

Alma Mater Studiorum – Università di Bologna

DOTTORATO DI RICERCA IN SCIENZE PSICOLOGICHE

Ciclo XXX

**Settore Concorsuale:** 11/E4

**Settore Scientifico Disciplinare:** M-PSI 07

**THE FOCAL-PLAY THERAPY WITH CHILDREN AND  
PARENTS:**

**How to promote the Parent-Therapist Alliance**

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Esame finale anno 2018

*To my Dad*

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## Abstract

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The therapeutic alliance is a crucial variable in explaining the outcome of psychotherapy across different treatments. While most of research to date is about the alliance in individual psychotherapy, more recent are studies on the alliance in family and, even more, in child-focused therapy. Nowadays parents represent essential components to youth's treatment success. Parental engagement allows the therapist to better understand child's symptoms within family dynamics and, at the same time, to build an alliance with parents based on a mutual understanding of the child's problems and on their collaboration and agreement on the main goals and tasks of the intervention.

The "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016) is actually used for several problems in preschool children connected to parent-child relationships. Goals of the first six sessions are: the assessment of child's symptoms within family relationships and the promotion of the alliance with parents.

The present study explored the quality of the parent-therapist relationship at two time points that coincide with the FPT-CP first and sixth sessions. A multi-method approach was used to collect data from 17 parental couples and their children (age range=2-5). Differences in alliance scores among parents and among each parent and therapist were investigated. Parental personality, levels of parenting stress and the quality of parent-child interactions were assessed. Further, relationships among multiple parental variables were investigated followed by an exemplification with two contrasting clinical cases.

Findings of the present research advise that special attention should be paid to the building of alliance with parents early in treatment. Empirical evidence has shown that the FPT-CP is a specific model of clinical intervention that is effective in promoting and maintaining a positive therapeutic relationship with parents seen as a precondition for a successful child-focused intervention.

## Overview of the present dissertation

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Nowadays most clinical interventions for children include parents from the early stage of treatment (Neri & Latmiral, 2004; Vallino, 2002, 2009). Specifically, the parental participation in the child assessment and, subsequently, in his/her treatment allows for a better understanding of the child symptoms within the family relationships. At the same time, therapists would find the opportunity to build a therapeutic relationship with parents based on a mutual understanding of the child's problems and, furthermore, on their collaboration and agreement on the main goals and tasks of intervention. These aspects refer to the therapeutic alliance (TA) with parents seen as a necessary component of a successful child assessment and intervention.

Although it is widely recognized that the alliance with parents is a necessary component of a successful child therapy, literature still lacks of studies on this topic. Specifically, to our knowledge, no studies have been conducted on the alliance in treatment for preschool children where parents play a significant role since they are responsible for many aspects of the intervention (taking the child to therapy sessions, paying for them etc.).

Efforts to conduct research in this field would be important to better inform practice and to improve quality of care for both children and their families. This work therefore aimed to expand on the literature and explore the quality of the parent-therapist alliance – from both parents' and therapist's points of view- in a specific modality of child-focused treatment.

It is named the "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016). The FPT-CP is actually being used for a large range of problems in preschool children usually connected to parent-child relationship problems. This psychodynamic model of clinical intervention is based on the use of play as a narrative dimension of family problems.

It consists of an initial phase (six sessions) where parents are actively involved along with their children. Main goals are: the assessment of the child's symptoms within the family dynamics, and the promotion of a positive and productive therapeutic relationship with parents along with its maintenance over time.

At this purpose, the present study was undertaken to explore the quality of the therapeutic relationship with parents at two time points that correspond to the beginning and to the end of the first phase of the FPT-CP (Time 1: end of the 1<sup>st</sup> session; Time 2: end of the 6<sup>th</sup> session). The assessment of parental personality took place at the end of the first session, while parents' levels of

stress and the quality of the parent-child relationship were evaluated at both time points. Furthermore, the relationships among multiple variables (parental personality, alliance, stress, adult-child emotional availability) were investigated as well.

The first part of the dissertation presents a review of the literature about the therapeutic alliance, the specific model of clinical intervention on which study focused, and the state of research on child and family interventions.

Chapter 1 presents an historical excursus of the concept of therapeutic alliance. Following, the chapter presents results of the studies that investigated the alliance in several therapeutic settings, such as individual, youth – child/adolescent, and family therapy..

Chapter 2 illustrates research studies on the effects of parental involvement in child treatment. In particular, a specific model of clinical intervention, the “Focal Play Therapy with children and parents” was thoroughly described.

Chapter 3 summarizes literature contributions on child and family interventions with a special attention on the study of two specific outcome measures, i. e. parenting stress, and parent-child emotional availability as a key indicator of the quality of the adult-child relationship.

The second part of the dissertation presents the research. First, a general introduction summarizes the main contributions of the literature and presents the research question that triggered the present study. Following, aims, methodology and results are presented. Both quantitative and qualitative data are reported through an exemplification with two contrasting clinical cases (good/poor outcome cases).

Last, results of the current research are discussed and general conclusions are drawn suggesting directions for future research and clinical interventions.

## CHAPTER 1

# **The Therapeutic Alliance: the “quintessential integrative variable” of psychotherapy**

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### **1.1 Conceptualization of the Therapeutic Alliance**

The concept of therapeutic alliance (TA) has received a considerable amount of attention from clinicians and researchers for decades. It has been named in many different ways: alliance, therapeutic alliance, working alliance, helping alliance (Hougaard, 1994). The recognition of the fact that different types of psychotherapy often reveal similar results lead to the study of those variables common to all forms of therapy, such as the alliance (Ardito & Rabellino, 2011).

TA has been studied extensively in adult process and outcome psychotherapy research as well (Castonguay, Constantino, & Holtforth, 2006). It is now considered as an essential element of the therapeutic process which is significantly associated with the outcomes across a wide range of psychotherapeutic orientations, such as cognitive, behavioral, gestalt, and psychodynamic ones (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991).

The alliance construct has evolved over time, and it has been characterized by the conceptualization about: the relation between a positive alliance and success in therapy; the path of the alliance over time; the variables that predispose individuals to develop a strong alliance; and the in-therapy factors that influence the development of a positive alliance (Lingiardi, 2002; Lingiardi & Colli, 2015; Migone, 1996).

As Safran and Muran (1995) stated, the quality of the alliance as a process variable is even more important than the type of treatment in predicting positive outcomes. Therefore, because of its role, it is now considered the “quintessential integrative variable” of therapy (Martin, Garske, & Davis, 2000).

Historically, the concept of TA originated in early psychoanalytic theories (Freud, 1912; Greenson, 1965; Zetzel, 1956) and it has evolved over time. Although it is often considered as a single construct (Sterba, 1934), the alliance consists of several independent dimensions (Bordin, 1979; Luborsky, 1976).

Luborsky (1976) distinguished two types of the alliance: the first one, established in the early stages of a treatment, was based on the patient’s perception of the therapist as a supportive, empathetic and trustworthy person. The second type of TA was more typical of the later phases of a therapy and it was characterized by the collaborative and active relationship between the client and the therapist to overcome his/her problems.



Although different definitions of the TA concept exist, Bordin (1979) proposed a theory which can be applied to all types of psychotherapy. Basically, it consists of three essential elements: the agreement on the goals of treatment; the agreement on the tasks, methods and activities used to achieve the goals; and the development of a personal bond between the patient and the therapist. The first two dimensions of the alliance (agreement on goals and an assignment of task or a series of tasks) can develop only if the patient believes in the clinician's ability to help him/her and the therapist, in turn, is confident about the patient's resources. In other words, without a strong client-therapist bond little collaborative work can be sustained, and probably therapeutic progress will be prevented (Obegi, 2008).

Nowadays, Bordin's "pan-theoretical" definition of TA is widely accepted. The basic idea behind this construct is that TA is not healing in its own right, but it is the essential element that allows the client to believe and follow treatment.

## **1.2 The Therapeutic Alliance in adult psychotherapy**

Multiple meta-analyses of studies in adult mental health research (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000) have shown a moderate (the effect size ranges from .22 to .26) but consistent alliance-outcome associations. These relationships remain stable across different types of treatment (e.g. psychodynamic, cognitive-behavioral), length of treatment, problem type (substance use, depression, anxiety), raters of alliance and outcome measures (client, therapist, observer versions). As a consequence, since the first session of a therapy, clinicians should establish, monitor and maintain a positive bond and a strong collaborative relationship with their clients.

A rupture in therapy is usually defined as a decline in the therapeutic relationship (Safran & Muran, 1996). Other definitions concern a breakdown in the collaborative process, periods of poor quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset (Safran & Muran, 2006).

Empirical evidence suggests that positive treatment outcomes are more associated with the successful resolution of ruptures in the alliance than with a linear growth pattern as the therapy evolves (Safran, Crocker, McMMain, & Murray, 1990).

Several studies have focused on the process of repairing ruptures in the therapeutic relationship (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder & Strupp, 1997; Muran et al., 1995; Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2002).

In the chapter entitled "A Strong Therapeutic Alliance", Sprenkle and colleagues (2009) assert that if the alliance ruptures are appropriately discussed, they can lead to positive outcomes;

otherwise, they will probably be linked with preventive drop-outs or other negative therapeutic outcomes.

For what concerns the development of the alliance, it is important to remember that it depends also on the type of psychotherapy, its characteristics and proceedings. A general rule is that, starting from the first minute of a therapy session, clinicians should foster the development of a positive relationship with their clients. Subsequently, once the therapy will proceed and the client will be engaged in the therapeutic process, therapists will find the opportunity to address the ruptures in the alliance (Marziali, Marmar, & Krupnick, 1981).

Certainly, in the first phase of a therapy, it is important to avoid ruptures in the alliance that can compromise the building of a positive therapeutic relationship and, therefore, which can prevent the client's commitment in the treatment. In such cases, what will probably occur is that the patient will prematurely interrupt the therapeutic contract (Ardito & Rabellino, 2011).

Since research shows that the alliance is more strongly associated with client outcomes than specific treatment techniques, there is a general consensus that the development and maintenance of the alliance is a primary curative component of therapy that allows for the implementation of specific therapeutic techniques (Wampold, 2001). Consequently, in order to reduce rates of dropout, therapists need enhanced skills in building and repairing the therapeutic relationship (Gaston, 1990; Lambert & Barley, 2001).

From a methodological perspective, several instruments have been designed to measure TA. They were developed according to the specific conceptual framework of the alliance. This fact, along with the lack of a single model of alliance, has led to a proliferation of measures (Elvins & Green, 2008).

To date the TA construct has been clearly operationalized and it has been measured, in a reliable way, more frequently than many other process variables. While most of measures have been anchored into the psychodynamic tradition, at least one of them, widely used and validated abroad, is the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). As mentioned above, it has been introduced from a trans-theoretical perspective, that one of Bordin's (1979).

Although the alliance is built interactively, it seems that client and therapist views of alliance diverge, especially during the early stages of a therapy (Safran et al., 2002). Patients tend to rate the alliance more consistently than do therapists or observers (Frank & Gunderson, 1990; Hartley & Strupp, 1983; Horvath, 2001; Klee, Abeles, & Muller, 1990; O'Malley Suh, & Strupp, 1983; Tunis, Delucchi, Schwartz, Banys, & Sees, 1995). Moreover, similarities between client and clinician ratings of TA at the middle and late stages of a treatment have been found to be associated with positive outcomes (Lingiardi, 2002). It seems that, the more the patient and the therapist will agree

on the quality of their relationship at the end of therapy, the better will be the outcome (Kivlighan & Shaughnessy, 2000).

In general terms, although clients and clinicians tend to have positive ratings of TA, those of patients are usually higher and more stable than the therapist's (Fitzpatrick, Iwakabe, & Stalikas, 2005; Hatcher, Barends, Handell, & Gutfreund, 1995; Kivlighan & Shaughnessy, 1995; Mallinckrodt & Nelson, 1991; Tichenor & Hill, 1989). As clients tend to perceive the alliance more consistently throughout the sessions, therapists must put a great effort in establishing positive alliances with their clients since the early stages of therapy.

Currently, few studies have used both patient and therapist data together when considering divergence/convergence at a particular point of a treatment and over time (Laws et al., 2017). Despite the paucity of this empirical evidence, it seems that the divergence between client and therapist views of alliance tends to decrease but it still remains (Atzil-Slonim et al., 2015; Fitzpatrick et al., 2005).

Differences between patient and therapist ratings of the alliance may be explained by several factors. First of all, clients' assessment seems to be more subjective, a-theoretical and linked with their own past experiences in relationships, while clinicians' ratings tend to rely more on the theoretical knowledge of the concept of TA (Hentschel, 2005). In this context, most probably, patients will find familiar concepts as liking, trust and empathy than the concepts of goals and tasks treatment (Horvath, 2000).

Several studies have been conducted to identify which factors may influence the alliance. Findings have shown that some client variables may impact the development and maintenance of TA (Dazzi, Lingardi, & Colli, 2006; Lingardi, 2002). Among them are clients' interpersonal factors, the attachment style and the quality of social and family relationships (Eames & Roth, 2000; Goldman & Anderson, 2007; Kokotovic & Tracey, 1990; Mallinckrodt, 2000); on the other hand clients' intrapersonal factors, level of personal motivation, quality of object relations and attitudes (Horvath & Luborsky, 1993; Marmar, Weiss, & Gaston, 1989; Piper et al., 1991; Ryan & Cicchetti, 1985).

It is true that patients enter the therapeutic process with their personal ways of thinking, feeling, and behaving (Taber, Leibert, & Agaskar, 2011). In this respect, Bachelor and colleagues (2010) assert that a comprehensive portrait of the client's personality helps the clinician to better understand and appear more empathic to the client, thus facilitating the development of the alliance. This idea is supported by the evidence that there are significant moderate correlations between the characteristics of the Five-Factor model of personality and client alliance scores (Goldberg, 1993; Smits, Luyckx, Smits, Stinckens, & Claes, 2015). Higher scores on the personality dimensions of

Agreeableness, Extraversion, Conscientiousness, and Openness were associated with better alliances (Coleman, 2006; Hirsh, Quilty, Bagby, & McFain, 2012). Gurtman (1996) found that since the beginning of a therapy disagreeable patients tended to show low ratings of TA, and negative outcomes. For this reason, clinicians should pay attention to the process of building the therapeutic relationship in order to increase client's cooperation and motivation to work (Costa & McCrae, 1992; Miller, 1991; Zinbarg, Uliaszek, & Adler, 2008).

For what concerns the patient's characteristics, the more adequate his/her general personality and intellectual functioning, the better therapeutic outcomes. Patients highly motivated and needed for help, are most likely to succeed in therapy (Lingiardi, 2002).

Clients' personality dysfunctions (e.g., interpersonal problems, personality disorders) may have a greater impact on the alliance than normal personality. In this sense, serious diagnoses (involving schizophrenia or psychosis) are associated with severe difficulties to achieve positive outcomes in psychotherapy (Bachelor et al., 2010).

As for the therapist factors, are the amount of experience, attitude, interest, and empathy patterns that play a crucial role in the context of successful psychotherapies (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985); Nissen-Lie, Havick, Hoglend, Ronnestad, & Monsen, 2015). In particular, Ackerman and Hilsenroth (2001, 2003) found that clinicians, who were perceived by their clients as empathic, warm, trustworthy and interested towards them, achieved higher client-rated alliance scores than therapists perceived as rigid, critical, tense and distracted.

Studies have found that the "match" between the patient and the therapist is linked with positive outcomes (Landfield & Nawas, 1964; Lesser, 1961; Sapolsky, 1965; Schonfield, Stone, Hoehn-Saric, Imber, & Pande, 1969). The "match" refers to those similarities between clients and clinicians in values, attitudes, interests, social class, and gender.

For example, it has been found that female patients tend to prefer female therapists and, in addition, compared to male therapists, female therapists tend to form stronger perceived therapeutic alliances with their clients (Wintersteen, Mensinger, & Diamond, 2005).

Despite the general preferences described above, results are inconsistent and more research is needed to better understand this issue. A possible explanation may come from the social psychology studies, which indicate that people tend to identify with and prefer people similar to themselves (Festinger, 1954). Moreover, Bem's (1981) gender schema theory suggests that clients and clinicians of the same sex would tend to view the world through the same gender lens, which in turn leads to similar perspectives on several life issues.

### 1.3 The Therapeutic Alliance in youth psychotherapy

Research on TA in child and adolescent therapy has also received empirical attention, particularly in the past decade, though it still lags behind that of adult alliance (Abrishami & Warren, 2013; Accurso, Hawley, & Garland, 2013; Elvins & Green, 2008; Green, 2006).

Reasons are both theoretical and methodological ones (Chu et al., 2004; Creed & Kendall, 2005). First of all, most referrals for treatment are made by parents, teachers, or other adults. In most cases they commission the therapy, pay for it, and take the child/adolescent to sessions. Moreover, parents's role in youth psychotherapy consists of identifying the child/adolescent difficulties in order to help the therapist and negotiate with him the main goals of treatment.

On the contrary, children and adolescents may feel that problems do not exist, or require treatment (Kabuth, Tychev, & Vidailhet, 2005). Often, adolescents' resistance to therapy is explained by their need of autonomy associated with the specific stage of life span. Furthermore, if children are very young, parents' role in psychotherapy is even more important.

Stallard (2002) identified three main roles that parents play in youth treatment. a) They can act as facilitators supporting the transmission of the therapy contents at home. b) They can be seen as co-therapists who actively work with the therapist to identify and deal with child problems. c) Parents can attend separate sessions to learn new skills or to address some own personal issues. In all cases, they play a central role in the process of child treatment.

As opposed to over 2000 adult studies as of 2000, there have only been 23 studies examining the therapeutic alliance in child therapy (Abrishami & Warren, 2013). Most research is about the alliance with children aged 7-8 years old and highest who are able to complete self-report measures of TA. At the same time the alliance with parents receiving different types of interventions (e.g. family education, family therapy, engagement, empowerment) has been assessed through self-reports used in adult literature on TA. As a result, to date, measures specifically designed for parents involved in child treatment are scarce (Hoagwood, 2005).

Research findings have shown correlations of .24 between the quality of the child-therapist alliance and treatment outcomes (Kazdin, Whitley, & Marciano, 2006; Shirk & Karver, 2003). Similar results to that found in the adult literature (.22 alliance–outcome associations) were observed in a more recent meta-analysis (Horvath & Symonds, 1991; Martin et al., 2000; Shirk, Karver, & Brown, 2011).

For what concerns the child diagnosis, TA was more strongly associated with therapy outcomes in children with externalizing disorders compared to those with internalizing problems (Shirk & Karver, 2003). Kaufman and colleagues (2005) found that higher alliance ratings of

depressed adolescents were not linked with better outcomes, while the level of severity of interpersonal problems was the best predictor of poorer outcomes.

Since research in this area is still scarce and results are quite inconsistent, more empirical data are needed. Nevertheless, there is a strong support for the notion that the child alliance remains stable throughout the treatment (Bickman et al. , 2004; Green, 2006).

From a methodological perspective, in the majority of studies on the youth psychotherapy, the construct of TA has been directly imported or mildly revised from the adult scales. Because of the characteristics of the patient life span, more scientific work should be done in order to implement specific and reliable measures of TA in youth samples (Elvins & Green, 2008; Faw, Hogue, Johnson, Diamond, & Liddle, 2005).

To date, very few studies have examined both the child and caregiver alliance with the therapist. As described previously, the alliance in youth therapy involves both child/adolescent and parent relationships with the therapist (Weisz, Huey, & Weersing, 1998). Most often, the child alliance has been assessed, whereas the caregiver alliance has been examined in few studies although it appears to account for significant variance in outcomes (Karver, Handelsman, Fields, & Bickman, 2006).

For what concerns the parent-therapist alliance, it has been found to be strictly related to the youth and family retention in therapy. Indeed, estimates of treatment attrition are from 28% to 85% of youths terminating prematurely (Armbruster & Kazdin, 1994; Hawley & Weisz, 2005; Kazdin, 1996). Garcia and Weisz (2002) found that the lack of TA with caregivers is significantly related to a premature termination, with parents reporting that they did not like the therapist, they did not perceive support from him, the therapist did not understand, or he focused on the wrong problems. Similarly, Kazdin and collaborators (1997) found that drop-out in child therapy was predicted by parents' perceptions of a poor alliance.

Furthermore, empirical evidence has shown a link between high levels of TA with parents and better outcomes, such as the parental use of skills learned in therapy at home, improved parenting practices and family functioning (Kazdin & Whitley, 2006; Kazdin, Whitley, & Marciano, 2006; Tolan, Hanish, McKay, & Dickey, 2002). Other studies have found that high levels of the parent-therapist alliance are also associated with decreased youth symptomatology, greater perceived social support and greater satisfaction with therapy (Hawley & Garland, 2008; McLeod & Weisz, 2005).

Another important aspect to consider is that child-therapist and caregiver-therapist alliances may be associated with different aspects of treatment.

As discussed previously, caregiver ratings of alliance are associated with fewer cancellations, less dropouts, more sessions attended and a greater satisfaction with care provided, whereas child alliance is linked with clinically significant symptoms reduction (Accurso et al., 2013). In addition, caregiver alliance seems to be more strongly associated with reductions in the child's general internalizing symptomatology (McLeod & Weisz, 2005), while child alliance appears to play a greater role in externalizing symptomatology (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Shirk & Karver, 2003) and improved family functioning (Hawley & Garland, 2008).

It is still unclear whether child or caregiver alliance is more strongly associated with therapy outcomes. Although child alliance accounted for more variance in child outcomes than caregiver alliance in one meta-analysis (Karver et al., 2006), a more recent meta-analysis found that caregiver-reported alliance was more strongly linked to treatment outcomes than youth and observer reports (McLeod, 2011).

To conclude, researchers agree that, although the caregiver alliance has clinically important correlates in youth psychotherapy, there are still few studies on this topic. Indeed, one question still open regards how to assess TA in therapy with very young children.

In child-focused treatments, since the first minutes, the therapist has to build a positive therapeutic relationship with parents who are responsible for many aspects of the therapy and who represent key agents in the delivery and reinforcement of the therapeutic contents at home.

Furthermore, since each parent has a personal idea about child treatment (duration, goals etc.), at early stages of the therapy, the clinician needs to come to an agreement with both parents over child treatment plan.

#### **1.4 The Therapeutic Alliance in family psychotherapy**

Compared with research on individual psychotherapy, research on conjoint family therapy is sparse, despite its importance as a common factor associated with the success of family treatment (Diamond, Liddle, Hogue, & Dakof, 1999; Johnson, Wright, & Ketring, 2002; Robbins, Turner, Alexander, & Perez, 2003; Sprenkle & Bow, 2004).

The lack of knowledge about the alliance in family therapy is not by chance and it can be explained by peculiarities of this kind of psychotherapy. Escudero and colleagues (2008) discussed about the fact that the alliance in family treatment is complicated, mainly because each client has the opportunity to observe each other client's relationship with the therapist.

While in individual treatment the relationship between the client and the therapist has a bidirectional nature, in couple and family therapy (CFT) each single alliance gives rise, at the same time, to multidirectional relationships in the therapeutic setting.

As a result, the therapist's alliance with each family member affects and it is affected by the alliance with the all other family members (Beck, Friedlander & Escudero, 2006).

In couple and family therapy, clinicians have to establish and maintain a therapeutic relationship with the different family members at the same time.

It may be difficult for different reasons: family conflicts are intense, each person has a personal idea about family problems, people fear to reveal family secrets, and real-life consequences can derive from therapy (Friedlander & Tuason, 2000). Last, but by no means least, each family member can be motivated by different reasons for therapy.

Pinsolf and Catherall (1986), starting from the Bordin's (1979) conceptualization of alliance (agreement on therapy goals and tasks, patient-therapist emotional bond), described the couple and family therapy as a unique, complex and multifaceted model of treatment. In this context, family members can vary in the nature and quality of the relationship they develop with the therapist. In addition, each family component can observe and be influenced by how the other members feel about the therapy and by how the couple or family unit as a whole is responding to what is happening in treatment (Friedlander, Lambert, Escudero, & Cragun, 2008).

It derives that clinicians must pay attention to potential disagreements and difficulties between family members that make it necessary to adapt the intervention during the process in order to improve a sense of common family purpose in therapy (Friedlander, Escudero, Heatherington, & Diamond, 2011).

In the couple and family therapy, the "safety" in the therapeutic system represents an important dimension of the alliance. What does it mean? In other words, therapy can only progress if family members feel safe and comfortable with each other and, most importantly, if they feel that the material discussed in-session will not used against them at home. For example, what feels safe to the children when only their father is there, for example, might feel quite unsafe when their stepmother is present (Beck et al., 2006).

Another essential aspect of the alliance in CFT is represented by the "within-family alliance" (Pinsolf, 1994) or "shared sense of purpose" (Friedlander, Escudero, & Heatherington, 2006). As the authors state, this construct refers to the level of productive, within-family collaboration in treatment and, furthermore, to the emotional bond among family members. In this respect, it is necessary to take into consideration at the same time how well family works in therapy as a unit, as well as how similarly family members feel about the therapist (Beck et al., 2006).



In CFT research it is referred to “split alliances” when individual alliances are weaker than those of other family members (Heatherington & Friedlander, 1990; Mamodhousen, Wright, Tremblay, & Poitras-Wright, 2005).

Robbins and collaborators (2003) found that “unbalanced” alliances were more predictive of family dropout after Session one than either the parent’s or the adolescent’s alliance alone.

In couple therapies, the degree to which partners show similar ratings of the alliance and, consequently, they are both equally involved in therapy, appears to be the best predictor of the treatment success (Knobloch-Fedders, Pinsof, & Mann, 2007; Symonds & Horvath, 2004).

In this field the majority of studies have found that low ratings on the dimensions of TA strictly related to the family systems, that are “safety” in the therapeutic system and “within-family collaboration”, are strongly associated with negative outcomes (Beck et al., 2006). Another research has found that an initial strong “intra-family collaboration” significantly predicted better outcomes at the end of therapy (Friedlander, Lambert, & Muniz de la Pena, 2008).

For what concerns research on the alliance in couple therapy, findings indicate that the early TA accounted for as much as 22% of the variance in outcomes (Knobloch-Fedders et al., 2007).

From a methodological point of view, only one measure of TA includes all the dimensions peculiar to the CFT settings. It is the System for Observing Family Therapy Alliances (SOFTA; Friedlander et al., 2006) that includes two dimensions (Engagement in the Therapeutic Process and Emotional Connection to the Therapist) which reflect Bordin’s (1979) pan-theoretical conceptualization of the alliance in terms of therapy goals, tasks, and patient-therapist emotional bonds.

The other two SOFTA dimensions reflect the unique systemic aspects of conjoint family therapy: Safety within the Therapeutic System and Shared Sense of Purpose within the Family (please, see above for details). This instrument has been designed in both observational and self-report versions and it takes into account both client and therapist views about the alliance.

To conclude, it is important to remember that if the alliance in individual psychotherapy only depends on the reciprocal contributions between the client and the therapist, in family treatment members’ alliances with each other are extremely important, since the collaboration among family members represents an essential element for the success of family treatment (Escudero et al., 2008).

It derives that risks are much more in family than in individual therapy, where information revealed by each member can bring direct consequences to the family life at home. For example, sharing a family secret in the therapeutic setting can lead to severe discussions, punishments, and/or

significant relationships along with other undesirable effects (Friedlander, Heatherington, Johnson, & Skowron, 1994).

## CHAPTER 2

### **The Focal Play-Therapy:**

#### **a clinical model of intervention with children and parents**

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##### **2.1 Parental involvement in youth psychotherapy**

For a long time, therapists preferred to work with children without involving their parents who, instead, were informed periodically about child's therapy.

Working with parents was seen by clinicians as difficult to manage and, for sure, less pleasant than working with children (Mastella & Ruggiero, 2004). This may be a paradox, with respect to the importance of planning child-focused preventive interventions that necessarily have to involve children's families.

To understand child's problems, clinicians need to consider the cultural and family context where the child lives and develops. It is well known that child development relies on parents' physical and emotional availability (Freud, 1979; Winnicott, 1968). Indeed, it is most likely to happen when children are very young.

Most often, child's symptoms are the result of dysfunctional parent-child relationships. In the context of psychotherapy, parents seem to represent a unique source of information useful to understand and, consequently, to plan the most appropriate child and/or family intervention.

Due to child's age, parents are responsible for taking the child to therapy, paying for it and so on (please, see the Paragraph 1.3). Indeed, the child cannot still get the reasons and need for therapy. As a consequence, parents need to understand and share with the therapist which are the main goals and tasks of therapy. As a child depends on his/her parents, the therapeutic work is a result of the family availability to begin and complete the treatment.

A variety of drop-outs or early terminations in child treatment relate with different collusions between parents' "misunderstandings", child's difficulties and the therapist's resistance to appreciate and motivate parents' involvement in child-focused therapy (Mastella & Ruggiero, 1992). Moreover, since a child belongs to his/her parents with whom he/she spends most of the time, clinicians need to intervene on real/at home child-parent relationships in order to integrate what has been done in therapy.

Many evidence-based treatments for children are parent-mediated. In this sense, parents would learn how to change their behavior that, in turn, would improve their child's behavior (Bagner & Eyberg, 2007; Brestan, Eyberg, Boggs, & Algina, 1997; Nixon, Sweeney, Erickson, & Touyz, 2003).

Nowadays, parental involvement is considered a crucial element in the planning and delivery of youth mental health treatment. Indeed, the majority of child interventions tend to involve parents from diagnosis to the stages of treatment (Sameroff, Donough, & Rosenblum, 2006).

Research has shown that engaging parents in child treatment can lead to better positive outcomes, such as a greater session-attendance and treatment effectiveness over time. However, conclusions should be interpreted with caution, because findings from clinical trials may not be applicable to community-based studies where research is still scarce and there is more variability in whether or how parents are involved in child treatment (Barmish & Kendall, 2005).

Recently, there has been a growing interest among researchers and clinicians in empirical analysis of parents' response to child-focused interventions in order to improve their satisfaction with care. Results of these studies indicate that parental involvement in child treatment has several benefits, in terms of decreased parenting stress and increased parenting self-efficacy (Broadhead, Chilton, & Stephens, 2011; Davis & Carter, 2008; Dykens, Fisher, Taylor, Lambert, & Miodrag, 2015; Heath, Curtis, Fan, & McPherson, 2015; Kazdin & Whitley, 2003; Ma, Lai, & Pun, 2002). Furthermore, Karver and colleagues (2006) found that, without parental involvement in child treatment, it is less likely that the therapeutic changes achieved in sessions will be generalized and used at home.

Parents seem to learn new strategies and skills to cope with their child problems, that results in lower levels of parenting stress and parent-child relationship problems, across different types of child disorders (Dowell & Ogles 2010; Hoagwood, 2005; Haine-Schlagel & Walsh, 2015; Tolan & Dodge 2005). Most importantly, the presence of parents makes it necessary for therapists to build a therapeutic relationship with them based on the agreement on child treatment goals and tasks (Algini, 2003; Barmish & Kendall, 2005; Neri & Latmiral, 2004; Trombini, 2004; Tsiantis, Boethious, Hallerfors, Horne, & Tischler, 2002; Vallino, 2002a, 2002b, 2009).

## **2.2 The Focal-Play Therapy with children and parents**

The "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016) is a psychodynamic intervention that involves parents in the treatment of their preschool children. It is a therapeutic method that was conceived for the child psychosomatic protest behaviors of both an eating and evacuation nature (Trombini G., 1969, 1970). Subsequently, on the basis of the "Participated Consultation" model (Vallino, 2002a, 2002b, 2007, 2009), the FPT was adapted to be applied to an extended context that also includes parents (Trombini & Trombini, 2006, 2007; Trombini E., 2008, 2010, 2011, 2016; Trombini, De Pascalis, & Neri, 2015).

Nowadays, this therapeutic technique is used for a large range of problems in preschool children usually connected to parent-child relationship problems. It is based on the play seen as a narrative dimension of family problems (Klein, 1929; Vallino, 2004, 2009).

As discussed above, in the history of child psychotherapy parents have been left outside the therapeutic settings for a long time (Algini, 2007). It has been a defensive strategy directed to allow the development of a close relationship with the child as soon as possible, and to avoid the therapist's emotional involvement with the family. Sometimes, during the first sessions, the adult (usually the mother) was used to be received along with the child.

Currently, the view on psychotherapy has changed and the child enters to the therapeutic process with his/her parents, even though with different modalities (Busato Barbaglio & Mondello, 2011; Lanyado & Horne, 2003; Neri & Latmiral, 2004; Trombini et al., 2015; Tsiantis et al., 2002) .

For this reason, clinicians need to deeply understand the relational context where the child lives and develops. Planning a clinical intervention on the family context, rather than on the child alone, represents the most effective therapeutic strategy in the preschool age (Sameroff, 2004; Sameroff et al., 2006; Vallino, 2007, 2009). To date, from a methodological and clinical perspectives, different models of intervention with the children their and families exist.

As expected, the pre-school period is characterized by the passage from the dyadic regulation of the first period of childhood to the child self-regulation (Sroufe, 1995). At this stage, parents are called to help the child to self-regulate its own emotional states because of child immature behavior (Trombini & Trombini, 2007).

Indeed, for a healthy child development, parents must support the child's desire to "do by oneself" (Lichtenberg, 1989; Trombini, G., 1969, 1994). It derives that the child will be able, over time, to manage and be responsible for him/herself, which will increase its own well-being and the family harmony.

However, as the child gets older, parents may find it difficult to do what is necessary to satisfy the child's needs and to sustain a sense of Self as agent (Arfelli Galli, 1995; Lang & Rivolta, 2015; Molinari & Lappi, 1994; Riva Crugnola, 2007; Stern, 2005). If parents do not facilitate the child's acquisition of autonomy, it is possible to find clinical populations consisting of child-parent relational problems expressed through several behavioral modalities such as difficulties concerning oppositional, eating, evacuation behaviors and so on (Baldaro, 2002; Benoit, 1996; Chatoor, 1996; Lucarelli, 2001).

According to the Lichtenberg's (1989) motivational theory, the human need to act autonomously derives from the exploratory-assertive motivational system. When the child's motivation to "do by oneself" is coherent with the feeling of being "I" but also part of the

family/"We", the child will feel that his/her needs are congruent with the caregivers' behaviors and expectations. If so, the child will feel and be regarded as a family member with the same consideration as the other family members. As a result, an harmonious family life will be possible (Stern, 1987, 2005; Trevarthen, 1992, 1998).

For what concerns child eating and evacuation behaviors, in the preschool period, the child's desire to establish a direct and autonomous relationship with the food and corporal contents are prominent (Baldaro, 2002; Baldaro & Trombini, 1989; Baldaro, Trombini & Trombini, 1994; Candelori, & Trumello, 2015; Trombini, E., 2002a, 2008, 2010; Trombini G., 1969, 1970). The child demand "I'll do it" can be received in different ways by family. In some cases, parents provide an emotional support to the child's growth, in others they may find it difficult to adapt the family life to the new scenario. It derives that conflicting dynamics and parent-child relationship problems may occur (Benoit, 1996; Bryant-Waugh, 2013; Bryant-Waugh, Markham, Kreipe, & Walsh, 2010; Bryant-Waugh & Piepenstock, 2008; Chatoor, 1996; Lebovici, Diatkine, & Soulé, 1990; Lucarelli, 2001; Trombini, 1994).

Certainly, a certain degree of conflict is expected as a part of the development of child autonomy and self-regulation. But, if the child does not feel integrated into an harmonious family life because of somewhat coercive adult interventions, he/she may feel dramatically isolated. As a consequence, the child may express a psychosomatic protest aimed to gain or regain lost autonomy. In all cases, preschool child oppositional conducts would signal a caregiver attitude which is perceived as inadequate (Trombini & Trombini, 2006, 2007; .Trombini E., 2010, 2011; Trombini, De Pascalis, & Neri, 2015).

The FPT-CP, on the basis of the Gestalt Theory (Wertheimer, 1912a, 1912b, 2014), takes into consideration the concepts of natural order, field, relational dynamics, focus and reference systems, in addition to those aspects associated to the frustrated child needs. Topics such as the relational approach of the field (Ferro, 1992, 2013), and the perceptive focus on the child needs (Lambruschi, 2006), are also discussed in other approaches, such as psychoanalytic and cognitive therapies.

Basically, the FPT-CP (Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016) consists of the therapist proposal to the child of a temporal sequence during which the main character is a plasticine puppet guided by the therapist. This puppet performs the human basic physiological functions (eating, evacuation, sleeping) that play a crucial role in the preschool period.

The therapist gives his/her voice to the puppet and let it talk about and ask for foods that are prepared with the same materials (plasticine). The puppet seems to appreciate food and, after eating,

it expresses the need to urinate and defecate in a potty or toilet bowl built with plasticine. Usually, this sequence is followed by exclamations of relief and comfort.

After this preparatory phase, the therapist allows the child to express through play its own psychological contents, desires, fears and internal conflicts. When appropriate, the clinician intervenes with simple interpretations that refer only to what is taking place in play or with suggestions on possible and alternative solutions to the play events (Trombini & Trombini, 2006, 2007).

The FPT-CP gives the child the opportunity to express his/her feelings, even hostile-aggressive ones and to start managing autonomously the relationship with both food and corporal contents. The focus is on the phenomenal qualities of these stimuli which clearly appear in their natural aspects in the therapeutic setting.

The therapist objectives are: re-establishing the natural valence of food and corporal contents, and allowing the child's direct contact with them through the food selection and preparation, the decision of eating, followed by the need to evacuate and the desire to do it in an appropriate place for the family (Trombini & Trombini, 2006, 2007; Trombini E., 2008, 2010, 2011, 2016).

Throughout the FPT-CP sessions, the child finds out a reference system which is very different from that proposed by the family where the adults may interfere with the process of child self-regulation (Metzger, 1976, 2000).

It is important to remember that the FPT-CP is now used for a wide range of problems in preschool children besides eating and evacuation disorders. In the majority of clinical cases, child problems have a relational nature and, therefore, the aims and modalities of this psychotherapeutic technique are the same.

In all cases, the therapist must develop and maintain a relationship with both parents based on the agreement on which are the main goals and methods used in therapy. An emotional bond with the child and, at the same time, with his/her parents are promoted, along with the integration of family as a unit as well.

Starting from the first sessions, the therapist creates a nice and comfortable family emotional background, as the classic insight cannot be used with preschool children who have not yet developed this capacity. When the child feels that the clinician is interested towards him/herself, he/she starts being interested in the adult's mind and in the relational dynamics among the adults.

The FPT-CP in an extended context is an opportunity for the child to talk about itself in the presence of its parents and for parents to talk with him/her, according to the model of "Participating Consultation" proposed by Vallino (2002a, 2002b).

The therapeutic setting is organized into weekly alternate play sessions with the parents and child together, and sessions with parents only. Although it is an extended context, the FPT-CP is a psychotherapy for the child only and it does not represent a family therapy or a therapy for parents. Parents represent the best “co-therapists” and, indeed, they are asked to exclusively concentrate themselves on observing their child’s behavior during the play.

Parental involvement in play sessions gives the child the opportunity to face problems with his/her family that is the primary source of both well-being and pain. In this way the child can experience his/her competence as an independent person and, at the same time, he/she can find a way to let his problems be understood by the others. Parents find the opportunity to understand the child’s interests expressed through play and, also, its way to non-verbally express desires, fears and angers.

Clinical evidence shows that the FPT-CP allows to re-evaluate parental abilities, reduce parenting stress and restore family harmony and well-being (Trombini & Trombini, 2006, 2007; Trombini E., 2008, 2010, 2011, 2016).

As discussed above, the theoretical assumption of this psychotherapeutic technique is that the child problems do not concern the individual alone, but they would rather originate from the relational dynamics inside the family system (Trombini & Baldoni, 1998).

For this reason, during the FPT-CP sessions the therapist pays great attention to both parents’ behavior that can encourage or impede the therapeutic process. It is expected that parents will show tolerance, patience, collaboration, support, trust and enthusiasm in child’s productivity in play. Moreover, parents’ proposals in play should be in line with the child’s creativity; whereas parents’ impositions, irrelevant or distracting interventions, lack of interest and self-exclusion are considered behaviors which interfere negatively in the therapeutic process.

Parents’ positive behavior, that makes use of their own parental abilities and experience, can be emphasized by the therapist through an evaluation of their relational interventions. Furthermore, it can be strengthened through acquiring a greater ability to see things from the child’s point of view.

It may take place in parents-therapist meetings and, also, in play sessions where parents find the opportunity to see how the therapist relates to the child and, most importantly, parents discover with relief how they can help the child.

This method in clinical practice allows the child to feel in contact with his/her family that is the primary aim of all psychotherapeutic approaches. In this way, the child finds features already experienced in relation with the therapist within the family context. He/she feels as a family effective member with an accepted and recognized role in the family.



All these factors have been found to be associated with an harmonic family life, that represents the standard to define the concept of socialization from a psychological point of view. If the child is well integrated in the family context, he/she will spontaneously desire to be part of larger and social systems, without conflicts (Metzger, 1976, 2000).

To conclude, in a healthy child development, the acquisition of the self-regulation abilities and autonomy will occurs only if the adults will show an empathetic understanding of child needs and desires (Trombini, 2002a, 2002b).

The FPT-CP, carried out in the extended context, gives parents the possibility to resolve child symptoms whilst promoting the family well-being and harmony (Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016).

## CHAPTER 3

### **Research on child and family intervention: the role of parenting stress and parent-child relationship**

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#### **3.1 Parenting stress**

Several studies have demonstrated that children with problem behaviors in the preschool years are at higher risk for subsequent adjustment problems (Heller, Baker, Henker, & Hinshaw, 1996; Timmermans, van Lier, & Koot, 2008). In order to plan clinical preventive programs which can promote a healthy social-emotional development for children and parents, a strong effort has been put to identify factors related to child and parent difficulties (Crnic, Gaze, & Hoffman, 2005). They are numerous and may be overlapping: socioeconomic disadvantage, social isolation, single-parent family (e. g. adolescent mothers), poor living conditions, parent psychopathology, high levels of stress, interpersonal conflict and violence among family members, and lack of social support (Maughan, 2001).

It is important to remember that all factors mentioned above can heavily influence whether families remain in treatment and whether and the extent to which children and parents improve during and after treatment. As a consequence, these contextual factors need to be addressed in order to optimize the impact of treatment.

What is psychological stress? According to Miller (1989) stress is characterized by both the events and reactions to them that are disruptive, that alter biological and psychosocial functioning, and that place individuals at risk for negative mental and physical health outcomes.

Life stress, that constitutes part of human life, is “role” specific and has a specific nature depending on the domain being interested (Creasey & Reese, 1996). From childbirth onward, parenthood presents new demands that can lead to the decreasing of psychological health and well-being.

Parenting stress has been defined as a specific kind of stress associated with parents’ role and demands. This construct consists of multiple dimensions, including characteristics of the parent, child and environmental context. Basically, high levels of stress occur when there is an imbalance in perceived parenting resources and demands (Ostberg, Hagekull, & Hagelin, 2007). Furthermore, psychological distress associated to the parental role represents an important aspect of dysfunctional parent-child relationships and a risk factor for adult and child psychopathology (Abidin, 1992; Reitman, Currier, & Stickle, 2002; Webster-Stratton, 1990).

As a complex process, parenting stress is characterized by different aspects related to: the demands of parenting, the parent's psychological well-being, the quality of parent-child relationships, and the child's adjustment (Deater-Deckard, 1998). Parents who feel themselves as less competent, with less knowledge and emotional and social support and, moreover, who view their child as difficult and/or impossible to manage, are at high risk for developing high psychological distress (Adamakos et al., 1986; Goldstein, 1995; Mash & Johnston, 1990; McLoyd, 1998).

Research has demonstrated that parents often experience high levels of stress related to raising their children, especially when they are in preschool years (Anthony et al., 2005; Crnic, et al., 2005), and such parenting stress is associated with children's problem behavior (Crnic et al., 2005; Deater-Deckard & Scarr, 1996; Huth-Bocks & Hughes, 2008).

Preschool-aged children may present a wide range of problems, both emotional and behavioral, that have been found to be associated with different contextual factors, such as parenting behavior, parenting stress, parental psychological functioning, and marital quality (Anthony et al., 2005; Benzies, Harrison, & Magill-Evans, 2004). In this regard, parenting stress and parenting behavior constitute two major family factors associated with children's difficulties.

It is important to remember that parenting itself represents a generally stressful life event (Mash & Johnston, 1983) and, certainly, some parenting stress has been expected to be normal and adaptive for all parents (Deater-Deckard & Scarr, 1996). For example, Abidin (1990, 1992, 1995) supported the idea that very low ratings of parenting stress are also associated with dysfunctional parenting because of the parent disengagement and, consequently, of low vigilant parental behaviors.

The presence of major and persistent child problems may be the most significant dimension of stress across a range of unpleasant parental effects (Weinberg & Richardson, 1981). Many difficulties showed by children are perceived by parents as annoying and represent an important source of stress in daily life (Jones, Reid, & Patterson, 1975). As a result, parents can react in different ways, including overt behavior, cognitions, emotions and physiological responses (Baker & McCal, 1995).

Day-to-day parenting stress has been found to be more strongly related to individual and family functioning than parenting-related stressful events (Creasey & Reese, 1996). It is well-known that an infant totally depends on his/her caregivers and, certainly, parents are called to face with several demands never experienced before. Even when children develop over time, parents have to satisfy their needs and desires (Hughes & Huth-Bocks, 2007).

An important aspect to consider is the social role of parenthood, which has to do with the expectation that the parent will invest in the care and rearing of the child to the benefit and well-being of the entire society. For example, many family issues concern whether mothers should work, how to balance the work inside and outside home, the organization of home day-life, the role of non-parental caregivers and so on (Alexander & Higgings, 1993).

There are individual differences in the cognitive evaluation of stressors (Dix, 1993). Often mothers and fathers have a personal idea about child misbehaviors, causes and effects. Some parents manage them better than others. What has been found is that correlations between mothers' and fathers' reports of child behavior problems are sometimes only modest or moderate in magnitude and do not converge very highly with teachers' ratings (Achenbach, McConaughy, & Howell, 1987).

However, it does not mean that there are not any universally stressful aspects of child and parental role. What makes a difference is the individual coping style which represents a crucial protective factor against potential problems in parenting behavior arising from increased parenting stress. Less probably, women prepared for a pregnancy and who can rely on a social support network will develop high levels of parenting stress (Sommer et al., 1993). Instead, denial and rumination are dysfunctional coping strategies related to a greater parenting stress (Barnett, Hall, & Bramlett, 1990; Miller, Gordon, Daniele, & Diller, 1992).

Furthermore, it has been found that problem-focused coping strategies and positive beliefs about parental efficacy are linked with lower ratings of parenting stress (Frey, Greenberg, & Fewell, 1989). Adaptive coping mechanisms appear to mediate the relation between parenting stress and the quality of parent-child relationships (Jarvis & Creasey, 1991).

Most studies have dealt with the impact of stress on parenting behavior and feelings towards the child (harsh discipline, negativity, detachment/coldness). Nevertheless, it is likely that parental distress influences parents' overall psychological well-being (Xing, Wang, Zhang, He, & Zhang, 2011).

Higher ratings of parenting stress are associated with lower parenting satisfaction (Crnic & Greenberg, 1990), negative parenting attitudes and parental well-being (Crnic & Low, 2002; Roach, Orsmond, & Barratt, 1999; Smith, Oliver, & Innocenti, 2001). Other negative outcomes are: child emotional, behavioral, and adjustment problems, higher levels of dysfunctional parenting styles (e. g. authoritarian), and parent-child interactions, along with less engagement in the parent-child relationship (Huth-Bocks & Hughes, 2008).

Both Belsky's (1984) parenting-process model and Abidin's (1992) parenting stress model support the notion that parenting stress leads to increases in poor parenting behaviors. Poor

parenting, in turn, negatively impacts child's behavior (Miller-Perrin, Perrin, & Kocur, 2009; Xing & Wang, 2013).

In particular, poor parenting behaviors appear to mediate the link between parenting stress and child adjustment (Liu & Wang, 2015). High family income, education, and job satisfaction are negatively correlated with parenting stress (Baldwin, Brown, & Milan, 1995; Barnett, Marshall, & Sayer, 1992; Brooks-Gunn, & Duncan, 1997).

Parents with high levels of stress are less likely to provide adequate stimuli to their children and they are more likely to have an "insecure" attachment relationship with them (Jarvis & Creasey, 1991; Teti, Nakagawa, Das, & Wirth, 1991). Furthermore, parenting stress represents an important factor in the etiology of child abuse and neglect (Liu & Wang, 2015).

Compared with parents of typically developing children, parents of children with neurodevelopmental disabilities tend to experience more stress, illness, and psychiatric problems (Miodrag & Hodapp, 2010). Nachsen and colleagues (2005) have found that parents whose children have multiple problems areas (e.g. internalizing and externalizing problems) tend to report even more stress than those whose children have one or no high score.

In this regard, scientific attention has been devoted to implement interventions specifically designed for parents who have to deal with children with disabilities and/or developmental delays. The final aim is to give support to families and to improve both parents' mental health and, therefore, their long-term caregiving of children with complex developmental, physical, and behavioral needs (Baker et al., 2003; Bristol & Schopler, 1984; Dykens et al., 2015).

Some research has focused on differences in parenting stress between mothers and fathers. In the past century important changes occurred in the Italian society, and fathers are now more involved in family life. However, researchers agree on the fact that mothers still take the main responsibilities for child caring, even in those families where both parents have full-time jobs (Delvecchio et al., 2014; Lamb, 2004; Russell, 1986).

Greater involvement in family life has been found for fathers who have more flexible sex-orientations, who have a higher work satisfaction and who have a positive relationship with their own fathers (Deater-Deckard & Scarr, 1996; Deater-Deckard, 1998).

It has been found that, despite the prominent role mothers play in child caregiving, parent gender is only modestly associated with ratings of parenting stress, with mothers presenting only slightly higher levels of stress than fathers (Beckman, 1991; Delvecchio et al., 2014).

Nowadays there is empirical evidence that mother and fathers are quite similar in levels of parenting stress (Hastings et al., 2005; Rimmerman, Turkel, & Crossman, 2003). These findings seem to be in line with contemporary changes in the distribution of caregiving responsibility and,

consequently, men and women who are similar in their work and family roles are expected to show similar ratings of parenting stress (Deater-Deckard, 1998).

Interestingly, there is some evidence that mothers and fathers experience different aspects of child behavior as particularly stressful (Keller & Honig, 2004). It has been found that, while mothers' stress was related both to child problem behaviors and fathers' mental health, fathers' stress ratings were not significantly associated with either (Hastings et al. 2005).

Other studies have shown that mothers are especially affected by children's self-regulation difficulties (e.g., eating, sleeping). As mentioned above, these findings may be explained by the fact that mothers are generally more involved in daily child rearing.

Whereas, for what concerns fathers' ratings of stress, child externalizing behaviors were strongly associated with stress. These behaviors may be very difficult to manage and can lead to negative and uncomfortable reactions in public settings. It is important to specify that child regulatory problems and externalizing behaviors were significantly correlated with stress for both mothers and fathers when examined independently. Different patterns emerged for each parents when these behaviors were examined in relation to different aspects of child functioning (Kadzin & Whitley, 2003).

To conclude, research on the interventions designed to reduce parenting stress and to increase parents' coping skills has shown that they can be effective, particularly if they include a parent educational component. What it is still unknown concerns the potential stability of the decreasing of parenting stress over time (Anastopoulos, Shelton, DuPaul, & Guevremont, 1993; Dihoff et al., 1994; McBride, 1991; Pisterman et al., 1992; Telleen, Herzog, & Kilbane, 1989).

### **3.2 Parent-child emotional availability**

Healthy parent-child interaction is essential to the early development of children (Fogel, 1993; Greenspan, 1997; Harris, Kasari, & Sigman, 1996; Marcheschi, Millepiedi, & Bargagna, 1990; Marfo, 1990; Marfo, Cynthia, Dedrick, & Barbour, 1998; Pino, 2000; Sander, 2000; Sroufe, 2000; Venuti, de Falco, Giusti, & Bornstein, 2008).

Moving from "Deprivation Models", Brazelton and Cramer (1989) described the pervasive damage children suffer when they are raised in contexts without opportunities for a deep human contact. Parents and children coregulate each other by shaping each other's response while, at the same time, being shaped by the other's response (Beebe & Lachman, 2002; Brazelton, 1988; Fogel, 1993). Over time dyads develop their own characteristic ways of communicating (Stern, 1987). It has been found that these patterns tend to remain stable throughout the years (Oppenheim & Koren-Karie, 2009).

It is important to a healthy child development, that caregivers show an adequate responsiveness and a sensitive reaction to child's needs (Dekovic, Janssens, & Gerris, 1991). Parental behaviors such as warmth, nurturance, acceptance, approval, affection, providing of comfort, and attunement to child needs are regarded as highly sensitive (Bogenschneider & Pallock, 2008; Karreman, van Tuijl, van Aken, & Dekovic, 2006; Warren & Brady, 2007).

What is human responsiveness? According to Siegel (2009) it is a flexible response, that is responding in the manner best suited to the other's needs avoiding automatic or impulsive reactions.

Studies have found that parental responsiveness is related to an authoritative parenting style characterized by a warmth and control attitude in parenting (Baumrind, 1967). This, in turn, has showed its beneficial effects on child development and mental and emotional health (Karreman et al., 2006; Paulussen-Hoogeboom, Stams, Hermanns, Peetsma, & Van Den Wittenboer, 2008).

As discussed above, high levels of parenting stress are associated with adverse outcomes, such as an authoritarian parenting style (harsh and cold), more negatives in parent-child interactions, and less general involvement in the relationship with the child (Crnic et al., 2005; Deater-Deckard & Scarr, 1996).

Researchers highlighted that the parent-child relationship cannot be considered as unidirectional, with only parents affecting their children. It should be viewed, instead, as a two-way exchange where each one's signals and behaviors constantly affect each other (Bornstein, 2002a, 2003; Sander, 2000; Stern, 1987; Trevarthen & Aitken, 2001; Van Egeren, Barratt, & Roach, 2001; Venuti et al., 2008). Even young children through different signals transmit their emotional states and needs to their caregivers (Bornstein, Gini, Suwalsky, Leach, & Haynes, 2006; Trevarthen, 1993, 2003). Parents involve their children, capture their attention and build the rhythm of expectable dyadic interactions through their voices, gestures, and faces expressing different emotions (Bornstein, Gini, Putnik, et al., 2006; Martin, Clements, & Crnic, 2002; Weinberg & Tronick, 1996).

Recently, a parenting domain that has been widely studied is the emotional availability (EA; Biringen, 2000; Biringen & Robinson, 1991), that refers specifically to the emotional transactions between children and parents (Aviezer, Sagi, Joels, & Ziv, 1999; Biringen & Robinson, 1991; Bretherton, 2000; Emde, 1980). In this regard, it is important to take into consideration that every caregiver gives a personal contribution to the relationship with the child and, therefore, individual qualities that each one brings to the interaction are unique (Zimmerman & McDonald, 1995).

Measurement of the emotional availability in the parent-child relationship has been accomplished using the EA Scales (Biringen, 2008; Biringen, Robinson, & Emde, 1998). They include four global ratings of caregiver behavior (sensitivity, structuring, nonintrusiveness, and

nonhostility), and two global ratings of child behavior (responsiveness and involvement of the caregiver), each of which are assessed in dyadic context (Biringen & Easterbrooks, 2012). Although the majority of studies using the EA scales have focused on parent-child relationships during infancy and childhood, the construct is still relevant across the life span.

Mahler, Pine, and Bergman (1975) first used the term “emotional availability” to describe as healthy those mother-child relationships that allow the child exploration and autonomy and, at the same time, that recognize the importance of the physical contact and emotional “refueling”. Other authors have emphasized that parents’ physical presence is important as well as their emotional signaling and receiving (Emde, 1980, 1983, 2000; Sorce & Emde, 1981).

Researchers have underlined the importance of considering the emotional availability in the parent-child relationship as an affective barometer of the parent-child relationship where central is the adults’ acceptance of a wide range of child emotions (negative such as distress, anger, sadness; and positive such as interest, joy, surprise etc.) Compared to the attachment framework, the EA system focuses more on positive (as well as negative) emotions and, on the basis of the systemic theories, the family is seen as a whole where each member affects and, in turn, is affected by each other (Biringen & Easterbrooks, 2012).

To date, most studies have involved typically developing children mainly interacting with their mothers. Few studies using the EA Scales have involved children with special needs or fathers (Bornstein, 2008; De Falco, Esposito, Venuti, & Bornstein, 2008; Venuti et al., 2008).

Research has suggested that the components of EA relate to key aspects of the parent-child relationship (for reviews, please see Biringen, 2000; Pipp-Siegel & Biringen, 1998) as well as to maternal characteristics (Biringen, Matheny, Bretherton, Renouf, & Sherman, 2000; Easterbrooks, Chaudhuri, & Gestsdottir, 2005; Ziv, Aviezer, Gini, Sagi, & Koren-Karie, 2000) and child behaviors (Pressman, Pipp-Siegel, Yoshinaga-Itano, & Deas, 1999; Sagi, Tirosh, Ziv, Guttman, & Lavie, 1998; Wiefel et al., 2005). Moreover, high correlations have been found between the level of dyadic EA during mother-child interactions and patterns of attachment (Easterbrooks & Biringen, 2000a, 2000b, 2005).

Furthermore, for what concerns parental intrusiveness, it refers to the adult behavior characterized by a lack of respect for the infant’s autonomy. Intrusive parents tend to overwhelm children with excessive stimulation or to interrupt their activities (Ispa et al., 2004). It has been found that maternal intrusiveness is associated with different patterns of maladaptation during childhood (Egeland, Pianta, & O’Brien, 1993; Rubin, Burgess, Dwyer, & Hastings, 2003).

Other studies have examined the characteristic of parent-child emotional availability in the contexts of foster and adoptive families (Beeghly, 2012; Hamre, & Pianta, 2001). For example,



Biringen and colleagues (2012) conducted an intervention study where the child care professionals caring for infants, after receiving a training based on the EA principles, were able to mitigate challenging home environments through enhanced work abilities.

The study by Easterbrooks and collaborators (2012) found significant associations between disorganized attachment and aspects of maternal EA during middle childhood (at the age of 7), extending the evidence for EA-attachment correlations already established in the early childhood. Another important finding concerns the associations between EA and children's functioning and development outside of the mother-child relationship, for example at school (van den Dries, Juffer, van Ijzendoorn, Bakermans-Kranenburg, & Alink, 2012).

Another research field focused on histories of family violence has highlighted the importance of considering how a parent history of externalized and internalized hostility can negatively impact mother-child relationships (Stack et al., 2012).

To date, it is widely recognized that both mothers and fathers contribute to their child's development (Lewis & Lamb, 2003). Despite this evidence, fathers are still rarely observed in the interaction with their children (Lamb, 2010; Lamb & Lewis, 2010). It seems that, compared to mothers, fathers show less sensitivity and more intrusiveness (Barnett, Deng, Mills-Koonce, Willoughby, & Cox, 2008; Schoppe-Sullivan et al., 2006; Volling, McElwain, Notaro, & Herrera, 2002).

Interestingly, child gender seems to play a significant role in the nature and quality of parent-child interactions, with some research suggesting higher sensitivity towards girls than boys (Lovas, 2005). A possible explanation may be that the level of parental sensitivity may also depend on specific parent-child gender combinations. However, results are quite inconsistent (Hallers-Haalboom et al., 2014; Schoppe-Sullivan et al., 2006).

Feldman (2003) found that the degree of interactive synchrony between parent and child is higher in same-gender parent-infant dyads, probably because they share the same innate emotion regulation system. However, according to other studies, fathers are less sensitive toward sons and they display more negative intrusiveness with sons than with daughters (Barnett et al., 2008; Tamis-LeMonda, Shannon, Cabrera, & Lamb, 2004).

As for parental gender, even though research is still scarce, there is some evidence that paternal sensitivity and intrusiveness predict child development in a similar way as found for mothers (Lewis & Lamb, 2003; Tamis-LeMonda et al., 2004). But, what is important to consider is that mothers and fathers do not exhibit the same levels of sensitive and nonintrusive behaviors.

Nowadays, as discussed previously, fathers' involvement in their children's socialization has substantially increased due to mothers' higher work engagement (Cabrera, Tamis-LeMonda,

Bradley, Hoffert, & Lamb, 2000). However, mothers are still generally the primary caregivers of young children and they spend on average two to three times as much time than fathers in direct one-on-one interaction with their children, especially in early childhood. It is true that, when a parent spends time with a child, he/she finds the opportunity to understand child needs (Lamb, 2010).

In addition, differences among men and women may result in differences in parenting behavior (Bem, 1974). For example, fathers may tend to choose more the direction for play, which could lead to more intrusive behavior (Power, 1985). It has been found that fathers are more goal oriented, asking for more questions and requests than mothers (Leaper, Anderson, & Sanders, 1998; Tenenbaum & Leaper, 2003).

On the other hand, mothers are able to capture child emotional and nonverbal expressions and, consequently, to behave more sensitively towards their children than fathers (Hall & Matsumoto, 2004; Hoffmann, Kessler, Eppel, Rukavina, & Traue, 2010).

To date, the majority of studies indicated that fathers show less sensitive and more intrusive parenting behaviors than mothers (Haller-Haalboom et al., 2014). For example, Power (1985) found that mothers were more responsive toward their young infants' cues of interest and attention than fathers. Similar results were found in other studies (Barnett et al., 2008; Roopnarine, Fouts, Lamb, & Lewis-Elligan, 2005; Volling et al., 2002).

However, few research did not find differences in sensitivity among mothers and fathers, with the latter ones being just as sensitive and nonintrusive as mothers (Braungart-Rieker, Garwood, Notaro, & Powers, 1998; Braungart-Rieker, Garwood, Powers, & Wang, 2001; Goossens & Van IJzendoorn, 1990; John, Halliburton, & Humphrey, 2012; Tamis-LeMonda et al., 2004). Since these studies are quite similar with regard to sample characteristics, procedures or measures, further research is needed.

### **3.3 Who are fathers?**

Over the past three decades, there has been growing interest in fathering and an emerging body of literature on the impact of fathers on children's outcomes. Overall, fathers are more directly involved with their children than fathers of past generations and they share the coparenting roles with women (Pleck & Masciadrelli, 2004).

As already explained in this Chapter, despite many aspects have been changed in the distribution of caregivers' responsibilities between men and women, mothers are still the primary responsible in childcare (Bruder, 2000).

In this respect, it is important to underline that mothers are often exclusive participants in the early intervention service delivery and, generally, in child research (Crais, Poston Roy, & Free, 2006). It is because of the obsolete idea that fathers have a limited role in childcare, or the belief that fathers are more difficult to recruit than mothers (Curran, 2003; McBride & Rane, 1997; Phares, Fields, & Binitie, 2006; Phares & Lum, 1997). For this reason, findings about the impact of involving fathers in research on child-treatments are still inconsistent (Fabiano, 2007; Tiano & McNeil, 2005).

To date, studies on fathers still lag well behind research on mothers and, when they are included, they mainly come from intact middle-class Caucasian families (Coley, 2001; Zimmerman, Salem, & Notaro, 2000). Some authors state that an increased father involvement in intervention services may ease the overall workload for mothers and, consequently, reduce maternal stress (Flippin & Crais, 2011).

Sometimes combined research data about mothers and fathers do not allow a clear understanding of each parent's unique contributions. Indeed, Phares (1992) noted the irony of commonly being asked to define "father" ("Who are fathers?") in papers and research presentations. It is as if the mother role is seen as exclusive, while the father role might be filled by any male individuals (biological father, stepfather, grandfather or any of whom may or not live with the child) (Biller & Trotter, 1994; Lamb, 1976, 1981, 1997, 2004; Parke, 1996, 2002; Phares, Lopez, Fields, Kamboukos, & Duhig, 2005; Pruett, 1998; Zimmerman et al., 2000).

Even when fathers do not have a frequent contact with their children, they still influence children's functioning (Greene & Moore, 2000). Fathers play an important role in child language, cognitive and social development, and physical health (Lamb, 2004). Similar findings have been found in the realm of abnormal child development (Tamis-LeMonda & Cabrera, 2002). Interestingly, Phares and Compas (1992) reviewed research on abnormal child development and they concluded that fathers were highly underrepresented. In a review of 577 articles on child psychopathology, they found that 48% of the studies included mothers only, 1% included fathers only, 26% included both mothers and fathers and analyzed for maternal and paternal effects separately, and 25% of the studies either included mothers and fathers but did not analyze the data separately or more commonly did not specify the gender of the "parents" included in the study. Similar findings are reported in other studies (Duhig, Phares, & Birkeland, 2002; Lazar, Sagi, & Fraser, 1991; Silverstein, 2002; Silverstein & Phares, 1996).

In a review of 508 articles, Phares and colleagues (2005) showed that fathers were included in child psychopathology research significantly less frequently than mothers. Moreover, no changes have been found over time since the review completed by Phares and Compas (1992).

For what concerns child development, both similarities and differences have been found in maternal and paternal influences. For example, both maternal and paternal psychopathology represent risk factors for the development of children's and adolescents' emotional and behavioral problems (Connell & Goodman, 2002; Phares, 1996a, 1996b, 1999; Phares & Compas, 1992).

Empirical evidence has shown that children's externalizing problems are associated in similar ways to mothers' and fathers' psychopathology, whereas children's internalizing problems appear to be linked more closely to maternal psychopathology than to paternal psychopathology (Connell & Goodman, 2002).

The lack of fathers' inclusion in both behavioral and family-oriented treatment has been documented (Budd & O'Brien, 1982; Duhig et al., 2002). Clinicians appear to be less likely to engage fathers in treatment, and fathers, in turn, seem to show some resistance to engage in therapy as well (Walters, Tasker, & Bichard, 2001). It might be that fathers are more willing to participate in research if they are contacted by a male researcher rather than a female researcher (Phares, 1996b).

However, it is well recognized that, any time a characteristic of mothers is investigated, the researchers should also explore that characteristic in fathers, even when it comes to pregnancy and postpartum issues (Phares et al., 2005). In this scenario, a detailed description of the sample, along with the gender and relationship of the parent pointed out (e.g., mother, father, stepmother, stepfather), are highly recommended. Researchers should report how mothers and fathers were targeted for recruitment, what percent of mothers versus fathers refused to participate in the study, and if fathers are not included, they should provide specific reasons for their lack of inclusion (Bagner, 2013; Phares, 1992).

For all reasons mentioned above, it is still unclear what are the main characteristics and effects of maternal and paternal processes in several domains of child-focused interventions. Indeed, more informed research should be carried out in order to guarantee more effective treatments for all children and families who ask for professional help.

## CHAPTER 4

### The research

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#### 4.1 Introduction

Today most child-focused interventions include parents from the early stage of treatment (Neri & Latmiral, 2004; Sameroff et al., 2006; Tsiantis et al., 2002; Vallino, 2002a, 2009). Attention to parents' engagement in child treatment has increased in recent years given the emphasis on implementing successful treatments into community settings, identifying methods to provide services more efficiently, and improving quality of care for children and families (Becker et al., 2015; Gopalan et al., 2010; Ingoldsby, 2010; Lindsey et al., 2013).

As discussed in previous chapters, the therapeutic alliance (TA) is a primary curative component of treatments that allows for the implementation of specific therapeutic techniques (Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). Nowadays TA represents the most cited generic, non-specific factor of change in psychotherapy (Wampold, 2001; Ardito & Rabellino, 2011) and it has been found to be strictly associated with retention and therapy outcomes (Horvath & Symonds, 1991; Horvath & Luborsky, 1993).

TA is important in child and family treatment as well, given the critical role that parents (or any primary caregiver) play in allowing child attendance at treatment. Further, the influence of family context on children's development and behavior often results in child treatment focusing on the family regardless of the underlying treatment approach or modality (Kazdin & Weisz, 1998). For example, parental participation includes asking questions, sharing opinions, providing caregivers' point of view on a problem or solution, as well as their participation in therapeutic activities (Haine-Schlagel & Walsh, 2015). Often, parents serve as "co-therapists" who continue the intervention delivery at home, for example increasing reinforcement of child positive behaviours, working on turn taking when playing games at home etc. (Hoagwood, 2005; Karver, Handelsman, Fields, & Bickman, 2005; Shirk & Saiz, 1992; Tetley, Jinks, Huband, & Howells, 2011).

Nowadays it is widely recognized that therapists would need to establish a therapeutic relationship with parents based on a mutual understanding of child's difficulties and, furthermore, on their collaboration and agreement on the main goals and tasks of the intervention.

Building an alliance with parents is crucial for at least two reasons. First, a strong therapist-parent alliance increases the likelihood that the family will consistently attend and participate in

treatment. Second, the success of treatment depends to a large extent on how much parents feel supported and understood by the therapist, agree with the treatment goals and tasks, and are willing to try new ways of interacting with their child. In situations where the family conflict is high and/or each caregiver has a personal idea about child's needs, the agreement with each parent over the plan of child's treatment represents the therapist's first goal aimed to guarantee the maintenance and success of child treatment (Algini, 2003; Barmish & Kendall, 2005; Neri & Latmiral, 2004; Trombini, 2004; Tsiantis et al., 2002; Vallino, 2002a, 2009).

To date, most research concerns the study of the alliance with children aged 7-8 years old and highest who are able to complete self-report measures of TA. At the same time the alliance with parents who are recipients of some kind of intervention (family education/ family therapy etc.) has been assessed through the self-reports used in adult literature on TA (Hoagwood, 2005). Findings of these studies showed that low parental scores of TA are strictly associated with a premature termination of child therapy without agreement (Garcia & Weisz, 2002). On the contrary, high parental scores of TA have been found to correlate with better outcomes, such as a decreased youth symptomatology, improved parenting practices and family functioning, greater perceived social support and greater satisfaction with therapy (Kazdin & Whitley, 2006; Kazdin, Whitley, & Marciano, 2006; Hawley & Garland, 2008).

Nowadays a research area to explore concerns the assessment of the alliance with parents in preschool child-focused treatments. From a methodological perspective, while there are several instruments to assess TA in individual psychotherapy, only recently some interest has been devoted to measure TA in conjoint/family treatment (Mazzoni, 2010). Certainly, existing research efforts along these lines need to be extended and built on the study of the alliance in child-focused treatments. Clinical settings where parents ask for help because of the child's difficulties are very different from individual and/or family settings.

This work therefore aimed to expand on the literature and explore the quality of the parent-therapist alliance – from both parents' and therapist's points of view- in a specific modality of child-focused treatment. It is called the "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016).

As discussed thoroughly in Chapter 2, the FPT-CP is a psychodynamic intervention that involves parents in the treatment of their preschool children. It was originally developed for child eating and evacuation disorders and, subsequently, it was extended to a large range of problems in preschool children usually connected to parent-child relationship problems. This technique is based on the use of play as a narrative dimension of family problems.

This work focused on the first phase (6 sessions) of the FPT-CP because it is specifically oriented to the assessment of child symptoms through the understanding of family dynamics, and to the promotion of the therapeutic alliance with parents as a pre-condition for a successful intervention.

At the end of this phase, once the therapist has established a nice and “productive/working” relationship with parents, therapeutic goals are discussed in light of child and parent changes. Parent efforts to deal with child difficulties and to modify some aspects of the parent-child relationship are emphasized. In most cases, the therapist comes to an agreement with parents about the opportunity to go on the therapeutic process. Modalities can be different according to each clinical situation and child/family needs: sessions with both caregivers, with one caregiver only, or with the child alone.

At this purpose, the present study was undertaken to explore the quality of the therapeutic relationship with parents at two time points that correspond to the beginning and to the end of the first phase of the FPT-CP (Time 1: end of the 1<sup>st</sup> session; Time 2: end of the 6<sup>th</sup> session). The assessment of parents’ personality took place at the end of the first session, while parents’ levels of stress and the quality of the parent-child relationship were evaluated at both time points.

## 4.2 Aims & hypotheses

The present research has both general and specific aims:

I. To assess the quality of the parent-therapist relationship in terms of alliance - from both parent and therapist perspectives. To this aim, we investigated:

- At Time 1 (end of 1<sup>st</sup> session)

a) associations between parent alliance scores and parental characteristics of personality.

- At Time 1 and 2 (Time 2: end of 6<sup>th</sup> session)

b) changes in the alliance over time - from both parent and therapist points of view;

c) in order to assess for congruity, differences by comparing mother and father alliance scores;

d) in order to assess for congruity, differences by comparing parent and therapist alliance scores.

We aimed:

II. To evaluate changes in parental stress. Moreover, we compared mother and father stress scores.

III. To evaluate changes in the adult emotional availability scores. Moreover, we explored differences between mothers and fathers in the parental dimensions of the EAS (Sensitivity, Structuring, Non-Intrusiveness, and Non-Hostility).

- IV. To evaluate changes in the child emotional availability scores. Moreover, we explored differences between mothers and fathers in the child's dimensions of the EAS (Responsiveness and Involvement).
- V. To explore differences in the alliance scores between those parents who agreed with the therapist to continue the intervention and parents who did not.
- VI. To investigate differences in the parental ratings of alliance according to the level of the therapist experience.

As for the described objectives, on the basis of existing literature, we hypothesized that:

- At Time 1:
  - I. a) parent alliance scores would be positively associated with parental characteristics of personality, such as extraversion, agreeableness, and conscientiousness; and they would be negatively associated with neuroticism.
- With respect to the comparison between Time 1 and 2:
  - I. b) parents and therapist would establish a positive therapeutic relationship. Moreover, it would be stable throughout sessions.
- With respect to the comparison between mother and father alliance scores:
  - I. c) there would be no differences between their alliance scores at both times of assessment.
- With respect to the comparison between parent and therapist alliance scores:
  - I. d) parental alliance would be higher than therapist alliance at T1 and T2.
- II. There would be a slight decrease in parental levels of stress. Furthermore, there would be no differences between mother and father stress scores at both times of assessment.
- III. At Time 2 both parents would show slightly higher levels of sensitivity and structuring, and less intrusiveness. Furthermore, we did not expect significant differences between mother and father EAS scores at both time points.
- IV. At Time 2 children would show slightly higher levels of responsiveness and involvement with both caregivers. No differences between child-mother and child-father emotional availability scores would result at both time points.
- At Time 2:
  - V. Parents who agreed with the therapist to continue the intervention would show higher alliance scores than parents who did not.
  - VI. There would be no differences in parental ratings of alliance according to the level of the therapist experience (due to the specific characteristics of the FPT-CP).



## 4.3 Method

### 4.3.1 Participants

#### *Families*

Participants were recruited consecutively from November 2015 to June 2017 at the Service of Psychological Consultation for children and parents - with fee - (main coordinator: professor Elena Trombini) at the Department of Psychology, University of Bologna.

As is common in studies of clinical populations, the sample was not homogeneous or balanced demographically. However, all procedures were appropriate to the age span.

The sample included seventeen families (N=34; 17 mothers and 17 fathers) and their children (N= 17; 13 little boys and 4 little girls). Presenting concerns included children's oppositional and aggressive behaviors, eating problems (poor appetite, selective feeding), encopresis and stipsis.

Families' access to the Service was voluntary and exclusion criteria for the present study were: a) child's organic diseases; b) child's neurodevelopmental disorders; c) parental past or present psychiatric disorders; d) parent's lack of proficiency in the Italian language.

All mothers ( $M_{age} = 41.41$  years,  $SD = 5.04$ , range = 34-53) were married or cohabiting with the father ( $M_{age} = 42.41$  years,  $SD = 4.76$ , range = 32-48) of the child ( $M_{age} = 3.87$  years,  $SD = 1.43$ , range = 2-5). Moreover, all parents were Italian, employed, and most of them had a university degree (73.5 %). The socioeconomic status of the families, calculated with the Four-Factor Index of Social Status, indicated a middle status in the Italian population (SES; Hollingshead, 1975).

#### *Therapists*

The therapist sample in the present study comprised five women psychoanalytic psychotherapists ( $M_{age} = 38.56$ ,  $SD = 2.99$ , range= 33-43) specialized in the use of the "Focal Play Therapy with children and parents" (FPT-CP). They completed a personal analysis and are under weekly supervision from at least 2 years for the clinical cases followed with this methodology.

Each therapist met once weekly her families and therapists' average patient caseload was approximately three families.

### 4.3.2 Procedure

The research was approved by the Ethic Committee of the University of Bologna (Italy). The participation in the present study was based on families' informed and signed consent.

Informed consent included confidentiality (i.e., therapists did not have access to client questionnaires) and the right to withdraw at any time.

The participating families who agreed to take part in this study were screened in terms of exclusion criteria (please, see the Paragraph 4.3.1). The therapists were the ordinary staff members at the Service of Psychological Consultation for children and parents (Department of Psychology, University of Bologna). Families were assigned by the Service coordinator (professor Elena Trombini) according to the availability of the therapists.

Parents completed a core battery of self reporting questionnaires (measuring personality, therapeutic alliance and parenting stress). Assessment of parents' personality took place at the end of the first session, while parents' levels of stress and the quality of the parent-child relationship were evaluated at two time points that correspond to the beginning and to the end of the first phase of the FPT-CP (Time 1: end of 1<sup>st</sup> session; Time 2: end of 6<sup>th</sup> session). Therapists completed parallel measures of the therapeutic alliance as well. As regards the assessment of the parent-child relationship, dyadic interactions (mother-child; father-child) were evaluated at the two time points mentioned above.

Each therapist fully described research aims and procedures to each family, while a PhD student dealt with data collection including video recording of parent-child interactions, and data analysis.

### *Treatment*

As regards the specific characteristics of the Focal Play Therapy with children and parents (FPT-CP), please see the Paragraph 2.2.

As discussed previously, this research focused on the first phase (6 sessions) of the FPT-CP because it is specifically oriented to the assessment of child symptoms through the understanding of family dynamics, and to the promotion of the therapeutic alliance with parents as a pre-condition for a successful intervention.

The therapy is organized into alternate sessions with parents and child together and sessions with parents only. Below are the first 7 sessions where data collection occurred (in the 7<sup>th</sup> session only the videorecording of parent-child interactions took place) .

-First session: with parents. The therapist informed each family about the structure of the intervention, its main goals and phases. Informed consents and privacy modules were required. Further, the therapist collected data about each child case history and his/her family context through an interview for sociodemographic and anamnestic data. Afterwards, she introduced parents to the narrative play and, at the end of this session, each parent was administered self-reporting

questionnaires aimed to evaluate the parent personality, the therapeutic alliance, and the parenting stress. The alliance measures were completed by the therapist as well.

-Second session: with the child and his/her parents. The FPT-CP was conducted for approximately forty-five minutes. It was preceded by a videotaped play interaction between the child and his/her parents (10 minutes for each caregiver) aimed to assess the global quality of the parent-child relationship.

-Third session: with the child and his/her mother. The child and his/her mother took part to the FPT-CP session.

-Fourth session: with parents only. Both parents discussed with the therapist on child's difficulties, themes and family topics emerged in previous play sessions.

-Fifth session: with the child and his/her father. The child and his/her father took part to the FPT-CP session.

-Sixth session: with parents. The understanding of the child symptoms was enriched by the family dynamics observed in the previous play sessions - both conflictual and adaptive ones. Parent's behavior during the FPT-CP can encourage or impede the therapeutic process. Behaviors that can encourage the process are characterized by tolerance, patience, collaboration, offers of support, and proposals that are in line with the child's creativity, along with a trust and enthusiasm in the child's productivity. Behaviors that hamper the process are characterized by impositions rather than proposals, irrelevant or distracting interventions, lack of interest and self-exclusion.

In the sixth session child and parent changes were discussed and parents' efforts to deal with child difficulties and to modify some aspects of the parent-child relationship were emphasized. If changes in child symptoms did not occur or not fully (in most cases), the therapist suggested families to continue the intervention. As regards the data collection, at the end of the sixth session parents were given the same measures they had received at the end of the first session (except the personality questionnaire). Again, the alliance measures were completed by the therapist as well.

-Seventh session: with the child and his/her parents. Similarly to the second session, a play interaction between the child and each parent was videotaped (10 minutes for each caregiver).

#### 4.3.3 Measures

**Parent's personality:** Parent's characteristics of personality were evaluated with the *Big Five Inventory* (BFI; John, Donahue, & Kentle, 1991; Italian version by Ubbiali, Chiorri, Hampton, & Donati, 2013) at the end of the first FPT-CP session, as explained previously.

The BFI is a brief inventory that allows a quick, efficient, and flexible assessment of the individual characteristics of personality when there is no need for a more differentiated measurement of individual facets (John, Naumann, & Soto, 2008).

The BFI is a 44-item inventory that measures an individual on the Big Five Factors of personality (Goldberg, 1993): *Extraversion* (E), *Agreeableness* (A), *Conscientiousness* (C), *Neuroticism* (N), *Openness* (O). It consists of short phrases with relatively accessible vocabulary that included trait adjectives known to be prototypical markers of the Big Five, to be rated on a 5-point, Likert type agreement scale (1= Strongly disagree; 5= Strongly agree).

Extraversion refers to individual expansiveness and enthusiasm, assertiveness and confidence. Agreeableness refers to characteristics of personality such as sensitivity towards people and their needs, and to kindness, docility and trust. Conscientiousness is defined in terms of impulse control in both its proactive and inhibitory aspects; and it refers to orderliness, precision, and to the capability of fulfilling one's own tasks and commitments. Neuroticism refers to the ability to cope with one's own anxiety and emotionality, and to the capability of controlling irritation, discontent, and anger. Last, openness refers to the broadness of one's own cultural interests, to openness to novelty, tolerance of different values, interest toward different people, habits and life-styles.

The BFI scales have shown adequate internal consistency (minimum level of .7; Cronbach, 1951, Nunnally, 1978), test-retest reliability, and a clear factor structure. They have also shown substantial convergence with longer Big Five measures (e.g., Benet-Martinez & John, 1998; John et al., 2008).

In the present study, mothers' alpha scores (Cronbach, 1951) were: poor for Agreeableness ( $=.55$ ) and Neuroticism ( $=.53$ ); good for Extraversion ( $=.81$ ) and Conscientiousness ( $=.84$ ); excellent for Openness ( $=.90$ ). With respect to fathers, internal consistency estimates (Cronbach, 1951) were: questionable for Agreeableness ( $=.65$ ); acceptable for Conscientiousness ( $=.73$ ) and Openness ( $=.73$ ); good for Extraversion ( $=.84$ ) and Neuroticism ( $=.82$ ).

**The therapeutic alliance:** It was assessed using two self-reporting questionnaires at Time 1 and Time 2.

*The Working Alliance Inventory-Short Form* (WAI- SF; Tracey & Kokotovic, 1989; Italian version by Lingiardi & Filippucci, 2002) has been specifically designed to assess the alliance in individual psychotherapy settings.

*The System for Observing Family Therapy Alliances-self report* (SOFTA-S; Friedlander, Escudero, & Heatherington, 2006; Italian version by Mazzoni, 2010) is a specific measure of the

alliance in coinjoint/family settings where it is important to assess the level of the productive collaboration and shared sense of purpose by family members in therapy.

Since the WAI-SF is one of the most internationally used and validated measures of the therapeutic alliance (TA), it was used in the present research as the main measure of TA. The SOFTA-S was utilized mainly as a clinical measure of the therapeutic alliance, because the use of this instrument is recent and more empirical support is needed.

- *The Working Alliance Inventory-Short Form* (WAI- SF; Tracey & Kokotovic, 1989; Italian version by Lingiardi & Filippucci, 2002) was used in both patient's and therapist's versions.

The WAI-SF is the 12-item (four for subscale) short version of the client and therapist forms of the WAI. It is based on the Bordin's (1979) pantheoretical conceptualization of the therapeutic alliance, and it consists of three scales (*Goal, Task, Bond*) and a total score.

The WAI-SF measures participants' level of agreement with the goals (Goal) and tasks (Task) of therapy and their emotional bond with the therapist (Bond). Each item is rated on a 7-point Likert scale ranging from 1= never to 7=always. With some items reverse scored, each subscale can range from 4 to 28 (total scale=12-84); higher scores reflect more positive ratings of the therapeutic alliance.

The reliability and validity of the WAI-SF have been repeatedly supported in a wide range of studies (Hanson, Curry & Bandalos, 2002; Horvath, 1994).

Time 1: With regard to mothers, alpha scores (Cronbach, 1951) in the present study were: poor for Bond (=0.59); acceptable for Goal (=0.76); good for Task (=0.80) and Total score (=0.88). Internal consistency estimates of the corresponding therapist version of the WAI-SF were: acceptable for Bond (=0.78); good for Goal (=0.83) and Task (=0.85); excellent for Total score (=0.93).

As for fathers, Cronbach's alpha scores (1951) were: acceptable for Bond (=0.78) and Goal (=0.77); excellent for Task (=0.94) and Total score (=0.92). Internal consistency estimates of the corresponding therapist version of the WAI-SF were: acceptable for Goal (=0.78); excellent for Bond (=0.90), Task (=0.91) and Total score (=0.96).

Time 2: Mothers' alpha values (Cronbach, 1951) were: questionable for Bond (=0.68); good for Goal (=0.87) and Task (=0.81); excellent for Total score (=0.90). Internal consistency estimates of the corresponding therapist version of the WAI-SF were: good for Goal (=0.85) and Bond (=0.84); excellent for Task (=0.91) and Total score (=0.95).

As regards fathers, Cronbach's alpha scores (1951) were: unacceptable for Goal (=0.41); good for Task (=0.86), Bond (=0.83) and Total score (=0.86). Internal consistency estimates of the

corresponding therapist version of the WAI-SF were: good for Goal (=0.84) and Bond (=0.85); excellent for Task (=0.90) and Total (=0.95).

*The System for Observing Family Therapy Alliances-Self report* (SOFTA-S; Friedlander et al., 2006; Italian version by Mazzoni, 2010) was used in both patient's and therapist's versions.

The SOFTA-S investigates the family members' therapeutic alliance on four subscales: *Engagement in the Therapeutic Process* (e.g., "The therapist and I work together as a team"), *Emotional Connection With the Therapist* (e.g., "The therapist has become an important person in my life"), *Safety Within the Therapeutic System* (e.g., "There are some topics I am afraid to discuss in therapy"), and *Shared Sense of Purpose Within the Family* (e.g., "Each of us in the family helps the others to get what they want out of therapy").

Following are the definitions of each scale (Lambert & Friedlander, 2008).

**Engagement in the Therapeutic Process:** the client viewing treatment as meaningful; a sense of being involved in therapy and working together with the therapist, that therapeutic goals and tasks in therapy can be discussed and negotiated with the therapist, that taking the process seriously is important, that change is possible.

**Emotional Connection to the Therapist:** the client viewing the therapist as an important person in his/her life, almost like a family member; a sense that the relationship is based on affiliation, trust, caring, and concern; that the therapist genuinely cares and "is there" for the client, that he/she is on the same wavelength with the therapist (e.g., similar life perspectives, values), that the therapist's wisdom and expertise are valuable.

**Safety Within the Therapeutic System:** the client viewing therapy as a place to take risks, be open, vulnerable, flexible; a sense of comfort and an expectation that new experiences and learning will take place, that good can come from being in therapy, that conflict within the family can be handled without harm, that one need not be defensive.

**Shared Sense of Purpose Within the Family:** family members seeing themselves as working collaboratively in therapy to improve family relations and achieve common family goals; a sense of solidarity in relation to the therapy, "we are in this together"; that they value their time with each other in therapy; essentially, a felt unity within the family in relation to therapy.

Clients respond to the 16 items (four per subscale) on 5-point Likert-type scales (1=not at all, 5=very much). With some items reverse scored, each subscale can range from 4 to 20 (total scale =16 -80); higher ratings reflect more favorable alliances.

Friedlander et al. (2005) reported internal consistency reliabilities of .87, with subscale scores ranging from .62 to .80.

Time 1: With respect to mothers in the present sample, alpha scores (Cronbach, 1951) were: unacceptable for Safety Within the Therapeutic System ( $=.44$ ); questionable for Emotional Connection With the Therapist ( $=.68$ ); good for Engagement in the Therapeutic Process ( $=.87$ ) and Shared Sense of Purpose Within the Family ( $=.81$ ); excellent for Total score ( $=.91$ ).

As regards fathers, alpha values (Cronbach, 1951) were: unacceptable for Engagement in the Therapeutic Process ( $=.48$ ); poor for Emotional Connection With the Therapist ( $=.58$ ) and Safety Within the Therapeutic System ( $=.52$ ); questionable for Shared Sense of Purpose Within the Family ( $=.64$ ); good for Total score ( $=.85$ ).

As for therapists' alliance scores referred to the family as a unit, the internal consistency estimates (Cronbach, 1951) were: poor for Emotional Connection With the Therapist ( $=.53$ ); acceptable for Engagement in the Therapeutic Process ( $=.72$ ); good for Safety Within the Therapeutic System ( $=.83$ ) and Shared Sense of Purpose Within the Family ( $=.81$ ); excellent for Total score ( $=.92$ ).

Time 2: With respect to mothers, alpha scores (Cronbach, 1951) were: unacceptable for Safety Within the Therapeutic System ( $=.43$ ); questionable for Emotional Connection With the Therapist ( $=.67$ ) and Shared Sense of Purpose Within the Family ( $=.67$ ); acceptable for Engagement in the Therapeutic Process ( $=.79$ ); good for Total score ( $=.87$ ).

As regards fathers, alpha values (Cronbach, 1951) were: unacceptable for Engagement in the Therapeutic Process ( $=.34$ ); poor for Safety Within the Therapeutic System ( $=.51$ ); questionable for Emotional Connection With the Therapist ( $=.66$ ); acceptable for Shared Sense of Purpose Within the Family ( $=.76$ ); good for Total score ( $=.85$ ).

As for therapists' alliance scores referred to the family as a unit, the internal consistency estimates (Cronbach, 1951) were: unacceptable for Emotional Connection With the Therapist ( $=.42$ ); questionable for Engagement in the Therapeutic Process ( $=.61$ ); good for Safety Within the Therapeutic System ( $=.83$ ) and Shared Sense of Purpose Within the Family ( $=.88$ ); excellent for Total score ( $=.91$ ).

**Parenting stress:** *The Parenting Stress Index— Short Form* (PSI-SF; Abidin, 1995; Italian version by Guarino, Di Blasio, D'Alessio, Camisasca, & Serantoni, 2008) was administered at Time 1 and Time 2.

The PSI-SF is one of the most commonly used measures for studying parenting stress. It is a shortened version of the original PSI, consisting of 36 items designed to identify stress in parent-child dyads. It has been used also to determine risk factors of maladaptive parent and child behavior (Spratt, Saylor, & Macias, 2007).

The PSI-SF includes three subscales: *Parental Distress* (Pd), *Parent-Child Dysfunctional Interaction* (Pcdi) and *Difficult Child* (Dc); a Total score is provided as well. Higher ratings represent high levels of parenting stress. Scores between the 15<sup>th</sup> and 84<sup>th</sup> percentiles are considered to be within the normal range for stress. Scores between the 85<sup>th</sup> and 89<sup>th</sup> percentiles represent a high level of stress and scores greater than or equal to the 90<sup>th</sup> percentile indicate clinically significant or severe parenting stress (Guarino et al., 2008).

The Parental Distress scale investigates the distress perceived by parents about their parenting role, such as an impaired sense of parenting competence and a lack of social support (e.g., “I feel trapped by my responsibilities as a parent”).

The Parent-Child Dysfunctional Interaction scale evaluates parents’ stress related to experiences of interactions with the child (e.g., “My child rarely does things for me that make me feel good”).

The Difficult Child scale describes the child characteristics that make him/her easy or difficult to manage such as a negative temperament (e.g., “My child seems to cry or fuss more than most children”).

Mothers and fathers are asked to indicate the extent (1=strongly disagree to 5= strongly agree) to which they agree with negative statements about their parenting experience separately.

Previous literature has shown the PSI-SF to have good internal consistency reliability ( $\alpha=.91$ ) and test–retest reliability ( $\alpha=.84$ ) for the Total parenting stress score (Ortega, Beauchemin, & Kaniskan, 2008). Further, convergent validity of the PSI-SF has been established using alternative measures related to parenting stress (Campbell, Thoburn, & Leonard, 2017).

Time 1: With regards to mothers in the present sample, alpha scores (Cronbach, 1951) were: good for Parent-Child Dysfunctional Interaction ( $=.80$ ), Difficult Child ( $=.85$ ), and Parental Distress ( $=.88$ ); excellent for Total score ( $=.91$ ). For fathers, alpha values were: acceptable for Difficult Child ( $=.70$ ), Parental Distress ( $=.76$ ), and Parent-Child Dysfunctional Interaction ( $=.79$ ); good for Total score ( $=.81$ ).

Time 2: With respect to mothers, alpha scores (Cronbach, 1951) were: good for Difficult Child ( $=.84$ ), and Parent– Child Dysfunctional Interaction ( $=.85$ ); excellent for Parental Distress ( $=.90$ ), and Total score ( $=.92$ ). For fathers, alpha values were: questionable for Difficult Child ( $=.68$ ); acceptable for Parental Distress ( $=.70$ ), Parent– Child Dysfunctional Interaction ( $=.78$ ), and Total score ( $=.78$ ).

**Parent-child emotional availability:** Emotional Availability (EA) was assessed with *The Emotional Availability Scales* (Biringen, 2008) at Time 1 and Time 2. This construct refers to the



dyad's capacity of emotional connection and to the extent to which the connection between the adult and the child is affectively genuine (Biringen, 2000, 2008).

To assess parent-child EA, data were collected during two consecutive 10-min sessions video recorded continuously by a female filmer at Time 1 and 2. Observations took place at the Service of Psychological Consultation (Department of Psychology, University of Bologna) in a quiet room that was familiar to the participants.

Although the authors recommend at least 20 to 30 min of observation time (Biringen et al., 1998), the findings of previous studies using 5- to 10-min observations of adult-child interaction indicate the validity of this temporal parameter with the EA Scales (Easterbrooks, Biesecker, & Lyons-Ruth, 2000; Swanson, Beckwith, & Howard, 2000; Ziv, Aviezer, Gini, Sagi, & Koren-Karie, 2000). They also show that adult-child EA is robust to context differences between home and laboratory (Bornstein et al., 2006).

A set of standard, age-appropriate toys was used that represented feminine, masculine, and gender-neutral categories (Caldera, Huston, & O'Brien, 1989). During each session, the mother and the father were asked to play individually with her or his child in the ways she or he typically would and to disregard the filmer's presence as much as possible. Mothers or fathers and children could use any or all of the toys and puppets provided.

The Emotional Availability Scales operationalize the concept of emotional availability and comprise four adult components (*Sensitivity, Structuring, Non-Intrusiveness, Non-Hostility*) and two child components (*Responsiveness, Involvement*). Each scale comprises 7 items and provides a total score, computed by summing up scores obtained at each item, and a direct score assigned directly on a 1-7 points Likert scale, where lower scores represent lower levels of emotional availability.

It is important to remember that direct scores are more commonly used for research purposes, as they provide a more immediate indication of the level of emotional availability displayed by the dyad (Biringen, 2000, 2005, 2008). Hence, direct scores were used in the present study. Following, the EAS dimensions are thoroughly described.

**Adult Sensitivity:** This scale evaluates the adult's appropriate and positive affective exchanges, that include adequate perception of emotions, responsiveness to the child's cues, ability to handle conflictual situations, and awareness of timing. Direct score is given on a 1-7 points Likert scale, where the high-end scores (6-7) represent optimal sensitivity; the mid-point ratings (4-5) "apparent sensitivity"; and the lower scores (1-2-3) represent emotional detachment.

**Adult Structuring:** This dimension evaluates the adult's scaffolding capacity, and it refers to the extent to which the parent is able to adequately guide the child during play. Direct score is

assigned based on a 1-7 points Likert scale. Highest scores indicate optimal structuring; the mid-point ratings indicate inconsistent structuring (mismatch between the adult and the child, for example there may be too much structuring in a way that the child cannot absorb it); and the lowest scores represent a lack of adult's structuring in the interactions.

**Adult Non-Intrusiveness:** This scale measures the absence of over-directions, overstimulation, interferences, or over-protection in adult behavior. Hence, this scale is also a measure of the parent's capacity to support or obstruct the child's autonomy. The score assigned considers also the child's reaction to the adult behavior, thus each parent can be considered intrusive only if the child responds in a way that indicates so. As for the other EA scales, direct score is assigned on a 1-7 points Likert scale, where high-end scores indicate the adult is a non intrusive and a supportive presence; middle-range scores represent benign intrusiveness and over protectiveness; low-end ratings indicate adult intrusiveness and physical intrusion.

**Adult Non-Hostility:** This dimension evaluates on a 1-7 points Likert scale the absence of adult hostile behaviors (covert or overt) towards the child. Hostile behaviors include verbal or physical aggressiveness, like demeaning comments, impatience, boredom, and critics, or manipulating the child in a rough and violent way. High scores indicate a lack of any hostility in face, voice or bodily actions; middle range ratings indicate covert hostility; and lower scores indicate overt hostility.

**Child's Responsiveness:** This scale evaluates on a 1-7 points Likert scale the quality of the child's affect and responsiveness to the adult. The high-end scores refer to a child who is able to appropriately connect to the adult, in an age-appropriate way. This scale is indicative of the "secure base" or "attachment-exploration balance" behavior proposed by Ainsworth (1979) (Biringen & Easterbrooks, 2012). Middle range scores indicate a child who is connected but he/she tends to be over solicitous to the adult's directions, with the exclusion of the child's autonomy. Low-end ratings indicate either over-connected or under-connected child who may/or may not reflect a disorganized-traumatized affective relationship with the caregiver.

**Child's Involvement:** This scale refers to the child's capacity to engage and include the adult in the interaction. Direct scores are assigned, as for the other scales on a 1-7 points Likert scale. High scores indicate the child's ability and interest in taking the initiative in the interaction; middle-point ratings reflect the child's way to engage the adult which is characterized by negative emotions, distress or crisis scenarios. Low-range scores indicate the child's passivity or lack of interest in the relationship with the adult.

The EA scales have been largely used in research settings to evaluate the quality of the adult-child relationship in populations at risk (Moehler, Biringen, & Poustka, 2007; Little & Carter,

2005), including samples with atypical development (Biringen, Fidler, Barret, & Kubicek, 2005; Wiefel et al., 2005). Moreover this instrument has demonstrated good stability and reliability properties (Bornstein et al., 2006; Biringen, 2008).

In the present research, for the ratings of mother-child and father-child interactions, two independent coders were first trained on the EAS to obtain satisfactory interrater reliability with the authors of the EAS (80% of agreement) (Biringen, 2005). Moreover, inter-rater reliability between the two coders on the direct scores was assessed using the average absolute agreement intraclass correlation coefficients (ICC; McGraw & Wong, 1996). In this study ICC for the direct scores ranged between 0.68 and 0.85 (mean = 0.79), that is quite good for research purposes (Biringen, 2005).

#### **4.4 Analytic plan**

Data analysis was performed using SPSS (version 20).

Internal consistency (Cronbach's  $\alpha$ ) of measures, and the EAS Interclass Correlation Coefficient were calculated and reported in the Paragraph 4.3.3.

The first section of Results provides descriptive statistics for each BFI, WAI-SF and SOFTA-S scales separately for mothers, fathers and therapists at the two time points (T1, T2). The second section presents group comparisons between mothers and fathers in terms of WAI-SF and SOFTA-S mean scores. Paired t-test were also conducted to investigate differences by comparing each parent and therapist alliance scores.

The following sections present group comparisons between mothers and fathers in terms of parent PSI-SF and parent and child EAS mean scores. Differences among families who agreed with the therapist to continue the intervention and families who did not were investigated using unpaired t-tests. Similar statistical analyses were employed to explore differences in parental alliance scores according to the level of the therapist experience. To conclude, a series of Pearson correlational analyses aimed to investigate the associations between the WAI-SF and SOFTA-S scales, and the relationships between multiple variables (parental personality, alliance, parenting stress, and adult-child emotional availability).

#### **4.5 Results**

##### **4.5.1 Big Five Inventory**

Descriptive statistics are displayed in Table 1. They are in line with the normative sample of Italian women and men (Chiorri, Marsh, Ubbiali, & Donati, 2016).

As expected (Chiorri et al., 2016; Schmitt, Realo, Voracek, & Allik, 2008; Ubbiali et al., 2013), gender comparisons of BFI scale scores revealed that mothers scored higher than fathers in the Agreeableness scale ( $M_{\text{women}} = 4.10$  vs  $M_{\text{men}} = 3.59$ ;  $t(16) = 3.24$ ,  $p = .005$ ), and the effect size was large ( $d = .97$ ; Cronbach, 1988).

**Table 1.** BFI means, standard deviations, and Tests for Differences among mothers and fathers.

	Mothers ( $M \pm SD$ )	Fathers ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Extraversion	3.41±.69	3.26±.75	.83	.42	.21
Agreeableness	4.10±.46	3.59±.58	3.24	.01	.97
Consciousness	3.83±.73	3.78±.63	.20	.84	.07
Neuroticism	2.86±.58	3.04±.82	-.83	.42	.25
Openness	3.72±.84	3.49±.55	.89	.39	.32

#### 4.5. 2 Working Alliance Inventory

Mean scores on the WAI-SF at each time of assessment are reported in Table 2 (for women), Table 3 (for men). In line with previous investigations (Lingiardi, 2002; Lo Coco, Gullo, Prestano, & Gelso, 2011; Gullo, Lo Coco & Gelso, 2012), mothers' and fathers' perceptions of alliance were positive and stable throughout the first phase of this intervention. Moreover, paired t-test did not reveal significant differences among mothers and fathers.

**Table 2.** WAI-SF means, standard deviations for mothers, and Tests for Differences between T1 and T2.

	T1 ( $M \pm SD$ )	T2 ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Goal	24.47±3.59	24.65±3.50	-.15	.88	.05
Task	23.94±3.17	23.76±3.23	.21	.84	.06
Bond	22.29±2.89	22.12±2.78	.23	.82	.06
Total	70.71±8.61	70.53±8.24	.07	.94	.02

**Table 3.** WAI-SF means, standard deviations for fathers, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	23.29±4.43	23.18±3.15	.10	.92	.03
Task	24.71±3.79	23.76±3.38	.96	.35	.26
Bond	22.47±4.02	21.06±3.83	1.39	.18	.36
Total	70.47±11.09	68.00±8.75	.90	.38	.25

For what concerns therapists' alliance with mothers (WAI-SF-Tm) and fathers (WAI-SF-Tf), results are reported in Tables 4a and 4b respectively. In line with the existing literature (Lingiardi, 2002; Lo Coco et al., 2011; Gullo et al., 2012), therapists' alliance with both parents was positive at each time point and stable. Paired t-test did not reveal significant differences in WAI-SF-T scores between T1 and T2.

**Table 4a.** WAI-SF-Tm means, standard deviations for therapists, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.18±3.36	20.71±4.48	-.57	.58	.13
Task	20.35±3.00	19.71±3.98	.67	.51	.18
Bond	18.59±2.92	19.65±3.18	-1.34	.20	.35
Total	59.12±8.74	60.06±11.03	-.38	.71	.09

**Table 4b.** WAI-SF-Tf means, standard deviations for therapists, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	19.35±3.43	19.18±4.49	.20	.85	.04
Task	17.82±4.28	18.12±4.23	-.32	.76	.07
Bond	16.82±4.13	18.59±3.36	-1.91	.08	.47
Total	54.00±11.41	55.88±11.71	-.75	.46	.16

### 4.5.3 System for Observing Therapy Alliances

Mean scores on the SOFTA-S at each time of assessment are reported in Table 5 (for women), Table 6 (for men), Table 7 (for therapists). In line with previous investigations (Mazzoni, 2010), mothers' and fathers' alliances were positive at each time of assessment and stable. Moreover, paired t-test did not reveal significant differences in mothers' and fathers' scores between T1 and T2.

**Table 5.** SOFTA-S means, standard deviations for mothers, and Tests for Differences between T1 and T2

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.41±2.12	16.71±2.17	1.27	.22	.33
Emotional Connection with the Therapist	16.59±1.94	17.00±2.09	-.75	.46	.20
Safety	16.53±2.35	16.94±2.19	-.85	.41	.18
Shared Sense of Purpose	17.59±2.27	16.65±2.85	1.50	.15	.36
Total	68.12±7.79	67.29±7.77	.43	.67	.11

**Table 6.** SOFTA-S means, standard deviations for fathers, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.12±1.96	16.59±1.77	1.45	.17	.28
Emotional Connection with the Therapist	16.88±1.65	16.76±1.60	.32	.76	.07
Safety	16.35±2.47	16.82±1.91	-.98	.34	.21
Shared Sense of Purpose	17.71±2.14	17.94±1.75	-.46	.65	.12
Total	68.06±7.04	68.12±5.97	-.04	.97	.01

With respect to the therapist alliance with family as a unit, SOFTA-S scores were quite favorable and they significantly increased on the dimension of the Emotional Connection ( $M_{\text{Time 1}}=14.59$  vs  $M_{\text{Time 2}}=15.65$ ;  $t(16)=-3.04$ ,  $p=.01$ ), with a medium effect size ( $d=-.64$ ; Cronbach, 1988).

**Table 7.** SOFTA-S means, standard deviations for therapists, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Engagement	14.71±2.14	15.06±2.51	-.64	.53	.15
Emotional Connection	14.59±1.80	15.65±1.50	-3.04	.01	.64
Safety	12.29±3.31	12.82±3.63	-.61	.55	.15
Shared Sense of Purpose	14.18±2.92	14.12±3.48	.10	.92	.02
Total	55.76±9.24	57.65±9.91	-.89	.39	.20

#### 4.5.4 Comparison of alliance among mothers and fathers

##### 4.5.4.1 Working Alliance Inventory

This study examined differences in alliance scores among mothers and fathers at each time of assessment. As for the WAI-SF, results are displayed in Tables 8 and 9. No statistically significant differences emerged (Total: Time 1  $M_{\text{women}} = 70.71$  vs  $M_{\text{men}} = 70.47$ ;  $t(16) = .09$ ,  $p = .93$ . Time 2  $M_{\text{women}} = 70.53$  vs  $M_{\text{men}} = 68.00$ ;  $t(16) = 1.32$ ,  $p = .21$ ).

**Table 8.** WAI-SF Tests for Differences among mothers and fathers at T1.

	Mothers ( <i>M ± SD</i> )	Fathers ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	24.47±3.59	23.29±4.43	1.28	.22	.29
Task	23.94±3.17	24.71±3.79	-1.00	.33	.22
Bond	22.29±2.89	22.47±4.02	-.17	.87	.05
Total	70.71±8.61	70.47±11.09	.09	.93	.02

**Table 9.** WAI-SF Tests for Differences among mothers and fathers at T2.

	Mothers ( <i>M ± SD</i> )	Fathers ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	24.65±3.50	23.18±3.15	1.55	.14	.44
Task	23.76±3.23	23.76±3.38	.00	1.00	.00
Bond	22.12±2.78	21.06±3.83	1.15	.27	.32
Total	70.53±8.24	68.00±8.75	1.32	.21	.30

#### 4.5.4.2 System for Observing Family Therapy Alliances

For what concerns SOFTA-S scores, results are reported in Tables 10 and 11.

No significant differences emerged among mothers and fathers except as for the scale of Shared Sense of Purpose, where men scored significantly higher than women at Time 2 ( $M_{\text{women}}= 16.65$  vs  $M_{\text{men}}= 17.94$ ;  $t(16)= -2.64$ ,  $p=.02$ ) with a medium effect size ( $d= .55$ ; Cronbach, 1988).

**Table 10.** SOFTA-S Tests for Differences among mothers and fathers at T1.

	Mothers ( $M \pm SD$ )	Fathers ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Engagement	17.41±2.12	17.12±1.96	.86	.40	.14
Emotional Connection with the Therapist	16.59±1.94	16.88±1.65	-.70	.49	.16
Safety	16.53±2.35	16.35±2.47	.25	.81	.07
Shared Sense of Purpose	17.59±2.27	17.71±2.14	-.24	.81	.05
Total	68.12±7.79	68.06±7.04	.04	.97	.01

**Table 11.** SOFTA-S Tests for Differences among mothers and fathers at T2.

	Mothers ( $M \pm SD$ )	Fathers ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Engagement	16.71±2.17	16.59±1.77	.31	.76	.06
Emotional Connection with the Therapist	17.00±2.09	16.76±1.60	.50	.63	.13
Safety	16.94±2.19	16.82±1.91	.21	.84	.06
Shared Sense of Purpose	16.65±2.85	17.94±1.75	-2.64	.02	.55
Total	67.29±7.77	68.12±5.97	-.58	.57	.12

#### 4.5.5 Comparison of therapist alliance with mothers and fathers

The present research investigated differences between the therapist-mother (T-M) and the therapist-father (T-F) alliance scores at T1 and T2. Results are reported in Tables 12 and 13.

For what concerns the first time of assessment, statistically significant differences emerged in the Total, Task, and Bond scales where the therapist's alliance with mothers resulted significantly higher than the alliance with fathers (Total:  $M_{\text{T-M}}=59.12$  vs  $M_{\text{T-F}}=54.00$ ;  $t(16)= 2.57$ ,  $p=.02$ . Task:



$M_{T-M}=20.35$  vs  $M_{T-F}=17.82$ ;  $t(16)= 3.04$ ,  $p=.01$ . Bond:  $M_{T-M}=18.59$  vs  $M_{T-F}=16.82$ ;  $t(16)= 2.27$ ,  $p=.04$ ). The effect size was medium (Cohen, 1988).

At Time 2 no statistically significant differences emerged, suggesting that the therapist’s alliance with mothers was similar to the alliance with fathers (Total:  $M_{T-M}=60.06$  vs  $M_{T-F}=55.88$ ;  $t(16)= 1.94$ ,  $p=.07$ ).

**Table 12.** WAI-SF Tests for Differences between therapist-mother and therapist-father alliance at T1.

	T- M ( <i>M ± SD</i> )	T-F ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.18±3.36	19.35±3.43	1.29	.22	.24
Task	20.35±3.00	17.82±4.28	3.04	.01	.68
Bond	18.59±2.92	16.82±4.13	2.27	.04	.49
Total	59.12±8.74	54.00±11.41	2.57	.02	.50

**Table 13.** WAI-SF Tests for Differences between therapist-mother and therapist-father alliance at T2.

	T-M ( <i>M ± SD</i> )	T-F ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.71±4.48	19.18±4.49	1.63	.12	.34
Task	19.71±3.98	18.12±4.23	2.12	.05	.39
Bond	19.65±3.18	18.59±3.36	1.77	.10	.32
Total	60.06±11.03	55.88±11.71	1.94	.07	.37

#### 4.5.6 Comparison of therapist and mother alliance

As regards the comparison of therapist and mother alliance scores, results are reported in Tables 14 and 15. In line with the existing literature (Fitzpatrick et al., 2005; Kramer, de Roten, Beretta, Michel, & Despland, 2008), therapist alliance scores were significantly lower than mother alliance scores at both times of assessment (Time 1 Total:  $M_{T-M}=59.12$  vs  $M_{Mothers}=70.71$ ;  $t(16)= 5.03$ ,  $p=.00$ . Time 2 Total:  $M_{T-M}=60.06$  vs  $M_{Mothers}=70.53$ ;  $t(16)= 5.61$ ,  $p=.00$ ). The effect sizes were huge (Cohen, 1988).

**Table 14.** WAI-SF Tests for Differences between therapist and mother alliance at T1.

	Therapist ( <i>M ± SD</i> )	Mother ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.18±3.36	24.47±3.59	4.22	.00	1.23
Task	20.35±3.00	23.94±3.17	4.25	.00	1.16
Bond	18.59±2.92	22.29±2.89	4.90	.00	1.27
Total	59.12±8.74	70.71±8.61	5.03	.00	1.34

**Table 15.** WAI-SF Tests for Differences between therapist and mother alliance at T2.

	Therapist ( <i>M ± SD</i> )	Mother ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.71±4.48	24.65±3.50	4.01	.00	.98
Task	19.71±3.98	23.76±3.23	6.36	.00	1.12
Bond	19.65±3.18	22.12±2.78	3.49	.00	.83
Total	60.06±11.03	70.53±8.24	5.61	.00	1.08

#### 4.5.7 Comparison of therapist and father alliance

Differences between therapist and father alliance scores are displayed in Tables 16 and 17.

As expected (Fitzpatrick et al., 2005; Kramer et al., 2008), therapist alliance scores were significantly lower than father scores at each time of assessment (Time 1 Total:  $M_{T-F}=54.00$  vs  $M_{Fathers}=70.47$ ;  $t(16)= 5.31$ ,  $p=.00$ . Time 2 Total:  $M_{T-F}=55.88$  vs  $M_{Fathers}=68.00$ ;  $t(16)= 4.58$ ,  $p=.00$ ). The effect sizes were huge (Cohen, 1988).

**Table 16.** WAI-SF Tests for Differences between therapist and father alliance at T1.

	Therapist ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	19.35±3.43	23.29±4.43	3.93	.00	.99
Task	17.82±4.28	24.71±3.79	6.31	.00	1.70
Bond	16.82±4.13	22.47±4.02	4.33	.00	1.39
Total	54.00±11.41	70.47±11.09	5.31	.00	1.46

**Table 17.** WAI-SF Tests for Differences between therapist and father alliance at T2.

	Therapist ( <i>M</i> ± <i>SD</i> )	Father ( <i>M</i> ± <i>SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Goal	19.18±4.49	23.18±3.15	3.02	.01	1.03
Task	18.12±4.23	23.76±3.38	5.57	.00	1.47
Bond	18.59±3.36	21.06±3.83	3.16	.01	.69
Total	55.88±11.71	68.00±8.75	4.58	.00	1.17

#### 4.5.8 Comparison of therapist and parental couple alliance

With reference to SOFTA-S scores, firstly a “parental couple” score was calculated for each scale (the average ratings of mothers and fathers). Secondly, unpaired t-tests were conducted to analyze differences between the therapist’s alliance with family and the parental couple alliance with therapist.

Results are reported in Tables 18 and 19. Similarly to WAI-SF, therapist scores were significantly lower than parental couple ratings at each time of assessment (Time 1 Total:  $M_{T-Family}=55.76$  vs  $M_{Parental\ Couple}=68.09$ ;  $t(32)= 4.47$ ,  $p=.00$ ; Time 2 Total:  $M_{T-Family}=57.65$  vs  $M_{Parental\ Couple}=67.71$ ;  $t(32)= 3.54$ ,  $p=.00$ ). The effect sizes were huge (Cohen, 1988).

**Table 18.** SOFTA-S Tests for Differences between therapist and parental couple alliance at T1.

	Therapist ( <i>M</i> ± <i>SD</i> )	Parental couple ( <i>M</i> ± <i>SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	14.71±2.14	17.26±1.92	3.67	32	.00	1.25
Emotional Connection	14.59±1.80	16.74±1.58	3.69	32	.00	1.27
Safety	12.29±3.31	16.44±1.92	4.47	25.66	.00	1.53
Shared Sense of Purpose	14.18±2.92	17.65±1.97	4.06	32	.00	1.39
Total	55.76±9.24	68.09±6.64	4.47	32	.00	1.53

**Table 19.** SOFTA-S Tests for Differences between therapist and parental couple alliance at T2.

	Therapist ( <i>M ± SD</i> )	Parental couple ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	15.06±2.51	16.65±1.82	2.11	32	.04	.73
Emotional Connection	15.65±1.50	16.88±1.59	2.34	32	.03	.80
Safety	12.82±3.63	16.88±1.70	4.18	22.71	.00	1.43
Shared Sense of Purpose	14.12±3.48	17.29±2.14	3.21	32	.00	1.10
Total	57.65±9.91	67.71±6.29	3.54	32	.00	1.21

#### 4.5.9 Parenting stress

##### 4.5.9.1 Descriptive statistics

Descriptive statistics are reported in Tables 20 (for mothers) and 21 (for fathers).

For what concerns mothers, no significant differences emerged between T1 and T2.

Moreover, at both times of assessment mothers reported clinically significant stress scores on the Difficult Child Scale (Time 1: 90<sup>th</sup> percentile; Time 2: 85<sup>th</sup> percentile), while scores were in normal clinical ranges on the other scales (Parental Distress, Parent-Child Dysfunctional Interaction, and Total scales < 85<sup>th</sup> percentile).

With respect to fathers, no significant differences emerged between the two time points. However, as shown in Table 21, there was an increasing in father total scores from T1 to T2, although it did not reach statistical significance.

Moreover, fathers reported clinically significant levels of stress on the Total (Time 1: 80<sup>th</sup> percentile – still not clinically relevant; Time 2: 85<sup>th</sup> percentile), and on the Difficult Child scales (Time 1: 85<sup>th</sup> percentile; Time 2: 90<sup>th</sup> percentile). Scores were in normal clinical ranges on the other two scales (Parental Distress and the Parent-Child Dysfunctional Interaction scales <85<sup>th</sup> percentile).

**Table 20.** PSI-SF means, standard deviations for mothers, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	28.88±9.02	29.18±8.45	-.24	.81	.03
Parent-Child Dysfunctional Interaction	23.12±5.80	22.12±5.69	.82	.42	.17
Difficult Child	31.94±8.59	30.94±8.09	.72	.48	.12
Total	83.94±18.77	82.24±18.10	.54	.60	.09

**Table 21.** PSI-SF means, standard deviations for fathers, and Tests for Differences between T1 and T2.

	T1 ( <i>M ± SD</i> )	T2 ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	27.41±6.57	28.71±6.89	-.95	.36	.19
Parent-Child Dysfunctional Interaction	23.71±6.53	25.06±6.15	-.99	.34	.21
Difficult Child	31.65±6.90	33.29±6.18	-.85	.41	.25
Total	82.76±14.18	87.06±13.16	-1.35	.20	.31

#### 4.5.9.2 Comparison of mother and father stress

Mothers and fathers reported similar levels of stress at each time of assessment (Time 1 Total:  $M_{\text{mothers}}=83.94$  vs  $M_{\text{fathers}}=82.76$ ;  $t(16)= .23$ ,  $p=.82$ . Time 2 Total:  $M_{\text{mothers}}=82.24$  vs  $M_{\text{fathers}}=87.06$ ;  $t(32)= -1.16$ ,  $p=.26$ ).

**Table 22.** PSI-SF Tests for Differences among mothers and fathers at T1.

	Mother ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	28.88±9.02	27.41±6.57	.86	.40	.19
Parent-Child Dysfunctional Interaction	23.12±5.80	23.71±6.53	-.38	.71	.10
Difficult Child	31.94±8.59	31.65±6.90	.12	.90	.04
Total	83.94±18.77	82.76±14.18	.23	.82	.07

**Table 23.** PSI-SF Tests for Differences among mothers and fathers at T2.

	Mother ( <i>M</i> ± <i>SD</i> )	Father ( <i>M</i> ± <i>SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	29.18±8.45	28.71±6.89	.22	.83	.06
Parent-Child Dysfunctional Interaction	22.12±5.69	25.06±6.15	-1.95	.07	.50
Difficult Child	30.94±8.09	33.29±6.18	-1.38	.19	.33
Total	82.24±18.10	87.06±13.16	-1.16	.26	.30

#### 4.5.10 Emotional Availability

##### 4.5.10.1 Descriptive statistics

Tables 24a and 24b report mean scores on the maternal and child dimensions of the EAS.

According to the manual (Biringen, 2008), mothers reported problems on the Structuring scale ( $M_{\text{Time 1}}=4.94$ ,  $M_{\text{Time 2}}=4.65$ ), while children on the Child Involvement scale ( $M_{\text{Time 1}}=4.85$ ,  $M_{\text{Time 2}}=5.12$ ). However, no significant differences emerged between T1 and T2.

**Table 24a.** EAS means, standard deviations for mothers, and Tests for Differences between T1 and T2.

	T1 ( <i>M</i> ± <i>SD</i> )	T2 ( <i>M</i> ± <i>SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	5.97±1.12	5.91±1.19	.33	.74	.05
Structuring	4.94±1.33	4.65±1.28	1.13	.28	.22
Non-Intrusiveness	6.32±.87	6.03±1.18	1.21	.24	.28
Non-Hostility	6.62±.49	6.59±.59	.44	.67	.06

**Table 24b.** EAS means, standard deviations for children, and Tests for Differences between T1 and T2.

	T1 ( <i>M</i> ± <i>SD</i> )	T2 ( <i>M</i> ± <i>SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Child Responsiveness	5.47±1.39	5.59±1.54	-.32	.75	.08
Child Involvement	4.85±1.30	5.12±1.67	-.77	.45	.18

Tables 25a and 25b report descriptive statistics on the paternal and child dimensions of the EAS. Compared to mothers, fathers showed a more problematic scenario. Indeed, they reported problems on the Sensitivity ( $M_{\text{Time 1}}=4.59$ ,  $M_{\text{Time 2}}=4.88$ ), and Structuring ( $M_{\text{Time 1}}=3.77$ ,  $M_{\text{Time 2}}=4.38$ ) scales; while children on the Child Responsiveness ( $M_{\text{Time 1}}=4.65$ ,  $M_{\text{Time 2}}=4.79$ ), and Child Involvement ( $M_{\text{Time 1}}=3.79$ ,  $M_{\text{Time 2}}=4.00$ ) scales. Again, no significant differences emerged between T1 and T2.

**Table 25a.** EAS means, standard deviations for fathers, and Tests for Differences between T1 and T2.

	T1 ( $M \pm SD$ )	T2 ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Sensitivity	4.59±1.53	4.88±1.59	-.77	.45	.19
Structuring	3.77±1.39	4.38±1.71	-1.84	.09	.39
Non-Intrusiveness	5.94±.68	5.94±.68	.00	1.00	.00
Non-Hostility	6.56±.66	6.38±.86	1.14	.27	.23

**Table 25b.** EAS means, standard deviations for children, and Tests for Differences between T1 and T2.

	T1 ( $M \pm SD$ )	T2 ( $M \pm SD$ )	$t(16)$	$p$	Effect size ( $d$ )
Child Responsiveness	4.65±1.61	4.79±1.80	-.43	.67	.08
Child Involvement	3.79±1.68	4.00±1.94	-.82	.42	.12

#### 4.5.10.2 Comparison of mother and father emotional availability

EAS mother and father scores were compared at both T1 and T2 (Tables 26a- 26b).

With reference to the first time of assessment, mothers scored significantly higher than men on the Sensitivity ( $M_{\text{mothers}}=5.97$  vs  $M_{\text{fathers}}=4.59$ ;  $t(16)= 3.27$ ,  $p=.01$ ), and Structuring ( $M_{\text{mothers}}=4.94$  vs  $M_{\text{fathers}}=3.77$ ;  $t(16)= 2.72$ ,  $p=.02$ ) scales. The effect sizes were large (Cohen, 1988).

At Time 2, statistically significant differences emerged on the Sensitivity scale ( $M_{\text{mothers}}=5.91$  vs  $M_{\text{fathers}}=4.88$ ;  $t(16)= 2.57$ ,  $p=.02$ ), where mothers obtained higher scores than fathers. The effect size was large ( $d=.73$ ).

**Table 26a.** EAS Tests for Differences among mothers and fathers at T1.

	Mother ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	5.97±1.12	4.59±1.53	3.27	.01	1.03
Structuring	4.94±1.33	3.77±1.39	2.72	.02	.86
Non-Intrusiveness	6.32±.87	5.94±.68	1.42	.18	.49
Non-Hostility	6.62±.49	6.56±.66	.30	.77	.10

**Table 26b.** EAS Tests for Differences among mothers and fathers at T2.

	Mother ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	5.91±1.19	4.88±1.59	2.57	.02	.73
Structuring	4.65±1.28	4.38±1.71	.61	.55	.18
Non-Intrusiveness	6.03±1.18	5.94±.68	.26	.80	.09
Non-Hostility	6.59±.59	6.38±.86	.91	.38	.28

Child emotional availability with mother and father were compared (Tables 27a- 27b).

At both times of assessment, children scored significantly higher on the Child-Mother Responsiveness (Time 1:  $M_{\text{child-mother}}=5.47$  vs  $M_{\text{child-father}}=4.65$ ;  $t(16)=2.18$ ,  $p=.05$ . Time 2:  $M_{\text{child-mother}}=5.59$  vs  $M_{\text{child-father}}=4.79$ ;  $t(16)=2.67$ ,  $p=.02$ ), and on the Child-Mother Involvement (Time 1:  $M_{\text{child-mother}}=4.85$  vs  $M_{\text{child-father}}=3.79$ ;  $t(16)=2.73$ ,  $p=.02$ . Time 2:  $M_{\text{child-mother}}=5.12$  vs  $M_{\text{child-father}}=4.00$ ;  $t(16)=4.10$ ,  $p=.00$ ) scales. The effect sizes were medium (Cohen, 1988).

**Table 27a.** EAS Tests for Differences between child-mother and child-father at T1.

	Mother ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Child Responsiveness	5.47±1.39	4.65±1.61	2.18	.05	.55
Child Involvement	4.85±1.30	3.79±1.68	2.73	.02	.71



**Table 27b.** EAS Tests for Differences between child-mother and child-father at T2.

	Mother ( <i>M ± SD</i> )	Father ( <i>M ± SD</i> )	<i>t</i> (16)	<i>p</i>	Effect size ( <i>d</i> )
Child Responsiveness	5.59±1.54	4.79±1.80	2.67	.02	.48
Child Involvement	5.12±1.67	4.00±1.94	4.10	.00	.62

#### 4.5.11 Dropout

##### 4.5.11.1 Dropout and parental personality

As described thoroughly in the Paragraph 2.2, at the end of the first six FPT-CP sessions, the therapist would suggest each family to go on the therapeutic process in order to achieve a complete remission of child symptoms and the family well-being.

In the present study, the term “dropout” refers to the parental decision not to continue the intervention in disagreement with the therapist. Only in two cases (out of 17) the six sessions were sufficient enough to solve child problems, because child symptoms were not severe and family resources were fully available since the beginning of the intervention.

Unpaired t-tests were conducted to investigate the relationship between parental personality and parental decision to continue (or not) the intervention.

Tables 28 and 29 are reported in the Appendix-List of additional tables. Results showed that fathers who accepted to continue the intervention scored significantly higher on the Agreeableness scale ( $M_{\text{agreement}} = 3.91$  vs  $M_{\text{disagreement}} = 3.37$ ;  $t(13) = -2.21$ ,  $p = .05$ ) than fathers who did not. The effect size was large ( $d = 1.10$ ; Cohen, 1988).

With respect to mothers, although no differences emerged, the effect size reported on the Neuroticism scale was large ( $M_{\text{agreement}} = 3.11$  vs  $M_{\text{disagreement}} = 2.60$ ;  $t(13) = -1.74$ ,  $p = .11$ ;  $d = .95$ ).

##### 4.5.11.2 Dropout and alliance

For what concerns WAI-SF scores, as expected, at T1 no significant differences were found between parents who accepted to continue the intervention and parents who did not (please, see the Appendix, Tables 30-31).

With respect to the second time of assessment, results are displayed in Tables 32-33.

Mothers who accepted to continue the intervention scored significantly higher on the Task scale than mothers who did not ( $M_{\text{agreement}} = 24.78$  vs  $M_{\text{disagreement}} = 21.17$ ;  $t(13) = -2.54$ ,  $p = .03$ ). The effect size was very large.

As for fathers, significant differences emerged on the Bond scale ( $M_{\text{agreement}} = 22.56$  vs  $M_{\text{disagreement}} = 17.67$ ;  $t(13) = -3.03$ ,  $p = .01$ ) with a huge effect size ( $d = 1.70$ ; Cohen, 1988). Moreover, the effect size on the Total scale was large ( $d = 1.00$ ), although differences did not reach statistical significance.

**Table 32.** WAI-SF – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T2.

	Agreement (N=9) ( $M \pm SD$ )	Disagreement (N=6) ( $M \pm SD$ )	$t$	$df$	$p$	Effect size ( $d$ )
Goal	25.11±2.80	23.00±4.43	-1.14	13	.28	.57
Task	24.78±2.59	21.17±2.86	-2.54	13	.03	1.32
Bond	22.11±3.26	21.00±1.26	-.79	13	.44	.45
Total	72.00±6.89	65.17±8.08	-1.76	13	.10	.91

**Table 33.** WAI-SF – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T2.

	Agreement (N=9) ( $M \pm SD$ )	Disagreement (N=6) ( $M \pm SD$ )	$t$	$df$	$p$	Effect size ( $d$ )
Goal	23.33±3.00	21.83±3.25	-.92	13	.38	.48
Task	23.78±2.91	22.50±3.94	-.73	13	.48	.37
Bond	22.56±3.61	17.67±1.86	-3.03	13	.01	1.70
Total	69.67±7.52	62.00±7.87	-1.90	13	.08	1.00

With respect to SOFTA-S, no significant differences were found among parents who accepted to continue the intervention and parents who did not at T1 (please, see the Appendix, Tables 34-35).

For what concerns the second time of assessment, results are displayed in Tables 36-37.

With respect to mothers, those who agreed with the therapist scored significantly higher on the Total ( $M_{\text{agreement}} = 70.44$  vs  $M_{\text{disagreement}} = 60.50$ ;  $t(13) = -2.99$ ,  $p = .01$ ), Emotional Connection ( $M_{\text{agreement}} = 17.89$  vs  $M_{\text{disagreement}} = 15.67$ ;  $t(13) = -2.15$ ,  $p = .05$ ), and Safety ( $M_{\text{agreement}} = 18.00$  vs  $M_{\text{disagreement}} = 15.00$ ;  $t(13) = -3.52$ ,  $p = .00$ ) scales than mothers who did not. The effect sizes were huge (Cohen, 1988). As for the other scales, although there were not statistically significant differences, effect sizes were large as well.

With regards to fathers, differences did not emerge. However the effect sizes on the Engagement, Emotional Connection and Total scales were large (Table 37).

**Table 36.** SOFTA-S – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.33±2.00	15.17±1.94	-2.08	13	.06	1.10
Emotional Connection	17.89±1.54	15.67±2.50	-2.15	13	.05	1.07
Safety	18.00±1.66	15.00±1.55	-3.52	13	.00	1.87
Shared Sense of Purpose	17.22±2.59	14.67±2.34	-1.94	13	.07	1.03
Total	70.44±6.48	60.50±6.02	-2.99	13	.01	1.59

**Table 37.** SOFTA-S – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	16.89±1.83	15.50±1.22	-1.62	13	.13	.89
Emotional Connection	17.22±1.56	15.67±1.37	-1.98	13	.07	1.06
Safety	17.33±1.32	16.00±2.76	-1.27	13	.23	.61
Shared Sense of Purpose	18.00±1.50	17.17±1.94	-.94	13	.37	.48
Total	69.44±5.36	64.33±5.99	-1.73	13	.11	.90

While no differences emerged in therapist WAI-SF scores at T1 (please, see the Appendix, Tables 38-39), at the second time of assessment effect sizes were large on both therapist-mother (except on the Bond scale,  $d=.55$ ), and therapist-father scales, although differences were not statistically significant (please, see Tables 40-41).

**Table 40.** WAI-SF– Unpaired t-tests for differences among therapist alliances with mothers who accepted to continue the intervention and mothers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	21.89±3.06	17.83±5.71	-1.60	6.94	.16	.89
Task	21.00±2.45	17.00±5.06	-1.80	6.58	.12	1.01
Bond	19.89±1.76	18.17±4.07	-.98	6.27	.37	.55
Total	62.78±6.53	53.00±14.34	-1.57	6.40	.17	.88

**Table 41.** WAI-SF– Unpaired t-tests for differences among therapist alliances with fathers who accepted to continue the intervention and fathers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	20.44±4.56	16.50±4.09	-1.71	13	.11	.91
Task	19.44±4.39	15.17±2.79	-2.11	13	.06	1.16
Bond	19.11±3.37	16.83±2.79	-1.37	13	.19	.74
Total	59.00±12.01	48.50±9.20	-1.81	13	.09	.98

Similarly to the WAI-SF, at T2 the SOFTA-S therapist scores of alliance with families who accepted to continue the intervention were significantly higher than ratings of alliance with families who did not (Total scale:  $M_{\text{agreement}} = 61.00$  vs  $M_{\text{disagreement}} = 50.00$ ;  $t(13) = -2.40$ ,  $p = .03$ ; Engagement scale:  $M_{\text{agreement}} = 15.89$  vs  $M_{\text{disagreement}} = 13.17$   $t(13) = -2.30$ ,  $p = .04$ ; Shared Sense of Purpose scale:  $M_{\text{agreement}} = 15.56$  vs  $M_{\text{disagreement}} = 11.00$ ;  $t(13) = -3.15$ ,  $p = .01$ ). Moreover, the effect sizes were huge. Hence, according to the therapist perceptions of alliance, the Shared Sense of Purpose (i.e. intra-family collaboration in therapy) and the Engagement scales discriminated families who were compliant from families who were not. Results are displayed in Table 43.

**Table 43.** SOFTA-S – Unpaired t-tests for differences among therapist alliances with families who accepted to continue the intervention and families who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	15.89±1.69	13.17±2.93	-2.30	13	.04	1.14
Emotional Connection	16.11±1.45	14.83±1.60	-1.60	13	.13	.84
Safety	13.44±4.28	11.00±2.10	-1.29	13	.22	.72
Shared Sense of Purpose	15.56±3.13	11.00±2.00	-3.15	13	.01	1.74
Total	61.00±9.46	50.00±7.29	-2.40	13	.03	1.30

#### 4.5.11.3 Dropout and parenting stress

At T1, mothers who were compliant with therapist suggestions to go on the therapeutic process scored significantly higher than mothers who were not on the Parent-Child Dysfunctional Interaction ( $M_{\text{agreement}} = 26.33$  vs  $M_{\text{disagreement}} = 19.67$ ;  $t(13) = -2.51$ ,  $p = .03$ ) scale. As reported in Table 44, the effect sizes were large on the Difficult Child and Total scales as well (Cohen, 1998).

For what concerns the second time of assessment, no differences emerged (please, see the Appendix, Tables 46-47).

**Table 44.** PSI-SF – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	31.22±11.62	26.67±4.59	-.91	13	.38	.52
Parent-Child Dysfunctional Interaction	26.33±5.05	19.67±5.05	-2.51	13	.03	1.32
Difficult Child	35.44±8.69	27.33±7.74	-1.85	13	.09	.99
Total	93.00±19.93	73.67±12.36	-2.11	13	.06	1.17

#### 4.5.11.4 Dropout and emotional availability

Results are displayed in the Appendix (Tables 48-49-50).

For what concerns the second time of assessment, fathers who were compliant with therapist scored significantly higher than fathers who were not on the EAS Sensitivity ( $M_{\text{agreement}} = 5.56$  vs  $M_{\text{disagreement}} = 3.42$ ;  $t(13) = -3.41$ ,  $p = .01$ ), Structuring ( $M_{\text{agreement}} = 5.39$  vs  $M_{\text{disagreement}} = 2.83$ ;  $t(13) = -3.80$ ,  $p = .00$ ), Child Responsiveness ( $M_{\text{agreement}} = 5.28$  vs  $M_{\text{disagreement}} = 3.33$ ;  $t(13) = -2.54$ ,  $p = .03$ ), and Child Involvement ( $M_{\text{agreement}} = 4.56$  vs  $M_{\text{disagreement}} = 2.58$ ;  $t(13) = -2.16$ ,  $p = .05$ ) scales. As shown in Table 51, the effect sizes were very large (Cohen, 1998).

**Table 51.** EAS – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T2.

	Agreement (N=9) ( $M \pm SD$ )	Disagreement (N=6) ( $M \pm SD$ )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	5.56±1.13	3.42±1.28	-3.41	13	.01	1.77
Structuring	5.39±.93	2.83±1.69	-3.80	13	.00	1.88
Non-Intrusiveness	5.94 ±.77	5.75±.52	-.54	13	.60	.29
Non-Hostility	6.61±.86	5.83±.75	-1.80	13	.10	.97
Child Responsiveness	5.28±1.44	3.33±1.47	-2.54	13	.03	1.34
Child Involvement	4.56±1.70	2.58±1.77	-2.16	13	.05	1.14

#### 4.5.12 Therapist experience and alliance

Unpaired t-tests were also conducted to investigate differences in parental WAI-SF and SOFTA-S scores according to the therapist level of experience (“high experience”= >5 years; “low experience”= <5 years). As showed in the Appendix (Tables 52-59), no significant differences emerged at both times of assessment. As described thoroughly in the Paragraph 2.2, the FPT-CP as clinical methodology was specifically designed to promote early in treatment the therapeutic alliance with parents of children.

#### 4.5.13 Correlational analyses

##### 4.5.13.1 WAI-SF and SOFTA-S

Correlations were computed among all WAI-SF and SOFTA-S scales at T1 and T2.

As reported in Tables 60-61 (for therapist, please see the Appendix, Tables 62-63), with some exceptions, the correlations were statistically significant and in the expected direction ( $r$  ranges from .48- moderate to .80 - strong).

Results were in line with our hypotheses, since SOFTA-S Engagement and Emotional Connection scales originated from WAI-SF Task, Goal and Bond scales; whereas the other two SOFTA-S scales (Safety and Shared Sense of Purpose) were designed to measure specific dimensions of the alliance in systemic therapy settings.

**Table 60.** Correlations between parent WAI-SF and SOFTA-S at T1.

	Mother				Father			
	Goal	Task	Bond	Total	Goal	Task	Bond	Total
SOFTA Engagement	.76**	.70**	.67**	.80**	.56*	.58*	.59*	.63**
SOFTA Emotional Connection	.66**	.80**	.68**	.80**	.63**	.72**	.69**	.75**
SOFTA Safety	.46	.48*	.42	.51*	.46	.43	.61**	.55*
SOFTA Shared Sense of Purpose	.44	.58*	.35	.52*	.48	.31	.10	.34
SOFTA Total	.64**	.70**	.58*	.72**	.61**	.58*	.57*	.65**

\* $p < .05$ ; \*\* $p < .01$

**Table 61.** Correlations between parent WAI-SF and SOFTA-S at T2.

	Mother				Father			
	Goal	Task	Bond	Total	Goal	Task	Bond	Total
SOFTA Engagement	.72**	.76**	.62**	.81**	.26	.48*	.52*	.51*
SOFTA Emotional Connection	.60*	.62**	.37	.62**	.24	.51*	.71**	.59*
SOFTA Safety	.10	.37	.35	.30	.35	.48	.40	.49*
SOFTA Shared Sense of Purpose	.53*	.68**	.36	.61**	.48	.84**	.63**	.77**
SOFTA Total	.58*	.73**	.50*	.70**	.40	.68**	.66**	.69**

\* $p < .05$ ; \*\* $p < .01$

#### 4.5.13.2 Personality and alliance

For what concerns the relationship among the BFI and WAI-SF scales, results are reported in the Appendix (Tables 64-65).

As for fathers, no significant correlations were found at both times of assessment.

With respect to mothers, at T1 the Consciousness dimension of personality was significantly associated to the WAI-SF Total ( $r=.56$ ,  $p < .05$ ) and Goal ( $r=.64$ ,  $p < .01$ ) scales; whereas the BFI Agreeableness scale was found to correlate significantly to the Bond aspect of alliance ( $r=.50$ ,  $p < .05$ ). At T2 a similar scenario emerged. Scores on the BFI Consciousness scale significantly correlated to the WAI-SF Total ( $r=.50$ ,  $p < .05$ ), Task ( $r=.53$ ,  $p < .05$ ) and Bond ( $r=.50$ ,  $p < .05$ ) scales. Moreover, the Extraversion dimension of personality was found to correlate significantly to the Bond aspect of alliance ( $r=.50$ ,  $p < .05$ ).

#### 4.5.13.3 Personality and parenting stress

Correlations among the BFI and PSI-SF scales are reported in the Appendix (Table 66).

As for mothers, at T1 positive correlations were found between the BFI Neuroticism scale and the PSI-SF Total ( $r=.57$ ,  $p < .05$ ), Parental Distress ( $r=.59$ ,  $p < .05$ ), and Parent-Child Dysfunctional Interaction ( $r=.53$ ,  $p < .05$ ) scales. Moreover, scores on the Agreeableness dimension of personality negatively correlated to the PSI-SF Parental Distress scale ( $r=-.55$ ,  $p < .05$ ).

With respect to fathers, negative correlations were found between the BFI Extraversion and the PSI-SF Parental Distress scales ( $r=-.52$ ,  $p < .05$ ).

#### 4.5.13.4 Parenting stress and alliance

For what concerns the associations among the PSI-SF and WAI-SF scales, results are displayed in the Appendix (Tables 67-68).

As for mothers, at T1 negative correlations were found between the PSI-SF Parent-Child Dysfunctional Interaction and the WAI-SF Total ( $r=-.54$ ,  $p < .05$ ), Goal ( $r=-.56$ ,  $p < .05$ ), and Bond ( $r=-.56$ ,  $p < .05$ ) scales. Similarly to mothers, fathers reported negative associations among the Parent-Child Dysfunctional Interaction scale and the WAI-SF Total ( $r=-.52$ ,  $p < .05$ ), Goal ( $r=-.49$ ,  $p < .05$ ), and Bond ( $r=-.53$ ,  $p < .05$ ) scales.

At the second time of assessment, mothers' parenting stress total score was significantly associated to the WAI-SF Total ( $r=-.50$ ,  $p < .05$ ), and Bond ( $r=-.53$ ,  $p < .05$ ) scales. Moreover, the Parental Distress scale was found to be negatively associated to the Total ( $r=-.60$ ,  $p < .05$ ), Goal ( $r=-.57$ ,  $p < .05$ ), and Task ( $r=-.50$ ,  $p < .05$ ) dimensions of alliance. Significant associations were not found in the sample of fathers.



#### 4.5.13.5 Parenting stress and emotional availability

Correlations among the PSI-SF and EAS scales are displayed in the Appendix (Table 69).

As for mothers, at T1 negative correlations ( $r=-.49$ ,  $p < .05$ ) were found between PSI-SF Total and EAS Structuring scales. Moreover, maternal scores on the Parental Distress scale negatively correlated to the EAS Child Responsiveness ( $r=-.51$ ,  $p < .05$ ), and Child Involvement scales ( $r=-.54$ ,  $p < .05$ ).

With respect to fathers, negative correlations were found between EAS Child Responsiveness and PSI-SF Total scales ( $r=-.49$ ,  $p < .05$ ), and between Child Responsiveness and Parent-Child Dysfunctional Interaction ( $r=-.57$ ,  $p < .05$ ) scales.

No significant associations were found at T2.

#### 4.5.13.6 Alliance and emotional availability

Correlations were also computed among the WAI-SF and EAS scales (please, see the Appendix, Table 70). At T2, as for fathers, it was found that the Bond scale was significantly associated to EAS Sensitivity ( $r=.56$ ,  $p < .05$ ), and Non-Hostility ( $r=.54$ ,  $p < .05$ ) scales. No other significant correlations were obtained.

## CHAPTER 5

### **The therapeutic alliance with families: two contrasting clinical cases**

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As discussed thoroughly earlier, this work focused on the first phase (six sessions) of the FPT-CP because it is specifically oriented to the assessment of child symptoms within the family dynamics, and to the promotion of the therapeutic alliance with parents as a pre-condition for a successful intervention. At the end of this phase, once the therapist has established a nice and “productive/working” relationship with parents, therapeutic goals are discussed in light of child and parent changes. Parent efforts to deal with child difficulties and to modify some aspects of the parent-child relationship are emphasized. In most cases, the therapist comes to an agreement with parents about the opportunity to go on the therapeutic process.

Following is the esemplification of two contrasting clinical cases: the first parental couple was compliant with the therapist suggestions to continue the intervention, while the second one decided not to continue - in disagreement with the therapist. Both families were seen by the same experienced clinician (woman).

#### **5.1 A good outcome case**

For what concerns the first family, it was composed by a 3-years old child (Giorgio), his mother (Francesca, 38 years) and his father (Riccardo, 39 years). Names are fictitious.

*Reasons for self-referral:* in this self-referred family, parents sought a clinical consultation for his child’s angry-oppositional behaviors at home. At the time of assessment, the child was delayed in his language development as well.

During the first session of the FPT-CP Francesca described Giorgio as a child having a strong bond with her and somewhat jealous of his younger brother, after he was born one year ago. Riccardo was used to work away from home for periods of time, and Francesca was very tired of managing the home life and children alone. Since Giorgio’s birth, they moved four times and, at the time of the assessment, they were living at Francesca’s mum’s home due to their house renovation. Moreover, Francesca’s mum suffered from a severe depression and the atmosphere was tense at home.

*Child and parental behaviors during sessions:* if at first Giorgio needed to adapt himself to the new play environment, he showed a very positive attitude during play and an enthusiasm with his family and the therapist. The child did not present a narrative-symbolic play but he still played building snails with play dough representing the members of his family.

During the FPT-CP sessions, Francesca appeared very exhausted, she had a blank stare and she joined play, especially if encouraged by the therapist. However, she always showed a loving attitude with her child. Compared to her, Riccardo looked more enthusiastic although he was not used to play with his child.

Parental behaviors during sessions were generally characterized by an attitude of tolerance, patience, and collaboration with the therapist proposals. If requested, they played a more active and facilitating role in child play; otherwise they were very attentive to observe what was happening during play. Riccardo, who was less used to spend time with Giorgio, seemed very happy to play the role of a “mechanic” repairing his child’s truck.

*At the end of the sixth session:* at the end of the sixth session, the therapist discussed with family about the child little changes occurred over the FPT-CP first phase. She found Giorgio with an enthusiastic attitude towards the play environment and appropriately interacting with his parents and the therapist as well.

At the end of this phase, Giorgio’s oppositional behaviors decreased, he was able to formulate sentences containing two-three words, and his fears about abandonment (showed at the beginning of the intervention) disappeared.

The therapist linked these child changes with the parental efforts to better interact with their child showing a more accurate understanding of child needs. On the other hand, at the end of this phase, the child appeared to be more in contact with his family expressing the desire to reproduce in play his own family “snail-mum, snail-dad, snail-child”.

To conclude, in this initial FPT-CP phase the therapist’s aim was to develop a positive alliance with parents based on the mutual agreement over the goals and methods used in sessions. At the same time, an emotional bond with the child and his parents was promoted leading to the family agreement about the opportunity to continue the intervention.

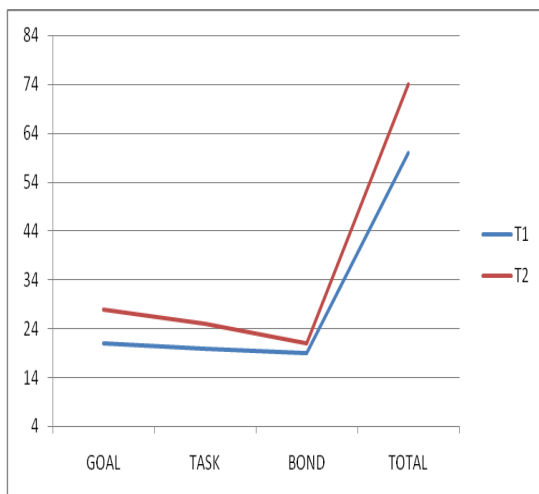
Parents trusted in the clinician abilities to help them and they started to make use of their own parental abilities which were emphasized by the therapist through an evaluation of their relational interventions. Although parents started to acquire a greater ability to see things from the child’s point of view, some difficulties still remained, with respect to Francesca’s high levels of stress and worries about family and children demands.

Figures below show alliance and parenting stress scores for each parent and the therapist at both times of assessment.

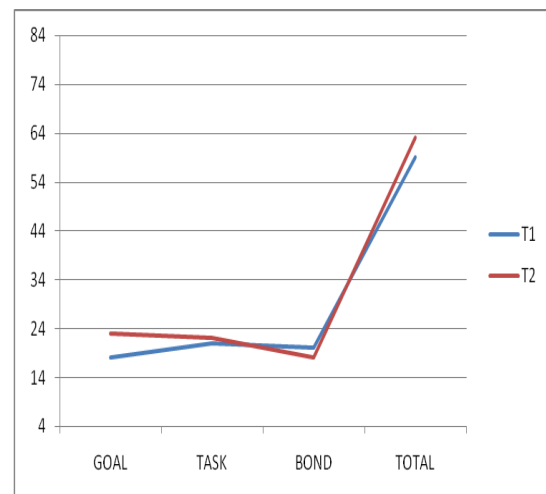
As described thoroughly in the Paragraph 4.3.3., the WAI-SF measures client's level of agreement with the tasks and goals of treatment and the emotional bond with the therapist (ranges for each subscale 4-28; total score 12-84).

The SOFTA-S two scales (Engagement and Emotional Connection) derive from the WAI-SF Goal and Task scales; while the other two dimensions (Safety and Shared Sense of Purpose) were created to specifically assess the therapeutic alliance in conjoint/family settings where it is important to assess the level of safety, comfort and the productive collaboration and shared sense of purpose by family members in therapy. In the present research SOFTA-S was used mainly as a clinical measure of the therapeutic alliance, because the use of this instrument is recent and more empirical support is needed (ranges for each subscale 4-20; total score 16-80).

**Figure 1a.** Francesca - WAI-SF



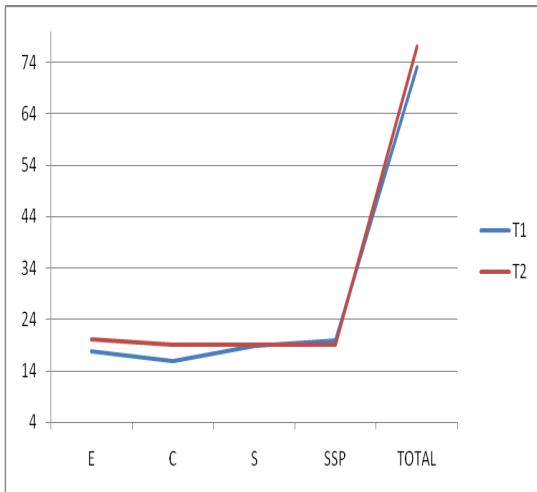
**Figure 1b.** Riccardo - WAI-SF



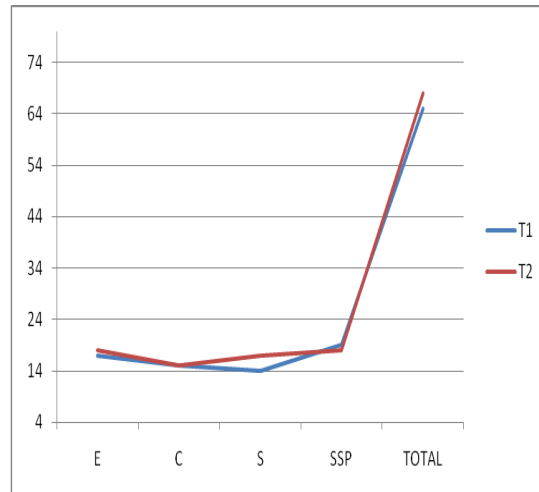
As shown in Figures 1a and 1b, Francesca and Riccardo developed a positive relationship with the therapist. Scores on each WAI-SF subscale were positive at both times of assessment and, as for Francesca, alliance scores increased significantly from T1 to T2 (Francesca: Total scores 60-74; Riccardo: 59-63). Since the beginning of the intervention, the parental couple showed high levels of motivation and need for a professional help. In particular, Francesca seemed to be overwhelmed by child demands and stressed for taking major responsibility in the family day-life.

Indeed, the Bond dimension of alliance was positive and stable through sessions, and what increased more was the family understanding about the goals and tasks of the intervention.

**Figure 2a.** Francesca - SOFTA-S



**Figure 2b.** Riccardo – SOFTA-S

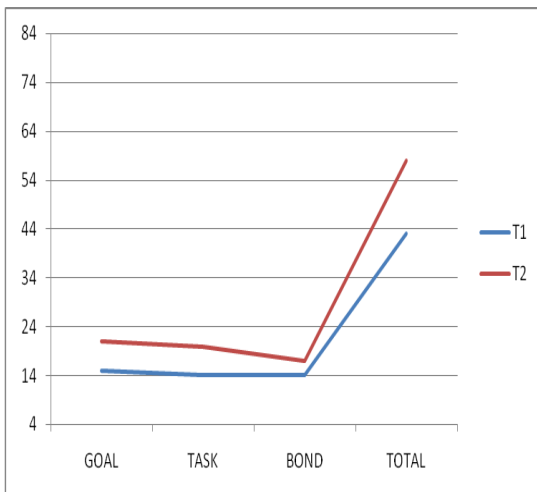


Figures 2a and 2b report SOFTA-S parental scores. Similarly to WAI-SF, the alliance scores were positive and they increased from T1 to T2 (Francesca: Total scores 73-77; Riccardo: 65-68). Both parents obtained high scores on the Shared Sense of Purpose scale, suggesting a positive intra-family collaboration (“we are here together”) with respect to the goals of the intervention, which is necessary for positive child and family outcomes.

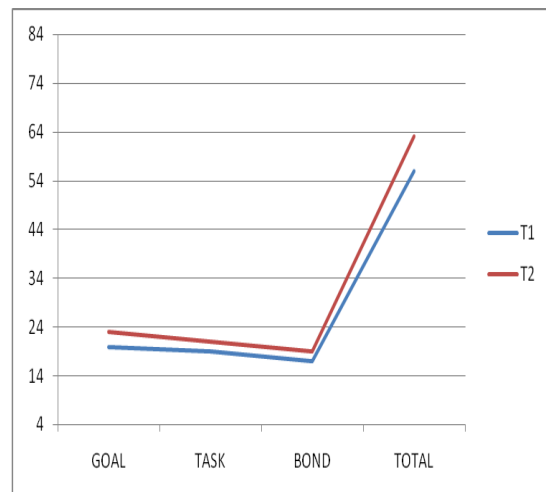
For what concerns Riccardo, scores increased on the Safety scale from T1 (14) to T2 (17), while Anna’s scores were positive and stable (T1: 19- T2: 19). It seems that Riccardo, at the end of this initial phase, felt more safe and at his ease in the setting. Probably Francesca, who worked as a psychotherapist, adapted herself more easily to the environment.

For what concerns the therapist perceptions of alliance, results are displayed in Figures 3a, 3b and 3c.

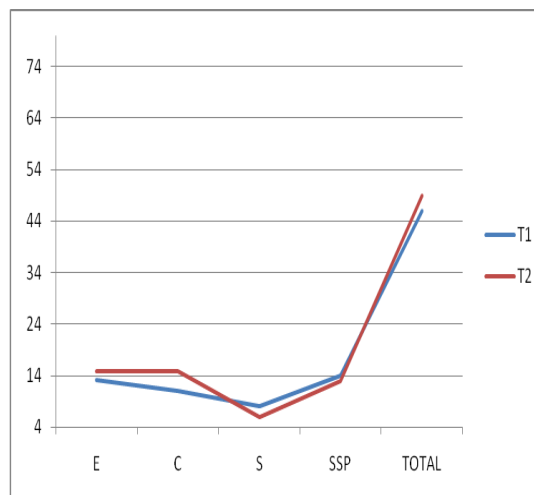
**Figure 3a.** T-mother – WAI-SF



**Figure 3b.** T-father – WAI-SF



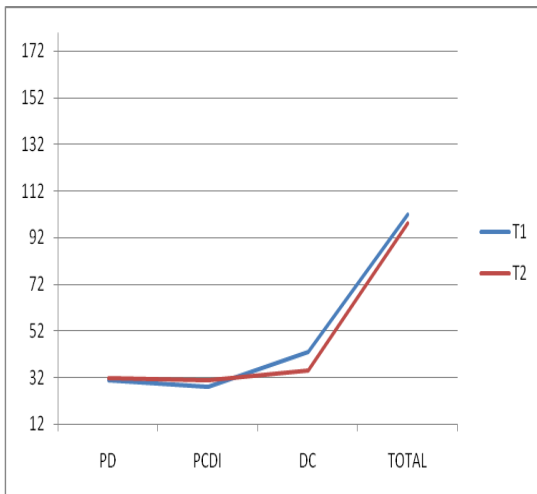
**Figure 3c.** T-family – SOFTA-S



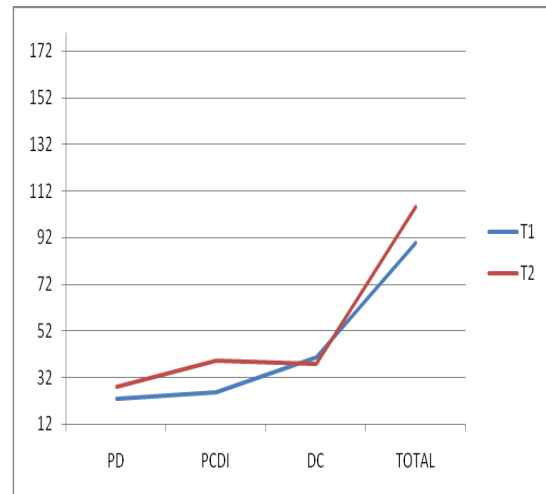
As shown in the figures above, the therapist alliance scores converged with the parental ratings of alliance. It means that patterns of the therapist alliance development were similar to patterns of each parent alliance development. In particular, the therapist alliance with both parents increased on each WAI-SF subscale and total scores (as for Francesca - Total: 43-58/17 points of difference; as for Riccardo: 56-63/7 points of difference).

With respect to SOFTA-s, the therapist scores indicated a positive alliance with the family as a “unit” that increased throughout the six sessions, although scores on the Safety scale were low at both times of assessment (T1:8 – T2:6). The Safety scale refers to client’s feelings of safety and comfort in the therapeutic setting, a dimension of alliance that requires more time to develop beyond this initial phase of child and family assessment.

**Figure 4a.** Francesca – PSI-SF



**Figure 4b.** Riccardo – PSI-SF



Figures 4a and 4b report PSI-SF scores at T1 and T2.

At both times of assessment, Francesca and Riccardo obtained clinically significant scores (from the 85<sup>th</sup> percentile above) on the Parent-Child Dysfunctional Interaction, Difficult Child and Total scales. However, patterns of stress development were different in both parents.

While mother's scores decreased on the Difficult Child and Total scales, father's scores increased in all scales, except on the Difficult Child dimension. It is important to remember that the Difficult Child scale is widely used in clinical and research studies as a measure of treatment outcomes. In this case, for both caregivers, the perception of their child as difficult changed. It represented a positive outcome of this initial phase of the intervention and a starting point for the following therapeutic work.

To conclude, as discussed previously, family alliance scores were positive. In particular, Francesca who was exhausted and felt a lack of support from her husband, through these sessions developed a strong bond with the therapist, and she had a more clear idea about what should have been done in order to restore the family harmony. These results were associated with an initial decreasing in her levels of stress.

With respect to Riccardo, he also developed a positive relationship with the therapist and this initial phase of the intervention allowed him to feel comfortable and become familiar with the new situation. He was often away on business and, probably, he felt more involved in family life because of the clinical work done with her wife and the therapist. The increase in levels of stress was probably related to a greater awareness about child and family problems.

These first steps towards the therapeutic process would have not been possible without creating a therapist-parents “nice/working” relationship. Furthermore, as mentioned earlier, at the end of these six sessions child little changes had occurred as well.

## 5.2 A poor outcome case

For what concerns the second family, it was composed by a 4-years old child (Luigi), his mother (Anna, 36 years) and his father (Franco, 32 years). Names are fictitious.

*Reasons for self-referral:* in this self-referred family, parents asked for help because of child’s encopresis and angry-oppositional behaviors at home.

Since the beginning of the FPT-CP Anna appeared very stressed, she talked most of time without allowing her husband to give his opinion over child and family problems. Luigi was described as an “authoritarian” and extremely “naughty-angry” child who protested if things were not done his own way. For example, parents told that they usually let the child play alone with the mobile phone or tablet, but then they took devices away from him without any reasons or explanations.

Anna had also a daughter (from a previous marriage) and another son from the current one. She felt overwhelmed by family commitments and she received only her mum’s support in dealing with them. Franco, who appeared quite silent and passive, was described by Anna as a man devoted to his job and to the football. At home he spent time watching TV or playing computer games.

Both parents were not used to play or spend nice times with their children and the family atmosphere was tense and confused. Moreover, they were not able to give clear rules and appropriate boundaries to children. In particular, Franco was not used to manage them who called him by name without recognizing him any parental role.

*Child and parental behaviors during sessions:* if at first the child related more to Anna than Franco, he was able to nicely interact with his parents and the therapist as well. Although play was still not narrative, Luigi was enthusiastic and active in play. Moreover, he was able to express his needs and to appropriately react when they were neglected. For example, at the end of the second session, the parental response to the child’s need to go to toilet was not well-timed and the play session was interrupted.

Luigi’s attitude in play was characterized by frequent requests to his parents to create a big house with building blocks and a lot of characters not clearly defined in their roles. There was confusion, no place to move, and children, in the end, had to play in their beds.



With respect to Anna, Luigi showed a strong bond and a loving attitude with her. Instead, the child play with Franco was characterized mostly by an exchange in play roles. Luigi played as the “father”, and Franco as the “child”, or alternatively, the child was a mean “foreman” who gave orders to Franco “worker”.

During the FPT-CP first phase, Luigi seemed enthusiastic and at his ease within the new play environment. Moreover, he developed a nice relationship with the therapist giving value to what occurred in play sessions. For example, at the end of each one he wanted to take home play dolls which were “special” for him, and he payed attention to take them back completely intact.

As for Anna’s behaviors in play, she seemed quite insecure in responding to child’s demands, but she was still positive and responsive. Franco appeared quite silent, shy, passive, and almost uncomfortable in the therapeutic setting. He was rigid and not involved emotionally in play sessions. Furthermore, these behaviors remained unchanged throughout the process. From Anna’s point of view, it was as if Franco was forced by her to be there.

With respect to the family as a “unit”, co-parenting skills were seriously compromised. Parents often changed appointments at the last minute and they did not accomplish any therapeutic task. During the fifth session, Anna appeared exhausted and overwhelmed by family demands. She was sad and angry with her husband because of the frequent arguing at home and his immature attitude and lack of involvement in family life.

Despite the therapist suggestions to spend more time with Luigi, they were not able to do it. Once they tried to play together, children preferred to interact with Anna and, consequently, Franco sadly stepped aside. In this context, the therapist told parents about the importance of supporting each other in their parental roles in order to improve co-parenting skills and, for Franco, of spending time alone with his child without any intrusion.

*At the end of the sixth session:* the therapist described Luigi’s positive attitudes and behaviors shown in play emphasizing the child’s need to find his own place in the home environment characterized by a lot of confusion and people without a well-defined role.

Parents saw child symptoms unchanged although some Luigi’s attempts to “poo” in the toilet occurred. On the other hand, Anna’s complaints were the same and, moreover, she confirmed parents’ inability to make use of the FPT-CP sessions at home.

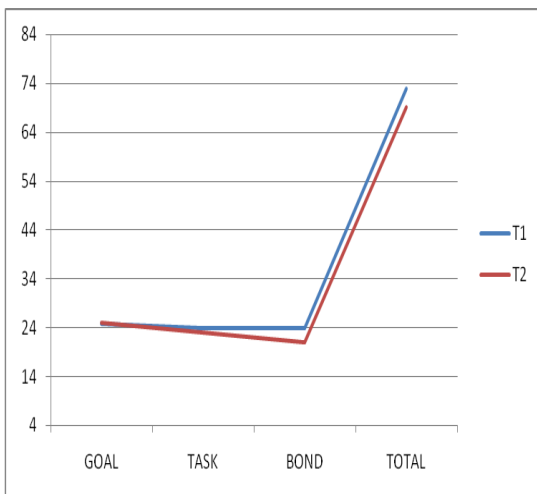
At this time, Franco gave his opinion and he blamed his wife for interfering in his parental role denying him the possibility of taking part to the family life.

At the end of the sixth session, the therapist recommended parents to go on the therapeutic process in order to face child symptoms and to improve family harmony and well-being. Parents

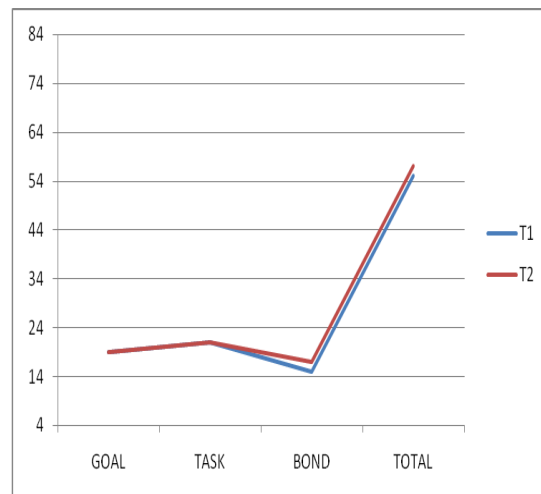
accepted and agreed with the therapist about the importance of attending the therapeutic process with more commitment, reciprocity and respect to each other. Actually, they attended some sessions only and, at the end, Anna decided to interrupt because of her husband's lack of collaboration in therapy - from her point of view. The therapist did not meet Franco due to his unavailability.

Figures below show alliance and parenting stress scores for each parent and the therapist at both times of assessment.

**Figure 1a. Anna - WAI-SF**



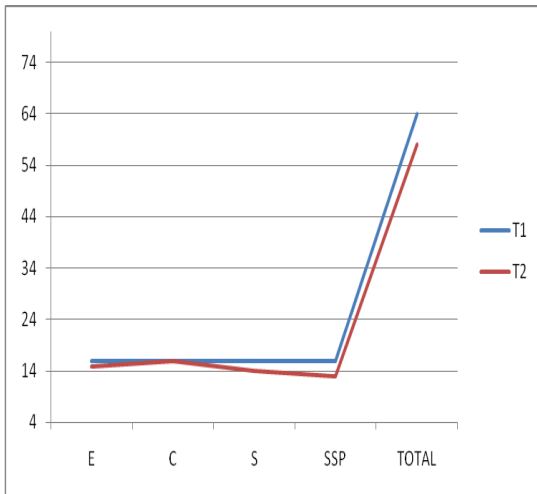
**Figure 1b. Franco - WAI-SF**



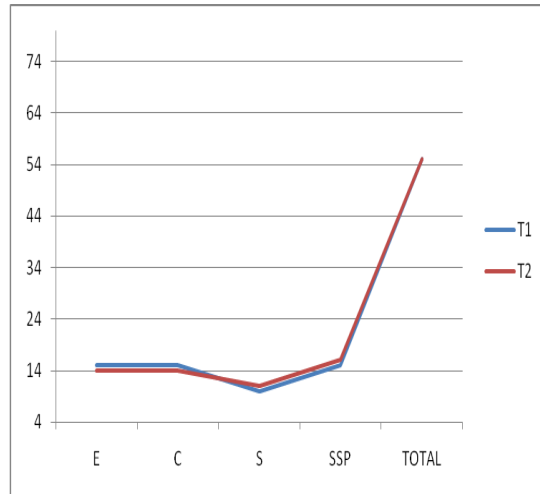
With respect to WAI-SF, both parents reported positive ratings of alliance. However, compared to the previous clinical case, scores were quite stable (i.e. they did not increase) throughout the first six sessions.

In particular, for what concerns Anna, scores slightly decreased on the Bond (24-21) and Total (73-69) scales, although they were still positive. As for Franco, alliance scores slightly increased on the Bond (15-17) and Total (55-57) scales.

**Figure 2a. Anna - SOFTA-S**



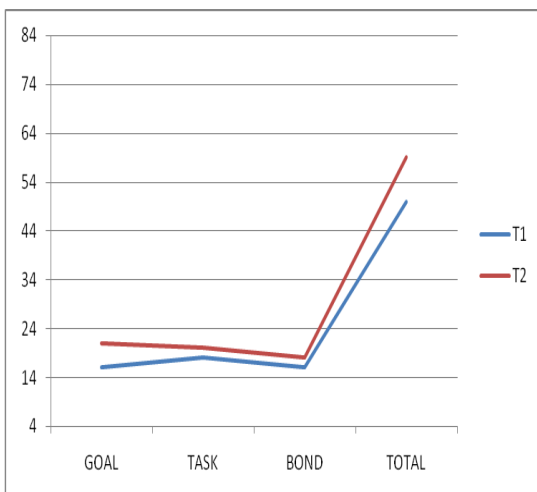
**Figure 2b. Franco – SOFTA-S**



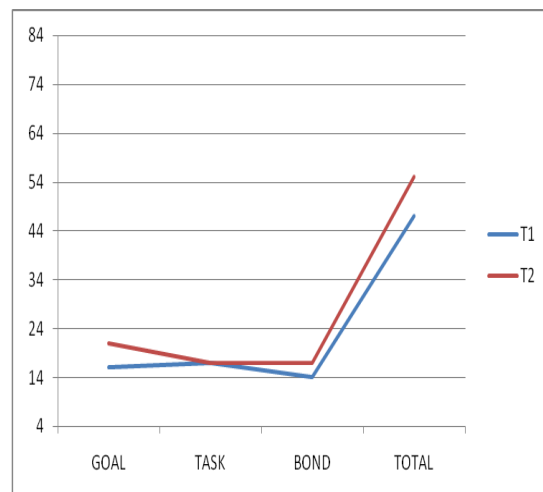
As shown in Figures 2a and 2b, Anna SOFTA-S scores slightly decreased on the Safety (T1:16, T2:14), Shared Sense of Purpose (T1:16, T2:13), and Total (T1:64, T2:58) scales, whereas Franco's scores were stable over time (Total: T1:55, T2:55).

As expected, scale comparisons revealed that both parents reported lower scores on the Safety and Shared Sense of Purpose scales. As described earlier, Anna and Franco reported high levels of marital conflict. The intra-family collaboration and sense of “being together” in therapy appeared to be compromised and, most probably, there were topics about the marital relationship that had not to do with a child-focused clinical setting.

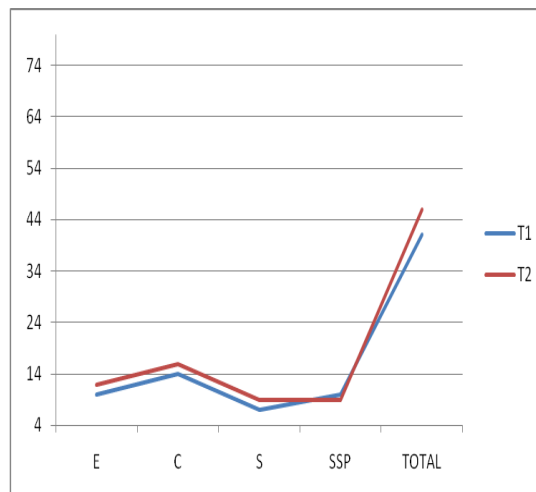
**Figure 3a. T-mother – WAI-SF**



**Figure 3b. T-father – WAI-SF**



**Figure 3c. T-family – SOFTA-S**

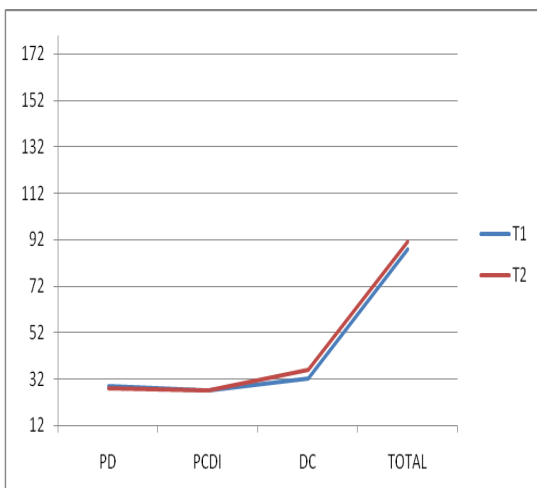


Figures 3a, 3b, and 3c report the therapist scores of alliance.

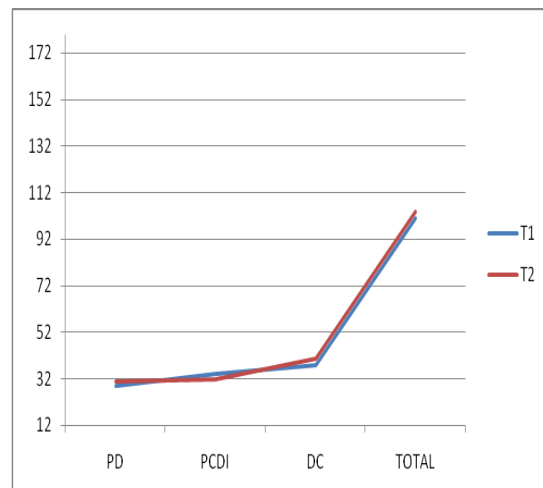
For what concerns both WAI-SF and SOFTA-S, the therapist ratings increased over time (alliance with Anna, T1: 50, T2: 59; with Franco, T1: 47, T2: 55, and with family as a “unit”, T1:41, T2:46).

Again, the SOFTA-S instrument gave interesting results, since the two dimensions where the therapist obtained lower scores were the same of the parental couple (Safety and Shared Sense of Purpose). Since the couple therapy is something different from a child-focused intervention, the therapist was aware that high levels of the marital conflict could have compromised the clinical work with the child. To this aim, the clinician suggested parents to put a great effort in achieving a mutual collaboration and agreement about what should have been done to help the child and family overall.

**Figure 4a. Anna – PSI-SF**



**Figure 4b. Franco – PSI-SF**



As shown in Figures 4a and 4b, at the end of the sixth session both parents reported high and clinically significant levels of stress. Differently from the previous clinical case, scores slightly increased in both parents on the Difficult Child (as for Anna, T1: 32, T2: 36; as for Franco, T1: 38, T2: 41), and Total (as for Anna, T1: 88, T2: 91; as for Franco, T1: 101, T2: 104) scales.

These results were in line with expectations. But then, no changes had occurred throughout the first phase of this intervention. Parents did not consistently attend sessions and, moreover, they did not accomplish any therapeutic task. They were in conflict each other, and they were not able to reach a compromise over treatment goals and tasks. At that moment co-parenting skills were seriously compromised. Moreover, if initially they agreed with the therapist about the importance of going on the therapeutic process, after few sessions, they abruptly interrupted.

Consequently, although the child-therapist relationship was positive until then, there was no possibility of working with the child without parental consent. As discussed thoroughly in the literature review, the intra-family collaboration and the family alliance with the therapist represent a necessary starting point to go on any therapeutic process.

## Discussion

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As discussed thoroughly the present work, the therapeutic alliance (TA) is a primary curative element of treatment that allows for the implementation of specific therapeutic techniques (Martin et al., 2000; Shirk & Karver, 2003). It represents the most cited generic, non-specific factor of change in psychotherapy (Wampold, 2001). High levels of alliance have been found to be strictly associated to positive outcomes and low drop-out rates (Ardito & Rabellino, 2011).

While there is an extended literature on the alliance in individual psychotherapy, studies on the alliance in youth and, even more, on conjoint family therapy are recent (Johnson, et al., 2002; Robbins et al., 2003; Sprenkle & Bow, 2004). However, results are promising and seem to indicate that in clinical interventions with families the collaboration among family members, i. e. the intra-family alliance, represents the first and essential ingredient of a successful treatment (Escudero et al., 2008).

From a methodological perspective, as for the alliance in youth psychotherapy, the construct of TA has been directly imported or mildly revised from the adult scales. Most studies have focused on the alliance with children aged 7-8 years old and highest who are able to complete self-report questionnaires. At the same time the alliance with parents who are recipients of some kind of intervention (family education/ family therapy etc.) has been assessed through the same questionnaires used in the adult literature on TA (Hoagwood, 2005).

To our knowledge, a gap in the existing research literature concerns the assessment of the alliance with parents in preschool child-focused treatments. Indeed, clinical situations where parents ask for a professional help because of their child's problems are different from individual and/or family settings. Certainly, existing research efforts need to be extended on the study of the alliance in child-focused treatments for different reasons.

First, a strong therapist-parent alliance is associated with more sessions attended, fewer cancellations and less dropouts (Accurso et al., 2013). Moreover, it has been found to be linked with better outcomes, such as a decreased youth symptomatology, improved parenting practices and family functioning, greater perceived social support and satisfaction with therapy (Hawley & Garland, 2008; Kazdin & Whitley, 2006; Kazdin et al., 2006; McLeod & Weisz, 2005; Tolan et al., 2002). Indeed, the success of child treatment largely depends on how parents feel supported and understood by the clinician. Without parental consent and the mutual agreement about the treatment goals and tasks, there is no possibility to clinically work with the child. Parents are responsible for

many aspects of child treatment (take the child to sessions, pay for them etc) and, certainly, they act as key agents in the delivery and reinforcement of the therapeutic contents at home.

Even more important, in situations where the family conflict is high and/or each caregiver has a personal idea about child's needs, the therapist agreement with each parent over the plan of child treatment represents the first goal to obtain in order to guarantee the maintenance and success of child treatment (Algini, 2003; Barmish & Kendall, 2005; Neri & Latmiral, 2004; Trombini, 2004; Tsiantis et al., 2002; Vallino, 2002a, 2009).

The present work therefore aimed to expand on the existing research and clinical literature. It has a high degree of specificity for different reasons. It focused on a modality of child-focused treatment that is called the "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016). Characteristics of this therapeutic method have been thoroughly described in the Paragraph 2.2. However, it is important to remember that the FPT-CP is a psychotherapy for the child and it does not represent a family therapy or a therapy for parents. Hence, parents are considered the best "co-therapists" who actively work with the therapist to identify and deal with child problems. Moreover, this therapeutic technique is based on the play as a narrative dimension of family problems (Vallino, 2004, 2009).

The present research focused on a specific phase of this intervention represented by the first six sessions aimed to the assessment of child symptoms within the family dynamics, and to the promotion of the therapeutic alliance with parents as a pre-condition for a successful intervention. Usually, at the end of this phase, once the therapist has established a positive relationship with the child and his/her parents, the therapist comes to an agreement with both caregivers about the opportunity to go on the therapeutic process. Modalities can be different according to each clinical situation and child/family needs. Certainly, the alliance built by the therapist with the family as a "unit" represents the pre-condition for any following treatment. In this phase, the therapist's aims are to establish a relationship with parents based on a mutual understanding of child difficulties and, consequently, on their collaboration and agreement on which are the main goals and tasks of the intervention.

At this purpose, the present study was undertaken to explore the quality of the therapist-parent relationship at two time points that correspond to the beginning and to the end of the first phase of the FPT-CP (Time 1: end of the 1<sup>st</sup> session; Time 2: end of the 6<sup>th</sup> session). Moreover, we investigated parental characteristics of personality, levels of parenting stress and the quality of the adult-child relationships. As said previously, because of the highly specific characteristics of the present study, aims were mostly exploratory.

- For what concerns the first objective of the present work, parental characteristics of personality were similar to the characteristics of the Italian general population. Moreover, in line with existing literature, women scored higher than men on the Agreeableness scale suggesting that their personality is characterized by a sense of trust and concern towards people and their needs.

In line with our hypotheses, positive associations were found between the Extraversion, Agreeableness, and Conscientiousness dimensions of personality and the alliance scores. Interestingly, these associations were found in women only suggesting that their personality was “naturally” prepared for building a positive alliance with the therapist (Chiorri et al., 2016).

- With respect to parental alliance scores, both caregivers reported high levels of alliance that were stable throughout the six sessions. This means that parents were highly motivated and in need of help for their child’s problems. They had high expectations of being helped and, since the beginning of the intervention, they trusted in the therapist’s ability to help them.

Furthermore, it was found that therapist alliance was positive as well and stable throughout sessions. In particular, in the first FPT-CP phase, the therapist worked to build a positive emotional climate (necessary for child and family disclosure) along with giving a clear definition of structure, goals and tasks of the intervention.

- Another objective of the present work was to compare mother and father alliance scores. In line with our expectations, we did not find differences between their scores. Instead, we found that parental scores were significantly higher than therapist scores. As Safran and colleagues (2002) have argued, although the alliance is built interactively, client and therapist views of alliance tend to diverge. Reasons can be different. While clinician’s alliance scores might be affected by the theoretical knowledge of the concept of alliance (Hentschel, 2005; Fitzpatrick et al., 2005; Kramer, et al., 2008), as already discussed, parents in the present sample had no mental illnesses or psychiatric disorders and, moreover, they were eager to receive a professional help for their child with high levels of motivation and expectations of being helped.

- A general objective of the present study was to go into more detail in analyzing client scores. We explored differences among mothers and fathers on different variables in order to enrich existing literature where often data refer to a “generic” client without differentiating between mothers and fathers. We thought about the importance in clinical research to gain a deeper understanding of what takes place in clinical settings with both mothers and fathers.

Starting from the alliance scores, we found that at the beginning of the intervention therapist-mother alliance resulted significantly higher than therapist-father alliance. More interestingly, these scores converged at the end of the first phase of the intervention, when the therapist seems to re-modulate its own internal expectations.



It is important to point out that, in the present study, therapists were all women. The available literature about the “match” between the patient and the therapist comes from the social psychology studies, which indicate that people tend to identify with and prefer people similar to themselves (Festinger, 1954). Moreover, Bem’s (1981) gender schema theory suggests that clients and clinicians of the same sex would tend to view the world through the same gender lens, which in turn leads to similar perspectives on several life issues.

In the present study, although at the beginning of the intervention therapist-mother alliance was significantly higher than therapist-father alliance, at the end scores converged suggesting that, probably, the therapeutic relationship with fathers took more time to develop but, at the end, there was a feeling of “unity” in the therapeutic setting (composed of two women -therapist, mother - and a man - father).

As for the alliance measures used in the present work (please, see the Paragraph 4.3.3 for details), it is important to point out that the Working Alliance Inventory-Short Form (WAI- SF; Lingardi & Filippucci, 2002) is one of the most internationally used and validated measures of alliance. Along with this instrument we used the System for Observing Family Therapy Alliances Self Report (SOFTA-S; Mazzoni, 2010). It was used mainly as a clinical measure of TA, since the use of this instrument is recent and more empirical support is needed. In the present study, the use of this measure allowed to evaluate some specific characteristics of a conjoint therapy (with more than one family member) where it is important to assess the level of the productive collaboration and shared sense of purpose by family members in therapy.

In the present sample, interestingly it was found that men at the end of the first phase of the intervention reported significantly higher scores on the Shared Sense of Purpose scale than women. Going deeper on this analysis, it resulted that the first FPT-CP six sessions were useful to create higher levels of closeness in the marital couple and sense of unity as “we are here together”. At this point it is important to remember that, despite a higher initial therapist-mother closeness, a relevant effect of these first six sessions was to get fathers more involved in the therapeutic field.

For what concerns the SOFTA-S therapist scores, they significantly increased on the dimension of the Emotional Connection, that is the emotional bond with the family seen as a “unit” (with mother and father together) and that probably requires more time to develop from the therapist perspective.

- Along with the assessment of the alliance, we aimed to investigate also parenting stress and the adult-child emotional availability scores seen as outcome measures in most clinical child and family interventions.

In line with our hypotheses, both parents reported significant levels of stress on the Difficult Child scale which measures how much the parent perceives the child as difficult or easy to manage (Abidin, 1995). Although in the present study stress scores did not decrease significantly from T1 to T2, at qualitative level mothers and fathers reported different patterns of stress development. While mother's levels of stress slightly decreased (T1: 90th percentile; T2: 85th percentile), fathers' scores slightly increased on the Total (T1: 80th percentile – still not clinically relevant; T2: 85th percentile), and Difficult Child scales (T1: 85th percentile; T2: 90th percentile) .

It is important to remember that the Difficult Child scale is widely used in clinical and research studies as a measure of treatment outcomes. In this case the mother perception of the child as difficult to manage started to positively change and this represented an initial outcome and a starting point for the following therapeutic work on a deeper level.

With respect to father increase in levels of stress it was probably related to a greater awareness about child and family problems achieved through these initial six sessions. Probably, fathers at the end felt more involved in family life because of the clinical work done with her wife and the therapist together. It represented an important outcome of the FPT-CP first phase, since stress is the initial “engine” of change. Moreover, it probably would have not been possible without the building of a positive therapist-parent relationship developed since the first session of the intervention and maintained over time.

- Other objective of the present research was to obtain quantitative and more qualitative data as well (Bornstein, 2002b). To this aim we obtained videotapes of each adult-child interaction at the beginning and at the end of the intervention. We referred to the construct of the adult- child emotional availability to mainly indicate the dyad's capacity of emotional connection each other.

We found that, compared to mothers, fathers showed a more problematic scenario. Indeed, they resulted less emotionally available and responsive with their children and, at the same time, children showed lower levels of emotionally availability with fathers than mothers at both times of assessment. The relationship remained stable throughout these initial sessions and was characterized by a father attitude that was warm and kind, but not so sensitive to the child's cues and communications. It might be that, compared to mothers, they were less used/trained to interact with their child and to correctly get the child signals and communications.

In this sense, the videotaped observations of adult-child interactions allowed us to get some peculiarities of mother and father-child interactions. Moreover, the FPT-CP play sessions were like a “gym” where parents, through therapist contributions, started to work out how correctly read and interpret child signals and behaviors. However, they were not sufficient to obtain significant

changes in the adult-child relationships but, certainly, they helped parents to be more aware about child problems and how to manage them.

It is interesting to note that both mothers and fathers presented problems on the Structuring scale that refers to the adult capacity to appropriately facilitate, scaffold, or organize the child play. This dimension of the parental behavior is usually connected to child behavioral problems (De Falco et al., 2009) that were reported by the majority of children in the present sample. With respect to it, both caregivers showed overstructuring or attempts to structure that were not well received by the child and that, at the end, were unsuccessful.

- Additional objectives of the present research were to investigate if some parental variables were associated to the decision or not to continue the intervention at the end of the sixth session. As described thoroughly in the Paragraph 2.2, at the end of the FPT-CP first phase, the therapist would suggest each family to go on the therapeutic process in order to achieve a complete remission of child symptoms and the family well-being.

In the present study, in 2 cases (out of 17) the six sessions were sufficient enough to solve child problems, because child symptoms were not severe and family resources were fully available since the beginning of the intervention. Out of the remaining 15 families, 9 families accepted and 6 ones did not.

With respect to the 6 families who did not accept, 3 argued that positive changes had occurred throughout sessions and they were sufficient to feel themselves strong enough to manage the child without a professional help. The remaining 3 couples presented high levels of marital conflict and this aspect had priority over child problems at that moment.

We obtained some interesting results to the question: “Were parents who accepted similar to those who did not?”. We found that fathers who accepted to continue the intervention scored significantly higher on the Agreeableness scale than fathers who did not, suggesting that the personality variable is significantly associated to the alliance.

Moreover, as for alliance scores, at T2 we found that, while mothers who accepted scored significantly higher on the Task scale than mothers who did not, for what concerns fathers, significant differences emerged on the Bond scale. In other words, while for mothers a greater awareness about the activities to carry out was crucial in taking the decision to continue the intervention, for fathers, it was the emotional bond, i. e. the affective dimension of alliance, that played a crucial role in taking the decision to go on the therapeutic process.

In general, SOFTA-S total and subscale scores were higher in families who were compliant with the therapist than families who did not. In the sample of mothers, the dimensions of Safety in the therapeutic system – that refers to feeling of safety and comfort - and Shared Sense of Purpose

played a crucial role in taking the decision to continue the intervention. Similarly, according to the therapist, the Shared Sense of Purpose (i.e. intra-family collaboration in therapy) discriminated families who were compliant from families who were not.

- Another exploratory objective of the present research was to investigate differences in the parental alliance scores according to the therapist level of experience. As expected, due to the specific FPT-CP characteristics, no significant differences emerged at both times of assessment suggesting that the therapist ability to build a positive therapeutic relationship with clients is not influenced by the years of experience. As described thoroughly the present dissertation, the FPT-CP as clinical methodology was specifically designed to promote early in treatment the therapeutic alliance with parents of children.

To conclude, we conducted correlational analyses to investigate, at first, associations among all WAI-SF and SOFTA-S scales. It was interesting and promising for a larger use of SOFTA-S to find all correlations statistically significant and in the expected direction ( $r$  ranges from .48- moderate to .80 - strong).

Although correlational results should be interpreted with caution, some interesting data were obtained. With respect to the associations between personality and stress, as expected, we found positive and moderate associations with the Neuroticism dimension of personality. Negative and moderate correlations were found between Extraversion/Agreeableness and parenting stress. It is important to remember that mothers showed significantly higher levels of Agreeableness than fathers in the present sample.

Interestingly we found in the sample of mothers significant associations between parenting stress and alliance scores. At the end of the first FPT-CP six sessions, higher levels of alliance were associated to lower levels of parenting stress. In particular, it was found that the maternal stress was significantly linked with all dimensions of alliance (Goal, Task, Bond). It did not occur in the sample of fathers since, as said previously, patterns of stress development were different. Furthermore, as expected, negative correlations between parenting stress and emotional availability were found at T1.

Lastly, positive correlations among the Bond dimension of alliance and the emotional availability scales of Sensitivity and Non-Hostility were found in the sample of fathers. As said previously, it is important for the therapists (especially, women) to pay attention to the building of an emotional bond with fathers, beyond a definition of more cognitive aspects of the intervention such as goals and activities.

## **Limitations**

Some limitations of the study must be considered when interpreting our findings. First, due to the small sample size, all results should be replicated on larger samples, and findings should be interpreted with caution. Indeed, we could not carry out complex analyses to detect smaller but clinically significant effects .

Second, since the lack of validated measures of alliance in conjoint treatments, we used the “System for Observing Family Therapy Alliances” (SOFTA) in the self-report version, even though more empirical support for the use of this instrument is needed.

Furthermore, due to the treatment constraints, we could not use the observational version of the SOFTA which has received much more empirical evidence. It would have allowed us to capture specific clients and therapist behaviors that shape the building of the therapeutic relationship over time.

Third, a potential limitation of our study is that we did not consider some characteristics of parents’ marital quality and co-parental alliance which might have played a role on the pattern of alliance development and on the families’ decision to accept or not the intervention. Future studies are recommended to further explore these aspects.

Further, caregiver-reported alliance may differ depending on child diagnosis, and these potential differences could not be examined with these data.

Last, in the present research we have only one measure of child with respect to adult-child interactions. In particular, repeated measures of child development throughout sessions might have detected more little child changes.

Furthermore, it would be clinically relevant to understand, through further longitudinal studies, how the pattern of alliance, stress and adult-child interactions observed in the present study would evolve in a longitudinal way.

Finally, future research would benefit from investigating the therapist-parent alliance associated to other family variables in several models of child-focused treatment and with different levels of parental involvement.

## Conclusion

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Attention to the parental engagement in child treatment has recently increased given the emphasis on implementing successful treatments into community settings, identifying methods to provide services more efficiently, and improving quality of care for children and families (Becker et al., 2015; Gopalan et al., 2010; Ingoldsby, 2010; Lindsey et al., 2013).

Today most clinical interventions for children include parents from the early stage of treatment (Neri & Latmiral, 2004; Sameroff et al., 2006; Tsiantis et al., 2002; Vallino, 2002, 2009). Specifically, parental participation in child assessment process and treatment allows for a greater understanding of child symptoms within the family relationships. Furthermore, in this way therapists would find the opportunity to build a therapeutic relationship with parents based on a mutual understanding of child difficulties and, furthermore, on their collaboration and agreement on the main goals and tasks of the intervention.

It is widely recognized that, among factors that can influence the therapeutic change, the alliance (TA) represents the most cited generic and non-specific factor of change in psychotherapy (Ardito & Rabellino, 2011; Wampold, 2001). While numerous studies have focused on the alliance in individual psychotherapy, research on the alliance in youth and family therapy are more recent (Johnson, et al., 2002; Robbins et al., 2003; Sprenkle & Bow, 2004). Reasons are different. First, the study of the alliance in child therapy involves parental figures as well. Second, studying the alliance in family therapy is even more complicated, because of the simultaneous alliances among family members (Escudero et al., 2008).

As discussed thoroughly the present dissertation, most studies have focused on the alliance with children aged 7-8 years old and highest who are able to complete self-report questionnaires. At the same time the alliance with parents, who were often receiving some kind of intervention separately, has been assessed through the same questionnaires used in the adult literature on TA (Hoagwood, 2005). An open question concerns how - which methods should be used to assess the alliance in young children's treatments.

Despite some limitations, the present work had the value to investigate an unexplored aspect of the study of alliance with parents in a preschool child-focused treatment named the "Focal Play Therapy with children and parents" (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016).

Compared to the amount of literature on the alliance in individual and family psychotherapy, to our knowledge, very few studies have been conducted about the alliance with parents who ask for

a professional help due to their child's problems. Parents are not considered as "patients" but, rather, they are seen as the best therapist "collaborators".

Certainly, also in a psychodynamic child therapy, the success of treatment largely depends on how parents feel supported and understood by the therapist. Indeed, in the available literature on family therapy a positive alliance with parents has been found to correlate to better outcomes, such as a decreased youth symptomatology, improved parenting practices and family functioning, less drop-outs, greater perceived social support and satisfaction with therapy (Hawley & Garland, 2008; Kazdin & Whitley, 2006; Kazdin et al., 2006; McLeod & Weisz, 2005; Tolan et al., 2002).

Without a parental consent it would be no possible to plan and, consequently, to carry out any child treatment. But then, the possibility that the treatment will be successful is even much lower. For example, in clinical settings where the marital conflict is high, co-parenting skills are seriously compromised, and/or each caregiver has a personal idea about child problems and how to solve them, the first therapist's aim would be coming to an agreement with both parents over the child treatment plan.

For all reasons mentioned above, the present project aimed to broaden the scientific knowledge about the importance of the alliance with parents in child treatment. We described a model of clinical intervention (FPT-CP) where parents are actively involved and a special emphasis is given to the early building of alliance as a precondition for a successful treatment. Therefore, the present research would represent an original contribution to the literature both for the topic, which has been quite unexplored, and for the methodological procedure.

Nowadays there is a general consensus that clinical practice needs to be placed on firm empirical evidence and that researchers and clinicians should work together to this end (Kadzin, 1990). Indeed, the development of clinical practice guidelines have increased the importance of establishing empirically supported treatments and best practices when working with children and families.

Therefore, in the present study efforts were addressed to implement an appropriate experimental methodology to adapt in the clinical setting (already described in the Paragraph 2.2). We realized a research design consisting of both quantitative and more qualitative measures for each caregiver, therapist and child as well (through the observation of adult-child interactions). We investigated the alliance from both clients and therapist points of view and, furthermore, at two time points to detect potential changes on some parental and child variables over time. Furthermore, we analyzed data separately for mothers and fathers with some interesting results.

For what concerns the model of the clinical intervention proposed, we found empirical evidence that the alliance with parents was effectively promoted since the first session of the FPT-

CP. Moreover, it was maintained over time leading to the building of a therapeutic relationship with caregivers characterized by high levels of trust, empathy, along with a clear definition of intervention goals and tasks.

It is important to point out that the focus of the present research was on the FPT-CP first six sessions aimed to the promotion of the therapeutic alliance with parents, and to the assessment of child symptoms within the family dynamics. Without the building of a strong therapist-parent alliance it would have not be possible to clinically work with the child and family and, furthermore, to plan any therapeutic work afterwards.

The “Focal-Play Therapy with children and parents” (FPT-CP; Trombini & Trombini, 2006, 2007; Trombini E., 2010, 2011, 2016) was originally designed for child eating and evacuation disorders, but it is actually used for a large range of common problems in preschool children usually connected to parent-child relationship problems. Hence, findings of the present research would highlight relevant clinical implications since the intervention proposed focused on building an early alliance with parents. Hence, it could represent a preventive model to apply for different disorders and to clinical contexts both public and private ones.

From a methodological perspective, we implemented a research design consisting of both quantitative and more qualitative data (through the observation of adult-child interactions). Along with the alliance assessment, we investigated several parental variables such as the parental characteristics of personality, levels of parenting stress and the quality of the adult-child relationships. Methods were original, since the classic research designs in this field consisted of the measurement of a process variable (usually the alliance) along with an outcome measure (the decreasing in child symptoms or the evaluation of the session impact/effectiveness).

With respect to the present study, we found interesting results pertaining to the relationships between multiple variables (parental personality, alliance, parenting stress and the quality of the adult-child relationship). Indeed, for example, some dimensions of personality such as the Extraversion, Agreeableness and Consciousness were found to be strictly associated to the alliance, confirming the importance for clinicians to pay attention to the client characteristics of personality in order to prevent drop-outs or poor therapeutic outcomes.

Despite results from the present research should be interpreted with caution (due to the small sample size), we found some associations between positive scores of alliance, lower levels of parenting stress and a greater adult-child emotional availability. Just to mention some of the data obtained that, certainly, will need a much more empirical support.

From a methodological point of view, we used two measures of alliance. The first one was the Working Alliance Inventory-Short Form (WAI- SF; Lingiardi & Filippucci, 2002) which is one



of the most internationally used and validated measures of alliance. The second one was the System for Observing Family Therapy Alliances Self Report (SOFTA-S; Mazzoni, 2010), that was used mainly as a clinical measure of TA, since the use of this instrument is recent and more empirical evidence is needed.

In the present study, the SOFTA-S gave some promising results that, as said previously, should be interpreted with caution. In particular, the dimensions of alliance that were relevant to the family decision to continue or not the intervention (after the first six sessions) were the “Safety in the therapeutic system” – that refers to feelings of safety and comfort with, at the same time, family members and therapist- and “Shared Sense of Purpose” (i.e. intra-family collaboration in therapy, feelings of “unity/we are here together”). Similarly, according to the therapist perceptions of alliance, it was the scale of the Shared Sense of Purpose that discriminated families who were compliant from families who were not.

Nowadays researchers argue that parallel investigations of mothers and fathers for any variables that relate to parenting should be provided. Thus, any time a characteristic of mothers is investigated, the researchers should also explore the same characteristic in fathers.

The present research analyzed data separately for mothers and fathers obtaining some surprising results with respect to the role of fathers in child clinical interventions. First of all, it is important to point out that over the past three decades, there has been growing interest in fathering and an emerging literature on the impact of fathers on children’s outcomes.

Overall, fathers are more directly involved with their children than fathers of past generations and they share the co-parenting roles with women (Pleck & Masciadrelli, 2004). However, empirical evidence showed that, despite many aspects have been changed in the distribution of caregivers’ responsibilities, mothers seem to be still the primary responsible in childcare (Bruder, 2000).

From a clinical perspective, it is important to underline that mothers are often exclusive participants in the early intervention service delivery and, generally, in child research. It is because of the idea that fathers still have a limited role in childcare, or the belief that fathers are more difficult to recruit and involve than mothers in child interventions. For this reason, we would need empirical evidence about the impact of involving fathers in child treatment.

In the present study, we have found that, compared to the therapist-mother alliance, the therapeutic relationship with fathers probably took more time to develop but, at the end of the FPT-CP first phase, there was a feeling of “unity/we are here together” in the therapy showed by father scores on the dimension of the SOFTA-S Shared Sense of Purpose.

We might think that, in the present research, the therapists (all women) themselves seemed to re-modulate their own internal expectations. With respect to it, the available literature suggests that clients and clinicians of the same sex might tend to view the world through the same gender lens, which in turn would lead to similar perspectives on several life issues. It probably could explain the fact that therapist scores of alliance with mothers were higher than those ones with fathers at the beginning of the intervention only. These differences did not emerge at the end.

Other interesting results concern the high father's levels of stress showed through the FPT-CP six sessions. They probably related to a greater awareness about child and family problems that fathers achieved in this initial phase of the intervention. Fathers, at the end, might get more involved in family life with a feeling of more closeness to their wife thanks to the clinical work done with the therapist and family together. But then, it is widely recognized that the stress is the initial "engine" of change, and it would have not been possible without the building of a positive therapist-parent relationship developed since the first sessions of the intervention and maintained over time.

Phares (1996b) argued the irony of commonly being asked to define "father" in her research presentations, although never being asked to define "mother." Along with it, we add that even much more we need to know about the "therapeutic field" composed of patient-patients and therapist, therapist roles, gender, expectations, stereotypes, and internal attitudes that the therapist tends to shape and re-shape during the therapeutic process. Clearly, given the importance of the caregiver's role, caregiver alliance needs to be examined more often and with measures that take into account the context of child and family psychotherapy.

Findings from the present study would highlight relevant research and clinical implications.

From a methodological perspective, in light of the sparse literature about the alliance with parents of young children, we implemented an original research design that allowed us to understand several characteristics of therapist-parent relationships. Interestingly, this was possible despite the limited dimensions of the sample used in the present study. With respect to it, as discussed previously, the SOFTA-S proved to be a promising tool for the evaluation of alliance in conjoint therapy settings, although much more research is needed.

For what concerns clinical implications, findings of the present research advise that special attention should be paid to the building of alliance with parents early in treatment. Complementary research could lead to a greater implementation of such treatment in real practice. Parents at risk for poorer alliance could be identified and early intervention would be adapted to improve early alliance and to reduce child treatment dropouts. Each of these efforts would be important to better inform practice and to improve quality of care for children and their families.

To conclude, we proposed a unique model of clinical intervention (FPT-CP) where parents are actively involved throughout the process. It is based on the use of play as narrative dimension of family problems. Clinical evidence has shown that the FPT-CP allows to re-evaluate parental abilities, reduce parenting stress and restore family harmony and well-being (Trombini & Trombini, 2006, 2007; Trombini E., 2008, 2010, 2011, 2016). Further, this clinical methodology, carried out in the extended context, gives parents the possibility to resolve child symptoms whilst promoting the family well-being and harmony.

Therefore, the present study had the value to provide some empirical evidence to this model of clinical intervention that is unique as specifically based on an active parental involvement through the promotion of an early alliance with parents as necessary precondition for a successful child-focused intervention. For these reasons, it might represent a preventive model to apply to clinical contexts both public and private ones.

With respect to it, efforts should be directed to develop and strengthen focused interventions based on the engagement of parents during the preschool period in order to promote the child's healthy emotional and affective development and the family harmony and well-being.

## Acknowledgements

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First, I would like to acknowledge and thank my thesis supervisor Prof. Elena Trombini, for her invaluable help, support and affection throughout my Ph.D. years. My sincere gratitude also to Prof. Valentin Escudero, Director of the “Unidad de Investigación en Intervención y Cuidado Familiar”, for contributing to reflections around the measurement of family therapy process and outcome. I would like to thank the clinical and research staff at the “Psychological Consultation Service for children and parents” (Department of Psychology, University of Bologna) who helped me to realize my project.

I am also grateful to my dear colleagues and good friends (in alphabetical order): Dr. Diana Mabilia, Irene Malaguti Psy.D., and Dr. Paola Salvatori for their support and closeness during these year. Finally, I am greatly indebted to my family and dear ones, for their love and unconditional support. Last but by no means least, I would like to thank all the parents and children that participated in the study, without whom this research wouldn't have been possible.

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## Appendix – List of Additional Tables

### 4.5.11.1 Dropout and parental personality

**Table 28.** BFI– Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
E	3.36±.84	3.40±.57	.09	13	.93	.06
A	4.06±.58	4.22±.23	.64	13	.54	.36
C	3.80±.87	3.83±.52	.08	13	.94	.04
N	3.11±.59	2.60±.48	-1.74	13	.11	.95
O	3.67±.88	3.78±1.01	.24	13	.82	.12

*Note.* E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness.

**Table 29.** BFI– Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
E	3.15±.88	3.31±.63	.38	13	.71	.21
A	3.91±.38	3.37±.58	-2.21	13	.05	1.10
C	3.62±.73	3.87±.54	.73	13	.48	.39
N	3.22±.77	3.06±.84	-.38	13	.71	.20
O	3.62±.58	3.42±.55	-.69	13	.51	.35

*Note.* E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness.

#### 4.5.11.2 Dropout and alliance

**Table 30.** WAI-SF– Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	23.56±4.48	25.67±2.42	1.05	13	.31	.59
Task	23.89±3.37	23.67±3.61	-.12	13	.91	.06
Bond	21.44±2.40	23.67±3.50	1.47	13	.17	.74
Total	68.89±9.24	73.00±9.17	.85	13	.41	.45

**Table 31.** WAI-SF– Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	23.67±4.27	22.17±5.49	-.60	13	.56	.31
Task	25.44±2.96	23.17±5.19	-.97	7.19	.32	.54
Bond	23.56±2.79	20.83±5.81	-1.07	6.56	.32	.60
Total	72.67±8.46	66.17±15.55	-.94	7.00	.38	.52

**Table 34.** SOFTA-S– Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.67±2.50	17.17±1.94	-.41	13	.69	.22
Emotional Connection	16.67±2.18	16.50±2.07	-.15	13	.89	.08
Safety	17.11±2.47	15.50±2.43	-1.25	13	.24	.66
Shared Sense of Purpose	17.78±2.73	17.17±1.94	-.47	13	.65	.26
Total	69.22±9.30	66.33±6.98	-.65	13	.53	.35

**Table 35.** SOFTA-S– Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.11±2.09	16.83±1.83	-.26	13	.80	.14
Emotional Connection	16.89±1.76	16.83±1.94	-.06	13	.96	.03
Safety	16.33±1.80	16.00±3.58	-.24	13	.81	.12
Shared Sense of Purpose	17.22±2.49	18.00±1.79	.66	13	.52	.36
Total	67.56±6.88	67.67±8.33	.03	13	.98	.01

**Table 38.** WAI-SF– Unpaired t-tests for differences among therapist alliances with mothers who accepted to continue the intervention and mothers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	19.22±2.91	20.33±3.83	.64	13	.53	.33
Task	19.78±2.82	19.67±2.42	-.08	13	.94	.04
Bond	17.56±2.92	18.83±2.32	.90	13	.39	.48
Total	56.56±8.05	58.83±8.21	.53	13	.60	.30

**Table 39.** WAI-SF– Unpaired t-tests for differences among therapist alliances with fathers who accepted to continue the intervention and fathers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	19.22±3.56	18.33±3.20	-.49	13	.63	.26
Task	17.89±4.14	15.83±3.66	-.99	13	.34	.53
Bond	17.22±3.87	14.67±3.98	-1.24	13	.24	.65
Total	54.33±11.32	48.83±9.95	-.97	13	.35	.52

**Table 42.** SOFTA-S– Unpaired t-tests for differences among therapist alliances with families who accepted to continue the intervention and families who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	14.56±1.59	14.43±2.61	-.52	13	.61	.06
Emotional Connection	14.44±2.13	14.33±1.51	-.11	13	.91	.06
Safety	11.67±3.54	12.33±3.14	.37	13	.72	.20
Shared Sense of Purpose	14.22±3.15	13.00±2.28	-.81	13	.43	.44
Total	54.89±9.53	53.67±8.87	-.25	13	.81	.13

#### 4.5.11.3 Dropout and parenting stress

**Table 45.** PSI-SF – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	26.56±8.14	29.50±4.42	.80	13	.44	.45
Parent-Child Dysfunctional Interaction	23.44±5.15	24.50±8.69	.27	7.36	.80	.15
Difficult Child	31.22±8.27	33.17±5.53	.50	13	.62	.28
Total	81.22±16.25	87.17±10.21	.79	13	.44	.44

**Table 46.** PSI-SF – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	29.44±10.43	30.50±6.41	.22	13	.83	.12
Parent-Child Dysfunctional Interaction	22.67±6.76	22.17±5.12	-.15	13	.88	.08
Difficult Child	31.67±9.77	31.83±6.34	.04	13	.97	.02
Total	83.78±22.13	84.50±13.31	.07	13	.94	.04

**Table 47.** PSI-SF – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Parental Distress	27.44±6.13	32.83±7.08	1.57	13	.14	.81
Parent-Child Dysfunctional Interaction	24.56±7.30	26.33±4.93	.52	13	.61	.28
Difficult Child	33.89±7.56	33.83±4.71	-.01	13	.99	.01
Total	85.89±14.92	93.00±8.56	1.05	13	.31	.58



**Table 48.** EAS – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	6.00±.87	5.58±1.50	-.69	13	.50	.34
Structuring	4.78±1.09	4.67±1.60	-.16	13	.88	.08
Non-Intrusiveness	6.28 ±.97	6.25±.88	-.06	13	.96	.03
Non-Hostility	6.67±.50	6.42±.49	-.96	13	.36	.51
Child Responsiveness	5.28±1.70	5.33±.88	.08	12.48	.94	.04
Child Involvement	4.61±1.41	4.75±1.04	.21	13	.84	.11

**Table 49.** EAS – Unpaired t-tests for differences among fathers who accepted to continue the intervention and fathers who did not at T1.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	4.78±1.44	4.17±1.51	-.26	13	.44	.41
Structuring	3.89±1.43	3.50±1.38	-.14	13	.61	.28
Non-Intrusiveness	6.06 ±.77	5.67±.41	-.55	13	.28	.63
Non-Hostility	6.72±.57	6.33±.82	-.87	13	.29	.55
Child Responsiveness	4.94±1.57	4.08±1.46	-.54	13	.31	.57
Child Involvement	4.33±1.80	2.83±1.21	-1.93	12.98	.08	.98

**Table 50.** EAS – Unpaired t-tests for differences among mothers who accepted to continue the intervention and mothers who did not at T2.

	Agreement (N=9) ( <i>M ± SD</i> )	Disagreement (N=6) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Sensitivity	5.83±1.06	5.67±1.47	-.26	13	.80	.12
Structuring	4.50±1.35	4.50±1.34	.00	13	1.00	.00
Non-Intrusiveness	5.89 ±1.52	5.92±.58	.05	11.08	.96	.03
Non-Hostility	6.72±.51	6.25±.69	-1.54	13	.15	.77
Child Responsiveness	6.00±1.25	4.58±1.74	-1.84	13	.09	.94
Child Involvement	5.22±1.77	4.58±1.69	-.71	13	.50	.37

#### 4.5.12 Therapist experience and alliance

**Table 52.** WAI-SF – Unpaired t-tests for differences in mother scores according to the therapist experience at T1.

	High experience (N=9) ( <i>M ± SD</i> )	Low Experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	23.89±3.37	25.13±3.94	.70	15	.50	.34
Task	23.67±2.12	24.25±4.20	.37	15	.72	.17
Bond	22.11±2.37	22.50±3.55	.27	15	.79	.13
Total	69.67±6.52	71.88±10.86	.52	15	.61	.25

**Table 53.** WAI-SF – Unpaired t-tests for differences in father scores according to the therapist experience at T1.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	23.78±4.18	22.75±4.92	-.47	15	.65	.23
Task	25.67±2.69	23.63±4.69	-1.08	10.89	.30	.53
Bond	23.00±4.50	21.88±3.60	-.56	15	.58	.27
Total	72.44±9.63	68.25±12.81	-.77	15	.45	.37

**Table 54.** WAI-SF – Unpaired t-tests for differences in mother scores according to the therapist experience at T2.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	24.56±2.46	24.75±4.59	.11	15	.91	.05
Task	23.56±1.94	24.00±4.41	.26	9.38	.80	.13
Bond	22.33±2.83	21.88±2.90	-.33	15	.75	.16
Total	70.44±5.46	70.63±11.01	.04	9.98	.97	.02

**Table 55.** WAI-SF – Unpaired t-tests for differences in father scores according to the therapist experience at T2.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Goal	22.33±3.71	24.13±2.23	1.19	15	.25	.59
Task	23.00±3.24	24.63±3.54	.99	15	.34	.48
Bond	20.33±3.67	21.88±4.09	.82	15	.43	.40
Total	65.67±8.75	70.63±8.52	1.18	15	.26	.57

**Table 56.** SOFTA-S – Unpaired t-tests for differences in mother scores according to the therapist experience at T1.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	<i>df</i>	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.33±1.32	17.50±2.88	.15	9.58	.88	.08
Emotional Connection	16.56±1.13	16.63±2.67	.07	9.21	.95	.03
Safety	16.22±2.22	16.88±2.59	.56	15	.58	.27
Shared Sense of Purpose	17.89±1.76	17.25±2.82	-.57	15	.58	.27
Total	68.00±4.85	68.25±10.57	.06	15	.95	.03

**Table 57.** SOFTA-S – Unpaired t-tests for differences in father scores according to the therapist experience at T1.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.33±1.94	16.88±2.10	-.47	15	.65	.22
Emotional Connection	17.11±1.90	16.63±1.41	-.59	15	.56	.29
Safety	16.22±3.23	16.50±1.41	.22	15	.83	.11
Shared Sense of Purpose	17.44±2.65	18.00±1.51	.54	12.95	.60	.26
Total	68.11±8.37	68.00±5.76	-.03	15	.98	.02

**Table 58.** SOFTA-S – Unpaired t-tests for differences in mother scores according to the therapist experience at T2.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.11±2.03	16.25±2.38	-.81	15	.43	.39
Emotional Connection	17.44±1.51	16.50±2.62	-.90	10.91	.39	.44
Safety	17.00±2.35	16.88±2.17	-.11	15	.91	.05
Shared Sense of Purpose	16.56±2.96	16.75±2.92	.14	15	.89	.06
Total	68.11±6.95	66.38±8.99	-.45	15	.66	.22

**Table 59.** SOFTA-S – Unpaired t-tests for differences in father scores according to the therapist experience at T2.

	High experience (N=9) ( <i>M ± SD</i> )	Low experience (N=8) ( <i>M ± SD</i> )	<i>t</i>	df	<i>p</i>	Effect size ( <i>d</i> )
Engagement	17.00±1.87	16.13±1.64	-1.02	15	.33	.49
Emotional Connection	16.89±1.76	16.63±1.51	-.33	15	.75	.16
Safety	16.89±2.52	16.75±1.04	-.15	15	.89	.07
Shared Sense of Purpose	17.78±1.86	18.13±1.73	.40	15	.70	.19
Total	68.56±6.98	67.63±5.01	-.31	15	.76	.15

#### 4.5.13 Correlational analyses

##### 4.5.13.1 WAI-SF and SOFTA-S

**Table 62.** Correlations between therapist WAI-SF and SOFTA-S at T1.

	Mother				Father			
	Goal	Task	Bond	Total	Goal	Task	Bond	Total
SOFTA Engagement	.75**	.81**	.75**	.82**	.70**	.62**	.78**	.72**
SOFTA Emotional Connection	.60*	.69**	.71**	.71**	.72**	.72**	.77**	.77**
SOFTA Safety	.65**	.74**	.74**	.75**	.50*	.40	.43	.46
SOFTA Shared Sense of Purpose	.66**	.79**	.77**	.78**	.70**	.65**	.72**	.72**
SOFTA Total	.74**	.84**	.82**	.84**	.70**	.63**	.71**	.71**

\* $p < .05$ ; \*\* $p < .01$

**Table 63.** Correlations between therapist WAI-SF and SOFTA-S at T2.

	Mother				Father			
	Goal	Task	Bond	Total	Goal	Task	Bond	Total
SOFTA Engagement	.78**	.80**	.75**	.82**	.77**	.79**	.78**	.81**
SOFTA Emotional Connection	.71**	.81**	.58*	.75**	.69**	.74**	.64**	.71**
SOFTA Safety	.50*	.51*	.59*	.55*	.51*	.59*	.66**	.60*
SOFTA Shared Sense of Purpose	.60*	.61**	.58*	.63**	.74**	.77**	.77**	.78**
SOFTA Total	.70**	.73**	.69**	.75**	.75**	.80**	.80**	.81**

\* $p < .05$ ; \*\* $p < .01$

#### 4.5.13.2 Personality and alliance

**Table 64.** Correlations between parent BFI and WAI-SF at T1.

	Mother					Father				
	E	A	C	N	O	E	A	C	N	O
WAI Goal	.20	.35	.64**	-.25	.01	.47	.17	-.05	.06	-.06
WAI Task	.21	.40	.41	-.07	.15	.43	.16	.09	.07	.04
WAI Bond	.28	.50*	.41	-.20	.09	.119	.46	.19	-.18	.16
WAI Total	.25	.46	.56*	-.20	.09	.38	.29	.08	-.02	.05

*Note.* BFI - E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness.

\* $p < .05$ ; \*\* $p < .01$

**Table 65.** Correlations between parent BFI and WAI-SF at T2.

	Mother					Father				
	E	A	C	N	O	E	A	C	N	O
WAI Goal	.03	-.22	.29	-.27	.10	.20	-.30	.23	-.14	-.20
WAI Task	.01	-.04	.53*	-.08	.05	.08	-.04	.19	-.26	-.26
WAI Bond	.50*	.42	.50*	-.30	.20	.02	.14	.05	-.12	-.03
WAI Total	.19	.03	.50*	-.25	.13	.11	-.06	.18	-.20	-.18

*Note.* BFI - E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness.

\* $p < .05$

#### 4.5.13.3 Personality and parenting stress

**Table 66.** Correlations between parent BFI and PSI-SF at T1.

	Mother					Father				
	E	A	C	N	O	E	A	C	N	O
PSI Pd	-.33	-.55*	-.02	.59*	.10	-.52*	-.21	-.01	.23	.05
PSI Pcdi	-.05	-.12	-.24	.53*	.11	-.28	-.18	-.33	.11	-.07
PSI Dc	-.26	-.29	-.15	.26	.15	-.19	-.22	-.20	.40	.05
PSI Total	-.29	-.44	-.15	.57*	.15	-.46	-.29	-.25	.35	.02

*Note.* BFI - E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness. PSI – Pd= Parental Distress; Pcdi = Parent - Child Dysfunctional Interaction; Dc = Difficult Child.

\* $p < .05$

#### 4.5.13.4 Parenting stress and alliance

**Table 67.** Correlations between parent PSI-SF and WAI-SF at T1.

	Mother				Father			
	Pd	Pcdi	Dc	Total	Pd	Pcdi	Dc	Total
WAI Goal	-.15	-.56*	-.31	-.38	-.21	-.49*	-.05	-.35
WAI Task	-.21	-.32	-.11	-.25	-.12	-.39	-.04	-.25
WAI Bond	-.19	-.56*	-.40	-.45	.06	-.53*	-.31	-.37
WAI Total	-.20	-.54*	-.30	-.40	-.10	-.52*	-.15	-.36

*Note.* PSI – Pd= Parental Distress; Pcdi = Parent - Child Dysfunctional Interaction; Dc = Difficult Child.

\* $p < .05$

**Table 68.** Correlations between parent PSI-SF and WAI-SF at T2.

	Mother				Father			
	Pd	Pcdi	Dc	Total	Pd	Pcdi	Dc	Total
WAI Goal	-.57*	-.19	-.15	-.39	-.25	-.20	.15	-.15
WAI Task	-.50*	-.28	-.16	-.40	-.19	-.14	-.33	-.32
WAI Bond	-.47	-.47	-.36	-.53*	-.17	-.20	-.20	-.28
WAI Total	-.60*	-.35	-.25	-.50*	-.24	-.21	-.16	-.30

*Note.* PSI – Pd= Parental Distress; Pcdi = Parent - Child Dysfunctional Interaction; Dc = Difficult Child.

\* $p < .05$

#### 4.5.13.5 Parenting stress and emotional availability

**Table 69.** Correlations between parent PSI-SF and EAS at T1.

	Mother				Father			
	Pd	Pcdi	Dc	Total	Pd	Pcdi	Dc	Total
EAS Sensitivity	-.10	-.25	-.25	-.24	-.07	-.32	-.32	-.33
EAS Structuring	-.41	-.32	-.42	-.49*	.08	-.30	-.47	-.34
EAS Non-Intrusiveness	-.24	-.36	-.15	-.29	.09	-.11	.23	.10
EAS Non-Hostility	.20	.08	-.17	.05	-.03	-.35	.05	-.15
EAS Child Responsiveness	-.51*	-.31	.01	-.34	-.24	-.57*	-.23	-.49*
EAS Child Involvement	-.54*	-.24	-.09	-.37	-.16	-.26	-.40	-.38

*Note.* PSI – Pd= Parental Distress; Pcdi = Parent - Child Dysfunctional Interaction; Dc = Difficult Child.

\* $p < .05$



#### 4.5.13.6 Alliance and emotional availability

**Table 70.** Correlations between parent WAI-SF and EAS at T2.

	Mother				Father			
	Goal	Task	Bond	Total	Goal	Task	Bond	Total
EAS Sensitivity	-.23	-.16	.07	-.14	.34	.08	.56*	.40
EAS Structuring	-.20	-.13	.21	-.07	.21	-.10	.40	.21
EAS Non-Intrusiveness	.32	.27	.20	.31	-.16	-.06	.31	.06
EAS Non-Hostility	-.06	.03	.13	.03	.41	.16	.54*	.45

\* $p < .05$

## Appendix – Study Measures

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### Informed Consent



ALMA MATER STUDIORUM  
UNIVERSITA' di BOLOGNA

**Dipartimento di Psicologia**  
**Università di Bologna**  
Direttore Prof. Vincenzo Natale

**Servizio di Consultazione Psicologica**  
**per bambini e genitori**  
Responsabile Prof. Elena Trombini

Il Servizio di Consultazione Psicologica per bambini e genitori dell'Università di Bologna (responsabile: prof.ssa Elena Trombini) svolge attività di consultazione e intervento psicologico per bambini in età prescolare e scolare e i loro genitori.

Le attività del Servizio vengono svolte in un clima di attiva e fruttuosa collaborazione tra il terapeuta, i genitori e il bambino. L' "alleanza genitori-terapeuta", che consiste nella fiducia reciproca e nell'accordo su obiettivi e compiti condivisi, sono dimensioni fondamentali del lavoro clinico.

In questo contesto, desideriamo chiedere la Vostra partecipazione a un progetto di ricerca (responsabile: prof.ssa Elena Trombini) inerente la valutazione dell' "alleanza terapeutica", quale aspetto centrale per la comprensione e il sostegno dei genitori e bambini con sintomi in età prescolare.

Il progetto prevede l'osservazione videoregistrata degli scambi interattivi bambino-genitori durante una breve sequenza di gioco (durata complessiva: 20 minuti). Saranno inoltre somministrati alcuni questionari ai genitori e verrà richiesto il parere circa l'utilità del percorso psicologico intrapreso.

Le videoregistrazioni e le somministrazioni, coordinate dalla dott.ssa Ilaria Chirico, verranno effettuate presso il Servizio stesso.

I dati raccolti saranno utilizzati unicamente a scopo d'indagine scientifica, in forma riservata e in pieno rispetto delle normative sulla privacy (D.Lgs. 196 del 30 giugno 2003 "Codice in materia di protezione dei dati personali").

La partecipazione al progetto di ricerca prevede la possibilità di ritirarsi in qualsiasi momento, previa comunicazione delle motivazioni.

Chiedendo la Vostra gentile collaborazione, Vi ringraziamo fin d'ora per la disponibilità e restiamo a Vostra disposizione per ulteriori chiarimenti (prof.ssa Elena Trombini, email: elena.trombini@unibo.it; dott.ssa Ilaria Chirico, email: ilaria.chirico2@unibo.it).

I sottoscritti.....,

genitori di .....

#### AUTORIZZANO

la propria partecipazione e quella del del\_\_ propri\_ figli\_ al progetto proposto.

Data

.....

Firma del padre

.....

Firma della madre

.....

---

#### Trattamento dei dati:

I dati raccolti saranno utilizzati unicamente a scopo d'indagine scientifica, in forma riservata e in pieno rispetto delle normative sulla privacy in ottemperanza al decreto legislativo 196 del 30 giugno 2003 "Codice in materia di protezione dei dati personali". Il trattamento dei dati sarà effettuato secondo modalità sia manuali, sia informatiche e, in ogni caso, idonee a proteggerne la riservatezza nel rispetto delle norme vigenti. Responsabile del trattamento è la prof.ssa Elena Trombini (email: elena.trombini@unibo.it).

I sottoscritti.....,

genitori di .....

AUTORIZZANO

la propria partecipazione e quella del del\_\_ propri\_ figli\_ al progetto proposto.

Data

.....

Firma del padre

.....

Firma della madre

.....

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Consenso alla videoregistrazione:

Esprimo il consenso alla videoregistrazione e al suo utilizzo nell'ambito del progetto di ricerca sopraindicato in ottemperanza al decreto legislativo 196 del 30 giugno 2003 "Codice in materia di protezione dei dati personali".

Sono stato informato che la videoregistrazione verrà trattata sempre in forma anonima e nessun dato verrà divulgato.

Data

.....

Firma del padre

.....

Firma della madre

.....

## Big Five Inventory

(BFI; John, Donahue, & Kentle, 1991)

Italian version by Ubbiali, Chiorri, Hampton, & Donati (2013)

Sono qui di seguito riportate alcune caratteristiche che possono riguardarLa o meno. Legga ciascuna caratteristica e poi scriva un numero (1,2,3,4,5) a lato di ogni affermazione che indichi quanto Lei è d'accordo o in disaccordo con quell'affermazione secondo i seguenti livelli:

1. fortemente in disaccordo
2. un po' in disaccordo
3. né d'accordo né in disaccordo
4. un po' d'accordo
5. fortemente d'accordo

*Io mi vedo come una persona che...*

1. È loquace \_\_\_\_
2. Tende a trovare da ridire sugli altri \_\_\_\_
3. Lavora in modo accurato \_\_\_\_
4. È depressa, triste \_\_\_\_
5. È originale, propone idee nuove \_\_\_\_
6. È riservata \_\_\_\_
7. È premurosa e altruista con gli altri \_\_\_\_
8. Può essere piuttosto sbadata \_\_\_\_
9. È rilassata, gestisce bene lo stress \_\_\_\_
10. Ha curiosità in molti ambiti diversi \_\_\_\_
11. È piena di energia \_\_\_\_
12. Attacca briga con gli altri \_\_\_\_
13. È un lavoratore affidabile \_\_\_\_
14. Può essere tesa \_\_\_\_
15. È ingegnosa, un pensatore profondo \_\_\_\_

16. Genera molto entusiasmo \_\_\_\_
17. Per natura tende a perdonare \_\_\_\_
18. Tende ad essere disorganizzata \_\_\_\_
19. Si preoccupa molto \_\_\_\_
20. Ha un'immaginazione attiva \_\_\_\_
21. Tende ad essere taciturna \_\_\_\_
22. Di solito si fida \_\_\_\_
23. Tende ad essere pigra \_\_\_\_
24. È emotivamente stabile, non si turba facilmente \_\_\_\_
25. È inventiva \_\_\_\_
26. Ha una personalità energica \_\_\_\_
27. Può essere fredda ed emotivamente distaccata \_\_\_\_
28. Persevera finché il compito è terminato \_\_\_\_
29. Può essere lunatica \_\_\_\_
30. Apprezza le esperienze artistiche, estetiche \_\_\_\_
31. È qualche volta timida, inibita \_\_\_\_
32. È premurosa e gentile pressoché con tutti \_\_\_\_
33. Fa le cose efficientemente \_\_\_\_
34. Rimane calma nelle situazioni tese \_\_\_\_
35. Preferisce un lavoro che sia di routine \_\_\_\_
36. È estroversa, socievole \_\_\_\_
37. È qualche volta scortese con gli altri \_\_\_\_
38. Fa dei piani e li porta a termine \_\_\_\_
39. Diventa facilmente apprensiva \_\_\_\_
40. Ama riflettere, giocare con le idee \_\_\_\_
41. Ha pochi interessi artistici \_\_\_\_
42. Ama cooperare con gli altri \_\_\_\_
43. È facilmente distratta \_\_\_\_

44. Ha una sensibilità raffinata per l'arte, la musica o la letteratura \_

## Working Alliance Inventory – Short Form

(WAI-SF; Tracey & Kokotovic, 1989)

Italian version by Lingiardi & Filippucci (2002)

### CLIENT VERSION

Le presentiamo una serie di quesiti che provano a definire alcuni aspetti del rapporto con il terapeuta di suo figlio. Mentre legge i quesiti inserisca mentalmente il nome del terapeuta al posto dello spazio bianco lasciato libero nel testo. Utilizzando la scala a 7 punti di seguito riportata, indichi, cerchiando il numero, il grado con cui ciascuna affermazione descrive ciò che pensa.

1= mai ; 2= raramente; 3= ogni tanto; 4= qualche volta; 5= spesso; 6= molto spesso; 7= sempre

1. _____ e io siamo d'accordo sulle cose di cui ho bisogno in terapia per migliorare la mia situazione.	1	2	3	4	5	6	7
2. Ciò che sto facendo in terapia mi dà la possibilità di guardare in modo diverso i miei problemi.	1	2	3	4	5	6	7
3. Credo di piacere a _____ .	1	2	3	4	5	6	7
4. _____ non capisce ciò che io sto cercando di ottenere dalla terapia.	1	2	3	4	5	6	7
5. Ho fiducia nelle capacità di _____ nell'aiutarmi.	1	2	3	4	5	6	7
6. _____ e io siamo impegnati in uno sforzo comune per raggiungere obiettivi concordati.	1	2	3	4	5	6	7
7. Sento che _____ mi apprezza.	1	2	3	4	5	6	7
8. Siamo d'accordo sulle cose su cui è importante che io lavori.	1	2	3	4	5	6	7
9. _____ e io ci fidiamo l'uno dell'altro.	1	2	3	4	5	6	7
10. _____ e io abbiamo idee differenti su quali sono i miei reali problemi.	1	2	3	4	5	6	7
11. Abbiamo stabilito un buon livello di comprensione reciproca sul tipo di cambiamenti che sarebbero giusti per me.	1	2	3	4	5	6	7
12. Credo che la strada intrapresa per risolvere i miei problemi sia quella giusta.	1	2	3	4	5	6	7



## Working Alliance Inventory – Short Form

(WAI-SF; Tracey & Kokotovic, 1989)

Italian version by Lingiardi & Filippucci (2002)

### THERAPIST VERSION

Le presentiamo ora una serie di quesiti che provano a definire alcuni aspetti del rapporto con la madre del bambino. Mentre legge i quesiti inserisca mentalmente il nome della signora al posto dello spazio bianco lasciato libero nel testo. Utilizzando la scala a 7 punti di seguito riportata, indichi, cerchiando il numero, il grado con cui ciascuna affermazione descrive ciò che pensa.

1= mai ; 2= raramente; 3= ogni tanto; 4= qualche volta; 5= spesso; 6= molto spesso; 7= sempre

1. _____ e io siamo d'accordo circa i passaggi che vanno affrontati per migliorare la sua situazione.	1	2	3	4	5	6	7
2. _____ e io ci sentiamo fiduciosi sulla utilità della nostra attività terapeutica.	1	2	3	4	5	6	7
3. Credo di piacere a _____ .	1	2	3	4	5	6	7
4. Ho dei dubbi su ciò che stiamo cercando di realizzare con la terapia.	1	2	3	4	5	6	7
5. Confido nella mia capacità di aiutare _____	1	2	3	4	5	6	7
6. _____ e io siamo impegnati in uno sforzo comune per raggiungere obiettivi concordati.	1	2	3	4	5	6	7
7. Stimo _____ come persona.	1	2	3	4	5	6	7
8. Siamo d'accordo su ciò su cui _____ deve lavorare.	1	2	3	4	5	6	7
9. _____ e io abbiamo costruito un rapporto di fiducia reciproca.	1	2	3	4	5	6	7
10. _____ e io abbiamo idee differenti su quali sono i suoi reali problemi.	1	2	3	4	5	6	7
11. Abbiamo stabilito un buon livello di comprensione reciproca sul tipo di cambiamenti che sarebbero giusti per _____	1	2	3	4	5	6	7
12. Credo che la strada intrapresa per risolvere i suoi problemi sia quella giusta.	1	2	3	4	5	6	7

## Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995)

Italian version by Guarino, Di Blasio, D'Alessio, Camisasca, & Serantoni (2008)

Il seguente questionario contiene 36 affermazioni. Le legga una ad una molto attentamente e si concentri su suo figlio; quindi indichi con un cerchio la risposta che meglio rappresenta la Sua opinione . Faccia un cerchio intorno a:

- FA se è fortemente d'accordo con l'affermazione
- A se è d'accordo con l'affermazione
- I se non è sicura
- D se è in disaccordo con l'affermazione
- FD se è fortemente in disaccordo con l'affermazione

Se non trova la risposta che interpreta esattamente i Suoi sentimenti, faccia un cerchio intorno a quella che descrive meglio ciò che lei prova. La sua prima reazione a ciascuna affermazione dovrebbe essere la sua risposta. Se desidera cambiare risposta faccia una X sulla risposta che intende cambiare.

1. Spesso ho la sensazione di non riuscire a far fronte molto bene alle situazioni.	FA	A	I	D	FD
2. Per venire incontro ai bisogni di mio/a figlio/a mi accorgo di sacrificare la mia vita più di quanto mi aspettassi.	FA	A	I	D	FD
3. Mi sento intrappolato dalle mie responsabilità di genitore.	FA	A	I	D	FD
4. Da quando ho avuto questo/a figlio/a non riesco a fare cose nuove e diverse.	FA	A	I	D	FD
5. Da quando ho avuto questo/a figlio/a mi rendo conto che quasi mai riesco a fare le cose che mi piacciono.	FA	A	I	D	FD
6. Non sono soddisfatta dell'ultimo acquisto di abbigliamento che ho fatto per me.	FA	A	I	D	FD
7. Ci sono un bel po' di cose della mia vita che mi disturbano.	FA	A	I	D	FD
8. Aver avuto un/a figlio/a ha causato, nel rapporto con mio marito (o con il partner), più problemi di quanto mi aspettassi.	FA	A	I	D	FD
9. Mi sento sola e senza amici.	FA	A	I	D	FD
10. Quando vado ad una festa di solito mi aspetto di non divertirmi.	FA	A	I	D	FD
11. Non sono così interessato alla gente come lo ero una volta.	FA	A	I	D	FD
12. Non mi diverto più come una volta.	FA	A	I	D	FD
13. Mio/a figlio/a raramente fa per me cose che mi gratificano.	FA	A	I	D	FD

14. A volte sento di non piacere a mio/a figlio/a e che lui/lei non vuole stare vicino a me.	FA	A	I	D	FD
15. Mio figlio mi sorride molto meno di quanto mi aspettassi.	FA	A	I	D	FD
16. Quando faccio le cose per mio/a figlio/a ho la sensazione che i miei sforzi non siano molto apprezzati.	FA	A	I	D	FD
17. Quando mio/a figlio/a gioca non ride né mostra di divertirsi spesso.	FA	A	I	D	FD
18. Mio/a figlio/a non sembra imparare così velocemente come la maggioranza dei bambini.	FA	A	I	D	FD
19. Mio/a figlio/a non sorride tanto quanto la maggioranza dei bambini.	FA	A	I	D	FD
20. Mio/a figlio/a non riesce a fare tanto quanto mi aspettavo.	FA	A	I	D	FD
21. Ci vuole molto tempo ed è molto difficile per mio/a figlio/a abituarsi alle novità.	FA	A	I	D	FD
22. Sento di essere: <ul style="list-style-type: none"> <li>1. Non molto brava come genitore</li> <li>2. Una persona che ha qualche problema ad essere genitore</li> <li>3. Un genitore medio</li> <li>4. Un genitore al di sopra della media</li> <li>5. Un genitore molto bravo</li> </ul>					
23. Mi aspettavo di provare per mio/a figlio/a sentimenti di maggiore vicinanza di quelli che provo e questo mi dispiace.	FA	A	I	D	FD
24. Talvolta mio/a figlio/a fa cose che mi disturbano, solo per farmi dispetto.	FA	A	I	D	FD
25. Mio/a figlio/a sembra che pianga o si agiti molto più della maggioranza dei bambini	FA	A	I	D	FD
26. Mio/a figlio/a di solito si sveglia di cattivo umore	FA	A	I	D	FD
27. Ritengo che mio/a figlio/a sia facilmente irritabile e di umore variabile (lunatico/a)	FA	A	I	D	FD
28. Mio/a figlio/a fa alcune cose che mi infastidiscono molto	FA	A	I	D	FD
29. Mio/a figlio/a reagisce duramente quando succede qualcosa che non gli/le piace	FA	A	I	D	FD
30. Mio/a figlio/a rimane facilmente male per le più piccole cose	FA	A	I	D	FD

31. I ritmi del sonno e dell'alimentazione di mio/a figlio/a sono stati molto più difficili da regolare di quanto mi aspettassi	FA	A	I	D	FD
32. Mi sono reso conto che convincere mio/a figlio/a a fare qualcosa o smettere di fare qualcosa è: 1. Molto più difficile di quanto mi aspettassi 2. Un po' più difficile di quanto mi aspettassi 3. All'incirca difficile come mi aspettavo 4. Un po' più facile di quanto mi aspettassi 5. Molto più facile di quanto mi aspettassi					
33. Pensi con attenzione e conti il numero di cose che suo/a figlio/a fa e che la infastidiscono (ad esempio: perde tempo, si rifiuta di ascoltare, è troppo attivo/a, piange, interrompe, fa le lotte, fa a pugni, piagnucola, ecc.)	+10	8-9	6-7	4-5	1-3
34. Alcune cose che fa mio/a figlio/a mi infastidiscono veramente molto	FA	A	I	D	FD
35. Mio/a figlio/a si è dimostrato/a un problema più grande di quanto mi aspettassi	FA	A	I	D	FD
36. Mio/a figlio/a mi chiede di più della maggior parte dei bambini	FA	A	I	D	FD

## System for Observing Family Therapy Alliances-self report

(SOFTA-s; Friedlander, Escudero, & Heatherington, 2006)

Italian version by Mazzoni (2010)

### CLIENT VERSION

I seguenti questionari devono riflettere la Sua percezione rispetto al percorso psicologico appena intrapreso. Si senta libera di esprimere il suo pensiero.

Gli strumenti proposti vengono utilizzati in diversi contesti psicoterapeutici pertanto quando si parla di terapia La invitiamo a pensare a questo percorso.

Valuti le seguenti affermazioni ed indichi quanto è d'accordo con esse cercando il numero più appropriato secondo la seguente legenda:

1= per niente; 2= lievemente; 3= moderatamente; 4= molto; 5= moltissimo

1. Quello che avviene in terapia può risolvere i nostri problemi.	1	2	3	4	5
2. Il terapeuta mi comprende.	1	2	3	4	5
3. Le sedute di terapia aiutano ad aprirmi (a condividere i miei sentimenti, a tentare cose nuove...).	1	2	3	4	5
4. Tutti i membri della mia famiglia che partecipano alla terapia vogliono il meglio per la nostra famiglia e vogliono risolvere i nostri problemi.	1	2	3	4	5
5. Mi risulta difficile parlare col terapeuta di ciò su cui dovremmo lavorare in terapia.	1	2	3	4	5
6. Il terapeuta sta facendo tutto il possibile per aiutarmi.	1	2	3	4	5
7. Mi sento a mio agio e rilassato durante le sedute di terapia.	1	2	3	4	5
8. Quelli di noi che partecipano alle sedute di terapia danno importanza al tempo e agli sforzi che tutti facciamo.	1	2	3	4	5
9. Io e il terapeuta stiamo lavorando insieme come squadra.	1	2	3	4	5
10. Il terapeuta è diventato una persona importante nella mia vita .	1	2	3	4	5
11. Ci sono alcuni argomenti di cui ho paura di discutere in terapia.	1	2	3	4	5
12. Alcuni membri della famiglia non sono d'accordo con gli altri sugli obiettivi della terapia.	1	2	3	4	5
13. Comprendo il senso di quello che si sta facendo in terapia.	1	2	3	4	5
14. Al terapeuta mancano le conoscenze e l'abilità per aiutarmi.	1	2	3	4	5
15. A volte in terapia mi metto sulla difensiva.	1	2	3	4	5
16. Ogni membro della nostra famiglia aiuta gli altri ad ottenere in terapia quello di cui ha bisogno.	1	2	3	4	5

## System for Observing Family Therapy Alliances-self report

(SOFTA-s; Friedlander, Escudero, & Heatherington, 2006)

Italian version by Mazzoni (2010)

### THERAPIST VERSION

Valuti le seguenti affermazioni ed indichi quanto è d'accordo con esse cerchiando il numero più appropriato:

	Per niente	Lievemente	Moderatamente	Molto	Moltissimo
1. Quello che succede in terapia può risolvere i problemi di questa famiglia.	1	2	3	4	5
2. Comprendo questa famiglia.	1	2	3	4	5
3. Le sedute di terapia stanno aiutando i membri della famiglia ad aprirsi (a condividere emozioni, tentare cose nuove ...).	1	2	3	4	5
4. Tutti i membri della famiglia che partecipano alla terapia vogliono il meglio per la famiglia e vogliono risolvere i problemi.	1	2	3	4	5
5. È difficile per me e per la famiglia discutere insieme di ciò su cui dovremmo lavorare in terapia.	1	2	3	4	5
6. Io sto facendo tutto il possibile per aiutare questa famiglia.	1	2	3	4	5
7. I membri della famiglia si sentono a proprio agio e rilassati durante le sedute di terapia.	1	2	3	4	5
8. Tutti coloro che partecipano alle sedute di terapia apprezzano il tempo e gli sforzi che ciascuno fa.	1	2	3	4	5
9. Io e la famiglia stiamo lavorando insieme come una squadra.	1	2	3	4	5
10. Sono diventato una persona importante nella vita di questa famiglia	1	2	3	4	5
11. Ci sono alcuni argomenti che i membri della famiglia hanno paura di discutere in terapia.	1	2	3	4	5
12. Alcuni membri della famiglia non sono d'accordo con altri sugli obiettivi della terapia.	1	2	3	4	5
13. Quello che io e questa famiglia stiamo facendo in terapia ha senso per me.	1	2	3	4	5

14. Mi mancano le conoscenze e le abilità per aiutare questa famiglia.	1	2	3	4	5
15. A volte alcuni membri della famiglia si mettono sulla difensiva in terapia.	1	2	3	4	5
16. Ognuno in famiglia aiuta gli altri ad ottenere in terapia quello che desiderano.	1	2	3	4	5

## Emotional Availability Scale

Infancy to Early Childhood Version, 4th Edition (EAS; Biringen, 2008)

### Emotional Availability Scale - Scoring Sheet

Screeener:

Sensitivity	Affect		Non-Hostility	Lack negativity	
Total	Clarity of Perceptions		Total	Lack ridiculing	
	Timing		Direct	Lack threats of separation	
	Flexibility			Loose cool	
Direct	Acceptance			Frightening	
	Amount of Interaction			Silence	
	Conflict			Themes	
Structuring	Guidance		Child Responsiveness	Affect	
Total	Success		Total	Responsiveness	
	Amount of Structure		Direct	Autonomy	
	Limit setting			Physical Positioning	
Direct	Firm in Pressure			Role-reversal	
	(Non)verbal structuring			Lack of avoidance	
	Peer vs. Adult			Task oriented	
Non-Intrusiveness	Following Child leads		Child Involvement	Simple Initiative	
Total	Ports of entry		Total	Elaborative Initiative	
	Commands		Direct	Use of Adult	
	Talking			Lack of over-involvement	
Direct	Didactic Teaching			Eye contact	
	Interferences			Body positioning	
	Feel Intrusive			Verbal involvement	