed homogeneity of variance for parental burnout: $F(1,28) = 2.71$, $p = .11$. The results of Mann-Whitney U-test revealed no statistically significant differences between intervention and control group at T1 on parental burnout ($p = .171$) with mean PBA scores of 61.3 (29.7) in FOVEA group and 47.4 (40.1) in the control group. The mean scores and standard deviations at T1 and T2 are presented in *Table 3*.

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To test the hypothesis that compared to the no-intervention control-group FOVEA intervention contributed to the significant decrease in parental burnout we applied the repeated measures ANOVA with a group variable (FOVEA vs control) as between subject factor. The repeated measures ANOVA revealed a statistically significant large within-group effect of time

on parental burnout severity ($F(1, 28) = 7.48$, $p = .01$, $\eta^2_p = .21$) and of time*group ($F(1, 28) = 8.68$, $p = .006$, $\eta^2_p = .24$). The between-group effect was statistically insignificant ($F(1, 28) = .05$, $p = .83$, $\eta^2_p = .002$). The post-hoc analyses showed no statistically significant mean differences in parental burnout between the two groups at T1 ($t(28) = 1.08$, $M_{diff} = 13.93$, $SE_{diff} = 12.88$, $p = .70$) and T2 ($t(28) = -.59$, $M_{diff} = .69$, $SE_{diff} = -8.40$, $p = .93$). However, there was a significant decrease in parental burnout symptoms between T1 and T2 only within the active intervention group ($t(28) = 4.02$, $M_{diff} = 21.53$, $SE_{diff} = 5.36$, $p = .01$). No statistically significant difference in parental burnout was observed within the waitlist control group between T1 and T2 ($t(28) = -.15$, $M_{diff} = - .80$, $SE_{diff} = 5.36$, $p = .99$). These findings confirmed our main hypothesis.

Discussion

The present study aimed to evaluate the effectiveness of FOVEA intervention among the parents at risk or suffering from parental burnout. We tested the hypothesis that compared to the no intervention control group parents participating in the FOVEA programme would present lower scores of parental burnout following the intervention.

The results of the study showed that the FOVEA programme significantly contributed to the reduction of parental burnout severity with a large effect-size ($\eta^2_p = .24$). Indeed, we observed a statistically significant reduction in parental burnout severity within the FOVEA group. Whereas among the parents from the waiting-list control group the levels of parental burnout remained stable. This suggest that the reduction of parental burnout symptoms can be explained by the effects of the intervention rather than by the spontaneous remission over time.

Previous research demonstrated that interventions based on formal practices significantly reduced parental burnout severity [18,19]. This can be explained by the protective role of mindfulness against the parental burnout [9,18]. Indeed, mindfulness practice was shown

to decrease the parental burnout through the reduction of abstract ruminations and the increase in self-compassion [9]. Moreover, Yet, the present study goes beyond these finding showing that informal mindfulness training also contributes to the significant decrease in parental burnout severity.

To our knowledge no previous study tested the effectiveness of informal mindfulness practices in the context of parental burnout. The advantage of the FOVEA intervention is its accessibility: mindfulness practices can be easily integrated into all daily activities and the programme to not require adding new exercises to the parents' tight schedules [3]. The present study showed that informal mindfulness practices are effective for parental burnout prevention and reduction.

Despite these promising results, it should be noted that the study presents several limitations. First, the study was carried out on a relatively small sample of parents (N = 30). Second, the studied sample consisted mainly of mothers (90%) which does not permit generalisation of the results to the population of fathers. The issue of underrepresentation of fathers in the research on parental burnout was identified also in the previous studies[9,24]. This can be explained by the fact that fathers may be more reluctant to seek help in the situation of parental burnout or that fathers are less exposed to the parental burnout. Future research should examine the differences in parental burnout prevalence among the mothers and the fathers as well as the potential barriers in searching the parental support among the fathers. In addition, although the waitlist control group enable to control for a spontaneous remission over time this design does not enable to control for non-specific factors such as quality of therapeutic alliance and relationship, empathy, being non-judgmental, time spent with a reflective person. In that sense, it seems important that future studies compare the effectiveness of the FOVEA programme with another intervention such as active listening or relaxation group.

In conclusion, the FOVEA programme showed its effectiveness in terms of parental burnout prevention and reduction with a large effect size. This promising results highlight the

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Figure 1. Flowchart diagram of participation rate at pre- and post-intervention measures.

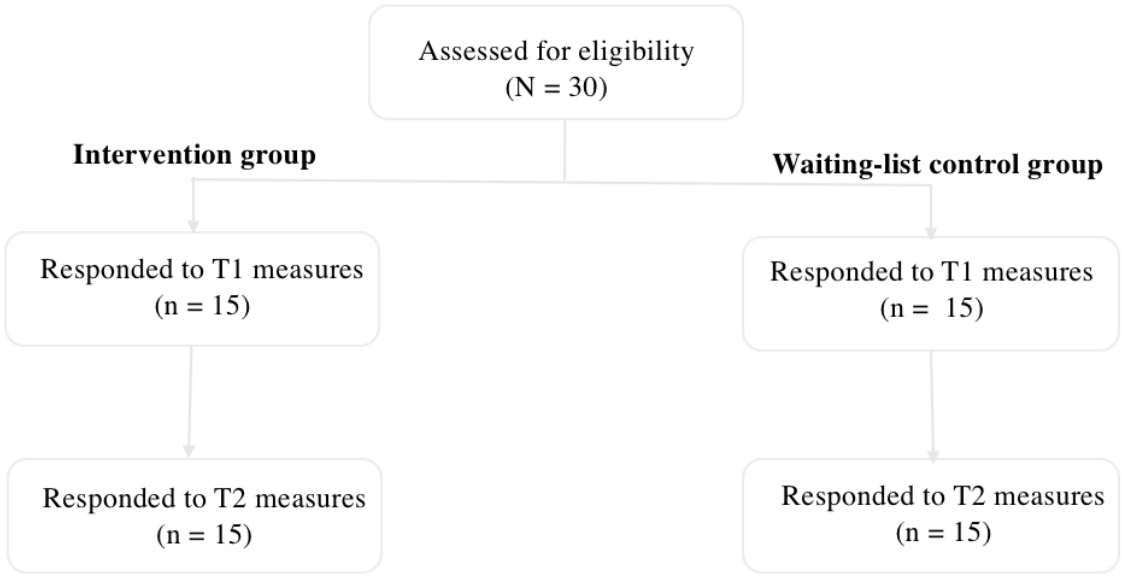

Table 1. *Overview of the FOVEA intervention protocol.*

	Session 1	**Session 2**	**Session 3**	**Session 4**	**Session 5**	**Session 6**	**Session 7**	**Session 8**
Theme	Auditory receptivity	Tactile receptivity	Olfactory receptivity	Taste receptivity	Visual receptivity	Welcoming difficult emotions	Self-awareness	Staying focused
Practices	Orientating the attention toward auditory sensations. Introduction of the notions of automatic reactions and negativity bias. Body scan.	Orientating the attention toward tactile sensations. Meditation focused on a breath. Body scan.	Orientating the attention toward olfactory sensations. Standing meditation. Body scan.	Orientating the attention toward taste sensations. Grape seed exercise. Mindful movements. Body scan.	Orientating the attention toward visual sensations. Mindful walking. Acting intentionally and consciously. Body scan.	Body scan. Acceptance of disturbing sensations or emotions. Acknowledging that there is always an opposed feeling or sensation and that the present sensation will pass. Acting intentionally and consciously.	Body scan. Recalling the memories and sensations of energy, calmness, and tenderness states. Paying attention to all occurring sensations.	Body scan. Summary of the program and developed skills. Meditation focused on a breath.
Objectives	Enhancing the state of presence, psychological flexibility, and the non-judgemental attitude. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Savouring of the present moment. Reduction of automatic responses by acting with consciousness. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Savouring of the present moment. Reduction of automatic responses by acting with consciousness. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Reduction of automatic responses by acting with consciousness. Cognitive reframing of automatic thoughts. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Implementation of the motivation to practice in between the sessions.	Enhancing the state of presence, psychological flexibility, body-awareness, and the non-judgemental attitude. Identification of observed changes. Implementation of the motivation to continue practices.

Table 2. D*emographic characteristics of participants*

	FOVEA		Control group		*p* value[a]
	N	%	*N*	%	
Gender					*p* = .07
Female	12	80	15	100	
Male	3	20	0	0	
Education					*p* = .38
Less than a high school diploma	0	0	0	0	
High school degree or equivalent	5	33.3	5	33.3	
Bachelor's degree	9	60	8	53.3	
Master's degree	1	6.7	0	0	
Above Master's degree	0	0	2	13.4	
Family situation					*p* = .31
Single (never married)	0	0	1	6.7	
Living in couple	15	100	14	93.3	
Divorced	0	0	0	0	
Widowed	0	0	0	0	
Professional situation					*p* = .52
Full time professional activity	10	66.7	8	53.3	
Part time professional activity	5	33.3	6	40	
Unemployed	0	0	1	6.7	
Retirement	0	0	0	0	

Note. [a] χ^2 *test*

Table 3. *Means, standard deviations of studied variables*

	FOVEA		Control Group	
	T1 (*N* = 15)	T2 (*N* = 15)	T1 (*N* = 15)	T2 (*N* =15)
Parental Burnout	61.3 (29.7)	39.8 (24.0)	47.4 (40.1)	48.2 (49.6)

Note. Standard deviations are presented in brackets. T1, T2 correspond to pre- and post- intervention measures.