A QUALITATIVE EVALUATION OF THE INFANT-MOTHER ATTACHMENT SECURITY PROGRAM BY MOTHERS' AND NURSES' VIEWS

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A Qualitative Evaluation of the Infant-Mother Attachment Security Program

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- this thesis contains no material that has been submitted or accepted for a degree or diploma in any other educational institution;
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ABSTRACT

A Qualitative Evaluation of the Infant-Mother Attachment Security Program by Mothers' and Nurses' Views

This study qualitatively examined the acceptability and feasibility of a newly developed, nurse-implemented attachment-based intervention, the Infant-Mother Attachment Security Program, integrated into Türkiye's primary healthcare system. Semi-structured interviews were conducted with 5 mothers and 6 nurses to explore their experiences and suggestions during the program's early stages. Reflexive thematic analysis revealed two main themes: (1) Seeing through new eyes, capturing the emotional and professional awareness gained by the stakeholders, and (2) Feasibility in practice: What it takes to make it work, outlining what facilitated or hindered the implementation and the conditions needed for sustainability. Overall, the findings suggest that both mothers and nurses appreciated the program and found it meaningful; however, challenges related to workload, time, and systemic support were identified as key barriers to long-term feasibility. The results highlight the program's potential for integration into family health centers, provided that structural adjustments are made to support its delivery.

ÖZET

Güvenli Bebek-Anne Bağlanma Programının Anne ve Hemşire Görüşleriyle Nitel Açıdan İncelenmesi

Bu çalışma, hemşireler tarafından uygulanan ve Türkiye'nin sağlık sistemi içinde yer alan yeni bir bağlanma temelli müdahale programı olan "Bebek-Anne Bağlanma Güvenliği Programı"nın kabul edilebilirliğini ve fizibilitesini nitel olarak değerlendirmiştir. Programın yarısını tamamlamış 5 anne ve 6 hemşireyle yarı yapılandırılmış görüşmeler yapılmış, deneyimleri ve önerileri derinlemesine incelenmiştir. Tematik analiz sonucunda iki ana tema ortaya çıkmıştır: (1) Yeni bir gözle bakmak, hem annelerin hem hemşirelerin kazandığı farkındalıkları ve deneyimlerini yansıtmaktadır, (2) Uygulamada fizibilite, uygulamayı kolaylaştıran ya da zorlaştıran etmenleri ve programın sürdürülebilirliği için gerekli koşulları kapsamaktadır. Genel olarak, hem anneler hem de hemşireler programı anlamlı ve faydalı bulmuşlardır; ancak iş yükü, zaman kısıtlılığı ve sistemsel destek eksikliği, uzun vadeli uygulamanın önünde önemli engeller olarak belirtilmiştir. Bulgular, gerekli yapısal düzenlemeler sağlandığı takdirde programın aile sağlığı merkezlerine entegre edilebileceğini göstermektedir.

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To my family…

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION……..……..1

1.1 General introduction ……...……..1

1.2 Literature review…….……...……...…….....3

1.3 The Infant-Mother Attachment Security Program……...29

1.4 Research gaps and current study …….…….…….…….....35

CHAPTER 2: METHODOLOGY……...…….…….....39

2.1 Design.……....……..……...…….....39

2.2 Participants…….…….…….…….…….....40

2.3 Procedure.…….…….……...…….....41

2.4 Qualitative data analysis.…….…….....44

2.5 Trustworthiness……..…….…….....45

CHAPTER 3: RESULTS…….…….....…47

3.1 Theme 1. Seeing through new eyes……48

3.2 Theme 2. Feasibility in practice: What it takes to make it work..…..….56

CHAPTER 4: DISCUSSION…….……...….…….……70

4.1 Acceptability of the program……...….…….……...…..70

4.2 Feasibility of the program……...….…….…….....73

4.3 Long-term application and sustainability of the program……....76

4.4 Strengths and limitations……...….…….……77

4.5 Conclusion……...….…….…….....79

APPENDIX A: PROGRAM MODULES OVERVIEW…….....…80

APPENDIX B: ETHICAL APPROVAL…….……...…82

APPENDIX C: NURSE INTERVIEW GUIDE…….…….…….….83

APPENDIX D: MOTHER INTERVIEW GUIDE ……...…….....….85

REFERENCES……...…….....87

CHAPTER 1

INTRODUCTION

1.1 General introduction

Early relationships between infants and their primary caregivers have a lasting influence on children's socioemotional, cognitive, and psychological development. Attachment theory, introduced by Bowlby (1969) and further developed by Ainsworth (1979), emphasizes that secure attachments formed during the early years can serve as a basis for future relationships, both with oneself and others. Secure attachment arises from sensitive and consistent caregiving, where caregivers adequately identify and respond to infants' cues and needs (Ainsworth et al., 1979; Bowlby, 1988). Substantial evidence consistently points to the link between secure attachment in infancy and positive outcomes across various domains, such as improved emotion regulation, social competence, and stronger cognitive development (see meta-analyses by Cooke et al., 2016, 2019; Deneault et al., 2023; Groh et al., 2016; Sroufe, 2005).

Considering the crucial role of attachment security for heathy child development, numerous interventions have been designed and implemented to promote secure attachment. There are a number of empirically supported attachment-based parenting programs (see Steele & Steele, 2018 for an overview). Of those programs, the Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer et al., 2008), the Attachment and Biobehavioral Catch-Up (ABC; Marvin et al., 2002), and the Circle of Security (COS; Hoffman et al., 2006) programs are of particular interest to the present thesis as these programs have been shown to be effective, particularly for families from

disadvantaged backgrounds. These interventions, similar to most attachment-based programs, aim to increase parental sensitivity, which is defined as the caregiver's ability to recognize and respond the infant's cues promptly and correctly (Ainsworth et al., 1974), to establish secure infant-caregiver attachment.

While the effectiveness of these attachment-based interventions is well-established, their integration into the routine pediatric check-ups, especially within non-Western and low-resource contexts, has been very limited. This gap is striking given the large number of families that can benefit from these programs through such universal services in the healthcare. In Türkiye, despite the promising implementations of the VIPP-SD based on home visitation (Sümer et al., 2020), and the center-based Circle of Security (COS) Parenting program (Arıkan, 2019), systematic evaluation and integration of attachment-based interventions within the primary healthcare services have not been established. Recognizing this need, the Infant-Mother Attachment Security Program was developed based on well-supported attachment-based interventions such as the VIPP-SD, ABC, and COS. The program was culturally and contextually adapted for the implementation by nurses within Türkiye's Family Health Centers and designed to utilize current routine well-child visits through the use of the video feedback method.

There are significant cultural and practical issues that need to be considered when designing and incorporating such an intervention into the primary healthcare system in Türkiye. Therefore, this thesis aims to bridge the gap between the research base and the practical application of the Infant-Mother Attachment Security Program by qualitatively examining its acceptability and feasibility from the perspectives of nurses and participant mothers. Acceptability measures how acceptable the program is to stakeholders, their satisfaction with it, and the perceived benefits they receive

from the program. Feasibility indicates how successful the program is for the specific context and population, their views on the program as viable and sustainable, and whether it can be appropriately implemented in a healthcare center (Proctor & Brownson, 2012, as cited in West et al., 2017). Understanding the stakeholders' experiences and incorporating their suggestions would help identify the program's strengths and areas needing adjustment, as well as inform its potential scalability across the Turkish healthcare system.

In the following chapters, this thesis will review the literature, outline the research methodology, and present qualitative results from the stakeholders' perspectives on the Infant-Mother Attachment Security Program.

1.2 Literature review

1.2.1 Background and theoretical framework

1.2.1.1 Attachment theory overview

John Bowlby laid the foundation of attachment theory in his influential series Attachment, Separation, and Loss (1969, 1973, 1980). Rooted in the evolutionary principles, his theory suggests that infants have an innate tendency to turn to their caregivers for comfort and security in times of distress and rely on them as a safe haven (Bowlby, 1969, 1988). They also tend to use their caregivers as a secure base from which they can explore their surroundings.

Mary Ainsworth continued the seminal work of Bowlby through her observational studies in Uganda and Baltimore and identified distinct patterns of attachment that reflect on the quality of the caregiver-infant relationship (Ainsworth, 1967; Ainsworth et al., 1979). Ainsworth's research led to the development of the famous Strange Situation Procedure, which is a structured assessment intended to

evaluate how infants respond to brief separations and reunions with their caregivers (Ainsworth et al., 1979). Through this procedure, three distinct attachment styles emerged: secure, insecure-avoidant, and insecure-ambivalent.

Children classified as securely attached typically show signs of distress when their caregivers leave the room and seek proximity upon their return. They exhibit a healthy balance between using the caregiver as a secure base and a safe haven. By actively seeking reassurance and proximity in times of stress, such as separation, they turn to the caregiver for a safe haven. Once soothed, they return to exploration, demonstrating their ability to use the caregiver as a secure base to engage with their environment.

In contrast, children who show insecure-avoidant patterns do not appear visibly distressed by the separation from their caregivers, continue their play, and avoid their caregiver upon reunion. These children often fail to use their caregiver as a safe haven, as they do not seek comfort in times of stress. They also struggle to use the caregiver as a secure base, often continuing to explore the environment in an emotionally detached and indifferent manner. This reflects a self-reliance that is typically ineffective in regulating their stress.

Children who are classified as insecure-ambivalent generally displayed intense distress reactions when separated from their caregivers and are unable to be soothed by their caregivers upon their return. They demonstrate inconsistency in utilizing the caregiver as both a safe haven and a secure base. While the caregiver is present, they often engage in clingy and hesitant behaviors, showing reluctance to explore due to uncertainty about the caregiver's availability as a secure base. Simultaneously, they struggle to be comforted even when seeking proximity, reflecting a lack of trust in the caregiver's role as a reliable safe haven.

A decade later, a fourth attachment style, disorganized attachment, was introduced by the work of Main and Solomon (1990) to account for behaviors that were difficult to classify within the three existing attachment styles. These children would show inconsistent and contradictory behaviors in response to their caregivers.

1.2.1.2 Importance of secure attachment for healthy child development

Decades of research have shown that a child's attachment style plays a crucial role in their emotional, social, and cognitive development (Cassidy & Shaver, 2016). When caregivers consistently respond to their children's cues and needs with sensitivity, the child learns to trust that their emotional and physical needs will be met. This sense of security provides them with a secure base from which they can explore the world, knowing they can return to this base for comfort and protection (Bowlby, 1988). Having someone to help them make sense of their emotional world, children with secure attachment are more likely to develop stronger emotion regulation skills. Results from a longitudinal study that followed individuals from infancy to age 22 showed that young adults who described a secure partnership in their romantic relationships often had mothers who were consistently sensitive to their needs during the first 16 years of life (Grossmann et al., 2002).

These individuals were also more adaptive in the face of social rejection. They exhibited secure attachment representations, reflecting a person's internalized sense of trust and security in relationships, which indicates greater relationship satisfaction. Supporting this, a recent meta-analysis (Groh et al., 2016) that examined a broad range of studies demonstrates that early attachment security was most strongly associated with social competence ($d = 0.39$), suggesting that securely attached children tend to develop better interpersonal skills. Furthermore, a strong

link was found between secure attachment and externalizing problems (d = 0.31), implying that securely attached children are less prone to acting aggressively or disruptively. Another landmark study presenting findings from the Minnesota Longitudinal Study (Sroufe, 2005), which followed children from birth to adulthood, provided comprehensive insights into the long-term effects of attachment. The study revealed that infants with secure attachment developed better relationships with their peers, had higher self-esteem, and exhibited greater emotional regulation skills as they grew up. Moreover, secure attachment was strongly associated with later academic and cognitive functioning. Furthermore, a recent comprehensive meta-analysis of 125 studies investigating the link between attachment security and language and cognitive outcomes reported secure attachment being moderately linked with better cognitive (r = 0.17) and language (r = 0.16) skills (Deneault et al., 2023). Additionally, they found that attachment security partially mediated the relationship between caregiver sensitivity and social and language outcomes, with a small but significant effect. These findings reinforce the notion that secure attachment during infancy is a major predictor of positive long-term outcomes, affecting not only interpersonal skills in life but also cognitive and academic skills.

While attachment security fosters emotional, social, and cognitive abilities, attachment insecurity has consistently been linked to a range of negative developmental outcomes. Children who experience inconsistent, unresponsive, or dismissive behaviors from their caregivers internalize these experiences, ultimately leading them to develop internal working models that reflect a lack of trust in relationships. As a result, insecure attachment has often been linked to difficulties in emotion regulation (Brenning & Braet, 2013), lower relationship satisfaction (Candel & Turliuc, 2019), increased internalizing and externalizing behaviors (Fearon et al.,

2010; Groh et al., 2016), and less frequent experiences of positive emotions (Park et al., 2023). More specifically, according to Fearon and colleagues (2010), meta-analyses of 69 studies (N = 5,847 children) indicate a moderate yet significant association (d = 0.31) between attachment insecurity and externalizing behaviors, with disorganized attachment being the strongest predictor of behavioral problems. Similarly, a meta-analysis conducted by Groh and colleagues (2016) revealed that internalizing symptoms, such as depression and anxiety, were significantly more prevalent in children with insecure attachment. These meta-analyses reinforce that attachment insecurity is a significant risk factor for emotional and relational difficulties later in life, rather than being a temporary stage of development. Children who do not form insecure attachments with their caregivers seem more likely to struggle with emotion regulation, social relationships, and lower overall well-being.

1.2.1.3 Relational pattern antecedents for secure and insecure attachment

Research indicates that children form different attachment styles with their caregivers based on their early experience patterns. Among these early relational experiences, the quality of parental sensitivity has been consistently identified as the primary predictor of attachment security (Ainsworth et al., 1979; Madigan et al., 2024). Sensitivity refers to the caregiver's ability to accurately perceive, interpret, and respond to the infant's signals, behaviors and needs (Ainsworth et al., 1979). Sensitive parents consistently provide a safe haven by demonstrating emotional availability when the infant is in distress and provide a secure base when the infant is ready for exploration. This responsiveness fosters a sense of trust that lays the foundation for secure attachment. Ainsworth's (1979) seminal research on the link between sensitivity and attachment is supported by many meta-analyses over the

years. For instance, Madigan and colleagues (2024), one of the most comprehensive meta-analyses on the topic, demonstrated that maternal and paternal sensitivity are both moderate predictors of attachment security by reviewing 181 studies over the last 50 years. This points out that parental sensitivity is a universal determinant across diverse contexts. Complementing these findings, Deneault and colleagues (2022) explored whether mothers and fathers differed in their observed sensitivity behaviors through a meta-analysis of 93 studies. They reported that mothers were slightly more sensitive than fathers, with the difference decreasing over time and not being significantly different in European samples.

While sensitivity is a well-accepted predictor of attachment security, it does not work in isolation and is shaped by contextual and individual factors (Neuhauser, 2018). Regarding parental factors, psychological well-being is an important determinant of sensitivity. Mental health problems, especially maternal depression, negatively affect mothers' responsiveness towards their children (Bernard et al., 2018; van Doesum et al., 2007). Low socioeconomic status (SES) is another major risk factor that consistently predicts reduced maternal sensitivity (Bakermans-Kranenburg et al., 2004; Mesman et al., 2012). Additional stressors such as low maternal education further contribute to this (Lovejoy et al., 2000; Mertesacker et al., 2004; van Doesum et al., 2007). Child characteristics such as developmental delays, prematurity, or negative emotionality have been proposed as factors influencing maternal sensitivity; however, meta-analyses indicate inconsistent findings, with several studies showing no significant findings (Bilgin & Wolke, 2015; van Ijzendoorn et al., 2007). Contextual factors, notably social support, significantly impact sensitivity, often by buffering the negative influences of psychosocial stressors (Mertesacker et al., 2004; Stack et al., 2012). Finally, social norms and

ideals regarding sensitive parenting vary culturally. Although sensitive behaviors are universally valued, cross-cultural research shows that their expressions vary among cultures (Posada et al., 2013). For example, in some collectivist societies, sensitivity may emphasize anticipating the child's needs without explicit verbal communication, while in more individualistic cultures, encouraging children's independence and emotional expression is emphasized as part of being a sensitive caregiver (Mesman et al., 2018). These variations reflect cultural values, parenting goals, and underlie the importance of culturally inclusive perspectives in understanding parental sensitivity and caregiving practices.

1.2.2 Attachment-based interventions

A substantial body of research highlights the importance of attachment security in children's social, emotional, and psychological development (Fearon et al., 2010; Groh et al., 2016). Given this, targeting attachment security in the early years of development has gained significance, and several attachment-based intervention programs have been developed over the last 25 years in Western countries (Steele & Steele, 2017). These programs often seek to strengthen the parent-child relationship by fostering positive parenting practices and improving parental sensitivity, which in turn will help children form secure attachments with their caregivers.

The majority of these early-year attachment interventions can be categorized as preventative in nature, which are distinct from treatment interventions in that they aim to support the developmental capacities and protect the mental health of the child to either prevent or delay the onset of mental health challenges (Çorapçı & Doğan, 2023). Preventative interventions focus on reducing the risk factors while increasing the protective factors in children's lives, often through adjusting their environment.

Recent reviews and meta-analyses have illuminated how these attachment-based interventions work, for whom they work, and under what conditions they are most effective. Most attachment-based interventions focus primarily on improving parental sensitivity, defined as the parent's capacity to notice, interpret, and react correctly to their child's cues. Research has consistently shown that children who experience sensitive parenting are more likely to experience secure attachment (Madigan et al., 2024; Wolff & van Ijzendoorn, 1997). Hence, attachment-based interventions often target this, aiming to make parents better at understanding and meeting their child's needs. A meta-analysis Bakermans-Kranenburg and colleagues (2003) found that interventions focusing solely on sensitivity and not incorporating support and representational components had the most substantial impact on infant attachment security. The difference between sensitivity-focused interventions and others was also significant, signifying the critical role of targeting maternal sensitivity for attachment security.

Expanding on this, it is essential to consider for whom these interventions are most beneficial. There is a higher likelihood of attachment insecurity in economically disadvantaged families both in Western and Turkish populations (Cyr et al., 2010; Sakman et al., 2023). Considering the risk is exacerbated by factors such as maltreatment, home violence, and poverty, these families are prioritized in attachment-based interventions to alleviate these difficulties by enhancing secure attachment and parental sensitivity in the face of hardship (Stewart-Brown & Schrader-Mcmillan, 2011; Sümer et al., 2020). Studies have, in fact, consistently shown that attachment-based interventions are more effective in families with maltreatment histories (e.g., abuse, neglect, violence) than in those without maltreatment histories (Facompré et al., 2018). This suggests that families from

disadvantaged backgrounds have more to gain from parenting interventions, as these interventions can help address the disparities in caregiving behaviors resulting from their environmental stressors.

Another important aspect to consider is the timing and duration of these interventions. While interventions that begin as early as prenatally are often encouraged in developmental research, Bakermans-Kranenburg and colleagues' (2003) meta-analysis has noted that interventions beginning after six months (d = 0.44) were more effective than those starting earlier (d = 0.32 for prenatal initiation, d = 0.28 for initiation during the first 6 months). This may suggest that parents benefit more from understanding sensitivity as their infants become more interactive, making it easier to respond to their cues. Additionally, the most effective interventions were shorter in duration and consisted of five sessions or fewer. This challenges the notion that longer and intensive interventions are required to promote attachment security, especially in high-risk populations. Given that disadvantaged and low-resourced populations often encounter obstacles in maintaining a long-term commitment to attachment interventions, this efficient delivery can enable reaching more individuals without compromising the program's effectiveness (Dozier & Bernard, 2023).

One final aspect of effective attachment-based interventions identified in Bakermans-Kranenburg and colleagues' (2003) the meta-analysis is the use of video feedback. Their findings show that the interventions that incorporated video feedback (d = 0.44) were more effective in increasing parental sensitivity than those that did not utilize this method (d = 0.31). This suggests that parents benefit significantly from observing and analyzing their real-time interactions with their children, which can help enhance their parental sensitivity. Given these findings, two widely studied

attachment-based interventions that make use of video feedback are the Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline program (VIPP-SD; Juffer et al., 2008, 2014, 2017) and the Attachment and Bio-behavioral Catch-up Program (ABC; Dozier et al., 2005). Additionally, the Circle of Security program (COS; Marvin et al., 2002), while not using video feedback in the same way, is another extensively researched intervention that utilizes visual materials and structured discussions to enhance caregivers' reflective functioning and sensitivity. The following sections will briefly outline the structure and key components of each of these three interventions (VIPP-SD, ABC, and COS) to illustrate how they aim to enhance parental sensitivity and promote secure attachment.

1.2.2.1 Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline

One widely used method for improving parental sensitivity is video feedback, which allows parents to observe and reflect on their interactions with their children while assisting them in identifying ways to improve their responsiveness (Juffer et al., 2008). Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD), developed by Juffer and colleagues (2008, 2014, 2017), is a program that aims to increase parental sensitivity and promote positive discipline behaviors in parents. Grounded in Bandura's Social Learning Theory, VIPP-SD leverages the power of observational learning by helping parents see and reflect on their real-life interactions with their children (Bandura, 1977).

VIPP-SD consists of six structured home-based visits, each focusing on one theme about sensitive parenting and sensitive discipline. Session one helps parents

distinguish between their child's exploration and attachment behaviors, enabling them to provide a secure base or a safe haven for their children. Session two introduces the concept of "speaking for the child," allowing them to understand better and internalize their children's behaviors. Session three focuses on the sensitivity chain, teaching parents to recognize and respond appropriately to their child's signals. Session four highlights the importance of shared emotional moments to demonstrate that this encourages their children to express their feelings freely. Concurrently, during the first four sessions, parents learn about sensitive discipline techniques, covering themes that align with each sensitive parenting theme. The last two sessions serve as booster sessions where parents can get the chance to reinforce what they learned in the first four sessions and ask any questions they have.

Empirical studies have accumulated to demonstrate the effectiveness of VIPP-SD over the past decades among various populations, including socioeconomically disadvantaged families, adoptive parents, and clinical groups (Negrão et al., 2014; Poslawsky et al., 2015; Yagmur et al., 2014). In a recent meta-analysis of the first 25 randomized controlled trials, VIPP-SD was found to improve parenting behaviors and attitudes and child attachment security significantly (van IJzendoorn et al., 2023). Since the sessions take place in a home setting, VIPP-SD is particularly advantageous for minimizing transportation barriers and increasing accessibility and engagement, especially for families facing economic challenges or having limited access to childcare services.

Several recent qualitative studies offer deeper insights into VIPP-SD's acceptability and feasibility across various settings and populations. Starreveld and colleagues (2024) investigated the feasibility of adapting video feedback interventions inspired by VIPP principles to educational settings. In their qualitative

pilot study with teachers, they identified key factors influencing successful implementation, including teacher motivation, scheduling, and working alliance between teacher and interveners. Their findings underscore that, while adaptations require careful consideration of context-specific challenges, the core principles of VIPP-SD can be feasibly transferred beyond the family context. Similarly, Lassen and colleagues (2025) conducted individual interviews with 11 parents of preschool children exhibiting externalizing behaviors who received VIPP-SD from trained childcare providers. Barnicot and colleagues (2024) explored the feasibility and acceptability of VIPP specifically adapted for mothers experiencing perinatal mental health difficulties and their 2-6 month old infants. Their pilot study, involving 14 mothers, showed that participants initially reported anxiety about being filmed, which was substantially reduced by strengths-focused feedback. Mothers reported notable improvements in parenting confidence, increased sensitivity to subtle infant cues, and strengthened parent-infant bonds, supporting the feasibility and acceptability of VIPP adaptations within various settings (Juffer et al., 2017).

Still, although VIPP-SD has demonstrated adaptability across various family types and daycare environments, to date, it has not been tested within healthcare settings. This remains a notable gap in existing literature. Exploring this potential adaptation could be especially valuable for embedding preventive parenting interventions into routine primary healthcare services.

1.2.2.2 Attachment and Biobehavioral Catch-Up

Similar to VIPP-SD, Attachment and Biobehavioral Catch-Up (ABC) is a short-term and structured attachment-based intervention aimed at increasing parental sensitivity and fostering secure attachment in early childhood (Dozier et al., 2005). This

intervention is unique because it is tailored for parents of young children who have faced adversity such as foster care, neglect, or maltreatment. Another significant differentiation from VIPP-SD is that ABC adopts a coaching-based method and provides in-the-moment feedback to caregivers during their interactions with their children. Specifically, the parent coach observes the interactions live, identifies specific behaviors that align with the intervention goals, and provides direct guidance in real-time to enable parents to practice sensitive behaviors immediately. Video feedback is also utilized to reinforce behaviors and motivate parents to understand and internalize desired interactions effectively (Dozier et al., 2017). The program consists of 10 home-based 1-hour long sessions and targets three primary areas: (1) providing support in times of stress, even when the child does not explicitly indicate their need; (2) following the child's lead and enjoying this, while also assisting them to self-regulate and explore; and (3) reducing intrusive and frightening behaviors (Dozier et al., 2017).

The positive impacts of ABC on the behaviors of both children and caregivers have been demonstrated through extensive ABC testing in randomized clinical trials (see Grube & Liming, 2018 for a systematic review). Studies with foster mothers and high-risk parents indicate that ABC is effective in improving their parental sensitivity and parenting quality (Bernard et al., 2012; Bick & Dozier, 2013; Yarger et al., 2019). The intervention also shows promising results for children with maltreatment histories and foster children. Children who participated in the ABC program showed more secure attachment patterns, normalized cortisol production, improved executive functioning, and better emotion regulation compared to children who received control intervention (Bernard et al., 2012, 2015; Lewis-Morrarty et al., 2012; Lind et al., 2014). Overall, strong evidence has accumulated in favor of the

ABC over the last few decades, showing that it provides significant benefits, particularly for high-risk parents and children (see Dozier et al., 2018 for a review).

Recent feasibility and acceptability studies offer deeper insights into the implementation of ABC. A qualitative study conducted with stakeholders reported that ABC's core techniques, particularly in-vivo commenting and video feedback, were essential in facilitating observable changes in caregiving behavior (Bergsund et al., 2022). Similarly, Labella and colleagues (2023) the study demonstrated the feasibility and acceptability of delivering ABC remotely to peripartum mothers online. Moreover, West and colleagues (2022)'s qualitative study revealed positive outcomes when ABC was integrated within existing home-visiting programs, highlighting strong acceptance among home visitors who especially valued ABC's structured focus on sensitive caregiving and the utility of video feedback in promoting secure attachment. These studies underscore ABC's adaptability across diverse contexts, emphasizing its video feedback and in-the-moment comment elements as key facilitators of positive intervention outcomes.

1.2.2.3 Circle of Security

While the ABC offers a highly structured, coaching-based approach to increase parental sensitivity, another well-established attachment intervention is the Circle of Security (COS) which also incorporates video feedback methods and aims to help caregivers reflect on their emotional responses and better understand their child's needs (Hoffman et al., 2006). The program was initially developed as a 20-week group intervention for at-risk families participating in the Head Start and Early Head Start Programs (Marvin et al., 2002). Since then, the program has been adapted into different versions, such as home-based, perinatal, and shorter group interventions

(Woodhouse, 2018). The intervention is based on three core assumptions: first, caregivers usually have good intentions towards their children; second, parents' past relational experiences can get in the way of their ability to recognize and respond to their child's cues accurately; third, caregivers' parenting can be improved by helping them reflect on their emotional responses (Woodhouse, 2018). The COS intervention incorporates video feedback, structured group discussion, shark music metaphor which helps parents recognize unconscious emotional triggers from their past, and the COS graphic, which is a user-friendly model that shows when to provide a safe haven and secure base for children.

A key feature of the original COS protocols is individualized video feedback. Specifically, facilitators conduct a detailed pre-intervention assessment, including a recorded interaction of the parent-child dyad. During COS sessions, facilitators show video clips of each caregiver interacting with their child, which are selected to illustrate both effective parenting moments and areas of struggle. These video reviews are conducted in a structured manner within a supportive group environment, including approximately six parents and facilitators (Woodhouse et al., 2018). Parents are guided to reflectively analyze these video clips using the COS graphic and concepts, such as recognizing their own "shark music," to identify emotional barriers and improve responsiveness.

There's growing evidence that the COS intervention helps improve parental sensitivity and fosters secure attachment in children. A meta-analysis Yaholkoski and colleagues (2016) found moderate effect sizes for improvements in child attachment security (g = 0.65, Note: Hedges' g is a measure of effect size similar to Cohen's d, but includes a correction for small sample sizes) and caregiving quality (g = 0.60), as well as reductions in caregiver depression (g = 0.53). Notably, it also showed a

strong impact on caregiver efficacy (g = 0.98). While these findings are promising, some researchers remain cautious about the overall strength of COS's evidence base.

Recent studies offer encouraging insights into the feasibility and acceptability of the COS intervention across diverse settings. A qualitative study by Gilhooly (2018) exploring the experiences of nine parents after completing the COS-Parenting (COS-P) program revealed high perceived benefits. Notably, themes such as "a new experience of parenting" and "seeing the child in a new light" emerged, pointing to enhanced reflective functioning and awareness in participants' parenting. In parallel, a qualitative study by Reay and colleagues (2019) explored clinician perspectives on delivering COS-P in community mental health settings. Clinicians viewed the program as effective and adaptable, emphasizing its user-friendly format. They also highlighted the transformative impact of the model on their own professional and personal lives, as well as the critical role of supervision during its delivery. Together, these findings reinforce the COS model's acceptability among both caregivers and clinicians, underscoring the importance of implementation supports, such as supervision and manageable workloads, for its sustainable delivery.

However, Mercer (2015) reviewed the literature and pointed out that despite COS being widely regarded as a practical and accessible intervention, the number of high-quality, independent studies, especially randomized controlled trials, remains limited. Even so, given its strong theoretical foundation in attachment theory, further well-designed research could reinforce its credibility and widespread application.

1.2.3 Attachment-based interventions in Türkiye and cultural context

1.2.3.1 VIPP-SD Türkiye

Given that attachment-based parenting interventions have gained increasing attention worldwide, adapting and implementing such interventions are particularly important considering approximately one in three children lives in poverty, and socioeconomic disparities continue to affect access to early developmental support in Türkiye (TURKSTAT, 2024). Research consistently shows that lower socioeconomic status is associated with lower levels of parental sensitivity (Bakermans-Kranenburg et al., 2004; Mesman et al., 2012). To date, two attachment-based interventions have been implemented: VIPP-SD and the Circle of Security Parenting (COS-P) program. These interventions seek to support Turkish mothers from economically disadvantaged backgrounds in nurturing secure attachments with their children, while also taking into account the unique parental perspectives of Turkish culture. This section discusses the implementation and effectiveness of these programs within the Turkish context.

VIPP-SD is one of the first attachment-based parenting programs implemented in Türkiye (Sümer et al., 2020). Due to its brief structure and video feedback method, VIPP-SD is particularly effective in enhancing parental sensitivity in a short period (Bakermans-Kranenburg et al., 2003; Juffer et al., 2008). Numerous studies have shown its success in Western cultures, especially among socioeconomically disadvantaged and high-risk families (Juffer et al., 2008; Negrão et al., 2014; Van Zeijl et al., 2006). When adapting the program to a non-Western culture, the differences between cultural contexts, such as the prevailing parenting norms, should be considered to ensure relevance and effectiveness. In Turkish culture, parents often emphasize warmth, emotional closeness, and attentiveness.

Fortunately, this aligns well with the VIPP-SD core principles. Hence, no fundamental structural changes were necessary, and the intervention seemed to be a fitting program for Turkish mother-child dyads. Only one minor adjustment was needed after observing mothers and children have difficulty with the singing activity in the pilot study, and the researchers replaced it with a more relevant activity, a toy tea play set (Alsancak-Akbulut et al., 2021; Sümer et al., 2020).

This implementation of the VIPP-SD in Türkiye demonstrated significant improvements in maternal sensitivity and a reduction in physically intrusive parenting behaviors (Alsancak-Akbulut et al., 2021). This randomized controlled trial with Turkish mothers (Alsancak-Akbulut et al., 2021) showed that those who participated in the intervention exhibited a significant increase in their global sensitivity (d = 0.51). They also showed a moderate decrease in the frequency of physically intrusive behaviors, which can be common among Turkish parents. Overall, these results are promising in that they show the video feedback method is beneficial for increasing maternal responsiveness with a sample of Turkish mothers.

One interesting outcome was that the intervention did not significantly alter mothers' self-reported attitudes toward sensitive discipline, suggesting the program may be more effective in modifying observable maternal behaviors rather than shifting perceptions (Sümer et al., 2020). These findings underscore the effectiveness of VIPP-SD in enhancing maternal sensitivity and decreasing intrusive behaviors in a non-Western cultural context. It also points out the potential for attachment-based interventions to foster positive parenting practices in Türkiye. Yet, the video feedback method has been one reason why some families refused to participate in the program (Sümer et al., 2020). As a result, a better understanding of mothers'

perspectives on being videotaped and receiving feedback based on filmed mother-child interactions is needed.

1.2.3.2 Circle of Security Parenting Türkiye

COS-P program was developed by Cooper and colleagues (2009) to reduce the challenges faced when implementing the original program, such as creating video vignettes for each parent-child dyad, and a lengthy training period for the program trainers, allowing COS to be implemented more easily. The parenting version of COS included pre-recorded video clips by the program's creators, provided on a DVD, enabling parents to observe other parents interacting with their children. Given its shorter training period and ease of application, the Turkish adaptation of the program utilized this version and became one of the first attachment-based programs implemented in Türkiye (Arıkan, 2019). This Turkish adaptation of the COS-P targeted mothers from socioeconomically disadvantaged backgrounds with children aged 1-3 years. The program was structured as an eight-week group intervention in small groups of 3-11 participants. Sessions were held once a week for approximately 90 minutes in a classroom environment and facilitated by trained facilitators.

Considering the limited number of studies on the effectiveness of COS-P, this research is a significant contribution to the COS literature. The findings from the Turkish adaptation of the COS-P indicate that the intervention was effective in increasing children's attachment security while no significant improvements were observed in maternal sensitivity (Arıkan, 2019). The program significantly reduced maternal stress and negative parenting behaviors. Importantly, the program also helped mothers feel less helpless regarding child-rearing, suggesting that the program's strength may lie in enhancing maternal confidence (Arıkan, 2019). These

results suggest that while the COS-P program has promising effects, additional reinforcement strategies, such as booster sessions, may enhance its long-term effectiveness in Türkiye.

1.2.4 Psychosocial interventions for young children and their families in healthcare systems

While attachment-based intervention programs such as VIPP-SD and COS-P have shown promising results in fostering attachment security among mother-child dyads, the dissemination of these programs to large numbers of families remains a critical challenge. Despite the brief structure of these interventions mentioned earlier, transportation and time commitments continue to pose barriers to regular attendance, particularly for high-risk families where social support may be limited, and the burden on mothers can be significant. One of the most effective ways to address this issue is by integrating such programs into healthcare systems, where families already have regular contact with health professionals. Given the routine and widespread use of healthcare services, embedding attachment-based interventions within these systems can significantly improve accessibility and reach. This section examines psychosocial interventions successfully implemented in healthcare settings to promote early childhood development and support parent-child relationships.

1.2.4.1 Nurse-Family Partnership

Among the earliest and most influential examples of healthcare-integrated interventions is the Nurse-Family Partnership (NFP; Olds et al., 1986), which established a foundation for integrating early childhood developmental support into the healthcare system. NFP is delivered by registered nurses to support first-time

low-income mothers through structured home visits. These visits start during pregnancy and continue until the child's second birthday. The nurses provide education and aim to improve the mother's support networks and connect the parents with community services. By doing this, nurses establish long-term, trusting relationships that, in return, help mothers feel more self-efficacious. Extensive randomized controlled trials have shown that NFP leads to improved birth outcomes and better maternal health, as well as reduced child maltreatment (Olds et al., 1997; 2010). The program has also shown long-term benefits, including reduced criminal behavior, less role impairment due to substance use, and reduced mortality rates both among mothers and first-born children living in challenging conditions (Olds et al., 1997, 2010, 2014). Building upon the NFP's pioneering model of integrating childcare support within healthcare systems, subsequent interventions have expanded on this model by utilizing pediatric well-child visits to reach a broader range of families.

1.2.4.2 Reach Out and Read

One well-established, evidence-based healthcare intervention is Reach Out and Read (ROR; Klass et al., 1999), which incorporates literacy promotion into the routine pediatric primary care visits and is now implemented in over 6,000 sites across the United States. Originally developed at Boston City Hospital by Klass and colleagues (1999), the program targets children from 6 months to 5 years old and uses well-child visits to promote language development and strengthen caregiver-child relationships. During these visits, trained primary care providers offer information about the importance of shared reading and provide developmentally appropriate books to the caregivers. By incorporating literacy promotion into routine healthcare visits, ROR

leverages the frequent and trusted relationship between healthcare providers and caregivers, making it a uniquely accessible and scalable intervention, especially for those from high-risk backgrounds (Zuckerman, 2009). The effectiveness of ROR has been consistently supported by research demonstrating improvements in language and literary skills development, which subsequently prepares children for school and contributes to their future academic success (Mendelsohn et al., 2001; Sénéchal & LeFevre, 2002; Sharif et al., 2002). Considering these positive effects, the ROR intervention is a powerful example of how early childhood interventions can be successfully integrated into primary healthcare systems to address barriers to access and promote healthy development from an early age.

1.2.4.3 Video Interaction Project

Another healthcare-based early childhood intervention demonstrating robust developmental outcomes is the Video Interaction Project (VIP, now called PlayReadVIP) developed by Mendelsohn and colleagues (2005) at Bellevue Hospital in New York City. VIP is a parenting program that utilizes videotaped interactions and strength-based feedback. It takes place in pediatric clinics when children and families come for their routine well-child visits. This makes it convenient, especially for low-income and high-risk families. Families meet individually with a trained coach for approximately 25 minutes during the sessions during each pediatric appointment. In the sessions, caregivers engage in shared play or reading activities with their children while their interactions are videotaped. Then, the coach reviews the video footage with the caregiver, highlights positive moments, and offers personalized feedback. Through this reflective process, parents learn to recognize their positive parenting behaviors and build on their strengths in promoting their

children's cognitive and socioemotional development. The intervention has been rigorously studied through randomized controlled trials, demonstrating significant benefits to children and families. Participation in VIP increases reading, play, talking, and teaching among caregivers and children (Miller et al., 2024; Roby et al., 2021), decreases screen time (Mendelsohn et al., 2011) , and decreases physical punishment (Canfield et al., 2015). Importantly, children who participate in VIP have shown improvements in language, literacy, and cognition (Mendelsohn et al., 2005; 2007; 2011). These results are particularly meaningful given the program's accessibility and integration within the primary care systems, which makes it scalable and effective for reaching underserved families.

1.2.4.4 SMART Beginnings

In addition to the Reach Out and Read and VIP programs, the SMART Beginnings program is another innovative example of early childhood development intervention implemented in the healthcare system. This comprehensive model combines universal primary (PlayReadVIP) and targeted secondary strategies (Family Check-up; Shaw et al., 2006) for families with additional risks (Miller et al., 2023; Shaw et al., 2021). PlayReadVIP sessions occur during well-child visits and include video-recorded parent-child interactions, followed by strength-based feedback. In contrast, Family Check-up (FCU) utilizes a home-visiting model incorporating motivational interviewing and personalized parenting sessions to tackle behavioral challenges. Together, these interventions offer a tiered and personalized approach to underserved families within primary care systems, enabling outreach to families from diverse backgrounds. Although it is a relatively new model, SMART Beginnings has shown

strong outcomes, including improvements in children's cognitive and language development (Miller et al., 2023; Roby et al., 2021; Shaw et al., 2021).

These healthcare-integrated models demonstrate the potential of utilizing routine pediatric care as a foundation for scalable and accessible interventions to support early child development. In the following section, I will turn to implementing such approaches in the Turkish healthcare context, where similar opportunities for integration are beginning to emerge.

1.2.5 Psychosocial interventions in healthcare systems in Türkiye

Several promising programs have been developed to address developmental and psychosocial needs within routine healthcare settings in Türkiye by building upon globally established models.

1.2.5.1 International Guide for Monitoring Child Development

One prominent example is the International Guide for Monitoring Child Development (GMCD), developed by Ertem and her colleagues at Ankara University (Ertem et al., 2008). GMCD integrates developmental monitoring into routine pediatric well-child visits and is specifically designed for low- and middle-income countries. By employing an open-ended interviewing technique, healthcare providers can assess developmental milestones in language, motor skills, and socio-emotional development using caregiver reports. Empirical evidence shows that the GMCD exhibits strong reliability and validity, including high sensitivity and specificity in identifying developmental delays (Ertem et al., 2008, 2018; Özalp Akin et al., 2021). Building on GMCD, an expanded version has been developed and demonstrated to be highly applicable and feasible for use in clinical practice, enabling caregivers to

provide detailed information without increasing their face-to-face time with healthcare providers. (Özalp Akin et al., 2021). GMCD enhances accessibility to early childhood interventions by incorporating developmental monitoring into healthcare services, particularly for families in underserved communities. The successful integration of GMCD highlights the Turkish healthcare system's capacity to implement culturally responsive, scalable, and evidence-based interventions.

1.2.5.2 Thinking Healthy Program

Beyond child-centered interventions such as the GMCD, supporting early childhood development in Türkiye also involves targeting maternal mental health, considering the mothers' emotional well-being's significant role in fostering optimal development environments for children in low- and middle-income countries (Honda et al., 2023). One initiative addressing this need is the Thinking Healthy Program (THP), which was originally developed in Pakistan by Rahman and colleagues (2008) and recommended by the World Health Organization (WHO) for wider dissemination.

THP is an intervention that includes elements from cognitive behavior therapy to prevent and manage perinatal depression. One of the key strengths of THP is that it does not require delivery by mental health specialists; instead, it can be effectively delivered by trained non-specialist health workers such as nurses, midwives, or community health workers (Rahman et al., 2008).

Additionally, several studies have assessed the acceptability and feasibility of the Thinking Healthy Programme in India and Pakistan. One notable qualitative study explored a peer-delivered adaptation of the intervention and found it to be both culturally acceptable and feasible (Atif et al., 2017). The study involved 41 in-depth

interviews (29 in Pakistan and 12 in India) with mothers and peers, providing rich insights into implementation experiences. Both mothers and peers highlighted how shared life experiences and personal traits was helpful in the implementation process. These findings highlight the potential for models that do not require mental health specialists to deliver psychosocial interventions in low-resource settings like Türkiye, where access to specialist mental health services is limited.

Recognizing the potential for widespread impact within the Turkish context, where maternal depression is high (Keser Özcan et al., 2017), Boran and her colleagues have adapted the THP for a group delivery format in the pregnancy schools within Turkish public hospitals (Boran et al., 2023). The research team specifically trained the nurses as intervention delivery agents to ensure better integration into the healthcare system. Preliminary findings suggest that the adapted THP is highly acceptable to nurses and participants, culturally relevant for Turkish women, and feasible in face-to-face and online delivery formats (the program was delivered online due to pandemic restrictions). Therefore, utilizing nurses as primary delivery agents appears to be a practical and scalable strategy for improving maternal mental health services throughout Türkiye.

In summary, the implementation of the THP in South Asian countries and its recent adaptation in Türkiye offer promising models for integrating maternal mental health interventions into primary healthcare systems. THP's success lies in its culturally sensitive approach, cost-effective delivery by non-specialists, and its demonstrated acceptability and feasibility. These features make it highly relevant for Türkiye, where access to specialist mental health services is limited, and the burden of maternal depression remains high (Keser Özcan et al., 2017).

Currently, to our knowledge, there are no attachment-based interventions implemented within Türkiye's healthcare system, indicating a lack of coordination between clinical practice, research, and healthcare policies. Despite substantial evidence emphasizing the benefits of attachment-based interventions in enhancing maternal sensitivity and fostering attachment security (Bakermans-Kranenburg et al., 2003; Juffer et al., 2017), such programs have not yet been introduced or evaluated within the Turkish healthcare context. This gap underscores the importance of exploring how healthcare providers and recipients perceive and implement attachment-based interventions, particularly given Türkiye's unique cultural practices and healthcare dynamics. That's why the Infant-Mother Attachment Security Program was developed in response to this need, aiming to provide a scalable, culturally appropriate, and evidence-based solution to foster attachment security between mothers and their children in Türkiye.

1.3 The Infant-Mother Attachment Security Program

The Infant-Mother Attachment Security Program was developed by adapting evidence-based, internationally recognized attachment interventions such as the VIPP-SD, COS, and ABC programs to suit Türkiye's family healthcare system. Elements from VIPP-SD were incorporated into the intervention through both its structured, strength-based video feedback method and its Sensitive Discipline module, which informed the strategies used in Module 4. COS principles guided the emphasis on the caregiver as a secure base and safe haven, particularly reflected in Modules 1 and 2. Additionally, components of the ABC intervention shaped the focus on reducing frightening and intrusive behaviors in Module 3 and on following the child's lead, especially in Module 4.

Specifically designed for mothers with 9-month-old infants attending routine health check-ups at family health centers, this program aims to enhance maternal sensitivity, thereby promoting secure attachment. The program consists of four core modules and one booster session, delivered during routine well-child visits.

1.3.1 Module 1: Sharing love, closeness, and play moments with the child

The first module, which takes place during the 9-month well-child visit, focuses on enhancing maternal sensitivity by encouraging mothers to notice and respond to their child's cues during moments of affection and play. Through video recordings of shared playtime, mothers are guided to observe eye contact, mutual smiling, gentle touch, and vocal responsiveness. The aim is to help the mother understand how these interactions foster a sense of love, safety, and being valued in the child. In the long term, such moments are expected to support the development of secure attachment and the child's emerging self-confidence.

1.3.2 Module 2: Mother as a safe haven for the child

The second module, implemented during the 12-month vaccination visit, builds on the safe haven concept from the COS and integrates elements from the ABC intervention by focusing on comforting the child in moments of stress. Video footage of the mother's soothing behaviors, such as physical closeness and calm verbal reassurance, is emphasized to highlight how these behaviors help the child feel safe and understood. The goal is to strengthen the mother's capacity to act as a safe haven during times of distress, thereby promoting the child's emotional resilience over time.

1.3.3 Module 3: Reading the child's signals

This module, conducted during the 14-month extra visit, addresses maternal responsiveness during feeding, focusing particularly on interpreting the child's nonverbal cues and adapting accordingly. Video recordings capture moments where the mother follows the child's pace, avoids intrusive behaviors, and responds sensitively to signs of hunger and fullness. Drawing on VIPP-SD and ABC principles, this session aims to foster attuned feeding interactions that support the child's autonomy, bodily awareness, and trust in the caregiver.

1.3.4 Module 4: Following the child's lead and sensitive discipline

The fourth module, held at the 16-month extra visit, combines themes of autonomy support and gentle limit-setting. During play and the restricted toy task, mothers are encouraged to follow the child's interests, allow space for exploration, and practice clear, calm boundary-setting when needed. The video feedback emphasizes moments of following the child's lead, collaborative play, rule setting, and redirection, inspired by the sensitive discipline framework of VIPP-SD. This module promotes the development of emotion regulation and positive parent-child communication.

Finally, at 18 months, a booster module revisits and reinforces previous themes. In addition to these face-to-face modules at 9, 12, 14, 16, and 18 months, the nurses send standardized supportive messages at 10, 11, 13, 15, and 17 months along with a related screenshot of the mother-child dyad from the videos recorded at the family health center in order to continuously encourage sensitive parenting practices. At the end of each session, mothers also receive a brochure related to the module theme. Appendix A offers a comprehensive overview of these modules, including module goals, observed behaviors, and example feedback. Each face-to-face session

follows a consistent structure: after welcoming the mother and child, the nurse begins the video recording (except for the first module, where the video is provided to the nurses from the pretest video). This is followed by a joint video review session, where the nurse pauses the footage at selected moments to highlight sensitive parenting behaviors, offer positive feedback, and reflect together with the mother. This video feedback session, which lasts about 15–20 minutes, serves as the primary mechanism for promoting greater parental sensitivity through the intervention.

A key component of this intervention is the use of the video feedback method which has been demonstrated to improve parental sensitivity and appears to be more effective than other interventions that do not utilize the video feedback method (Bakermans-Kranenburg et al., 2003). Video feedback is increasingly recognized as an effective intervention tool in early parenting programs, especially for enhancing parental sensitivity by helping parents observe their sensitive behaviors while the intervener highlights those moments (Fukkink, 2008; Mira & Parada, 2025). Based on social learning theory (Bandura, 1986), the video feedback method utilizes the principle that individuals are more inclined to replicate behaviors of those who are similar to themselves. It also helps parents recognize and reflect on less desirable behaviors, such as frightening behaviors, while enhancing awareness and serving as a catalyst for change (Fukkink, 2008). This process supports a core component of parental sensitivity: accurately interpreting a child's signals and responding promptly to them (Ainsworth et al., 1979; Juffer et al., 2017). Video feedback also allows the intervener to interpret the child's nonverbal behaviors, helping parents enhance their observational skills (Juffer et al., 2017).

The video feedback approach is especially well-suited for culturally sensitive interventions in Türkiye, where intrusive or controlling parenting behaviors, though

often well-intentioned, are commonly observed (Berlin et al., 2016; Dinn & Sunar, 2017; Sümer & Kağıtçıbaşı, 2010). By offering parents the chance to see themselves interacting with their child, this method provides an opportunity to reflect on these automatic or habitual behaviors from the child's perspective. In doing so, it enables mothers to perceive themselves both as subjects and objects, simultaneously experiencing the interaction and observing it from an external viewpoint, which fosters deeper self-awareness and insight. A key element that supports this reflective process is the program's "speaking for the child" technique (Juffer et al., 2008), in which nurses verbally interpret the child's inferred needs, thoughts, emotions, and intentions based on their observable behaviors. This strategy helps caregivers recognize the emotional and psychological needs behind children's actions and encourages more sensitive parenting. Research shows that this type of reflection enhances parental mentalization (the ability to understand the child's internal states), which in turn promotes secure attachment (Berthelot et al., 2015; Slade, 2005). Moreover, by emphasizing non-judgmental and strength-based observations, the feedback helps reduce defensiveness and strengthens the parent's emotional experience of competence and connection (Fukkink, 2008; Stewart-Brown & Schrader McMillan, 2011).

Importantly, video feedback promotes the modeling and internalization of positive caregiving behaviors by reinforcing sensitive moments and drawing attention to what the parent is doing well (Bakermans-Kranenburg et al., 2003; Stewart-Brown & Schrader McMillan, 2011). Because feedback is provided immediately after watching the relevant video segment, it enhances the parent's insight and learning through timely, relevant cues (Balldin et al., 2016; Fukkink, 2008). The visual nature of the method also makes it a powerful learning tool,

particularly for parents with low literacy skills. In addition, the collaborative nature of the sessions, where positive feedback is paired with small, manageable suggestions, makes the intervention engaging, increasing motivation and reducing dropout risk (Stewart-Brown & Schrader McMillan, 2011; Sümer et al., 2020).

A growing body of evidence highlights the effectiveness of video feedback interventions in enhancing parenting sensitivity across diverse populations (Balldin et al., 2018; Fukkink, 2008; O'Hara et al., 2019). A meta-analysis by O'Hara and colleagues (2019), which included 22 studies from seven European countries and two from North America, found moderate-certainty evidence that video feedback improves parental sensitivity. Similarly, Balldin and colleagues (2018) reviewed 29 studies and reported moderate to large effect sizes for improvements in maternal sensitivity and child behavior, though they highlighted the need for greater consistency in program components and measurement tools. Fukkink's (2008) meta-analysis of 29 studies further reinforces these findings, demonstrating that video feedback interventions significantly enhance parental behavior and enjoyment in parenting, with shorter programs being particularly effective.

One unique aspect of this intervention is that it was designed to be implemented by nurses during routine well-child visits and culturally adapted from previous empirically supported attachment-based interventions for the Turkish context. To improve feasibility and accessibility, the intervention was designed to be carried out entirely within family health centers, thereby eliminating the need for home visits. This decision, based on feedback from both the nurses and mothers, aligns with Stewart-Brown and Schrader-Mcmillan (2011)'s emphasis on reducing logistical barriers that can hinder consistent participation.

Within the context of the Infant-Mother Attachment Security Program, a dedicated playroom was created in each family health center to create a warm, child-friendly space for recording the video interactions and providing feedback to mothers. The program was also structured to minimize the workload for nurses and mothers. Outside of the standard 9-, 12-, and 18-month well-child visits, mothers were only invited to attend two additional intervention sessions at 14 and 16 months. Except for the initial module, nurses review video recordings of mother-infant interactions immediately after recording and prepare their feedback, which allows them to implement the program with minimal preparation time. Moreover, a comprehensive four-day training program was implemented to prepare nurses for this role effectively by the research team, and each nurse received a tablet for the intervention delivery. These strategic adaptations ensure that the intervention is practical for nurses and scalable across healthcare settings in Türkiye.

1.4 Research gaps and current study

1.4.1 Research gaps

Existing studies emphasize the importance of interventions being accessible, culturally relevant, and provided by trusted healthcare professionals such as nurses (Boran et al., 2023; Graves et al., 2016). However, there is limited research specifically exploring these factors in the context of nurse-implemented programs for Turkish mothers and children. For example, the THP was successfully implemented in pregnancy schools in Türkiye, while the researchers demonstrated its acceptability and feasibility through qualitative evaluations (Boran et al., 2023). Nevertheless, similar comprehensive evaluations have yet to be conducted for attachment-based interventions within Turkish primary healthcare settings.

Qualitative research examining international interventions in healthcare systems has consistently identified several practical implementation challenges, including staff workload, participant recruitment, and logistical constraints (Matrook et al., 2024; Rogers et al., 2021; Schreiweis et al., 2019; Wändell et al., 2018; Wolk et al., 2018). Exploring and addressing these barriers through a qualitative examination of acceptability and feasibility is essential for effectively integrating attachment-based interventions into Türkiye's primary healthcare system.

Another gap is the limited understanding of how early childhood attachment-based interventions are perceived by both implementers and recipients in non-Western, low-resource healthcare settings. While many interventions have demonstrated efficacy in Western contexts (Dozier et al., 2018; Juffer et al., 2017; Woodhouse et al., 2017), their successful integration into routine healthcare systems requires careful consideration of local contextual factors. Therefore, exploring stakeholders' experiences is crucial for identifying contextual barriers and facilitators, perceived benefits, and discrepancies between the intervention model and existing service structures. For instance, nurses' perceptions of their preparedness, workload, and how well the program aligns with their usual practices may affect the future scalability of the intervention. Similarly, understanding mothers' experiences, particularly concerning video recording and trust in nurses, can offer essential insights into the acceptability and sustainability of these programs. By investigating these perspectives, this study aims to inform future scaling and policy integration efforts.

1.4.2 Current study and research objectives

The challenges associated with implementing evidence-based interventions in real-world settings are well recorded in implementation research (Schreiweis et al., 2019; Wändell et al., 2018; Wolk et al., 2018). Implementation scientists stress the importance of evaluating the acceptability and feasibility of interventions to address these difficulties. Acceptability and feasibility are two elements, often underscored in implementation science (Brownson et al., 2012). Acceptability refers to how well the program is received by stakeholders, in this case, mothers and nurses. It focuses on whether the program is acceptable and beneficial for the stakeholders (Proctor & Brownson, 2012; West et al., 2017). Feasibility, on the other hand, assesses the practicality of the program for widespread adoption in a specific setting. Understanding these factors is crucial for ensuring the Infant-Mother Attachment Security Program's effective integration into routine healthcare practices. The current study aims to address these identified gaps through a qualitative evaluation that assesses the acceptability and feasibility of a nurse-implemented, attachment-based intervention in family health centers in Istanbul. More specifically, the current study aims to:

- Explore the stakeholders' satisfaction with and perceived benefits of the Infant-Mother Attachment Security Program, as reported by both nurses and mothers (i.e., acceptability).
- Investigate the feasibility of the program implementation in family health centers with respect to its barriers and facilitators, and the demand for this program from potential beneficiaries (i.e., feasibility)
- Identify potential improvements to the program based on stakeholder feedback to inform future scaling and implementation.

With these objectives in mind, this study seeks to answer the following research questions:

- How do mothers and nurses perceive the program's acceptability and effectiveness?
- Is the program feasible for routine use in family health centers?

Through in-depth interviews with the implementer nurses and participating mothers, this research will gather insights into their perspectives, experiences, and suggestions for improvements to inform future scalability. In the next section, the methods used to investigate these research questions will be detailed.

CHAPTER 2

METHODOLOGY

2.1 Design

This study employed a qualitative research design and was reported in line with the Journal Article Reporting Standards for Qualitative Research (JARS-Qual; Levitt et al., 2018). Reflexive thematic analysis, which explores and describes consistent patterns of participant discourse, was chosen as the analysis method due to its many advantages (Braun & Clarke, 2006, 2019, 2020). These include flexibility, relative ease of learning participant perspectives, and usefulness in producing qualitative comments for program/policy development (Braun & Clarke, 2006).

According to Braun and Clarke (2006), researchers can employ various methods for thematic analysis. The first is the essentialist method, which focuses on what is said and treats experiences as facts, such as exploring how nurses find the program helpful. The second is the constructionist method, which focuses on why things are said a certain way, such as how nurses talk about helpfulness and how this reflects gender norms. Finally, the contextualist method takes both into account, considering not only what is said but also the context in which it is said. For example, nurses find the program helpful, but factors like time and healthcare center conditions influence this. In line with Braun and Clarke's (2006, 2013) framework and following their advice to explicitly choose and justify the analytical approach in advance, this study adopts the contextualist approach. The researcher aimed to acknowledge participants' experiences while also considering the broader social and institutional factors that shape those experiences (Willig, 1999).

The analysis was primarily inductive; codes were developed directly from the data, rather than from pre-existing theory or a structured codebook. However, the research questions informed decisions about what to focus on in the data. This reflects Braun and Clarke's (2019, 2020) assertion that inductive and deductive approaches are not mutually exclusive but often coexist in qualitative analysis.

Another decision was made regarding the level at which themes should be identified, either semantic or latent (Braun & Clarke, 2006). Semantic-level themes are grounded in what is directly communicated, what the participants say, and what this data tells us. Data are taken at face value and then described and interpreted in relation to the research questions. In contrast, latent-level analysis goes beyond the surface and explores the unspoken beliefs or societal structures that influence what is said. Both semantic and latent coding were used. At the semantic level, the analysis examined what participants explicitly said. At the latent level, the researchers engaged with the underlying assumptions and meanings that shaped what was said. This dual-level engagement allowed for both descriptive insights and more interpretive understandings of stakeholder experiences (Braun & Clarke, 2006).

2.2 Participants

Participants included five mothers who were participating in the Infant-Mother Attachment Security Program and who had completed at least half of the program, as well as six nurses who were implementing the program in family health centers. The program consists of four core modules, followed by a fifth booster module. As part of the inclusion criteria, mothers needed to have completed at least two of the four core modules to ensure sufficient exposure to the program content. The inclusion criteria for nurses required implementing the program with at least one mother. One

nurse applied the program to five mothers, one to four mothers, one to three mothers, two to two mothers, and one to a mother.

The mothers were between 23 and 33 years old (M = 29.40, SD = 3.78). Two were high school graduates, and three had completed higher education (two years). Three mothers had one child, while two had two children. Four of the mothers were stay-at-home caregivers, and one was employed full-time. All mothers were married and living with the father of their participating child. Mothers were recruited using purposive sampling. In line with the reflexive thematic analysis approach (Braun & and Clarke, 2021), this study did not aim to reach data saturation, which is commonly defined as the point where no new themes emerge. According to the authors, this concept is incompatible with the reflexive thematic analysis approach, where themes do not emerge but are instead actively generated by the researchers. Instead, the focus was on collecting rich and relevant data that could inform an in-depth analysis of stakeholders' experiences. All mothers and nurses who met the inclusion criteria and were available within the timeframe of this thesis were invited to participate.

The nurses, all females, were aged between 30 and 40 years (M = 34.67, SD = 4.32). Four nurses worked at the Kaynarca Family Health Center located in Pendik, and two nurses worked at the Orhangazi Family Health Center, located in Bağcılar. Two of the nurses held master's degrees, while the other four had bachelor's degrees. Their experiences in the field ranged from 8 years to 18 years.

2.3 Procedure

Upon the beginning of the implementation of the Infant-Mother Attachment Security Program in January 2025, data collection for this thesis started in April 2025. Ethical

approval was obtained from Boğaziçi University's Institutional Review Board for Research with Human Subjects (see Appendix B). Eligible mothers were invited to participate immediately after completing either the second or third module of the program. The study's purpose and procedures were explained in person, and mothers who agreed were interviewed either on the spot or via a scheduled video call, depending on their availability.

Each session of the Infant-Mother Attachment Security Program followed a standardized flow: a video recording of the mother-infant interaction, followed by the nurse briefly reviewing the video, and then guided feedback with the mother based on the module's objectives, along with a theme-specific brochure. In Modules 2 through 5, the nurse recorded a short video during the session (e.g., play, feeding, or a restricted toy task depending on the module) and then reviewed it with the mother immediately afterward. The first module was an exception, here, the video used during the feedback session was a pre-recorded clip provided by the research team during the program's pre-test session.

During the video review, nurses paused the footage at selected moments and provided structured, strength-based feedback. Following the format outlined in the program manual, this feedback typically involved three components: (1) a clear description of the mother's observed behavior, (2) its immediate effect on the child (e.g., calming, feeling understood), and (3) occasionally, a reflection on the long-term developmental benefits (e.g., improved emotional regulation). Beginning with Module 4, nurses also began addressing less optimal behaviors in a gentle and constructive manner. This was done by first opening the session with a positive comment, then introducing suggestions for improvement midway through the review (often in the second quarter of the video) and always ending on an encouraging note.

Suggestions were framed using empathetic and non-judgmental language, for example, “Could we try doing this differently?” or “From the child’s point of view, it might be like…” to invite reflection without criticism. This was always paired with reaffirmation of what the mother was doing well (“You did this beautifully here, see how she responded?”), reinforcing that the behavior is achievable. Nurses also used the ‘speaking for the child’ technique (Juffer et al., 2008), verbalizing the child’s inferred thoughts, feelings, or needs to help mothers better understand and respond to their infant’s cues.

All data collection of this thesis study was completed through in-person interviews upon the completion of the module session at the family health center, except for one mother who joined over her lunch break. The mother and child were escorted to the playroom, where the researcher provided the child with toys. Demographic information (e.g., age, number of children, marital status, education level, employment status) was retrieved from the broader program’s questionnaire set administered to participating mothers. Semi-structured interviews were conducted with both mothers and nurses using pre-developed interview guides (see Appendix C and D). The interviews with mothers focused on their experiences of participating in the program, perceived benefits or challenges, and its impact on their parenting and relationship with their child. Each interview lasted around 15-20 minutes, after which mothers were thanked and the interview session concluded.

All nurses meeting the inclusion criteria agreed to participate. The researcher coordinated with each nurse to identify a convenient time during their work hours, and interviews were conducted in the playroom. After a brief overview of the study and obtaining written consent, audio recording commenced. The interviews with nurses explored their implementation experiences, perceptions of maternal

engagement, observed changes in mothers or infants, and suggestions for future improvements. Nurse interviews lasted approximately 25 to 40 minutes.

All interviews were conducted by the lead researcher, who had previously obtained a Master of Science degree in Psychology of Mental Health from the University of Edinburgh and had been trained in thematic analysis and semi-structured interviewing as part of her course. The audio recordings were transcribed verbatim by the lead researcher. To ensure confidentiality, all identifying information was anonymized, and participants were assigned unique ID numbers. were informed about the study verbally and in writing, and their informed consent was obtained through signed consent forms. Audio recordings and transcripts were securely stored on password-protected devices. In accordance with ethical guidelines, all data will be permanently destroyed five years after the completion of the publication and research procedures.

2.4 Qualitative data analysis

Qualitative data analysis was performed by the lead researcher, a postdoctoral researcher, and a graduate student working on the project as a TÜBİTAK scholar, under the supervision of the thesis advisor, who is also the primary investigator of the Infant–Mother Attachment Security Program. Prior to analysis, the thesis supervisor and the lead researcher provided training on Braun and Clarke's (2006, 2019, 2020) reflexive thematic analysis approach to the second and third coders.

The research team met regularly during coding to ensure reflexivity throughout the analytic process. Following the initial meeting, all team members independently coded three transcripts and subsequently met to review the initial codes. After this meeting, the lead researcher and the graduate student each

independently coded four additional transcripts and then met to review their codes. Through collaborative discussion, they resolved discrepancies, refined code definitions, and established a shared coding framework. The lead researcher then developed a codebook that incorporated all the generated codes. Using this framework, she coded the remaining transcripts and generated preliminary themes. A team meeting was held afterward to review and finalize these themes.

Throughout the process, the lead researcher documented meeting notes and reflections, which were included as memos alongside the codebook. She also recorded her reflections and observations after each interview and during each phase of the coding process in her reflective journal and audit trail.

The analysis followed Braun and Clarke's six-phase reflexive thematic analysis framework: (1) Familiarization with the data, (2) Generating initial codes, (3) Searching for themes, (4) Reviewing themes, (5) Defining and naming themes, and (6) Producing the report.

2.5 Trustworthiness

The trustworthiness of this qualitative study was established using the widely recognized criteria proposed by Lincoln and Guba (1985), which are commonly employed in qualitative research (Nowell et al., 2017). Building on Braun and Clarke's (2006) six-phase framework for thematic analysis and Lincoln and Guba's (1985) trustworthiness criteria, Nowell and colleagues (2017) expanded the original framework to ensure a rigorous and trustworthy analytic process. Table 1 shows how trustworthiness criteria were integrated throughout each phase of thematic analysis, based on the framework developed by Nowell and colleagues (2017). As suggested by qualitative researchers (Koch, 1994; Tobin & Begley, 2004), an audit trail was

maintained to track methodological decisions such as changes in codes, theme development process, and analytical insights. Additionally, the lead researcher kept a reflexive journal to record personal reflections throughout the study. Regular discussions were held between the researchers and the supervisor to ensure a trustworthy process.

Table 1. Implementation of Thematic Analysis and Trustworthiness Criteria

Braun and Clarke's thematic analyses phases	Trustworthiness criteria established by Nowell and colleagues (2017)
1.Familiarization with the data	Transcripts were read several times. Initial notes and reflections are recorded. Researcher reflexivity was practiced by journaling early observations in reflexivity journal.
2.Generating initial codes	Data were coded. Notes on coding decisions were recorded in the journal. Regular discussions were held among research team members for consistency.
3.Searching for themes	Codes were grouped into potential themes using MAXQDA. Mind-maps were used to visualize theme connections. Initial themes were compared with research aims. Team meetings were held to discuss potential themes.
4.Reviewing themes	Themes were reviewed across the full dataset for coherence and distinctiveness. Disconfirming cases and inconsistencies were examined with the research team to test the robustness of themes.
5.Defining and naming themes	Each theme was refined and clearly defined to capture its essence. Subthemes were created when needed. Definitions were discussed and finalized collaboratively with the research team.
6.Writing the report	Final themes were supported with rich, contextualized quotes. Methodological decisions and reflexivity were transparently documented through reflexive journaling and an audit trail. The findings were interpreted in relation to the research questions and considered within the practical realities of the healthcare setting.

CHAPTER 3

RESULTS

As illustrated in Figure 1, two themes were identified following the thematic analysis of the interviews. Theme 1 examines stakeholders' awareness gained during the program, offering insights into the first research question regarding the program's acceptability and perceived effectiveness. Theme 2 focuses on the implementation process of the intervention from stakeholders' perspectives, addressing the second question regarding the feasibility and long-term application of the intervention. Together, these themes reflect the internal transformations of mothers and nurses through their heightened awareness in various aspects (Theme 1), as well as the external systemic realities that shape how the program is delivered and received (Theme 2). The sub-themes illustrate the complex nature of stakeholders' experiences with the program, offering a comprehensive view of the intervention's perceived value and viability.

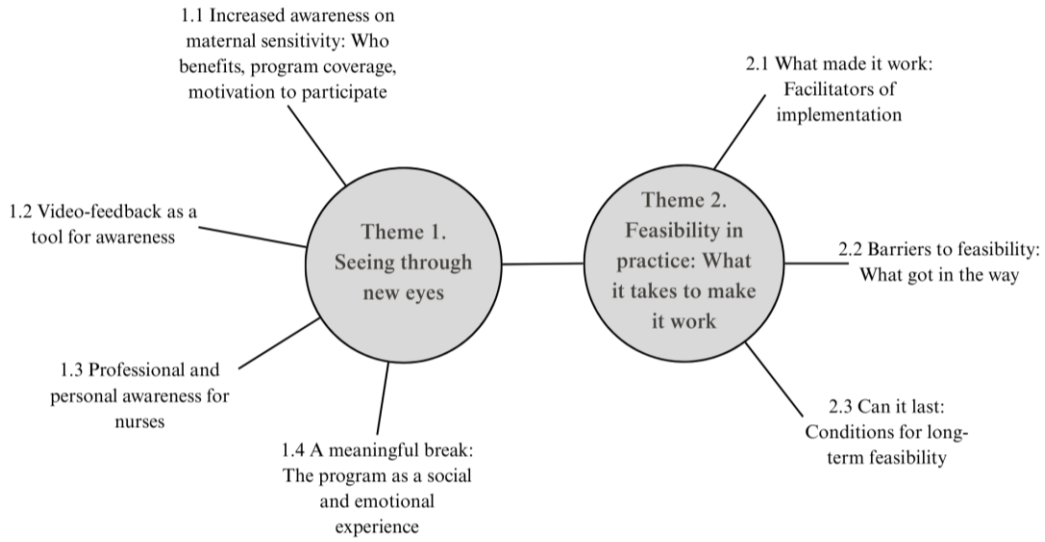

Figure 1. Themes and sub-themes from the qualitative interviews with mothers and nurses

3.1 Theme 1. Seeing through new eyes

This theme captures the various ways in which awareness emerged and evolved throughout the program for both mothers and nurses.

3.1.1 Subtheme 1. Increased awareness on maternal sensitivity: Who benefits, program coverage, motivation to participate

This subtheme highlights a layered awareness of maternal sensitivity developed through the program. It includes reflections on who might benefit the most from the program, which modules were perceived as particularly impactful, and how the motivation to join the program itself was rooted in the desire to become more aware and responsive.

3.1.1.1 Who benefits the most from the program

Almost all the mothers (four out of five interviewed) mentioned the importance of such programs for mothers expecting their first child. Four out of five interviewed mothers stated that such interventions would be particularly helpful for women who are expecting or raising their first child, as this is often the most challenging stage in terms of uncertainty and lack of guidance.

> I think it would be very useful. There are mothers who struggle with their first child and don't know how to behave. I believe this education should be given even before they become mothers, while they're still pregnant. They start acting instinctively, but these should be taught beforehand. (Mother 1)

Nurses also considered first-time motherhood both as a motivator for joining the program and a factor that shaped the program's effectiveness. One nurse shared that all five of the mothers she was working with were first-time parents, which she believed explained their eagerness to attend the program. Another nurse reflected on how some mothers were driven to join the program not only because they were

having their first child, but also because they had previously struggled with parenting and wanted to do things differently this time around.

> First-time mothers tend to be more motivated. They only have one child, and they're more invested in doing things right. Two of the mothers I work with joined because of their past experiences. One had a child with autism and was hoping to avoid similar issues this time. The other had a teenage daughter she had difficulty parenting, she told me, "If I made mistakes with her, I want to get it right this time." (Nurse 6)

Educational background also played a complex role in shaping awareness. Some nurses believed that mothers with lower educational backgrounds could benefit more from the program, but noted that, in practice, they were more often implementing the program with highly educated mothers. They attributed this to factors such as higher caregiving burdens and paternal skepticism regarding video recording in mothers with lower educational backgrounds. Nonetheless, nurses observed that even highly educated mothers gained new insights from the program.

> Both of the mothers I'm working with are already very aware. I sometimes wish I could observe this kind of change in mothers with less background knowledge. But even so, these educated mothers still notice things they hadn't before. (Nurse 3)

Another nurse questioned the direct link between education level and parenting insight, noting that all mothers, regardless of background, act with care, and what the program offers is a more conscious form of caregiving.

> It's not always about education. Some mothers may not be aware, but they still care deeply and act on instinct. But when instinct and awareness come together, that's where it becomes really powerful. Even I changed how I did things after training, did less of some things, more of others. (Nurse 4)

She also reflected on how both her higher- and lower-educated participants responded positively to the feedback, with no noticeable difference in how they processed or applied it.

Fathers, while not directly involved in the program, were also reported to benefit indirectly. All mothers stated that they shared their learning at home and

made their partners watch the recorded videos. Several noted that the fathers attempted to replicate the approaches modelled in the sessions. One mother and one nurse remarked that involving fathers more directly could have further enhanced awareness and participation.

3.1.1.2 Program coverage

Regarding which areas awareness was regarded as most beneficial, both mothers and nurses frequently emphasized the importance of the feeding module. Half of the nurses and several mothers described feeding not only as a central aspect of early parenting but also as a moment where mothers often felt the most uncertain or overwhelmed. It was seen as both emotionally charged and practically challenging.

> Feeding is one of the areas mothers struggle with most. It was the same for me with my own child, it's truly one of the hardest parts. Play is also important; it really reveals a lot. It shows how much you're attuned to your child and what you can give emotionally. (Nurse 1)

Another area highlighted by both a mother (who is also a special education teacher) and a nurse was supporting mothers and children in times of stress, such as in the vaccination module. These moments were seen as key opportunities for emotional regulation and secure bonding.

Additionally, the first module, which focused on moments of love and closeness, particularly through eye contact, was perceived as emotionally impactful and influential in raising awareness. Two nurses and one mother observed how even subtle moments, such as sustained eye contact, led to emotional recognition and reflection.

3.1.1.3 Motivation to participate

Finally, gaining awareness itself was not only an outcome of the program but also a core motivator for participation. Many mothers joined the intervention with the hope of learning something new or validating their existing approaches. The program was viewed as a space to gain reassurance and identify potential areas for improvement.

> (Interviewer asking whether she would recommend the program to other mothers). Absolutely. Because they'll learn things they didn't know; it builds awareness. Even though I've attended countless seminars, watched and listened to so much, I still wanted to join. I thought maybe there'd be something new, something I didn't know. Or maybe I'd realize something I was doing wrong. That's why I joined. (Mother 2)

3.1.2 Subtheme 2. Video feedback as a tool for awareness

Across interviews, both mothers and nurses described the video feedback component as one of the most powerful elements of the program in fostering awareness. All participating mothers emphasized the value of observing themselves from an external perspective. Seeing their own interactions with their child on video not only validated their efforts but also helped them reflect on sensitive behaviors and moments of connection they might have otherwise missed. One mother noted, "Thanks to this program, I got to see myself. I was truly happy to observe myself from the outside like that" (Mother 1).

Nurses also regarded video as a crucial tool in facilitating reflection and delivering effective feedback. Four out of six nurses expressed that without the use of video, much of the feedback might remain abstract or unconvincing for mothers. They highlighted how video provided concrete, visual evidence that allowed mothers to see for themselves what was being discussed, bridging the gap between intention and actual behavior.

> Watching yourself in the video… I realized that without video, they wouldn't understand anything in the program. There's almost no chance they'd get it. I wouldn't be able to convince them either. If I told them, "You did this," they'd say, "But I meant to do it differently." But with video, they see it for themselves. It works like proof. (Nurse 3)

The ability to see rather than simply hear about their behavior created a reflective space where awareness could emerge with more clarity and emotional resonance. For many mothers, this external view seemed to offer not only insight but also a sense of reassurance and validation.

Across interviews, all mothers expressed that receiving positive feedback made them feel emotionally supported and more confident in their parenting. Hearing affirmations such as "you're on the right track" from someone outside their immediate circle, especially from a professional, helped ease self-doubt and allowed them to approach caregiving with greater clarity and reassurance.

> I definitely feel happy when I get positive feedback. It relaxes me. I often wonder whether I'm doing things right, whether I'm approaching my child the right way. I question myself. But when an observer says it, I feel at ease, and then I notice that I start approaching things even better. (Mother 3)

A related benefit reported by several mothers (three out of five) was a noticeable increase in self-confidence. Seeing their interactions reflected back to them and hearing validation from the nurse helped them believe more in their capacity to parent effectively. For some, this also seemed to counteract pre-existing feelings of inadequacy or guilt. One mother said, "I think my confidence increased. I used to feel like something was missing, that I wasn't enough for them. But now I'm more involved with them. I pay more attention. I feel like I've become more attentive overall*"* (Mother 5).

Five nurses also expressed satisfaction with the impact of positive feedback on mothers, particularly in helping them recognize their sensitive caregiving behaviors. Several nurses noted that mothers often became emotional when they saw

themselves interacting with their child and received validation for their efforts. These moments appeared to deepen mothers' understanding of their role and the significance of small but meaningful gestures in promoting their child's development.

> She looked into her baby's eyes, and then at herself, and was about to cry. She was deeply moved. She hadn't realized how connected they were, how much the baby loved her. We weren't expecting that kind of emotional reaction from her, but she cried eventually. It was such a touching moment. (Nurse 4)

In addition to boosting confidence, nurses also used the feedback process to gently address intrusive behaviors by applying the "speaking for the child" technique, which is an approach used when mothers overlook or override their baby's cues. Four out of six nurses observed such moments during the sessions. One nurse explained how she spoke for the child to offer reflective guidance during these interactions. She said, "There were one or two moments when the mother didn't really observe the baby's cues and tried to make the baby do what she wanted. In those cases, I used feedback that spoke from the baby's point of view" (Nurse 5).

Despite the overall effectiveness of positive feedback, some nurses voiced the need for greater variation and depth in the feedback they were providing. Two nurses working at the same family health center noted that the feedback occasionally felt repetitive and could be expanded to include more concrete information. While they emphasized the importance of maintaining a supportive tone, they also acknowledged that mothers were often eager to receive more explicit guidance on what they could improve.

> Maybe we could add more variety to our phrasing. Include more informative sentences. Not just the kind that says, 'Your child will feel safe and understood,' I'm not sure how exactly, but a change like that might help. I think the feedback could be made more diverse and more enriched. (Nurse 1)

3.1.3 Sub-theme 3. Professional and personal awareness for nurses

One notable finding across all interviews with nurses was that the program not only supported mothers but also positively impacted the nurses themselves, helping them to gain awareness both personally and professionally. All nurses shared that the program influenced their own parenting behaviors or their ideas about how they would parent in the future. Even the one nurse who did not yet have children noted that the program had prompted her to reflect on how she might approach parenting when the time comes.

> Since I've always loved psychology, I thought I was already interacting this way, but I realized there were many moments where I wasn't. It really made an impact. Even when I see a friend with a child now, I find myself saying, "Try doing it this way." Or with my nephew, I talk to his mother differently now. So, it's made a big difference in that way. (Nurse 4)

Another nurse reflected on how the program helped her become more aware of her communication style, particularly her tendency to focus on negative aspects in her relationships. She described how the program prompted her to provide more supportive feedback, even outside the intervention context.

> It helped me in this way: I realized I have a tendency to focus on the negative. It might be because of my job, trying to convince patients who reject treatment, so I've gotten used to saying things like, "If you don't do this, these are the consequences." I wasn't always like this. I used to be softer, but over time I've become more direct, and maybe even overly focused on problems. I didn't have much of a habit of expressing things gently or indirectly. The program made me reflect on that. (Nurse 2)

Professionally, all nurses shared that the program enhanced their interactions with mothers and children in their daily work. They reported gaining valuable knowledge about child development, which they began applying in routine visits at the family health center. Many also described feeling more confident when responding to mothers' questions and more fulfilled in their roles as healthcare providers. One nurse noted, "It also helps on an emotional level. Normally, you feel a

bit hesitant, but the more you support mothers, the more relaxed you become, too. And that feels good, it's nice to feel like you're genuinely helping them" (Nurse 1). Another nurse said:

> It really improved my understanding of child development. I've been learning very in-depth things. These are insights I can use even outside the project, during routine visits, when a mother asks for advice, I can draw on what I've learned. So in that sense, it also contributes to my job." (Nurse 2)

Overall, the program acted as a reflective mirror for the nurses, encouraging self-awareness in both their personal relationships and professional practice. Their dual role as implementers and learners highlights the transformative nature of the intervention, not just for those receiving it, but also for those delivering it.

3.1.4 Sub-theme 4. A meaningful break: The program as a social and emotional experience

Beyond its parenting goals, the program also served as a valuable social and emotional experience for mothers. All interviewed mothers described it as an activity that allowed them to step outside the routines and isolating demands of early parenthood. Coming to the family health center became not only a chance to engage in a structured intervention but also a reason to leave the house, interact with others, such as researchers and healthcare providers, and reengage with the outside world.

One mother who completed the first three modules shared that she would gladly attend the program every day if she could. Two others noted that coming to the health center helped their babies get used to new environments and interact with people outside the home, which they considered beneficial for their children's social development. One mother noted, "It's a change of scenery for my baby too. We haven't been able to go out much during this time, so this is something different. She sees you, she interacts with other people" (Mother 4). Another mentioned while

talking about whether other parents would like to attend the program, *"*I think if it's a fun program like this, they would come running. We truly enjoy it*"* (Mother 1).

Nurses also recognized this aspect of the program. Two nurses mentioned that mothers often arrived at the sessions more prepared and put together than usual, sometimes wearing makeup as if they were preparing for a special occasion. One nurse recalled a mother who asked to apply extra makeup for the video recording, while another mother expressed concerns about her appearance and postpartum weight before being filmed. These seemingly small details reflected how the program supported mothers' psychological well-being by giving them a sense of visibility and self-care during a period when these aspects often feel out of reach.

> I never got the sense that the mothers felt burdened by coming here. In fact, they seemed to really enjoy it. Some had just given birth, but they showed up with their makeup done, looking elegant. It was obvious they were happy to be here. (Nurse 2)

In this way, the program created a space that extended beyond parent-child dynamics. It offered mothers a sense of community and emotional uplift, an unexpected yet meaningful dimension of their experience. For many, attending the program became more than an obligation; it was something they looked forward to, a reason to care for themselves, and a chance to see their children and themselves through new eyes.

3.2 Theme 2. Feasibility in practice: What it takes to make it work

This theme focuses on how the program is applied in the real world, moving from research to practice; what made the program work, what challenges it faced, and how it could be continued in the long term.

3.2.1 Sub-theme 1. What made it work: Facilitators of implementation

This sub-theme explores the key factors that made the program practically and emotionally feasible for both nurses and mothers. Five main facilitators were generated from the data: delivering the program within the family health center, the quality of the mother–nurse relationship, the usefulness of the program materials (e.g., manuals and brochures), regular supervision, and well-structured program training for the nurses.

3.2.1.1 Delivering the program within the family health center

The first and perhaps most consistently emphasized facilitator was delivering the program at the family health center. All mothers highlighted how the location contributed to their sense of safety, routine, and accessibility. The family health center was already part of their parenting journey, and its familiar environment helped ease logistical and emotional burdens. One mother said, *"*If you came to our home, we wouldn't know you, we wouldn't know who's coming, and we'd be alone. This way felt much better for us" (Mother 4).

Nurses (three nurses) echoed this perspective, noting that home visits often introduced stress for mothers, including concerns about cleanliness, preparation, or hospitality, even when explicitly told not to prepare extra. One nurse reflected that after piloting home visits early in the project, they realized how comfortable and practical it was to hold sessions at the family health center.

> We tried home visits at first, but they didn't really work. We saw how many people declined. I think people feel bad, like, even if we tell them not to clean or prepare anything, they probably feel they have to. This adjustment was a really good one. (Nurse 4)

Another nurse emphasized that the family health center functions not just as a location but as a relational hub where trust is already established. Because nurses follow mothers from pregnancy through the postpartum period, strong bonds form, creating a warm and familiar setting for the intervention.

> Since we already see each other often, during pregnancy and after the birth, we gradually get closer to the mothers. It really starts to feel like a family atmosphere. In that sense, "family center" lives up to its name. (Nurse 5)

3.2.1.2 The quality of the mother–nurse relationship

The second key facilitator was the quality of the relationship between mothers and nurses. Four mothers reported that the program did not drastically change their relationship with their nurse, because it was already strong to begin with, but they still appreciated the added connection and support. Mothers emphasized feeling heard, validated, and emotionally supported throughout the process. One mother noted, *"*My relationship with my nurse is already great. I've always been happy with her. She answers all of my questions and explains everything clearly*"* (Mother 2).

Nurses also reflected on how the quality of their existing relationships with mothers influenced participation. One nurse noted that prior trust built through vaccinations and routine care may have played a role in mothers' willingness to join the program. One nurse mentioned, "These two mothers were already close to me, I had been doing their children's vaccinations and knew them from their previous babies. That might be why they agreed to join the program. They trusted me" (Nurse 3).

Other nurses (three out of six) shared that the program not only relied on existing rapport but also strengthened the bond between them and the mothers. They described a deepening of warmth and familiarity over time, with mothers checking

in, greeting them more personally, and expressing fondness even outside the structured sessions.

> It definitely became warmer. They now stop by to say hello even when they're not here for the program. When they left after the last session, both said, "We're leaving today, Ms. Nurse!" It's like we became part of each other's lives, I started to feel something like familial affection, as if they were a part of me. (Nurse 2)

3.2.1.3 The usefulness of the program materials

Another factor that facilitated the implementation of the intervention was the use of structured program materials, including a printed manual and accompanying brochures. Four out of six nurses emphasized how helpful the structured manual was, particularly during the early stages of implementation. The materials, visually appealing and clearly organized, helped reinforce the flow and content of each module, reducing confusion and offering nurses a reliable guide. Brochures also supported the delivery of feedback, providing mothers with a tangible reference for what was discussed. One nurse mentioned, *"*The book is really useful. It's in our hands, and we don't need to write things down. It helps us keep everything organized. The manual was a great addition*"* (Nurse 2). Another one said, "Honestly, in the beginning, before we had these brochures, we were confused. We'd ask, 'What were we supposed to do this month? Which module was it again?' But now it's settled" (Nurse 6).

3.2.1.4 Regular supervision

In addition to printed materials, all nurses identified biweekly supervision meetings with the research team as an important support mechanism. Nurses described how these sessions created a space to share experiences, hear about unique challenges

their peers face, and receive direct guidance from the research supervisor. This process helped them feel more equipped to manage difficult situations and offered a sense of connection to the broader project.

> Hearing about others' experiences helps me figure out how I can respond. Maybe they will talk about an interesting case. Sometimes the supervisor would explain how to approach certain situations, like if a mother reacted a certain way. It's really valuable to share experiences, and to have someone guiding you, someone saying, "This happened, but let's try this next time." That kind of support was very effective. (Nurse 2)

While the meetings were appreciated, half of the nurses noted that biweekly sessions occasionally felt too frequent, particularly when they had no new cases or challenges to bring up. They suggested that the meetings could shift to once every three weeks as their confidence and experience with the program grew.

3.2.1.5 Well-structured program training for the nurses

Lastly, all nurses reflected positively on the four-day training they received prior to implementation, which was delivered over two consecutive weekends, two days of theoretical background followed by two days of module practice. While everyone found the training informative and well-structured, opinions varied regarding the practical component. Half the nurses appreciated the opportunity to role-play each module, stating that it helped solidify the procedures and gave them confidence. Others felt that this part of the training was somewhat lengthy and suggested shortening it by limiting the number of practice role-plays required from each participant. One nurse said, "The training was great. First, we had the theory, then we practiced. That really helped. Honestly, when we started implementing it here, we didn't experience much difficulty, thanks to how much we practiced beforehand" (Nurse 5).

Together, these structured supports, materials, supervision, and training were foundational in equipping nurses to deliver the program clearly and confidently.

3.2.2 Sub-theme 2. Barriers to feasibility: What got in the way

While the program was seen as valuable, several challenges were generated that made its implementation more difficult for nurses. These barriers can be grouped into three broad categories: logistical and structural constraints, role-related uncertainty, and mothers' hesitancy to participate.

3.2.2.1 Logistical and structural constraints

The first and perhaps most pervasive barrier was the logistical complexity and time demands of the program. Nurses reported difficulties in coordinating sessions, keeping up with paperwork, and balancing the program alongside their regular duties. Four nurses highlighted how the multi-stepped structure (involving scheduling, feedback preparation, module delivery, form filling, supervision attendance, and communication with researchers) required ongoing mental effort and added significantly to their workload.

> It's not the program itself that's difficult, I actually enjoy delivering it. If it were just filming a short clip while the child plays and then watching it together, that would be great. But afterward, there are forms to fill out, and so many little admin tasks that add up. Once you get into the flow, it's doable, but the paperwork and tracking everything, that's what makes it feel heavy. (Nurse 2)

These demands were felt even more acutely in light of recent changes to the healthcare regulations that further increased nurses' responsibilities. Half of the nurses reported that their existing workload was already very high, particularly in centers with many infant patients, making it hard to deliver the intervention consistently.

> To be honest, I have a lot of patients. I'm constantly moving from one task to another. Things have gotten even busier recently with new duties added to our workload. I already have many babies under my care, so I'm one of the busiest among my colleagues. (Nurse 5)

Another logistical hurdle involved scheduling sessions with mothers, which nurses found unpredictable and time-consuming. Half of the nurses described the difficulty of finding mutually convenient times that aligned with the availability of the mother, the nurse, and the researcher. In addition, frequent last-minute cancellations and dropouts due to illnesses made it more time-consuming.

> Some of them just don't show up. You call to ask why, and they say things like, "Oh, I forgot," even though they only have one child. They don't even let us know. For example, one mother didn't show up for a measles vaccine appointment where we were also going to give her video feedback. She said, "I'm thinking of skipping the vaccine for now, I'll check with other doctors first." She delayed me for a week. Eventually, she called back and rescheduled, but it threw things off and made you worry, "Will she now start rejecting all vaccines?" That kind of thing affects the whole flow. (Nurse 4)

Lastly, two nurses shared that some sessions ran longer than planned due to mothers sharing personal stories or asking many questions, which, although relationally meaningful, added further pressure to their tightly packed schedules. One nurse said, "One session lasted about half an hour and even went into my lunch break. I wanted to keep watching the video and stay on topic, but I also didn't want to cut her off" (Nurse 1).

3.2.2.2 Role-related uncertainty

Almost all nurses (5 out of 6) reported experiencing role-related uncertainty during the implementation of the program. A central source of this tension was the mismatch between the psychological content of the intervention, rooted in attachment theory, and the nurses' traditional training, which is more focused on physical health and developmental milestones. Nurses expressed discomfort about

how to respond to mothers' questions, especially when the topics extended beyond their medical expertise into areas of child psychology.

One nurse shared that, although she had done additional reading in child development and parenting due to her own experiences as a mother, she still felt uneasy about how much she should say and whether giving advice outside her official scope was appropriate.

> In those moments, I hesitate. Maybe it's because I'm a mother myself and someone who reads and researches a lot… I feel the urge to share what I know, right or wrong. But I wonder, should I say something or not? Is it appropriate? I get nervous. I try to keep things vague, without going into too much detail. (Nurse 1)

This role ambiguity also contributed to feelings of inadequacy. Two nurses expressed concern that they might not be able to meet the mothers' expectations, particularly when questions touched on psychological or emotional development, areas they felt less equipped to address. One nurse shared that she was afraid mothers might feel disappointed or unsatisfied with vague or limited answers and might eventually disengage from the program altogether.

> What worries me is the fear of not being enough for the mother, like if she asks something and I can't answer it. That moment, that lack of satisfaction, might make her think, "This isn't really helpful for me," and she might drop out. That makes me really anxious. I remember trying to be very careful with my wording, choosing what I say intentionally so that I can avoid repeating myself. (Nurse 1)

Another common area of uncertainty involved how to behave during video-recorded sessions, particularly in the vaccination module, where both the nurse and mother are filmed. One nurse described feeling tense during filming, unsure whether she should interact naturally, prompt the mother to comfort her child, or stay silent to allow the moment to unfold.

> During the video, especially when I'm giving a vaccine, I find myself tightening up. I feel like I shouldn't speak, but I want to say things like "Hold her this way" or "Bring your cheek close." Then the patient asks me something, and I don't know if I should answer. It's uncomfortable. (Nurse 3)

The changing dynamics of the nurse-mother relationship also contributed to role-related uncertainty. As the program fostered closer emotional bonds, some nurses reported difficulty maintaining professional boundaries. Mothers began using first names instead of formal titles and sometimes referred to the nurses with affectionate terms, such as "dear." While the warmth was welcomed, it created ambiguity around expectations, especially in time-limited healthcare settings.

> I try to keep speaking the way I did from the beginning, maintaining the professional tone, because at the end of the day, she's my patient. I don't want to drop the formal boundary. But they start seeing us more like friends. One mother already treats it that way. I keep wondering: should I say something? But I don't really have the courage to do it. (Nurse 6)

This deepening relationship also had practical consequences. As mothers grew more comfortable, they often extended the sessions by asking more questions or sharing personal stories. While this enhanced emotional connection, it also increased session duration and created tension with the nurses' already full schedules, raising concerns about the long-term sustainability of the program.

3.2.2.3 Mothers' hesitancy to participate

One of the most frequently reported challenges among nurses was the difficulty of inviting and recruiting mothers to the program. Because participation was voluntary, nurses often felt they were trying to "sell" the program, an experience that three nurses described as uncomfortable and burdensome.

> The fact that we had to go and persuade mothers… It felt like we were the ones looking for "customers", like we were trying to sell something that didn't already have demand. And it takes a lot of effort to build trust in our approach. (Nurse 2)

This hesitancy was often rooted in a growing distrust in the healthcare system, especially in the aftermath of the COVID-19 pandemic and recent insurance fraud scandals in Türkiye. Three nurses pointed to this broader mistrust as a major obstacle in motivating mothers to participate in the program. They reflected on how even standard healthcare services, such as routine checkups and vaccinations, were now met with suspicion, and how that sentiment had spilled over into new projects like this one.

> There's a serious distrust toward healthcare workers right now, and vaccines have played a part in that. Some mothers feel like we're forcing them into things. They don't even come when invited for regular appointments, and this isn't just with mothers; pregnant women and other patients are like this, too. Some even deregister from the system just to avoid the family health center. I don't understand it, we're the most accessible service, and yet that accessibility is now being seen as less valuable. (Nurse 1)

Another common concern, particularly during recruitment, was the video-recording component of the program. Although mothers often found the video feedback meaningful after participating, the idea of being filmed initially provoked anxiety and contributed to mistrust. Three nurses mentioned that concerns about privacy and data use were among the most frequently cited reasons for declining to participate.

> The first issue that always comes up is security. They ask, "You're going to record us, where will you show the video? What will you do with it?" That's one of the first concerns I address when inviting mothers, because it immediately creates doubt in their minds. (Nurse 1)

To address this, nurses reported that they emphasized transparency, assuring mothers that the videos would only be viewed by the intervention team, would not be shared externally, and would be deleted after the program. Framing the video component as a tool for supporting the mother-child relationship and emphasizing the direct benefits for their child were noted as strategies that helped persuade hesitant participants, though they were not always successful.

In addition to trust-related concerns, another reason for hesitancy among mothers was the perception of the program as an extra burden. This concern was especially prominent among mothers who were working or caring for multiple children. Nurses reported that some mothers worried about whether the program would take up too much of their time or require them to attend additional appointments beyond their usual routine. One nurse said, “They’re often anxious about whether this will take too much time. They ask, ‘Will I have to come a lot? What if I can’t make it every time?’ These kinds of concerns make them hesitant” (Nurse 1). To tackle this, nurses highlighted the importance of clearly communicating that the program would primarily be conducted during routine family health center visits, thereby minimizing any additional time commitment. They explained that, aside from the initial observation (pretest), which might take slightly longer, approximately thirty minutes, most sessions would be short and integrated into their existing healthcare schedule. By clarifying time expectations, emphasizing convenience, and building trust through transparent communication, nurses were sometimes able to reduce reluctance. However, even with these strategies, participation remained a challenge for certain groups of mothers, particularly those balancing multiple demands or having skepticism toward the healthcare system.

3.2.3 Sub-theme 3. Can it last: Conditions for long-term feasibility

This final sub-theme explores nurses’ views on the long-term applicability of the program and whether they would be willing to implement it routinely in the future.

3.2.3.1 "Not under these conditions": Why nurses don't want to continue

Across interviews, all nurses expressed reluctance about continuing to deliver the program under current conditions. As described in previous sub-themes, they viewed the program as an additional burden on top of already demanding workloads. Although they valued the program's content and outcomes, they did not feel it was feasible to deliver it routinely without major adaptations to staffing, time, or structure.

One nurse explained that while it may be possible to implement the program with one or two mothers at a time, expanding the program to include every mother in the family health center would be unrealistic, particularly during busy peak periods.

> Right now, things may not seem so busy, but when we hit peak times, if every mother were enrolled in the program, it would be impossible. Let's say this gets implemented in all family health centers, and every mother is included, I would need to dedicate an hour to each one. But in practice, I can only give about 15 minutes per mother. You could schedule one mother on a separate day, sure, but not everyone. If each mother gets an hour, it becomes unsustainable. Honestly, I don't think this could be fully implemented across all centers because most nurses wouldn't accept it. (Nurse 3)

Nurses also voiced concerns that, if the program were to be mandated as a routine task, it could suffer from the same lack of proper implementation seen in other standardized screenings, such as autism spectrum disorder screenings. One nurse warned that forcing such programs into routine care, without adequate structural support, may lead to superficial compliance.

> If it becomes mandatory, it might end up being done carelessly, like the autism screening forms we're asked to do. They come in during inspections and say, "Make sure you complete those too." But when it's forced like that, people don't really take it seriously. (Nurse 2)

3.2.3.2 "But it could work if…": What needs to change for sustainability

Although nurses expressed reluctance to continue the program under current conditions, they also offered several suggestions that could enhance its long-term feasibility and sustainability. Their insights centered on structural improvements, motivational incentives, and integrating the program into routine visits.

One of the most important structural considerations was the availability of resources across different types of family health centers. One nurse emphasized that delivering the program in well-equipped, Type A family health centers, where responsibilities are divided among nurses and there are more rooms available to convert into a playroom, was much more feasible than in under-resourced Type D family health centers.

> I think it might be difficult to implement this everywhere. Not every nurse has the time or capacity to do this. For example, we're a Type A family health center and we're relatively comfortable, we have a nurse for blood draws, for injections. But in Type D centers, one nurse handles everything from morning to evening. There's no lab nurse. If I imagine doing this in our previous family health center before we became Type A, it would have been impossible. Some centers don't even have proper break areas. For places like that, this would be overwhelming. (Nurse 4)

She also noted that the program's core communication strategies, such as positive feedback, should be taught to all nurses, even if video recording is not used, because such skills benefit nurse-parent interactions more broadly.

Another suggestion focused on providing motivational incentives for nurses who participate in the program. One nurse compared the model to private sector dynamics, where employees are rewarded through events, bonuses, or recognition. She proposed offering social and financial incentives, such as organizing special events for participating nurses or giving a bonus for every few mothers served. Half of the nurses agreed that financial incentives could play a significant role in encouraging broader participation.

> Honestly, I might not want to participate under the current conditions. But maybe if there were nice events just for the nurses who apply the program, like they do in the private sector. You know, a dinner, a gathering, something to make us feel appreciated. Or maybe a bonus after every few mothers. Things like that really motivate people. Think about how salespeople work, because they know something is waiting at the end. That kind of motivation could really help. (Nurse 6)

A final suggestion for improving sustainability was to integrate the program fully into routine visits, rather than scheduling additional appointments for mothers. For example, one nurse proposed delivering the modules during scheduled vaccinations at 9, 12, and 18 months, or during growth monitoring (optional) visits at 15 months. This would reduce the logistical burden on both mothers and nurses while maintaining the program's effectiveness.

> It's not a difficult thing; I can have the camera open while I give the vaccine. That part's doable. But what's hard is calling mothers in just for the program, filming a play session separately… that's where it gets complicated. I think using routine visits would work better. If the child's already coming for height and weight checks, the mother is there and engaging anyway. Extra appointments would be difficult and, honestly, unnecessary. (Nurse 3)

Together, these recommendations reflect a desire to preserve the program's benefits while reducing its practical burden. With appropriate structural support and incentives, the program may be successfully adapted for long-term, sustainable use across diverse family health settings.

CHAPTER 4

DISCUSSION

The current study examined the acceptability and feasibility of the Infant-Mother Attachment Security Program, the first attachment-based intervention implemented in the Turkish healthcare system. Eleven semi-structured interviews were conducted with mothers and nurses, who are the beneficiaries and implementers of the program, respectively. The reflexive thematic analysis of the interviews showed that both mothers and nurses highly appreciate the program, particularly for its positive impact on the mother and the personal and professional fulfillment it provides to the nurses. Despite this, the nurses are not very optimistic about the program's feasibility and sustainability due to structural barriers in the healthcare sector and their role within it.

4.1 Acceptability of the program

Two overarching themes were generated after the thematic analysis of the interviews: Theme 1. Seeing through new eyes and Theme 2. Feasibility in practice: What it takes to make it work. The first theme consists of five subthemes: (1) Increased awareness on maternal sensitivity: Who benefits, program coverage, motivation to participate; (2) Video feedback as a tool for awareness; (3) Professional and personal awareness for nurses; and (4) A meaningful break: The program as a social and emotional experience. This theme examines the various forms of awareness acquired by both nurses and mothers, including how this awareness developed, in which areas it was most pronounced, and what could be added to the program to enhance its

impact further. It primarily addresses the first research question, which focuses on the acceptability of the program.

This theme reflects the program's core objective to enhance maternal sensitivity, a foundational predictor of secure attachment that has been long established (Ainsworth et al., 1979; Madigan et al., 2024). It is particularly emphasized in early attachment-based interventions, such as VIPP-SD, ABC, COS, where developing reflective capacity and recognizing one's parenting behaviors have been consistently linked to increased parental sensitivity and secure attachment (Dozier et al., 2018; Juffer et al., 2017; Marvin et al., 2002)

Both mothers and nurses believed that the intervention would be particularly beneficial for first-time mothers who are navigating the challenges of new motherhood and often feeling unsure about their parenting. The program supports them in this regard by offering an opportunity to observe themselves through video recordings and receive positive feedback on their sensitive caregiving behaviors. Similarly, mothers with more than one child, especially those who experienced difficulties with their older children, were also seen by nurses as more motivated to participate in the program. In both cases, the video feedback component was especially appreciated, as it allowed mothers to step outside their perspective and gain insight into what they were doing well. This emphasis on maternal reflection through video feedback resonates with the program's theoretical grounding in social learning theory (Bandura, 1986), as well as the empirical findings suggesting that video feedback is one of the most effective strategies for enhancing parenting sensitivity (Bakermans-Kranenburg et al., 2003; Balldin et al., 2018; Fukkink, 2008; O'Hara et al., 2019). This also aligns with findings from previous implementation studies, which consistently identify video feedback as one of the most well-received

and impactful components of parenting interventions (Bergsund et al., 2022; West et al., 2022).

Both mothers and nurses found the feedback they received valuable. Mothers described the positive feedback as reassuring, and many reported feeling more confident in their parenting, echoing results from other studies (Iles et al., 2017; Lassen et al., 2025; Williams, 2017). However, some nurses noted that the feedback could sometimes feel repetitive. This concern also emerged in implementation studies of other attachment-based programs, where practitioners expressed hesitations about the repetitive nature of the feedback (West et al., 2017). They suggested that feedback content could be expanded or enriched to better meet mothers' needs. A few nurses also expressed initial hesitation about offering predominantly positive feedback, as they felt some mothers might expect to hear more about what they were doing wrong to improve. These concerns align with findings from Bergsund et al. (2022), who noted that some parent coaches were concerned that strengths-focused comments might lead certain parents, particularly those with limited reflective capacity, to believe they no longer needed support, resulting in premature withdrawal from the intervention. That said, it's important to consider that most nurses in this study had only delivered the first or second modules of the program. The later modules include more psychological content and additional feedback that addresses less positive parenting behaviors, providing greater opportunities for enriched feedback. Therefore, their impressions may not fully reflect the program's scope.

In addition to its parenting benefits, the program was also described by mothers as a meaningful social outlet, something less commonly emphasized in prior implementation studies. Mothers reported that the sessions provided them with a

reason to prepare for social occasions, engage with others outside the home, and experience a sense of connection. The program created space not only for learning and reflection but also for visibility and self-care. This aligns with broader research highlighting the importance of maternal well-being on the socioemotional development of children in the early years (see Honda et al., 2023, for a systematic review and meta-analyses), which reinforces the value of programs that support both parenting behavior and emotional well-being. Importantly, this sense of meaning also extended to the nurses. Their reflections revealed increased self-awareness, shifts in their own parenting and communication approaches, and a strengthened sense of purpose in their roles as both caregivers and professionals. These resonate with findings from other implementation studies, such as Reay and colleagues' (2019) study, where clinicians delivering COS-P reported personal and professional growth as a result of facilitating the attachment-based intervention.

4.2 Feasibility of the program

The second theme consists of three subthemes: (1) What made it work: Facilitators of implementation; (2) Barriers to feasibility: What got in the way; and (3) Can it last: Conditions for long-term feasibility. These subthemes highlight different aspects of the implementation process and address the second research question, which explores the feasibility and sustainability of the intervention within the healthcare setting.

Among the program's key facilitators, nearly all nurses appreciated the structured training they received, as well as the program materials, including brochures and the printed manual booklet. Regular supervision and the consistent support from the research team, particularly the presence of the graduate research assistant during the first implementation of each module, were also highlighted as

important strengths. This kind of structured implementation support, including training, manuals, and supervision, has consistently been identified in the literature as essential for maintaining intervention fidelity and motivation among implementers (Reay et al., 2019; West et al., 2022). The quality of the nurse-mother relationship was another notable facilitator; mothers were more inclined to participate in the program when they already had a sense of trust and rapport with their nurse.

Interestingly, while the video feedback component was highly valued once mothers engaged with it, it initially posed a barrier to recruitment due to concerns about privacy and confidentiality. This trajectory, from initial apprehension to eventual appreciation, is a recurring theme in many parenting interventions that utilize video feedback (Barnicot et al., 2023; Bergsund et al., 2024). Most nurses emphasized the importance of fostering a warm and trustworthy relationship, as well as clearly explaining how the videos would be used, specifically, who would view them, how long they would be stored, and when they would be deleted. This finding mirrors implementation challenges encountered in other culturally adapted video feedback interventions, such as the Turkish adaptation of VIPP-SD (Sümer et al., 2020), where transparency and trust were crucial to acceptance. This level of transparency was essential in alleviating mothers' concerns and is also emphasized as a "lesson learned" in both the pilot and primary studies of the 3-year implementation of an early intervention program (West et al., 2017; 2022).

Skepticism about the video-recording component may stem from a broader lack of trust in the healthcare system, which is not uncommon in implementation research (Aparicio et al., 2016; Bergsund et al., 2024). Recent healthcare scandals in Türkiye have likely intensified these feelings (Utucu, 2024). Nevertheless, conducting the intervention within the familiar and accessible environment of the

family health center, where mothers have known their nurses since pregnancy, helped reestablish a sense of security. Despite broader skepticism, the trust built through long-term nurse–mother relationships seemed to override some of the general distrust toward the healthcare system.

Regarding structural and logistical barriers, as echoed in other studies (Reat et al., 2019; West et al., 2022), nurses identified scheduling as one of the most demanding aspects of the program. Coordinating sessions with mothers was time-consuming and often unpredictable. Mothers could cancel sessions at the last minute, postpone them indefinitely due to illness, or drop out without notice. This scheduling burden came on top of an already heavy workload, a longstanding issue for nurses (Pearson et al., 2006; Yuan et al., 2023), and was recently exacerbated by changes in national healthcare regulations. Most nurses clarified that their difficulty was not with the program content itself, but with the additional responsibilities associated with the research protocol, including scheduling pretests, coordinating with the research assistant, preparing module notes, attending supervision sessions, and sending feedback messages with video screenshots to the mothers. These small yet numerous administrative tasks added a layer of cognitive and logistical overload, a pattern also observed in other implementation studies (Bergsund et al., 2022). These findings reinforce broader concerns noted in the introduction about the feasibility of embedding multi-step interventions within low-resource health systems, particularly when implementers already face time pressure and bureaucratic responsibilities (Schreiweis et al., 2019).

Although the nurse-mother relationship supported recruitment, it occasionally led to blurred boundaries during the implementation phase. As familiarity deepened, some mothers began using nurses' first names or affectionate terms instead of

professional titles, and many started asking more questions or sharing detailed stories. This often resulted in lengthened session times, making it harder for nurses to maintain their professional roles. Such role-related ambiguity has also been noted in prior literature on the implementation processes of parenting interventions (Harden et al., 2010).

4.3 Long-term application and sustainability of the program

Overall, all nurses expressed a rather pessimistic outlook regarding the program's long-term application. While they believed in the value and importance of the intervention, they felt that implementing such a multi-stepped program under current working conditions was unrealistic. This mirrors wider concerns raised in implementation science literature, which suggest that even highly acceptable programs may falter in sustainability without adequate systemic support, particularly in overburdened public healthcare contexts (West et al., 2017; Schreiweis et al., 2019). In some family health centers, even the physical infrastructure was seen as a limiting factor. To enhance the program's future adaptability, nurses suggested simplifying its multi-stepped nature and fully integrating it into routine visits (rather than the extra sessions at child age 14 and 16 months), thereby avoiding the burden of additional scheduling. This suggestion aligns with the emphasis on brief, low-intensity interventions as more scalable and realistic for integration into low-resource settings, such as Türkiye (Bakermans-Kranenburg et al., 2003; Sümer et al., 2020). They also emphasized the importance of providing financial incentives and recognition to nurses implementing the program, for instance, organizing social events exclusively for participating nurses or offering performance-based bonuses.

These findings suggest that while the intervention was well received in principle, its feasibility in real-world primary care settings is hindered by heavy workloads, administrative demands, unpredictable scheduling, and time constraints. Adapting the program to reduce these burdens will be essential for ensuring its long-term sustainability.

Regarding role-related uncertainty, particularly around maintaining professional boundaries, nurses' reflections indicate that this issue is relevant for nearly all implementers. It is recommended that this topic be explicitly incorporated into the nurse training component of the program. Similar reflections have emerged in COS-P implementation studies, where facilitators noted the challenges of navigating emotional boundaries and managing their own emotional responses when supporting caregivers through sensitive content (Reay et al., 2019). Additionally, another area of uncertainty arose in responding to mothers' questions related to the psychological content of the program. Thanks to the iterative nature of the current study, this concern was addressed promptly in supervision meetings. It was agreed that supervisors would develop a frequently asked questions guide, which could serve as a helpful resource for nurses, allowing them to respond to mothers with greater confidence and clarity.

4.4 Strengths and limitations

This study evaluated the implementation process of the intervention from the training period through to the delivery of the first two modules. It aimed to identify areas for improvement while the program is still ongoing. The primary goal of this research was to obtain a detailed picture of the program's participants, including both beneficiaries and implementers, which is one of the study's key strengths, offering

insight from multiple perspectives. Another important strength is the triangulation of methods, which was achieved through the inclusion of both stakeholder groups and the collaborative analysis conducted by four researchers, which enhanced the credibility and richness of the findings.

Qualitative analysis does not inherently aim for generalizability but instead seeks to gain a comprehensive understanding through a meaningful and in-depth exploration of the participants (Lassen et al., 2025). The study was conducted after the participants had completed half of the program, which presents both a strength and a limitation. Strength lies in providing opportunities for iterative changes to the program while it is still being implemented, and a limitation is not evaluating the participants' experience regarding the entire program.

Nevertheless, the findings offered valuable insights, many of which are already being used to inform the rest of the implementation. For example, concerns raised by nurses during interviews about how to address mothers' difficult questions about child psychology, such as being overly close and attached to the mother, have already been addressed in supervision meetings. Additionally, a frequently asked questions booklet will be developed to help nurses respond to common queries from mothers with more confidence. Another area addressed after the interviews was nurses' concerns about how to act during the second module, which takes place during vaccination, as the nurses are also featured in the video. They were advised to act naturally, allowing space for the mother to soothe the baby, rather than being too rigid and potentially affecting ecological validity. Overall, this study makes a valuable contribution to the literature by demonstrating how real-time qualitative evaluation can inform responsive, context-sensitive adaptations during the implementation of intervention programs within the healthcare system.

4.5 Conclusion

This qualitative study offers insights into the acceptability and feasibility of a nurse-implemented, attachment-based program integrated into Türkiye's primary healthcare system. Both nurses and mothers highlighted the benefits of the program in increasing awareness; mothers gained insight into what they were doing right in their parenting practices, while nurses reported increased awareness in both their parenting and professional interactions with other mothers. The video feedback component was especially well-regarded by both stakeholder groups, despite initially posing a challenge during the recruitment process.

For long-term feasibility, it seems essential to reconsider certain structural and logistical components, such as reducing workloads and offering institutional incentives for the implementing nurses. These findings suggest that attachment interventions implemented by nurses have the potential to foster sensitive parenting practices and create a meaningful impact. This is especially important in settings like Türkiye, where preventive mental health efforts and early parenting interventions are not yet widely implemented within the public health system.

Future research may benefit from including the perspectives of those who declined to participate, evaluating stakeholders' views after completing the full intervention, and exploring sustainable pathways for broader implementation. Overall, the program demonstrates promise for integrating an attachment-based approach into primary healthcare, potentially contributing to enhanced sensitive parenting practices and improved developmental outcomes in the long run.

APPENDIX A

PROGRAM MODULES OVERVIEW

Module 1: Sharing love, closeness, and play moments with the child			
Module goals	Observed behaviors in video	Effect on the child	Long-term effects
- For the mother and baby to enjoy play together - For the mother to notice what interests her child - For the mother to pay attention to the child's cues and responses	- Eye contact between mother and child - Smiling together - Holding the child's hand or stroking their hair - Responding to the child's babbling or cooing	- Feels loved - Feels safe - Feels valued	- Strengthens the parent-child bond - Develops a secure attachment - Enhances ability to self-soothe during stressful times - Builds confidence and emotional security in future relationships
Example Feedback Sentences	- "Look how much your child enjoys playing with you. These are such special moments." - "That moment when you made eye contact and smiled was so warm. Your child clearly feels how important she is to you." - "When she was in your arms, she looked so relaxed. That closeness is comforting and helps her feel secure."		
Module 2: Mother as a safe haven for the child			
Module goals	Observed behaviors in video	Effect on the child	Long-term effects
- Increase the mother's awareness of the child's signs of distress, fear, or stress - Encourage sensitive soothing responses and social referencing awareness	- Mother hugs the child after vaccination - Holds the child's hand, pats the child gently - Speaks to the child in a calm and comforting tone - Redirects attention	- Feels secure and soothed - Feels understood - Recovers more quickly from distress	- Develops the ability to self-soothe - Builds trust in caregiver during stressful moments - Strengthens the emotional bond between mother and child
Example Feedback Sentences	- "Look how your touch immediately calmed her down." - "When she was afraid, your closeness and soothing voice helped her feel safe." - "By naming her feelings, you showed her she is understood. That builds a strong bond."		
Module 3: Reading the child's signals			
Module goals	Observed behaviors in video	Effect on the child	Long-term effects
- Help the mother notice and respond to child's feeding cues	- Recognizing signs of hunger or fullness - Waiting for the child to finish chewing	- Feels understood and respected	- Builds internal regulation of appetite - Develops healthy eating behaviors

- Encourage pacing with the child and reduce intrusive behaviors	before offering more food - Responding to interest or disinterest in food	- Gains clarity on hunger and fullness	- Strengthens the parent-child bond
Example Feedback Sentences	- "You noticed she was full and didn't insist. This shows you're attuned to her." - "You noticed her opening her mouth and fed her, you are following her pace." - "Talking to him while feeding shows you're connected, he feels understood."		
Module 4: Following the child's lead and sensitive discipline			
Module goals	Observed behaviors in video	Effect on the child	Long-term effects
- Encourage following the child's pace and interests during play - Support appropriate and gentle limit-setting - Promote positive discipline and emotional regulation	- Waiting for the child to finish an activity -Allowing the child to go at her own pace - Explaining rules clearly and calmly - Praising efforts and redirecting attention without shaming - Offering choices and naming the child's feelings	- Feels empowered and understood - Feels happy - Learns to regulate emotions during challenging situations	- Builds emotional resilience and confidence - Develops self-regulation and problem-solving skills - Gains healthy understanding of limits and social rules
Example Feedback Sentences	- "You gave him time to figure out the toy. That supports his independence." - "By naming his frustration, you helped him feel understood and calm down." - "You allowed him to try things himself while being present. That fosters confidence."		

APPENDIX B

ETHICAL APPROVAL

T.C.
BOĞAZİÇİ ÜNİVERSİTESİ REKTÖRLÜĞÜ
Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (Sbinarek)

Sayı : E-84391427-050.04-214500 14.01.2025
Konu : 2024-89T Kayıt Numaralı Başvurunuz Hakkında

Sayın Dr. Öğr. Üyesi Deniz TAHİROĞLU

Tez danışmanlığını yürüttüğünüz öğrenciniz Melis Çetin'in "A Qualitative Evaluation of the Infant-Mother Attachment Security Program by Mothers' and Nurses' Views (Güvenli Bebek-Anne Bağlanma Programının Anne ve Hemşire Görüşleriyle Nitel Açıdan İncelenmesi)" başlıklı projesi ile Boğaziçi Üniversitesi Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (SBİNAREK)'e yaptığınız 2024-89T kayıt numaralı başvuru 03.12.2024 tarih ve 2024/09 sayılı kurul toplantısında incelenmiş ve projeye etik onay verilmesi uygun bulunmuştur.

Bu karar tüm üyelerin toplantıya on-line olarak katılımıyla ve oybirliği ile alınmıştır. Onay mektubu tüm üyeler adına Komisyon Başkanı tarafından e-imzalanmıştır. Bilgilerinizi rica ederiz.

Saygılarımızla,

Dr. Öğr. Üyesi Işıl ERDUYAN
Kurul Başkanı

Bu belge, güvenli elektronik imza ile imzalanmıştır.
Belge Doğrulama Kodu : 0BU3-AI9T-0KKL Belge Doğrulama Adresi : https://www.turkiye.gov.tr/bogazici-universitesi-ebys

APPENDIX C

NURSE INTERVIEW GUIDE

1. How many mothers have you implemented the Infant-Mother Attachment Security Program with so far?
2. How did mothers generally respond to the module themes in the program? What kind of feedback did they give regarding the information and reflections you shared?
3. Which module themes attracted the most interest from mothers?
4. To what extent do you think the program has been beneficial for the mothers? Which themes did they say they benefited from the most, or did you observe this in any way?
5. What kinds of changes have you noticed in the babies?
6. When starting the program with a mother for the first time, what do you pay attention to?
7. Did your relationship with the mother change over time? If so, how?
8. Thinking first about mothers you worked with easily and who did not challenge you, can you describe those experiences?
9. Can you share your experiences with mothers you found challenging to work with? What were the specific difficulties for you? How did you try to manage those situations? What did you do? What kind of feedback did you receive from the mothers?
10. What were the most significant or serious problems you encountered with the mothers you worked with?

11. Do you have any suggestions about the content of the program modules? Have you thought about any changes that could make the program more effective in the future?
12. What are your thoughts on how the modules were implemented? What parts were easy for you, and what parts did you find challenging? What do you think was easy or difficult for the mothers?
13. How would you evaluate the training you received for implementing the program?
14. How would you evaluate the supervision you received during the program?
15. How would you describe the benefits of the program for yourself?
16. After this project ends, would you like to continue implementing the program in the future?

APPENDIX D

MOTHER INTERVIEW GUIDE

1. What did you think of the Infant-Mother Attachment Security Program? What was it like for you to participate in this program? What impact did it have on your relationship and interaction with your baby?
2. What do you think you gained from this program? What do you think your baby gained? Did you notice any changes in your baby's behavior after starting the program?
3. How did you feel about the guidance provided by your nurse during the visits? How would you describe your relationship with the nurse?
4. How did you feel about the feedback you received regarding your interactions with your baby?
5. To what extent have you been able to apply what you learned in the program, or the behaviors you became more aware of, in your daily life?
6. How do you think the program affected your awareness about parenting and child development? How did it affect your confidence in your parenting?
7. Did you share what you learned in the program with your husband? If yes, what impact did you observe?
8. Were there any aspects of the program that you found difficult?
9. Were there any parts of the program that you felt didn't quite fit into your daily routine? If so, what were they?
10. Do you think it would be beneficial to implement this program with all mothers during routine check-ups?
11. Do you think the number of module themes is sufficient?

12. Was it comfortable for you to participate in the program at the family health center? Was the time allocated to the program sufficient?
13. Do you have any suggestions for making the program more effective? In what areas do you think improvements could be made?
14. Would you recommend this program to others? If yes, why? If not, why not?

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