Triple P for Baby: Parenting support across the perinatal period

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The importance of the first three years of a child's life for their long-term development is well-established. For new parents, the transition from pregnancy to parenthood is an exciting and daunting time, with many parents feeling inadequately supported. This is especially true for parents with additional vulnerabilities, such as socio-economic disadvantage, mental health challenges, infant health problems, relationship conflict, and social isolation. The presence of these factors in the perinatal period can have cascading negative impacts on both parents and children across parental mental health, parenting quality, household functioning, and infant social, emotional, behavioural, and motor development. Few programs exist that address the multiple challenges involved in raising an infant, and there is a lack of evidence for interventions that support parenting skills and confidence. This article provides an overview of Triple P for Baby, a perinatal parenting program designed as a comprehensive, preventative, group or individual support for parents at the transition to parenthood.
Keywords: infants, parenting intervention, transition to parenthood, preventative parenting, infant wellbeing.

The first three years of life have long been recognised as fundamental to a child's future development, and are critical for long term physical, cognitive, and socio-emotional wellbeing (Bust & Pedro, 2022). It is a period of vulnerability, but also opportunity to promote the development of children. Working with parents during this time is essential, as the quality of parenting is one of the most important and modifiable factors for the course of a child's development (Adebiyi et al., 2022).

TRANSITION TO PARENTHOOD

The transition to parenthood is a joyous, exciting and much anticipated event, yet even for parents who are well supported and adequately resourced, it can also be a challenging and stressful time. For parents who experience vulnerabilities, such as financial difficulties, mental health problems, relationship breakdown or lack of social support, the transition to parenthood can be even more difficult. There are several central tasks and challenges for parents at the transition to parenthood. Central is forming a strong bond and attachment relationship with their baby and responding sensitively to their baby's need. Parents also need to develop the skills and confidence to manage day-to-day baby behaviours and set up and adapt family routines that meet the evolving needs of their baby and their own needs as parents. Learning about infant development and engaging with their baby in ways that promote development is another important aspect of the early period of development. Furthermore, parents need to learn appropriate and positive ways to manage more difficult baby behaviours and adapt their parenting strategies to the changing needs of their baby during the first 12 months of life. Finally, parents need to look after their own needs and sustain the important relationships in their lives that are essential to supporting the transition to parenthood.

RISK FACTORS AT THE TRANSITION TO PARENTHOOD

Various risk and protective factors can increase the probability of, or act as a buffer against, the development of mental health problems in both caregivers and children (Van Haeken et al., 2020). Risk factors for poor parental adjustment (across pregnancy, birth, and the neo-natal period) include pregnancy and birth-related complications, particularly the presence of trauma during labour and delivery, and infant irritability (Biaggi et al., 2016). Variations in infant temperament, health, crying, and sleep patterns all influence the parenting environment in which responsivity and secure attachment occur (Bilgin & Wolke, 2020; Bozzette, 2007). Infants born with additional vulnerabilities, including those born preterm, can introduce further challenges to family adjustment. For example, infants born preterm are at greater risk of developing difficult temperaments, excessive or prolonged crying, feeding and/or sleeping difficulties (Caravale et al., 2017). They are also typically less responsive to parental attempts to engage (Harel-Gadassi et al., 2020). Parents of preterm infants are at greater risk of developing

depression and anxiety (Winter et al., 2018; Yaari et al., 2019), and those who have difficulty coping with their infant's needs may develop negative attributions for their infant's crying, feeding, and sleeping patterns. As parental attributions are related to perceptions about the cause of children's behaviour, this can impact negatively on parental responsiveness (Knappe et al., 2020).

Individual risk factors for difficulties with postnatal parent adjustment include a history of depression or anxiety, life stressors during pregnancy, the quality of parenting received as a child, and unmet expectations of parenthood (Chhabra et al., 2020). Overarching family and social risk factors for poor parental adjustment include limited support from partners (including poor communication and increased conflict), limited social and professional supports, and sociodemographic disadvantage (Adebiyi et al., 2022; Alhusen & Alvarez, 2016).

Both poor maternal and paternal adjustment during early parenthood have been shown to have cascading negative consequences for parents and their children. Higher levels of depressive symptoms in new mothers predict poor mental health in the future, higher difficulty controlling their anger, greater perceived stress, poorer household functioning, and higher levels of relationship difficulties (Slomian et al., 2019). Mothers who report experiencing perinatal panic disorders also report negative impacts to infant gestational outcomes, duration of breastfeeding, parenting practices, the mother-child bond, and infant regulation (Martini et al., 2020). Paternal perinatal depression negatively impacts the quality of both the father-child and interparental relationships, and is a risk factor for maternal depression (Paulson et al., 2016). Postnatal depression in fathers is also associated with negative emotional and behavioural outcomes in children at ages three to five years (Ramchandani et al., 2005).

THE NEED FOR PERINATAL PARENTING SUPPORT

For the new parent, there is an abundance of information on parenting babies both in the popular media and from health and social service agencies. Yet much of this information is not evidence-based and sometimes inaccurate and confusing. Many new parents say they were not sufficiently prepared for parenting and wish they had been given more relevant information beforehand (Morawska et al., 2018). Given that antenatal education appears to have limited effects (Ferguson et al., 2013; Gagnon & Sandall, 2007), it is unsurprising that parents do not feel adequately prepared.

Successful interventions for early parenthood provide not only practical guidance for infant care, but also socio-emotional support to strengthen the inter-parental relationship, parent self-care, and the promotion of secure attachment (Izett et al., 2021). First time parents have differing preferences for support during pregnancy and after birth, from basic infant care needs in pregnancy to coping skills and infant behaviour support following birth (Morawska et al., 2018). However, there are a lack of parenting programs supporting parents across both pregnancy and after birth, and existing programs may be limited in their scope (Ladyman et al., 2022).

Few programs exist that address multiple aspects involved in raising an infant, including the couple's relationship, parenting, and individual adjustment during this transition period. There is a paucity of empirical studies that evaluate the effects of interventions on parenting confidence and competence during the perinatal period (Mihelic et al., 2017), and limited evidence for outcomes such as sleep interventions for babies under 6 months of age (Douglas & Hill, 2013). A meta-analysis of interventions targeting early infant and parenting behaviours (Mihelic et al., 2016), found only five studies that examined parenting competence and confidence. Interestingly, a meta-analysis of parenting interventions delivered during the perinatal period found reductions in maternal depression (Adina, Morawska, Mitchell, et al., 2022), suggesting that parenting support has a critical role to play not only in parent and infant outcomes, but also in addressing some of the other risk and vulnerability factors that may occur in a child's early environment. Thus, while many interventions have been tested, the evidence base for parenting interventions that support the central role of parents during infancy is still limited.

The parental relationship, parenting factors, and individual parent adjustment across the perinatal period are crucial for an infant's wellbeing. Successful interventions for parents provide psycho-education and practical parenting skills, as well as positively support the co-parenting relationship, secure attachment style, and parent reflecting skills (Izett et al., 2021). Working with parents is a key point of intervention in supporting best outcomes for families and is consistent with parent needs and preferences for support (Corkin et al., 2018; Morawska et al., 2018). Parenting interventions can improve parental responsiveness (Commerford, 2017; Mihelic et al., 2018), help prevent infant sleep problems (Mihelic et al., 2017) and reduce maternal depression (Adina, Morawska, Mitchell, et al., 2022). When parents are given the skills to regulate their own emotions, be better prepared for parenthood, and better able to understand their baby's needs and what to expect, they can better provide the nurturing, responsive care their baby needs.

TRIPLE P FOR BABY

The Triple P Positive Parenting Program - Triple P - is a multi-level system of evidenced-based parenting interventions, which has been extensively evaluated for parents of children from birth through to adolescence (Sanders et al., 2014). Key features of the system include a self-regulatory framework that informs all levels of the program, from training of practitioners to

delivering programs to parents. This mode of delivery assists parents to build on their capacity to problem solve their own parenting challenges (rather than relying on parenting practitioners to tell them what to do), and to encourage self-regulation in their children. Furthermore, the system is designed to flexibility support parents to a minimally sufficient level, with universal and targeted interventions aimed to promote positive parenting at a whole of population level. Triple P takes a public health approach on the basis that positive parenting is essential to all children and promotes development, adjustment, and wellbeing across the lifespan. Strategies within the Triple P model directly supporting dimensions of social and emotional health include self-confidence, self-efficacy, self-regulation, personal agency, patience, persistence, conflict resolution, effective communication, and empathy.

Triple P for Baby was designed as a comprehensive, preventative, group or individual delivered approach to support parents at the transition to parenthood, and targets known risks factors common across the transition (i.e., early parenting confidence and behaviour, parental coping, and supporting the couple relationship). It is an evidence-based perinatal education program that is designed to equip parents with the skills needed to achieve a successful transition to parenthood. The program aims to increase parental competence and confidence in raising their children by increasing parents' skills in building a strong bond with their baby, promoting infant development, providing adaptable strategies for their infant (crying, settling, sleeping), improving partner communication, and increasing parental coping skills. Figure 1 outlines the logic model for the program, while Table 1

FIGURE 1
TRIPLE P FOR BABY LOGIC MODEL

INPUTS

Theory

- Social Learning Theory
- Self-Regulation Model
- CBT principles

Triple P for Baby sessions include:

Session 1. Positive parenting

Session 2. Responding to your baby

Session 3. Survival skills

Session 4. Partner support

Sessions 5 – 8. Parenting routines & parenting skills

OUTPUTS

Implementation

- Face-to-face education and skills training
- Telephone support for further skills training
- Reflecting exercises
- Homework exercises
- Flexible program delivery to meet participant needs
- Trained and accredited practitioners to deliver interventions to parents
- Resources for parents to assist with program completion
- Implementation support

PARENT OUTCOMES

- Improved bonding/ attachment with baby
- Increased responsiveness to baby signals & interaction with baby
- Increased knowledge of child development and ways to reduce common child accidents
- Improved communication with partner and others
- Mastering positive parenting skills
- Improved mental health and wellbeing
- Reduced parenting stress & family conflict
- Improved emotion regulation
- Reductions in stigma for seeking parenting support
- Greater access to services

INFANT OUTCOMES

- Experience of more secure attachment with parents
- An environment supportive of the development of emotion regulation
- Learning environments that support thriving
- Fewer experiences of accidents / harm
- Fewer experiences of distress
- Better cognition and language development, social, emotional, and motor skills

TABLE 1
TRIPLE P FOR BABY CORE STRATEGIES

Developing a positive relationship with your baby	Teaching new skills and behaviours	Responding to your baby	Survival skills	Partner support
• Spend quality time with your baby • Communicate with your baby • Show affection	• Praise your baby • Give your baby attention • Have interesting activities • Develop a flexible routine	• Encourage contentment • Use settling techniques • Use diversion to another activity • Establish limits	• Coping statements • Finding out what you need to know • Looking after yourself • Abdominal breathing • Social support	• Communication skills • Casual conversations • Communicating about parenthood • Maintaining relationship happiness • Sharing tasks and chores

describes the core components of the program.

Triple P for Baby is delivered as an eight-session group or individual program or as a self-directed online program, Triple P Online for Baby. The program is designed to be completed by parents either during pregnancy or after the child is born and includes ongoing opportunities for parents to apply learned skills across diverse behaviours and settings.

TRIPLE P FOR BABY - FEASIBILITY, SATISFACTION, AND ACCEPTABILITY

Studies examining the feasibility, acceptability and satisfaction of Triple P for Baby program content and delivery indicate high acceptability for a wide range of parents. This includes research in Australia with parents of babies born very preterm (Ferrari et al., 2011; Whittingham et al., 2013), and England in a psychiatric setting (Mother and Baby Unit), (Butler et al., 2014; Wittkowski et al., 2021). Parents clearly like Triple P for Baby and find it highly acceptable. Many parents and practitioners continue to ask for the program, often noting that there simply are no available parenting programs for the transition to parenthood.

Overall, parents consistently report being satisfied to very satisfied with Triple P for Baby (McPherson et al., 2022; Popp et al., 2019; Seah & Morawska, 2016; Seah, 2016). Mothers experiencing severe mental illness found Triple P for Baby to be accessible and engaging, beneficial in developing parenting skills and techniques, and non-stigmatising. They also noted the importance of feeling a sense of achievement when completing the program (Butler et al., 2014). There was high program acceptability across parents of very preterm infants (Whittingham et al., 2013). Promisingly, parents have reported that the program met their needs, gave the right amount (Tsivos et al., 2015) and also gave the right type of help (McPherson et al., 2022), as well as improving the relationship with their partner (McPherson et al., 2022).

TRIPLE P FOR BABY – PARENT AND CHILD OUTCOMES

Several randomised controlled trials have been conducted assessing the effectiveness of Triple P for Baby (e.g., McPherson et al., 2022; Popp et al., 2019).

Indications are that program participation can significantly enhance child and parent outcomes when compared to usual care. Parents who have completed Triple P for Baby have reported significant improvements in parental adjustment (Wittkowski et al., 2022), significantly lower maternal anxiety and depression (Adina, Morawska, & Mitchell, 2022) and significantly lower maternal depression and paternal anxiety compared to care as usual (McPherson et al., 2022). Fathers reported significantly lower levels of anxiety two years following completion of the program (McPherson et al., 2022). As both paternal and maternal mental health have extrapolating effects on the family system, in particular in relation to parental conflict and child development, successful improvement in mental health symptoms can provide a buffer against poor child outcomes (Bakermans-Kranenburg et al., 2019). Indeed, mothers who reported reductions in psychiatric symptoms and severity following program completion, also reported an increase in their parenting competence and improvements in the mother-infant bond at six-month follow-up (Wittkowski et al., 2022). Triple P for Baby also demonstrates efficacy in low-resource settings with mothers at risk for depression (Adina, Morawska, & Mitchell, 2022).

Parents who have completed Triple P for Baby also report positive outcomes for their infant, including improvements in infant temperament and crying frequency at six-months old (Popp et al., 2019), fewer mother reported baby behaviour difficulties (Adina, Morawska, & Mitchell, 2022), significant improvements in cognitive and motor skills at two years of age (Colditz et al., 2019), and significant improvements in infant fine motor skills and receptive language at 6-months of age (Adina, Morawska, & Mitchell, 2022).

CONCLUSION

Parenting is a lifelong journey, and the early days of parenting set the foundation for parent-child relationships, parenting confidence, and parent and child wellbeing. The transition to parenthood is a time of great joy but is also challenging for many parents. It is a time when parents are seeking information and looking for support in their parenting journey and thus an opportunity to engage parents with evidence-based parenting supports. Successful parenting programs focus on non-judgemental, evidence-based support, with the flexibility to reach parents at any stage in family life. Parenting programs that are positive, prevention-focussed, and ideally, universally available ensure the best outcomes for parents and children alike (Doyle et al., 2022).

Normalising parenting support in the early days can help address this, making parenting education and support as readily accepted and available as antenatal classes. The increased emphasis on, and recognition of, parent-infant relationships and perinatal mental health and wellbeing also underscores the need for support for parents-to-be and new parents. When we talk about parenting support at the transition to parenthood, we need to meaningfully engage with all parents, especially fathers, who play a central role in child development. Finally, we need interventions that support the diversity of parents and families across the world in a way that is culturally appropriate and acknowledges the socio-ecology of parenting. Triple P for Baby and Triple P Online for Baby are tools practitioners and parents can use to achieve these outcomes.

Information of Triple P and Triple P for Baby can be obtained from our website: https://www.triplep.net/

CONFLICT OF INTEREST STATEMENT

The University of Queensland (UQ) owns the Triple P–Positive Parenting Program® (Triple P). The University, through its technology transfer company, UniQuest Pty Ltd, has licensed Triple P International Pty Ltd to publish and disseminate the program worldwide. The UQ Parenting and Family Support Centre is partly funded by royalties stemming from published Triple P resources. Royalties are also distributed to the Faculty of Health and Behavioural Sciences at UQ and contributory authors of published Triple P resources. No author has any share or ownership in Triple P International Pty Ltd. Dr Morawska receives royalties from TPI and is an employee at UQ. Dr Herd and Ms Jackson are employees of TPI and do not receive royalties from sales of Triple P resources.

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