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NEW BEGINNINGS

A TIME-LIMITED, GROUP INTERVENTION FOR HIGH-RISK INFANTS AND MOTHERS

'New Beginnings' (NB) is a structured, manualized program that addresses the mother–baby relationship within a group format. The program, developed at the Anna Freud Centre (Baradon, 2009, 2013), works with the nuanced, cross-modal emotional interactions between mother and infant, tracking attunement and communication errors and emphasizing interactive repair. To this purpose, open (non-defended) and genuine transactions are privileged, confounding intergenerational transference expectancies of rejection and shaming by a 'bad' world in which the individual is not seen as a worthwhile person. NB aims to increase mentalization in relation to self, baby, and the relationship between them (Baradon, with Biseo, Broughton, James, & Joyce, 2016). This takes place via the content of sessions, group processes (between the adults, adults and babies and the baby-group) and personalization of the program. A reopening of epistemic trust – trust in the authenticity and personal relevance of interpersonally transmitted knowledge (Fonagy, Luyten, & Allison, 2015) – is seen as the product of the above, and the vehicle for the socialization of the babies into a more benign social context. This chapter will begin by setting out the basic structure and aims of the program, before going on to explain how the program was developed, how the program runs and its theoretical foundations in attachment and mentalizing. We will then describe how NB has thus far been evaluated, and will finish with a more detailed account of the implementation of the program.

NB is delivered by two facilitators and the groups comprise up to six mother–infant dyads. The program consists of 18 sessions in total, spanning approximately 4 months. The 1.5-hour NB group is embedded in a full morning activity program, involving an informal play session before the group (with facilitators, and including interested fathers), and lunch together afterwards. These activities complement the aims of the program and scaffold the emotionally intense content and processes of the group sessions.

Mothers and babies attend together. Participants are asked to attend sessions regularly with their babies, and to stay in the session. The first two sessions are made up of individual meetings between group facilitators and potential group members to engage the parents' interest in the program, to create a personal relationship, and to administer initial evaluation measures.

The following 12 sessions are group sessions run on consecutive weeks. Each session is structured around a topic. The topics were selected on the basis of evidence

for their potential to activate the attachment relationship. The subjects cover the history of the pregnancy, the family tree of the baby, mother's representations of her own childhood experiences, her aspirations for herself and her baby, and separations. The sequence of session topics has been planned sensitively, beginning with topics that are often easier for mothers to tolerate and reflect upon – for example, 'how does my baby learn about his world?' – progressing to more emotionally painful topics, such as relationships with fathers.

Mid-way through the program there is an individual session with mother and baby to reflect on progress and remaining difficulties, and to review feedback to the family's social worker (and thereby to the commissioners). At the end of the 12-week program there is another individual meeting between mother and baby and facilitators to bring personal closure, and to administer the evaluation measures. Three monthly follow-up sessions are held in a local Children's Centre. These sessions mediate the transition from the intensive support offered by the closed NB group to use of local service resources.

The central aims of the program are:

a) To extend mothers' capacity to think about their babies' intersubjective and attachment needs as separate from their own,
b) To mobilize genuine emotional interest between mother and baby,
c) To broaden the adults' contingent responsivity to their babies' communications,
d) To encourage the parent's ability to trigger epistemic trust in their child, which would manifest in the babies as showing preference for interactions with mother, using mother as a safe base for exploration and demonstrating age-appropriate pleasure, ability to be stimulated and soothed, and explorative curiosity.

The clinical process tools used to enhance these capacities are:

Observation of individual, dyadic and group behaviors, communications, transactions, and states of mind
Group discussion between all the adults of attachment-related topics, presented in the formal content of the program and linked r*eflective discussions* about the observations
Psycho-educational handouts.

Table 1: Structure of the NB program

Activity	Timing	Participants/location
Social worker referrals to the next group are	6-8 weeks before program starts	Facilitators email the relevant service work-force and join team

invited		meetings to discuss the program and potential referrals, held at the Children's Social Services base
Selection of 6 dyads out of the total referred by the	1-2 months before program starts	Facilitators and social workers
First interview with dyad to explain program and assess interest and commitment	1-3 weeks before program starts	Both facilitators with mother-infant dyad, in home visit
Research measures (pre)	1-3 weeks before program starts	Each facilitator will administer the measures with a different dyad , in a home visit
Program	12 consecutive weekly sessions	Both facilitators, whole group
Midway dyadic feedback session to discuss progress and remaining challenges	5-7 weeks into program	Both facilitators with mother-infant dyad, in home visit
Midway report feedback to social worker	Following meeting with dyad	Both facilitators, written report
Administration of post-intervention evaluation measures	2-3 after end of program	Each facilitator will administer the measures with a different dyad, in home visit
3 follow-up sessions	Monthly, after end of program	Group and facilitators at Local Children's Centre

I. <u>Development</u>

NB is rooted in the parent-infant psychotherapy model developed at the Anna Freud Centre (Baradon et al., 2016; Baradon et al., 2005). The program was originally developed for incarcerated mothers residing with their babies in Mother–Baby Units

(MBUs). Imprisoned mothers constitute a high-risk group in terms of past and current trauma (Borelli, Goshin, Joestl, Clark, & Byrne, 2010; Trust, 2012; Zlotnick, 1997). At the time NB was being developed, high turnover in the MBUs necessitated a relatively short and focused program. The result was an 8-week intervention consisting of intensive weekly sessions for 6 weeks, which were bookended by administration of the evaluation measures (Baradon & Target, 2010). Following a pilot in two HM Prison Mother Baby Units in 2000–5, the program was rolled out to four major MBUs in a cluster randomized trial in 2006–9.

NB was subsequently replicated and evaluated in hostels for HIV-positive, homeless mothers and babies in a deprived urban area in South Africa (Bain, 2014).[1]

New Beginnings in the community (NB-C)

In 2012, NB was adapted for implementation in non-residential settings by locally employed staff (Baradon, 2013). It is a model that seeks to disseminate knowledge so that local staff are skilled up and, thus, resources are built up within community statutory services.

As with mothers and babies in prison, the community-based program (NB-C) is designed to intervene at a point in time when the authorities are placing active demands on the family system. The families targeted in the community are often characterized by intergenerational relational trauma, a broken attachment history (many have experienced the fostering system), economic and educational deprivation, and multiple current stresses. Their babies are selected for the program because they are within the Child Protection system, often at a point where separation of mother and child is being considered. Many families have previously had children removed from their care; this is a juncture of great pressure for the parent, but one that can also motivate them to try the program. It is also a point of pressure for the professionals and organization, since the legal and protection issues in the service are paramount and evoke enormous anxiety. The facilitators – social workers and psychologists employed by the Social Care services – are experienced in working with families and infants, but do not necessarily have a specialist infant mental health background.

The program

Referral and engagement

[1] In a collaboration between the Anna Freud Centre, University of Witwatersrand, and Ububele – a local NGO, funded by the Carnegie Foundation.

The referred families are often characterized by chaotic lifestyles that seem predicated on sensitized stress-response mechanisms and impulsive "flight responses" – e.g. into crises, substance abuse or sexual activity – to avoid overwhelming negative emotions. Thus, the NB-C groups are subject to the widely acknowledged difficulties in engaging and sustaining the attendance of families who have already tended not to maintain participation in parenting programs (Brown, Khan, & Parsonage, 2012). Supporting the mothers to engage in the program is seen as an ongoing process, to be continuously addressed and reinforced. This is done on a practical level by providing transport for mothers and babies to the program, through building the group itself as an attachment object (James, 2016), and by personalizing the program for each dyad by making it meaningful to them.

A typical session

The mothers and babies start the NB day with an informal 'stay-and-play' session. It is a time where mothers can make the step from their often chaotic and stressful lives towards forming relationships, scaffolded play and calm reflection. It provides an informal way of checking-in with each other and enables the facilitators to spend focused time with each parent and infant.

At an allotted time, they then move to the NB room. The sessions take place on the floor: parents and facilitators sit on large cushions, with the babies placed on baby mats at the parents' feet, forming a little congregation in the center. Time is given to come together as a group, settle the babies, and settle in with each other.

The facilitators then introduce the topic of the day and the rationale for it. Simply worded illustrated handouts, which summarize research findings and give psycho-educational information, are read together and thought about in terms of the mothers' own experience and that of their babies. The facilitators alternate leading on the activity in order to model collaborative working. Interactive group activities follow. For example, three consecutive sessions directly address aspects of separation and loss from the mothers' and babies' perspectives. These start with reading, in the group, an illustrated book (*Owl Babies* (Waddell, 1994)), which poetically describes the experiences of three small owl siblings whose owl-mother has gone (to fetch food). The mothers are invited to explore their identifications with the owl babies or mother, and may bring their own experiences to back these up. The topic can be emotionally stirring; some mothers may bring very painful personal memories while others may defend against it, and working through a book – i.e. in displacement – aids with engagement with the topic. The facilitators pace their engagement in accordance with the evolving dyadic and group process and maintain a stance of warm enquiry and reflectiveness. The weekly topics assist parents in sharing their experiences and noticing similarities in others. The parents are often interested in the ways in which others have negotiated their struggles and begin to share ideas with and take inspiration from each other. This appears to reduce their fear of being negatively judged. Sharing experiences can also

consolidate narratives of survival and aid the group in accepting vulnerabilities. Facilitators assess how the participants are making use of the group and intervene to regulate high levels of emotional arousal.

The facilitators are guided in their training and in the programme structure to work directly with the individual infant and the infant 'group'. Thus, significant program time is devoted to more spontaneous observation and reflection about the babies, and this may, at times, cut across the more adult conversations and activities. The focus thus moves between adult and infant, individual, dyad and group. At first, this direct engagement with the babies – voicing the apprehended feeling states, talking in motherese, playing even with very small babies – can be puzzling and somewhat embarassing to the mothers. However, they soon notice their babies' reactions and their curiosity about their babies increases.

A second informal session ends the morning with the mothers, babies and facilitators eating lunch together. This serves as a powerful connecting activity and facilitates the development of a sense of community.

Building up the group as an attachment object

Many of the participants have experienced criticism, social isolation and bullying, and come to the group apprehensively. The facilitators urge the participants to co-construct a group in which listening, acknowledging and respecting each other confound transference expectations of rejection. As the group coheres, the mothers increasingly recruit each other into more authentic sharing and reflective exchanges, and some parents can begin to sensitively challenge the rigid representations held by others in a way that may be too threatening if done by a facilitator. This mother-to-mother interaction, while sometimes uncomfortable, can significantly strengthen the individual's sense of worth in relation to others in the group.

The group element is also of crucial importance for the babies. A 'baby group' is created in its own right as the infants explore and respond to one another and form connections. The facilitators help mothers to view the babies as separate social beings, and this is further reinforced by ongoing observations of the other infants. Discussions about the babies' group processes can foster greater awareness in the mothers of the babies' responses to their actions, evoking surprise, pride and pleasure. Mothers can visibly take on aspects of attuned and sensitive care demonstrated by other members of the group and/or modelled by facilitators.

Moreover, the facilitators are careful to be explicit in their mentalizing stance – talking in a direct, emotionally genuine way, providing explanations for what they are doing at each step of the program, making their thinking available to the participants ('I am saying this because I noticed a few times that…'). The facilitators acknowledge the women's experience of them and behaviours in themselves that may have contributed to bad feelings, and consider with the group how they may work together towards re-establishing trust when it has been peturbed. For many of the women, a readiness on

the part of the facilitators to recognise their own contributions to an interaction will come as a surprise. The process of 'interactive repair' (Tronick & Weinberg, 1997), whereby mismatches or misunderstanding are recognised, acknowledged and addressed, mirrors the kind of work mothers and babies need to do together to repair mismatches between them.

Personalizing the program for the dyad

NB is built to foster the unfolding relational-developmental story of each infant–mother dyad in parallel to the group process. As trust and safety build between group members and facilitators, facilitators are able to become increasingly explicit in comments and actions that are aimed at intervening in the relationship between mother and baby, in the expectation that these can be benignly held at a group level.

The individual sessions at the mid-way point (5-6 weeks into the 12 week program), as well as constituting a report to the responsible social worker (see table 1), open a dialogue about the mother's experience in the group, her and the facilitators' perceptions of her baby's experiences, and the facilitators' thoughts on the mother's progress. These sessions also enable the co-creation of plans for addressing specific areas in the mother–infant relationship which would benefit from further, focused intervention. By this point there has often been sufficient relationship building with the mother to enable her to experience discussion around issues of concern as supportive rather than critical. The feedback process is repeated at the end of the group, providing an opportunity to consolidate progress and highlight areas to build on.

The role of attachment thinking in *New Beginnings*

NB is designed to work with mothers and babies who are at the higher end of risk of attachment disorders (Sleed, Baradon, & Fonagy, 2013) and who are parenting within non-mentalizing cultures linked with chaotic lifestyles, often involving substance misuse and domestic violence. The program addresses conscious, nonconscious (procedural) and unconscious (psychologically defended against) elements of the attachment relationship between mother and infant, and this continuously informs the stance taken by facilitators, as manifest in the here-and-now transactions and narratives shared among facilitators, mothers and their infants.

In their microanalytic study of mother–infant dyads, developmental researchers have demonstrated the extent to which attachment and the emergence of the internal working model is a highly nuanced conversation; when an affectively genuine and personally meaningful dialogue is irregular or absent, the unfolding attachment pathway of the infant can be affected (Feldman, 2007; Tronick & Weinberg, 1997). In a study of the intricate 'action-dialogue' that takes place between mothers and their babies as young as four months, Beebe and colleagues (Beebe, 2013; Beebe, Lachmann,

Markese, & Bahrick, 2012; Beebe & Lachmann, 2014) have shown that the emergence of the disorganised internal working model is associated with incongruences in the dialogic conversation. They examine the temporal, cross-modal interactional mechanisms through which the infant's 'range, flexibility, and *coherence* of experience' (Beebe, 2013) of becoming known to and getting to know their mothers takes place. NB draws on this body of research and clinical work regarding parent-infant bi-directional behaviours and infant development. The notions of coherence, mid-range monitoring and contingency and the nuances of attunement and repair are woven into facilitator interventions.

Intergenerational transmission of patterns of attachment and its psychoanalytic counterpart in parent infant psychotherapy – 'ghosts in the nursery' (Fraiberg, Adelson, & Shapiro, 1975) (Fonagy, Steele, Moran, Steele, & Higgitt, 1993) – informs the content of the sessions, as described above. Revisiting the past – to the extent that this happens in the programme – is contextualized by the mother's conscious wish to provide her infant with different relational experiences. Through a careful focus on the mentalizing processes taking place in the sessions, the intervention supports the mothers' reflective capacities and seeks to make them more robust in the face of heightened affect. Mentalizing – the ability to understand actions by both others and the self in terms of thoughts, beliefs, wishes and desires (Fonagy, Gergely, Jurist, & Target, 2002; A. Slade, Grienenberger, Bernbach, Levy, & Locker, 2005) – underpins humanity's unique capacity for social complexity and nuance. Research has demonstrated the central role of mentalizing in the intergenerational transmission of attachment patterns and in the quality of parent-child relationships (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; A. Slade et al., 2005).

These ideas lie at the core of the verbal and non-verbal reflective processes in NB. The program attempts to direct the mother – through observation, focused attention, modelling and group discussion – to become more aware of the infant's signals and the moments where her response (or lack of it) needs to be re-considered. This would include, for example, bringing alternate dialogic frameworks, that is, mentalizing different possibilites, to reframe negative maternal explanations or attributions ('my baby cries to get under my skin') and encourage a broader range of possible ways of understanding her infant. It would also involve reflecting on incongruences in verbal and non-verbal maternal communication (' You called him over, but when he tried to crawl into your lap it seemes that perhaps you were pulling away from him') that address the communication errors noted by Beebe in mothers' interactions with their four-month olds (Beebe, 2013), and highlighted by Lyons-Ruth and colleagues in vulnerable mothers and their older infants/children (Bronfman, Parsons, & Lyons-Ruth, 1999; Lyons-Ruth, 2002). In mirroring and marking the infant's communications, the facilitators offer the infants' experiences of being recognised and 'known', which are pivotal to the infant's core sense of safety (Beebe, 2013; D. Stern et al., 1998; D. N. Stern, Hofer, Haft, & Dore, 1985). Moreover, attachment relationships, where attachment figures are interested in the child's mind and the child is safe to

explore the mind of the attachment figure (Fonagy, Lorenzini, Campbell, & Luyten, 2014), allow the infant to explore other subjectivities, including that of his/her caregiver. Finding him/herself accurately represented in the mind of the caregiver as a thinking and feeling intentional being is necessary for the infant's own capacities for mentalizing to develop (Fonagy et al., 2002).

Recent elaborations have extended this thinking about the role of attachment as the communication system via which the infant learns to mentalize, with a focus on the significance of how social knowledge and understanding are more broadly conveyed to the child. Building on the model of Csibra and Gergely (Csibra & Gergely, 2006, 2009, 2011), we suggested that contingent responding and mentalization have a crucial place in establishing *epistemic trust*, that is, trust in the authenticity and personal relevance of interpersonally transmitted specific pieces of knowledge (Fonagy & Allison, 2014; Fonagy et al., 2015). The biological predisposition to learn and abstract what is personally relevant and generalizable from communications is conditioned by the capacity of the communicator to establish epistemic trust by independently recognizing the agency (personhood) of the learner. Secure attachment is obviously one way that epistemic trust is – in most normative experience – conveyed across infant development. This is a transactional process. The predisposition to recognize that others are recognizing one's agency and selfhood is essential in making one's mind accessible to learning, and this predisposition is facilitated by secure attachment. In the context of NB, the facilitators were trained to provide the recognition of agency that formed the underpinning of the participants' willingness to adopt for themselves messages concerning childcare. At the same time, we hope that these modifications to their caregiving found their way to enhance the capacity of the infant to learn from their parents through their increased ability to demonstrate to their baby that his/her personal agency was recognized.

For example, an observation of an ordinary, brief, in-the-moment sequence between mother and baby may be used to engage the whole group in thinking about the meaning of what has just happened for the dyad and each partner in it, and to be meaningful to others in the group.

The facilitator observes: *'He fretted, you offered him the breast, he looked at you, into your face, but did not latch on. I wonder why he didn't latch right on*?'

The group offers different thoughts - some thinking sympathetically about mother, some curious about baby, and others holding to concrete ideas about feeding.

The facilitator addresses the baby, summarizing and slightly extending the group's suggestions: *'We think that Mummy wants to feed you when you are hungry so your tummy doesn't hurt and you grow big and strong…'* (validating mother's positive intentions, acknowledging mid-range contingency in that mother is seen to recognize her baby's cues, rather than intrude or ignore). *'…But perhaps you felt mummy's tension when she offered you her breast, because her nipple is very cracked…'* (personalized group

construct recognizing baby's embodied experience). '*And maybe you need to see mummy's face reassure you that it is OK to hurt her if you are hungry and you will both be OK*' (emphasizing authentic communication between the dyad, disruption and repair).

An infant whose channels for learning about the social world have been disrupted – in other words, whose social experiences with caregivers have caused a breakdown in epistemic trust – is naturally left in a position of mistrust in the authenticity of interactions with their caregiver and others. In this state, social communications may be rejected, their meanings confused or distorted, or misinterpreted as having hostile intent. Such 'epistemic disruption' or 'freezing' can render an individual therapeutically 'hard to reach' (a very familiar description to those working in Social Services) (Fonagy & Allison, 2014; Fonagy et al., 2015). Many of the women in NB will have been inadequately mentalized as infants and children in precisely a way that generates the epistemic freezing that can make them so hard to help through conventional services. The accumulating effects of social adversity and alienation from the institutions they encounter and the culture they inhabit will have made such epistemic closure a highly understandable adaptation.

Through the content of the program, as elaborated and interactively personalized in the sessions, NB implicitly provides the parents with a meaningful model of mind and an understanding of their own and their babies' singular development, as well as an idea of the process of change. The work of NB is to create an environment in which epistemic trust can be re-opened in the parents. At a group level there is a transactional and gradual development of a culture whereby the parents entrust the practitioner, and each other, with aspects of their vulnerability and helplessness, and the facilitator reliably helps to hold painful emotions and create meaning out of experience (Sleed et al., 2013). For this critical sense of 'genuineness' to pervade the group, the facilitators need to model their own authentic mentalizing processes – observing, listening, and reflecting – and their capacity to be open to their own thoughts and responses, consistently enquiring in a non-judgmental way the difficulties and uncertainties that are intrinsic to mentalization. In their facial expressions, tone of voice and body cues as much as in what each person says, the facilitators will be communicating their attitudes. This mental–affective–behavioral stance is linked to the growing understanding across therapeutic modalities about the quality of the practitioner's presence and the co-constructed encounter between client(s) and practitoner as a potentially transformative attachment experience (Bollas, 1987; Broughton, 2016; Fonagy, 1999; Loewald, 1979; D Stern, 2004).

At a dyadic level, the work is to attempt to follow and feed back to the mother the complexities of the dyadic interaction in a way that allows the mother to personalize the mentalizing approach, both of herself in relation to her infant, and of the baby in relation to her. This process of personalization is so significant because it is what reveals the relevance of the model to the parents. According to the theory of epistemic trust, the parents' recognition of the personal relevance and validity of the approach is

the critical first stage in reopening epistemic trust: the emergence of a state of mind that allows the parents to benefit from more positive social interactions and experiences, reinforcing reflective abilities and becoming open to mentalizing their own relationships. We would suggest that the proverbial 'hard-to-reach' parents are those whose emotional and social experiences have generated high levels of epistemic mistrust. The highly mentalizing and personalizing aspects of NB serve to reawaken epistemic openness that social adversity has shut down. The parents' experiences of being 'known' translate into greater awareness of their babies' psychological experiences. In parallel, the facilitators' direct work with the babies, in which they consider the babies' communications about how they are feeling, make the infants' mental states more accessible. The most frequent feedback from the participants has been 'I understand my baby better' and 'I realize that s/he has his own feelings from the beginning'.

II. Evaluation of New Beginnings

Table 2: Summary of Outcomes of New Beginnings

Study	Population	N	Design	Measures	Positive treatment outcomes	No treatment effects found
Baradon et al., 2008	Mothers and babies in prison, England	27 intervention	Pilot cohort study	-PDI (RF ratings & qualitative analysis)	-Parental reflective functioning (RF) -More adaptive representations of baby	
Sleed et al., 2013	Mothers and babies in prison, England	88 intervention vs 75 control	Cluster RCT	-PDI (RF) -CIB -CES-D -MORS	-Parental reflective functioning (RF) -Parent-infant interaction (CIB dyadic attunement)	-Maternal depression (CES-D) -Infant interactive behaviour (CIB) -Maternal representations (MORS)
Bain, 2014	Mothers and babies in homeless shelters, South Africa	16 intervention vs 6 control	Cohort study with small control group	-PDI (RF) -EAS -GSMD	-Parent-infant interaction (EAS maternal structuring)	- Parental reflective functioning (RF) -Maternal sensitivity and infant interactive

	-Infant speech development (GSMD)	behaviour (EAS) -Infant personal-social development (GSMD)

PDI = Parent Development Interview; RF = Reflective Functioning; CES-D = Center for Epidemiological Studies Depression Scale; CIB = Coding Interactive Behaviour, EAS = Emotional Availability Scales, MORS = Mother Object Relations Scale, GSMD = Griffiths Scales of Mental Development

Outcomes of New Beginnings from previous studies

The NB intervention in prison MBUs was evaluated first as a pilot outcome study (T. Baradon, P. Fonagy, K. Bland, K. Lénárd, & M. Sleed, 2008) and subsequently as a cluster randomized controlled trial (Sleed et al., 2013).

The pilot study made use of the Parent Development Interview (PDI; A Slade, Aber, Berger, Bresgi, & Kaplan, 2004) to capture qualitative elements of the mothers' representations of their babies, themselves as mothers, and their relationship with their babies, as well as their capacity for reflective functioning (RF; A. Slade, Bernbach, Grienenberger, Levy, & Locker, 2004). The interview was conducted with 27 mothers before and after the intervention. The results of this study demonstrated an overall increase in maternal RF from pre- to post-intervention. Furthermore, after the intervention, the mothers' representations were found to be less idealized, more nuanced, and more focused on the child as a separate person with his/her own thoughts and feelings (Tessa Baradon, Peter Fonagy, Kirsten Bland, Kata Lénárd, & Michelle Sleed, 2008).

In the cluster randomized controlled trial (Sleed et al., 2013), parent and infant outcomes were evaluated for 88 mother–infant dyads participating in the NB intervention and 75 mothers and infants in prisons where the intervention did not take place. The measures used in this trial were parental RF on the PDI (A. Slade et al., 2004), the quality of parent–infant interactions as rated by the Coding Interactive Behavior scales (CIB; Feldman, 1998), maternal depression as measured by the Center for Epidemiological Scales Depression Scale (CES-D; Radloff, 1977), and mothers' reports of their representations of the babies on the Mother Object Relations Scale (MORS; Oates & Gervai, 2003). The findings confirmed the beneficial outcomes seen in the pilot study with regard to maternal RF; mothers taking part in the NB program demonstrated significantly better levels of mentalizing over time relative to those in the control prisons. Similarly, there were significantly better mother–infant interactions in the intervention group over time relative to the control dyads. There were no significant group effects over time for the CES-D or the MORS.

A third evaluation of NB was carried out with 16 mothers and babies in homeless shelters in South Africa who participated in the program and a comparison group of 6 mother–baby dyads not in the program (Bain, 2014). In this study, contrary to the findings in the prison population, the mothers' capacities for RF did not improve significantly. However, significant shifts were found in the infants' speech abilities and in the mothers' abilities to structure their interactions with their infants. The number of sessions attended by the dyads correlated with improvements made by the mothers and their infants, suggesting a dosage effect.

The findings of both the pilot qualitative study and the larger randomized controlled trial in the prisons point to the effectiveness of the intervention in improving maternal mentalizing capacity. The capacity for mothers to be curious about their infants' and their own internal psychological worlds and to make sense of the impact that each person's mental states can have on others has been identified as a crucial component of attachment security (A. Slade et al., 2005), non-disrupted maternal behavior (Grienenberger, Kelly, & Slade, 2005), and infant social and emotional development (Fonagy, Gergely, & Target, 2007). The content of the intervention is highly focused on drawing the mothers' attention to their babies' internal world, and the evaluation findings indicate that the program appears to be effective in meeting this aim. These findings were not replicated in the South African evaluation (Bain, 2014); no changes in RF were found for this sample. Cultural factors may have played a part in this discrepancy, or there may have been more rigid mentalizing difficulties in this group that made it harder to achieve a shift in this domain. What did shift positively for this group were the more obvious parenting behaviors. The intervention appears to have been successful in helping the mothers to provide playful and appropriate structure to their interactions with their babies. These improvements were seen alongside, and probably directly translated into, improvements in the babies' language development. The prison evaluation also showed improvements in the behavioral quality of parent–infant interaction. Thus, across both contexts there was evidence that NB was successful in achieving the aims of improving the mothers' genuine interest in and responsivity to their infants.

The prison evaluation provided some insight into the appropriateness of certain measures in high-risk parent–infant dyads. High levels of idealization were found on the mother-report questionnaires; mothers tended to report very low levels of depressive symptomology and had extremely positive representations of their relationships with their babies as measured by the MORS at baseline. There was a ceiling effect on these measures and there was no further room for 'improvement' at the follow-up. Thus, measurement insensitivity may have resulted in bias in assessing clinically meaningful change for this sample. Given that the qualitative analysis of the PDI in the pilot study demonstrated a reduction in idealized maternal representations of the parent–infant relationship following the intervention, it could be argued that a positive outcome in this sample would have been a reduction in overly positive representations on parent-report questionnaires. In fact, defensive idealization has been recognized by many

attachment theorists to be indicative of less optimal attachment relationships and the intergenerational transmission of psychopathology (George & Solomon, 2008; Kernberg, 1983; Lerner & Van-Der Keshet, 1995; Lyons-Ruth, 2002). Thus, in planning evaluations with similar high-risk parenting populations, data should be collated from multiple sources and should not rely solely on parent-report questionnaires.

Taken together, the evidence for the effectiveness of the program is promising. The differential outcomes found in different settings highlight the importance of ongoing evaluations that can add to the knowledge base in various contexts.

Evaluation of NB-C

A service evaluation has been incorporated into the implementation of NB-C. The planning of this ongoing evaluation has been informed by the experience gained from evaluating the program in prisons as well as the local policies and practices relating specifically to the social work unit setting. Data are collected by the course facilitators themselves, and the measures have been selected as instruments that can serve the dual purpose of providing research data and clinically meaningful information. The underlying principle of the evaluation is that routine outcome monitoring not only provides information about the outcomes of treatment, but can also serve to improve outcomes (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Lambert et al., 2006). The evaluation data are collected during the initial and final home visits that the facilitators made to each family. It was therefore important to ensure that the collection of evaluation data did not impinge on the important processes of engagement and ending.

The measures employed in this evaluation include the PDI, which will be coded for maternal RF, and video-recorded parent–infant interactions, which will be coded for maternal sensitivity. Both of these measures demonstrated beneficial outcomes for the NB program in prisons and the aim is to ascertain whether similar outcomes can be observed from the community-based program. In addition to these externally rated measures, two parent-report questionnaires are being used in this evaluation: The Parenting Stress Index: Short Form (PSI-SF; Abidin, 1995) and the Clinical Outcomes in Routine Evaluation Scale (CORE; (Evans et al., 2000)). These are widely used measures, and normative data from multiple sources will provide meaningful comparison data in the absence of a control group in this evaluation. Parent-report questionnaires were not found to be appropriate measures in the prison sample due to defensive responding. It is possible that similar socially desirable biases will be observed in the community program with families in the child protection system, although this will only be ascertained through the collection of this data.

The context of the NB-C program has enabled a further source of data collection for the purposes of triangulation. Each family in the program is supported by a case-

holding member of the social work team who is independent of the intervention. The case-holding social workers are also asked to provide ratings of the quality of parent–infant relationships for each of the participating dyads on the Parent-Infant Relationship Global Assessment Scale (PIR-GAS; ZERO TO THREE, 2005; Zero-to-Three, 2005). This rating is provided at the start and end of the intervention and provides an independent clinical assessment of the dyads' functioning over time.

The final set of outcomes being measured relate to the public health priorities of the setting in which the program is being carried out. A service-use inventory is used to record the families' engagement in specialized supportive services such as smoking cessation, breastfeeding, and healthy eating support programs, as well as universal health and social care services. The child's status on the child protection register is also recorded pre- and post-intervention. The aim of this is to determine whether families are more likely to engage with services as they develop more trusting relationships with professionals, and whether there are any changes in the use of more costly services such as hospital emergency visits after the NB-C program.

As sufficient numbers of mothers and babies move through the program and evaluation, the results of these outcomes will become available.

Impact of Training and Implementation of NB-C on Social Worker Practice

In addition to the outcomes for parents and babies in the NB-C program, a qualitative study was carried out to assess the impact of the course on the facilitators' professional practice. The facilitators of the first group were interviewed by the research team about their experiences of running these groups and a thematic analysis of the interviews was carried out. The analysis revealed six broad themes from these interviews.

a) A privileged experience

A recurring theme from all of the facilitators was that they felt that the NB program enabled them and the families to develop an intimate and privileged relationship.

This experience was marked as very different from their usual way of working. For example, one of the facilitators spoke of her frustrations of working in a system which was very stretched for resources to support families, but spoke of the NB experience being very different:

> *"You might have very strong opinions about what you want for a baby and a mother, but there´s just not the resources or the system to support that, so it just, yeah, feels a bit hopeless sometimes"*

Interviewer: "Did that come up with the New Beginnings families you worked with?"

"Less, that was a really great thing about the New Beginnings, it felt like you are providing something to the mums, that was so, so, like nurturing and, and they had so much support for that time that they´d never had before."

Another facilitator spoke of the shift in how the families perceived them, and how that might be carried into other aspects of their work:

"They feel persecuted by social services anyway, so I´m kind of, I´m interested in how to try to shift that, cause it can, that was part of the feedback that we got from the group, that they didn´t feel like it was a social services intervention, it felt like something very special and separate… I´m looking at how that could be implemented in different services, social services."

b) Difficulty with ending

Given the sense of intimacy that the facilitators felt they had developed with the families, it is probably not surprising that they found the ending of the group very difficult.

"It felt really hard when it ended. Because we knew that what was left was a really, really stretched social work system… It felt really hard to end the group, and to think about what, what would sort of become of those dyads."

c) Assessing parent-infant relationships

All of the facilitators talked about how the experience of training and implementing the program had increased their knowledge of what to look out for when carrying out assessments, a large component of their usual work.

"I think that I´m better equipped now to spot where are, to identify when the sort of needs of baby are not being met… There´s a whole other dimension that I kind of didn´t understand as well, which I think I understand much more now, which is the relationship, and the bond, and all the kind of nuances within that, that are more kind of complex… really subtle signs.

d) Interventions with parent and infants

The team also spoke of the practical intervention skills they felt they gained from the course which would be carried forward in their future practice.

"The way in which I would support a parent to communicate with their babies, it´s very, very different to what I would have done before. I would have talked to the baby before, but now I´m much more comfortable with talking from the baby´s position, so being able to verbalize how baby might be experiencing the world in

that moment, what it might be like for them to, for a mum to walk away and make a cup of tea, how they might experience that, verbalize that for the baby."

e) Professional competence

A strong theme throughout the interviews was the overall sense of confidence that the facilitators all felt they had gained from the experience, particularly in relation to working with babies.

"Now there is a whole new client group that I feel able to work with."

f) Effective intervention

The facilitators were unambiguous in their belief that the program was one that could make a positive difference for parents and babies. They all spoke of the observable improvements they noticed in the mothers and babies over the duration of the intervention.

"For example, constantly talking to baby, and explaining to baby: 'mummy is going over there, she´s making a drink, you can see her', even just kind of talking to them. And at the beginning the mothers thought we were bonkers. They didn´t understand the reasoning behind it, and whether they understood fully the reasoning behind it at the end of the group, I don´t know, but they were all implementing it, so I think that they could see how the baby benefited from that, and how the baby responded to that."

The training and supervised experience of running the program in this context appears to have been a positive experience for the facilitators and for the families they work with. Importantly, the facilitators felt that they had gained new skills and more experience of working therapeutically with parents and babies, which informs their practice in other aspects of their work. Thus, the program appears to have met a further aim: to embed the NB principles into the broader professional culture. This could have far-reaching implications for all families in contact with the service, not only those in the NB-C groups.

III. Implementation

The emphasis on the importance of epistemic reopening in the NB program is also applied within the professional and organizational setting from which clients are referred, and in which the program is delivered. In the following section we describe how the need to maintain this focus was approached in the implementation of the program.

Review and planning for delivery of NB-C

The changes made for delivery in the community were carefully planned to ensure that there was no drift from the core manualized and evidenced program while addressing the challenges of a new model of delivery. A number of principles guided the process.

a) Partnership planning

The starting point was a process of consultation: focus groups and individual meetings were held with the program facilitators, commissioners, and service users to review the program, learn from experience and plan for sensitive, local delivery.

Each of the above groups made important contributions. For example, mothers who had participated in the program recommended adaptations to make certain elements of the program more user-friendly. These were endorsed by the facilitators, who also fed back those aspects of the program that worked well, in their view, and those aspects which were not sufficiently sensitive to the mothers' states of mind or group dynamics. The commissioners were invested in the use of NB as an intervention which could inform their decision-making process regarding their most worrying families. To accommodate their agenda, we built in formal but transparent procedures for feedback to professionals while preserving boundaries of confidentiality of the participants. The focus groups with potential service users, which were held with local mothers of babies, placed particular emphasis on engagement and supporting participants to complete the program. They brought to the discussion both the realistic difficulties (such as transport and finances) and the personal narratives of discouragement and disengagement due to shame, a feeling of being judged, and of being targeted, and had ideas about how these may be addressed in implementing the program. On the basis of discussions with them, we increased the emphasis on increased flexibility in building the relationships with each mother and baby (e.g., telephone calls and messages, home visits when necessary) to accommodate their histories of disrupted attachments and difficulties in sustaining ongoing investment in a group in which attachments are the focus of attention.

b) Embedding the program in the local services

Whereas NB had previously been delivered in the prisons by the Anna Freud Centre as an external body, with the complexities and advantages this brought (Tomas-Merrills & Chakraborty, 2010), we aimed to embed the community program within local services. This was considered advantageous for a number of reasons. At the level of planning and implementation, the local statutory services were involved in decisions about key areas: staffing, facilities and budget, evaluation design, defining the inclusion criteria, recruitment and engagement processes, feedback model and management of risk. On the level of public policy it was felt that with the statutory providers taking

ownership of the program, infant mental health would become a locally endorsed priority.

The training of the service staff contributed to skill transfer from specialist to generic settings – from the Anna Freud Centre to local services. Within the broader upskilling of the professional workforce employed by the local authority, training and supervising of selected social workers and psychologists as NB facilitators (below), created a more specialized core who, in time, took over IMH trainings within the service.

c) Embedding the NB principles in the local services

A central tenet of all mentalization-based approaches is that reflectiveness within the broad professional network is critical to making an impact at the individual level; in other words, mentalizing cannot occur in isolation (Bevington, Fuggle, Fonagy, Target, & Asen, 2013; Midgley & Vrouva, 2013). This was deemed to be of particular importance in the context of the Social Service system, where child protection requirements predominate. For this reason, an initial phase of training was provided to a broad cross-section of the staff group working with these families. The aim of this training was to raise awareness of relational development and difficulties in infancy and to promote a more knowledgeable and thoughtful approach to work with parents and infants. Thus, the main principles were embedded into the organizational culture, an important element of the model since all families in the NB-C groups are referred and supported by the broader staff alongside the program.

d) Selection and training of facilitators

Facilitators are clinically trained professional (psychologists, social workers) chosen on the basis of interest and experience in parent–infant work and with groups, ability to assimilate a clinical-therapeutic focus in their work, and ability to work collaboratively in co-facilitating the program. The personal stance of the facilitator in imbuing a sense of interest, safety and sensitivity, is critical. Facilitators who offer a sense of authenticity and commitment construct a stronger foundation for change to occur.

The training program comprises 10 sessions on Infant Mental Health and the parent–infant relationship (shared with the broader staff group) and working with mothers and infants in a group, and 10 sessions addressing the content and process of the program, maintaining fidelity, and conducting the evaluation measures. The facilitators are expected to model an open, trusting relationship between collaborating adults to the mothers and babies, where domestic friction is a common occurrence. Therefore, their working relationship is central to the program and is attended to by them and in supervision.

e) Implementation as an iterative process

The local service management was highly invested in maximizing the contributions of the program to the execution of their legal responsibilities. Therefore, regular reviews were held with them to monitor delivery in relation to local client and organizational culture. These meetings were helpful to the Anna Freud Centre in refining the program, and to the local authority in terms of reliability of input to their care processes. Similar processes took place with professional and client focus groups.

f) Clinical supervision

Weekly supervision is provided to the facilitators during the course of the program as a reflective space, to maintain safety, therapeutic efficacy and adherence to the NB program. Central in this is the need to process highly arousing experiences generated by the individual histories of the mothers and babies and the group dynamics. Supervision also helps to monitor unconscious attempts by the parents to recruit the facilitators into a worldview that may be indicative of split-off and defensive processes and to maintain awareness of how these are acted upon, sometimes in the facilitator relationship. Supervision is a forum to formulate ways to manage such processes in the group, and to consider how this might influence systemic and risk factors. Tension between facilitators – whether interpersonal or due to group processes or e.g. one of them being less experienced in working with dyads - is also addressed within supervision.

Challenges in the implementation of the NB-C program

The process of embedding NB-C within the statutory authority at a cultural level was one of the issues that required monitoring and reflection. Traditionally, work in child protective services requires transparency and sharing of information within the professional network. To this end, in an innovative model of work, social work units work therapeutically alongside clinical services, with clinical hypotheses shared in an ongoing dialogue. The feedback processes for NB-C were a departure from this model, in that feedback is provided to the social work units only at the mid-way and final stages of the program, in a formalized report that is discussed with the parent first (outside of any reporting of imminent risk of harm). It was recognized that this shift was likely to be met with resistance and frustration from the social work units, since this dialogue is at the heart of the social work model. Social workers could also be impacted by perceptions of 'their' clients enjoying privileged relationships with facilitators who fed, nurtured and held the dyads in ways their social work roles prevented them from doing. The potential of bias against the program and/or facilitators made it imperative for program facilitators to prepare the ground with the social work units. Collaboration was achieved with the understanding that the model allowed facilitators more space to build upon the clinical hypothesis for each dyad, thereby allowing them to make more considered and robust proposals at the end. However, social worker and facilitator

recommendations may conflict and the possibilities for disagreement and implicit tensions, rare as they may be, need attention.

The parallels between the experiences of the program clients and that of the facilitators in this instance were striking; both were in the position of having to learn to trust the program at a time when there were tensions about how information would be interpreted, shared and recorded. Both were susceptible to experiencing splitting, which, if not handled sensitively, could undermine the efficacy of the program and diminish outcomes. Supported by the supervisory process, program facilitators subsequently found themselves holding the anxieties of both the institution and the dyads.

Over time, the institutional anxieties reduced when positive outcomes for the first NB-C dyads were achieved, thereby increasing confidence in the model and further embedding it in the culture of the social work unit. It has become increasingly seen as a provision for families, where concerns about the risks to the baby – and therefore the possibility of separation – are high.

A second challenge pertained to the facilitator–client relations. The delivery model made for a situation whereby the very authority that was monitoring child welfare, and therefore seen as bad/persecutory to most of the mothers, was also the agency delivering what was hoped the mothers would experience as a 'good' program. Thus we anticipated that suspicion could initially taint the mothers' trust in the facilitators' intentions and therefore their belief in the authenticity and personal relevance of the program. These expectations were met in a large number of the mothers, who initially challenged the facilitators' trustworthiness ("These people are social workers!!") or withdrew from confiding in the group because of this. However, we also hypothesized that the process of building this trust could indirectly address a central, maladaptive mode of mental functioning in many mothers, typically characterized by splitting between 'good' and 'bad' objects (people, organizations, baby, etc.). Yet to be tested is whether there is carry-over in their relationships with their babies and others over time.

Table 3: Implementation principles

Principle	Aims	Activities	Outcome
Collaboration in program planning, implementation and review	Ensure program is relevant to commissioning and participants agenda	Focus groups and individual meetings with commissioners and service users before and during program implementation	Deliver a locally appraised program Reduce organizational anxiety and increase positive

			regard for the introduction of a new and different program Increase participation rates through enhancing relevance and sensitivity to user group
Embeddedness in local services	Infant mental health becomes a locally endorsed and budgeted priority	6 monthly meetings with statutory social services management Training of general social work and psychology staff	Program review and development is an iterative process Improved referral pathways and risk management
Recognition of the importance of a rolling program of training and supervision to change practice	Increase knowledge and reflectiveness within the broad professional network regarding infant mental health Create local specialist resource in the facilitators	Training of social work and psychology workforce Training of facilitators	Up-skilling the local workforce
Culture of reflectiveness and transparency	Offer program participants relational and organizational experiences that increase their trust in professionals	Create and adhere to transparent procedures for reporting back to social workers (who monitor and make decision regarding child welfare)	Increase participants attendance in the program Input to considered decisions regarding the future of mother and baby

Summary

New Beginnings reaches out to the 'hardest to reach' families, with complex and entrenched socio-familial difficulties who are operating under the risk of separation arising from very real child protection needs. These are mothers, therefore, who are in the fright without solution predicament (Main & Hesse, 1990) of struggling to forge attachments to their infants in the here and now, while dealing with both past traumatic attachment histories and the prospect of future attachment disruption of the severest kind. The babies, upon commencement of the program, may already show features associated with trauma, such as avoidance, blank face and freezing (Beebe et al., 2012; Beebe & Lachmann, 2014; Guedeney, Matthey, & Puura, 2013; Lyons-Ruth et al., 2013). NB mobilizes compelling empirical evidence and theoretical insight, in a coherent model that can be replicated and applied to support a wide range of families, and is establishing itself with a growing evidence base.

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