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Subjective experiences of participating in an attachment-based early intervention parenting program

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Abstract

This qualitative study evaluated an attachment-based group parenting program that utilises mentalisation-based approach. The Building Early Attachment and Resilience (BEAR) program was designed to promote parent-child attachment across the perinatal period and has pre- and post-natal arms. The post-natal component targets mothers and infants at risk for early disturbances of attachment to, and emotional interaction. This evaluation study aimed to explore mothers' subjective experiences of the post-natal BEAR program in encouraging mothers' reflection on their role as a parent. Thirteen mothers were interviewed. Transcripts were analysed using thematic analysis, with five themes emerging. Overall, mothers reported that the intervention promoted reflection about the parenting role, contributed to perceptions of improved mother-infant interactions and increased understanding of their infant's internal experiences. The results suggest the BEAR program is acceptable and facilitates the development of secure parent-infant attachment.

Keywords

Mental health, mentalisation, reflective functioning, parent-child relations, parenting, attachment

Introduction

Infancy is regarded as a critical period for neurological and psychosocial development and occurs in the context of attachment and care-taking relationships. The carer plays a central role in supporting the infant's regulation of stress and emotion by providing responsive care and validating infant social communication (Newman et al., 2015). Disruptions in early interactions are associated with high levels of infant stress, with potential impacts on neurodevelopment and emerging capacities for stress regulation and models of relationships. Relational trauma may also have a negative

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impact on infant mental health (Perry et al., 2017; Schore, 2001). However, in the face of stress and adversity, resilience is a protective factor that begins to develop in early infancy in healthy relationships and fosters secure attachment (Rutter, 2012).

Attachment: A foundation for resilience

Resilience in infants is promoted by sensitive and responsive care which facilitates the infant's capacity for stress tolerance, adaptation to environmental change and recovery from stress and trauma (Mandleco & Peery, 2000; Rutter, 2012). The foundation of such care is secure attachment, in which infants' emotional states are consistently regulated by their carer (Schore, 2001). This enables infants to understand, effectively cope with and regulate their own emotions (Bunce & Rickards, 2004), forming the basis for the development of resilience in later childhood (Beeghly & Tronick, 2011). However, these processes can be disrupted by adverse environments and when parents are compromised in their ability to serve as emotionally responsive and sensitive attachment figures (Easterbrooks et al., 2008).

Mentalisation and reflective functioning

Secure attachment is strongly related to a parent's capacity for mentalisation – the ability to understand and make meaning of others' and one's own mind (Fonagy et al., 2002). Parental mentalising capacity predicts parental sensitivity in parent-child interactions and the formation of secure child attachment (Kalland et al., 2016). Accurate parental mentalisation of the child stimulates positive development of the child's own mentalising capacity and facilitates the formation of a secure attachment to his/her parent. In the context of attachment in parent-child relationships, mentalisation is operationalised as reflective functioning. This is a parent's capacity to recognise, hold and regulate their own and their child's internal mental states, and make accurate and meaningful sense of these mental states by forming links to behaviours (Sharp & Fonagy, 2008).

The impact of maternal mental illness and trauma

Maternal mental illness can affect mother-infant interactions and attachment. Tronick and Reck (2009) suggest that maternal depression negatively impacts maternal capacity to respond to infants' affective communication. This can lead to an intergenerational transfer of negative affect from mother to infant, impacting infant social-emotional development. Trauma and unresolved attachment issues may also impact upon parenting and parent-child attachment. Holmes' (1999) model of transgenerational transmission of maternal trauma posits that mothers with a history of childhood trauma struggle to engage in sensitive and responsive parenting. Cristobal et al. (2017) found that physical neglect and insecure attachment promoted significant negative disruptions of infants' emerging mentalising abilities. Parents with childhood trauma may therefore have poorly developed mentalising abilities and have difficulty recognising, labelling and responding to their child's internal states. This can adversely impact the child's sense of self and his/her ability to predict others' behaviours in social settings.

BEAR Program

The BEAR program (Newman, 2012) is an early intervention for families at risk of early disturbances of attachment to and interaction with their infants. The program is underpinned by attachment theory and employs a mentalisation-based approach to foster: mother-infant interaction, the

Table 1.

Modules	Purpose
1. Getting to know you	Provide developmental framework; describe infant capacity for emotional communication.
2. Parenting with feeling	Examine role of parent in emotional regulation of the infant, highlight importance of mirroring and mutual gaze.
3. Managing difficult feeling	Provide strategies for dealing with feelings elicited by the infant; examine parents' needs for emotional support and validation.
4. Models of parenting	Focus on emotional attunement and understanding the infant's emotional needs.
5. Parenting reflective capacity	Strengthen parents' capacity to understand their infants mental states.
6. Responsive parenting	Develop capacity to recognise infant needs and respond to cues.
7. Dealing with the past	Explore approaches to managing parents' histories or experiences of pregnancy/birth that impact their relationship with their infant.
8. Being a safe base	Examine the role of parent as provider of infant attachment security.
9. Getting it right	Develop positive parental self-evaluation; recognising parental contributions to child emotional development.
10. Moving towards the future	Summarise main themes; highlight parents' progress and understanding

maternal sense of self as an attachment figure and maternal understanding of the infant's emotional state. The program was developed for 'at risk'[1] women attending a metropolitan hospital for antenatal care, who were referred to and receiving mental health services at the hospital.

The BEAR program has pre- and post-natal arms. The post-natal arm is the focus of this study and involves mothers and their infants (aged 1–12 months) attending 10 group sessions. Sessions last 1.5 to 2 hours and are completed over 10 weeks. The program includes psychoeducation about infant socioemotional capacity, mother-infant interactional work, emotion regulation and trauma-informed discussions and exercises focussed on parental reflective functioning. The discussions and exercises during the program encouraged mothers to reflect on their communication with their baby and their baby's interactions with their environment. Each session includes a review of the previous week's topic, an introduction to a new topic and discussions and reflections (see Table 1 for session topics). During sessions, mother-infant interactions are video-recorded, and group exercises aim to help mothers build a sense of self and an understanding of the factors that influence their parenting. The program is delivered at the hospital and facilitated by trained mental health clinicians who are experienced and have special interests in perinatal and infant mental health. The program is ongoing and being evaluated in a longitudinal randomised controlled trial (RCT).[2]

Aims

As infants are able to detect and respond to maternal affective quality from birth (Tronick, 1989), mothers with risk factors including early trauma, mental illness and psychosocial adversity may experience difficulty in reading and responding to their infant's emotional communication. This suggests the need for early intervention focussed on parental understanding of emotional communication and their infants' inner states. Early intervention may also have the potential to prevent direct intergenerational transmission of trauma and foster emotional communication in mother-infant relationships. Early intervention programs like *The Mothers and Toddlers Program (MTP)* (Suchman et al., 2011) and *Minding the Baby (MTB)* (Slade et al., 2005) suggest that

mentalisation-based interventions are effective in improving maternal reflective functioning and promoting secure parent-infant attachments.

As the BEAR program is an early intervention for 'at-risk' mothers, this study sought to understand these mothers' subjective experiences of their participation in the program using a qualitative approach. Although previous programs have been evaluated with the intention to assess maternal reflective functioning and attachment patterns, this study was not designed to do so. Rather, the authors were interested in learning about mothers' experiences of participating in the program through the reflection on their role as a parent, regarding: (1) baby's internal experiences, (2) interactions with their baby and (3) mothers' self-regulation of emotions.

Methods

Eligibility

Women in this study participated in the larger RCT where they were recruited in the antenatal period. Women considered 'at risk' were eligible to participate. Other eligibility criteria included: being 18 years and over; having basic English literacy and communication skills; receiving antenatal care and being booked to deliver at the hospital; being in their second trimester of pregnancy.

Women were ineligible if they had acute psychosis; uncontrolled drug abuse; a level of intellectual disability precluding informed consent; a known serious medical illness which would preclude participation; major depression requiring hospitalisation or precluding them from participating; had their child removed from parental care (mother no longer primary attachment figure); were already engaged in a parenting or meditative program that was therapeutic in nature.

In order to participate in *this* study, women had to meet the inclusion criteria for the RCT and also have (1) participated in the BEAR program less than 3 months before being contacted for the present study; and (2) attended at least 5 of the 10 program sessions. Ethics approval was obtained from the hospital's Ethics Committee (ID 18/16).

Recruitment

Purposive sampling was used to recruit participants from the three post-natal BEAR groups conducted from March to December 2018. Eligible participants were contacted by a member of the BEAR research team. Women who expressed interest in participating in the current study and gave consent for their contact details to be passed on, were then contacted by the first author ST via email and phone. The nature and purpose of the project was explained. An interview date was then scheduled for consenting participants.

Data collection

An interview schedule was developed based on empirical literature on parent-infant attachment and reflective functioning, input from clinicians involved in the BEAR program, the content and intention of the program and the research aims. A preliminary schedule was piloted with two mothers who had completed the program and their feedback was incorporated. The schedule was further refined with clinician input.

Interview questions focussed on participants' thoughts of participating in the BEAR program; childhood experiences; their relationship and interactions with their baby and emotions and thoughts about themselves and their baby. Data on demographic characteristics and mental health was obtained from a short (5–10 minute) questionnaire that was developed for the RCT.

Procedure

In-person/telephone interviews were conducted. After providing informed consent, participants completed the questionnaire. Following this, audio-recorded interviews of approximately an hour were conducted by the first author ST.

Participants interviewed via telephone were required to return the completed questionnaire and consent form electronically. When this did not occur before the scheduled interview, verbal consent was obtained. Follow-up emails were sent to participants to ensure that written consent was obtained, and participants completed the questionnaire.

Data analysis

This study utilised the phases of thematic analysis suggested by Braun and Clarke (2006). Interview recordings were transcribed verbatim and checked for accuracy by author ST.

Authors ST and HJ gained familiarity with the interview content by reviewing the completed transcription and/or audio-recording independently. The authors' impressions of each participant's responses were noted, to aid in the interpretation of the data. The authors worked independently to identify working domains for coding and analysis and met three times to ensure uniform coding of the transcripts and to review the derived themes. Any discrepancies were resolved through discussions, resulting in changes between the data and identified themes. The main themes and subthemes were identified through this process, reviewed by the other authors and then refined to determine the main essence of the data captured. Transcripts were coded and analysed using NVivo 12 qualitative software. Data saturation was reached by the 13th transcript.

Data from the questionnaire were analysed using SPSS version 25 for descriptive purposes and frequency counts.

Results

Eighteen individuals expressed interest in the study. Of those, 13 consented to participate, 3 declined because of work/parenting commitments and 2 were uncontactable. Thirteen mothers participated, aged 27 to 45 years ($M = 33.69$, $SD = 5.02$). Eleven/thirteen women were first-time mothers. All participants had received past treatment (medication and/or counselling) for depression/anxiety, with 11/13 women currently receiving treatment. Three mothers reported a past diagnosis of another mental illness, including eating disorder, obsessive compulsive disorder and bipolar disorder. Nine mothers were born in Australia, the remainder were from Asia, Europe and Africa. Five mothers were married, six were living with their partners, one had never been married and another was separated from her partner. Twelve/thirteen participants had a tertiary education and were employed (paid/self-employed), with only one mother reporting home duties. Most mothers reported that they require ongoing support in parenting and managing their emotions which led to their participation in the group. Mothers perceived several factors that affected the extent to which they participated in the program (e.g. difficulty working around baby's nap schedules, being tired from parenting duties).

Themes

Data was thematically analysed and five overarching themes were identified.

Theme 1: The baby as an individual. This theme describes the way mothers recognised their baby as a separate individual and understood that their baby might be feeling different emotions from themselves.

The baby as a social being. Mothers made numerous observations of how their baby interacted in a social environment. Mothers described their babies as '*sociable*' and enjoying meeting other babies and mothers in the group. They noticed that their babies displayed curiosity and interest in their social environment and could recognise faces.

The baby's personality. Mothers used various terms to describe their baby's character traits, which reflected their perceptions of the baby as a separate individual. The term '*happy*' was most commonly used, as well as '*curious*', '*sociable*' and '*affectionate*'. Mothers described their babies with warmth and affection and some mothers felt that their baby was similar to their younger selves.

Understanding and regulating the baby's internal world. Some mothers expressed an increase in reflection on their baby's thoughts and feelings. They believed this helped them better understand their baby's behaviours and better regulate their baby's emotions.

> "*I never thought about how the baby feels. So, I start to really to put myself in his shoes. . . I actually started to think that you and me, it's not to say that we are the same person, but I really think about your feelings*." [1701]

Some mothers also felt that this gave them greater insight into how they respond to their baby.

Other mothers described feeling '*frustrated*' and '*anxious*' when they had difficulty understanding their baby's inner world. Some mothers expressed the awareness that their babies picked up and were impacted by maternal emotions. These mothers recognised that in order to regulate their baby's emotions, they needed to first regulate their own emotions.

> *". . .if I'm feeling a bit frustrated or something, I can just take a step back and think and reframe the situation, which is a huge thing I've taken from the course. . . it wasn't really the way I looked at in the beginning. . . how can I help him? What does he need from me? As opposed to, he's just cranky or whatever, it's looking at it in a different way*." [1705]

Mothers reported using specific strategies to regulate their baby's emotions, including providing comfort through physical touch and speaking to their baby.

Theme 2: Mothers' perceptions of the BEAR group. Mothers reflected on the key messages that they took from the program and how participating had benefitted them.

Parenting support. Mothers perceived the group as a form of parenting and/or emotional support which was a main reason for their participation. Some mothers who were receiving ongoing mental health support at the hospital were encouraged to attend the group by their attending mental health clinician for ongoing support. Mothers' reason(s) to participate were evident in their interview responses:

> *"I knew I wanted to be a parent to my son differently to how I was parented. . . I was seeking out and on the lookout for programs and means of support that looked at the relationship between the parent and the child and the emotional development of the child. . ."* [1502]

Perceived benefits of the program. Perceived benefits included developing reflective skills and practices, and learning strategies such as mirroring, in order to guide their parenting. Most mothers felt the program content encouraged general reflection. Some mothers described increased reflection on their own childhood experiences, which brought awareness about how they want to parent their children.

"I think the group really highlighted the differences in how we were parented and how we are parenting at the moment. . . it opened my eyes to pay more attention to those things. I didn't want to repeat these. I wanted it to be a better experience for her." [1602]

Other mothers thought the group offered a reflective and supportive space. One mother commented that it was not an '*educational program*' but a space, '*more for sharing and comforting*' [1701]. Most mothers generally found the space created by the group as '*safe*' and were able to be honest and open about their challenges without feeling the fear of being judged:

"It felt a very safe space to be able to talk with other people. . . no one's going through the same thing but going through similar stages. . ." [1601]

Furthermore, hearing other mothers were facing similar parenting challenges and difficult emotions was reassuring and validating, as mothers felt '*normal*' and '*not alone*' in their struggles.

Although some mothers did notice difficulty opening up and sharing their problems for various reasons (e.g. being unable to relate to other mothers' difficulties parenting), they expressed that the group facilitators were excellent at guiding reflections and encouraging them to explore alternative perspectives.

Comparison to council-based mothers' group.[3] Mothers' perceived significant differences between their experiences of the BEAR group and their mothers' groups, and highlighted difficulties relating to their mothers' group (as they presented with different experiences).

Some mothers felt that their mothers' group lacked a sense of honesty, as it was not a platform to process difficult emotions.

". . . in mother's groups their honesty is not there. It's not really a forum for emotional baggage. . ." [1703].

Theme 3: Mothers' emotional experiences

Coping with and managing difficult emotions. Mothers were asked if they spent time thinking about their feelings and/or difficult emotions. Most reported reflecting on their difficult emotions, however, a few stated that they did not spend time thinking about feelings.

Mothers utilised various coping strategies to manage stress and difficult emotions including mindfulness, keeping a diary, talking to their partners and taking time out. Mindfulness seemed to be particularly helpful for several mothers when they felt emotionally overwhelmed.

Mental health history. Most mothers reported struggling with mental health issues at different stages in their lives. Some mothers believed their childhood family environment contributed to their development of mental health problems in adulthood.

"Some days, she [mother]said, when I was crying, she would lock me in the room close the door and keep doing her housework. And people say that even if you don't remember what happened to you before three, that actually is planted in you. *And now I have depression, I wonder if it's something to do with that*." [1701]

A number of mothers reflected on how their own parents' struggles with mental health issues may have impacted their own psychological state, which subsequently influenced their parenting.

"I wasn't allowed to go out because you've got to be careful. People out there, stranger danger. . . but it was really over the top, so much so that it was meant that I have issues with anxiety like that today, and it's always about just safety and that kind of thing. And I do notice that anxiety coming up for me with [baby], because he's very adventurous, and I kind of go, oh, no." [1705]

The impact of maternal emotions on the baby. Mothers were generally aware of the impact of their emotions on their baby's emotional state, some noting their baby '*picked up*' on their emotions. Others recognised their role in helping to regulate their baby's distress.

> *"I was upset, and I was trying not to cry in front of [baby]. . . every time that I would start to tear up, he'd stop playing and look at me, like he was registering that there was something wrong."* [1505]

Theme 4: Mothers' experiences of childhood and of being parented

Role reversal of parent and child. The role reversal of parent and child in the family was described; some mothers given early responsibilities and taking on a carer role within their family. These mothers reflected that their parent(s) were not very involved in their childhood for various reasons (e.g. mental illness) and described a lack of parental warmth and emotional support. One mother who, with her father, was the co-carer of her mother who had mental health issues, stated:

> *"As an adult, I now realise that I wasn't nurtured very much and had care responsibilities put on me quite early on. And a lot of independence before I was ready and not much emotional support. . . my relationship with my mum very much when I was about 11 years old changed to be one of she would confide in me, I would be looking out for her. . ."* [1502]

Another mother described how family members had mental health issues and that she '*was always the strong one*' and '*couldn't share a lot of [my] emotions*' [1601]. This prevented her from displaying emotional vulnerability with family members.

Mothers' experiences of parenting. Mothers' own experiences of parenting were felt to be highly influenced by how they were parented. Some mothers reported making conscious decisions and efforts to be different/the same in their parenting.

> *"My mum was great. . . she taught me a lot of really good values that I continue to use today, and I want my daughter to have those. But as well, I feel she was very soft, and she internalised a lot of things. . . I wasn't taught how to deal with those things as they happened, and I think that's been a negative in my life. . . I really want to provide a platform for my daughter to be open, but also, to protect her from the stuff I suffer from."* [1503]

Other mothers wanted to be supportive of their children because they did not receive much emotional support and validation from their own parents. Some mothers also struggled with the parenting process and expressed doubts about their parenting, however had realised through the group that doing their best was good enough.

> *"I do still have doubts about my ability to be a good parent for her. But I think what the group also made me realise is that it's okay to feel that way. It's a feeling that passes. But if I can be a good parent 80% of the time that's more than enough."* [1503]

A few mothers described having set high expectations of themselves and finding it challenging to be less self-critical when they believed that they were *not good enough* parents. Other mothers, experienced a sense of failure, reporting that they feel '*inadequate*' and '*frustrated*' when they cannot understand their baby or meet their baby's needs. However, mothers understood the importance of self-care, and understood that taking some time to meet their own needs did not necessarily make them a bad parent.

Theme 5: The parent-child relationship

Understanding the baby deepens connection. Some mothers reported that the group facilitated better understanding of the connection they had with their baby and deepened this bond. Most mothers reported '*mirroring*' their baby's verbal and non-verbal expressions. They noted this encouraged dyadic interaction and communication, which fostered increased mutual understanding and connection with their baby and enabled them to respond accurately and sensitively to their baby's needs.

As the 'the Circle of Security' (Powell et al., 2009) concept was introduced in the group, some mothers noticed they had this in mind when interacting with their babies. These mothers observed how their baby returned to them for assurance and comfort when needed. With an understanding and awareness of this, mothers perceived their ability to provide this secure base for their baby to meet their needs and encourage exploration.

Projecting maternal emotions and experiences onto the baby. Some mothers described how their baby might be experiencing similar emotions to those they had experienced as children. For example, one mother who felt 'abandoned' during her childhood thought her baby may have felt the same when distressed, while simultaneously recognising the transference of her emotions onto her baby.

> *"Sometimes I feel like when my daughter's just acting up that she doesn't love me. This is not something that necessarily might be showing but because of my past experience it's something that I reflect back on her."* [1503]

Another mother stated that she '*didn't like*' her parents very much and was '*quite scared of ending up with kids that don't like me*' [1601].

Discussion

This qualitative study explored mothers' subjective experiences of the BEAR program. Five main themes emerged, broadly reflecting mothers' views about the program, parenting and communication with the baby, mother's relationships with their babies, emotion regulation and mothers' own experiences of being parented. Overall, mothers' statements reflected positive experiences of the program with the group being viewed as validating, non-judgmental and a normalising experience in comparison to mothers' reported experiences in their council-based mothers' group. The findings also reflect the aims and purpose of the BEAR approach.

A significant finding that emerged was that mothers' understanding of their baby's internal experience appeared to be facilitated by wondering about their baby's experience and responding in a sensitive manner. Mother-baby connection can be fostered when mothers are able to perceive their baby as an individual with a separate mind from themselves (e.g. Powell et al., 2009). Mothers also noted that as they were able to reflect more on their baby's internal experience and better regulate their own emotions, they have the capacity to be more responsive to their baby's needs. This is important in alleviating parental misinterpretation of non-empathic responses to their infant, which could otherwise disrupt their baby's experience and risk the infant experiencing a breakdown of communication and self-monitoring (Stern, 1985).

Mothers in this study perceived greater awareness of how their emotions impacted their baby and responded sensitively by mirroring their baby's feelings. They also noted an awareness of their baby's ability to attune to maternal emotions. This reflects a co-regulation of the dyadic interaction through responses to one another's emotions and behaviours (Beeghly & Tronick, 2011). It is also facilitated by mothers' understanding of their role as an external regulator for their baby. Mothers reported that they were consciously aware of drawing on psychological concepts and coping strategies introduced

in the program and felt that they were able to effectively manage psychosocial stressors and difficult emotions. BEAR appears to serve as a platform for mother-infant dyadic learning and may facilitate opportunities for the re-establishment of previously disrupted mother-infant interactions.

The program also explored mothers' own childhood experiences of being parented, with mothers finding themselves more conscious of their own parenting experiences. In particular, mothers who described an unfavourable childhood environment understood that their negative experiences of being parented or a lack thereof, had likely affected their mental health and the way they interacted with their baby. Furthermore, mothers who have experienced attachment trauma in childhood and postpartum depression have been found to have lower maternal self-efficacy (Brazeau et al., 2018). Although some mothers in this study reported a sense of disappointment and perceived failure in their parenting, an association between attachment trauma and lower maternal self-efficacy could not be concluded.

Some mothers in this study described being a caregiver for their parent from a young age, and mothers with carer responsibilities as a child have been found to be less accepting of their own child as a separate, unique individual and thus less supportive in encouraging their child's autonomy and exploration (Nuttall et al., 2012). In this study, mothers revealed that they were consciously trying to avoid repeating this experience with their children, and their own experiences of being parented might have contributed to some mothers setting high expectations for themselves in the way they parent. In addition, the transition into parenthood and associated challenges can trigger memories of the parent's childhood. This may interfere with the parent's ability to respond sensitively to the infant in times of distress, and impact on the parent-infant attachment (Cristobal et al., 2017). Some mothers in this study expressed that they have been aware of times where they projected their own emotions (e.g. feeling abandoned) onto their baby. However, it is not evident from mothers' responses that they were made conscious of this projection through the group. This awareness is perhaps likely to be further reinforced by mothers' reflection that their baby is a separate individual.

Limitations

The sample size for this study was small, limiting the generalisability of the findings and rendering quantitative measures inappropriate. It was not the aim of this study to evaluate the effectiveness of the program in increasing mothers' reflective functioning, or changes in mothers' mentalisation and development of secure attachment with their infants. As a qualitative study, whilst inferences are possible, definitive conclusions regarding group outcomes and program effectiveness cannot be made. Further to this, the authors were not aware whether mothers' overall positive experience of the program was affected by individual therapy and/or an antenatal mindfulness program.

Future studies evaluating BEAR or similar programs using a comparison/control group would improve generalisability of findings and could explore individual protective factors (e.g. resilience, self-efficacy, support systems, paternal mental health) that might impact mothers' perceived ability to effectively manage psychosocial stressors and mental health difficulties.

Clinical implications

The study's findings highlight the potential for early interventions to provide a safe space for mothers to engage in trauma-sensitive discussions and help mothers to acknowledge and process how their past experiences can be triggered by the transition into parenthood. Direct support of mother infant emotional interaction is an important technique for building parents' sense of understanding of their infant and of their own role as an attachment figure. The findings also reflect important themes that may increase relevance of future programs and clinical work to improve parent-child attachment and parental reflective functioning against the context of potential intergenerational trauma among at-risk mothers.

Considering the impact of childhood attachment issues and relational trauma on the psychological processes of mother-infant attachment, future programs should emphasise strategies that mitigate intergenerational transmission of negative affect by supporting parents with experiences of early trauma and their emerging capacity to protect their infant. Formal follow-up sessions or support post-program may also have a role and keep the group connected.

Conclusion

This study provides evidence that the BEAR program is perceived by at-risk mothers as helping them develop a better understanding of their role as a parent and their sense of self as an attachment figure. This is facilitated by opportunities for mothers to reflect on the way they parent and interact with their baby. Most importantly, the present study supports the acceptability of the BEAR program as a beneficial and safe environment for vulnerable women.

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Notes

1. Having a current/past, personal/family (first degree relatives) history of any mental illness including symptoms of anxiety and depression, and/or current psychosocial stressors
2. Australian and New Zealand Clinical Trial Registry (ANZCTR). ID: ACTRN12615000684527.
3. Mothers' groups are a state-wide initiative facilitated by maternal child health nurses from local councils. They are for first-time mothers with babies of similar ages.

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Christina Bryant an associate professor Christina Bryant is currently serving as the Director of the University of Melbourne's clinical psychology training programme. Previous experience includes working as a clinical psychologist at the Royal Women's Hospital Melbourne, where she developed clinical and research interests relating to women's health, including persistent pelvic pain, issues relating to fertility and menopause. She collaborates extensively with researchers within and outside psychology and has published widely in international journals and books. Christina has a broad interest in the relationships between physical and mental health, especially as they affect women's health. She also pursues an interest in the mental health of older adults.

Hannah Jensen is a Clinical Psychologist who specialises in perinatal mental health, trauma and cross cultural psychology. She has worked clinically in the Australian public health system and in private practice.

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Louise Newman is professorial fellow in Psychiatry at the University of Melbourne and Consultant Psychiatrist in Perinatal and infant Psychiatry at the Albert Road Clinic. She is Director of the BEAR early parenting research group at the University of Melbourne involved in evaluation of intervention for parents and infants with risk factors for attachment and developmental issues. She specialises in parenting concerns for women with histories of complex trauma.