

**PRELIMINARY FINDINGS OF THE PROJECT: THE LAUSANNE TRILOGUE
PLAY AS A PSYCHODIAGNOSTIC AND THERAPEUTIC TOOL - AN
INNOVATIVE CLINICAL EXPERIENCE WITH PSYCHIATRIC CHILDREN
AND ADOLESCENTS**

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ABSTRACT. Introduction: Considering the whole family as a structured subsystem defined on the basis of the members' different functions, this work focuses on the Lausanne Trilogue Play (LTP), which is a semi-structured interview procedure. **Method:** The research is an ongoing longitudinal study lasting 36 months. The sample is being recruited at the Neuropsychiatry Unit for Children and Adolescents, ULSS 16 in Padua, Italy, and consists of patients aged between 3 and 18 years and their parents, referred for psychodiagnostic assessment due to emotional and/or behavioral problems. The sample (a hundred families) is divided into two groups: in one the child is administered psychotherapy; in the other, the child's treatment is associated with intervention to support parenting. The tools used as test retest are: YSR 11-18, SCL 90 R, 20 TAS, CBCL, FES and the LTP. The aims of this research project are firstly to test the LTP as a diagnostic and therapeutic tool for the purpose of planning effective therapy tailored to each family; and secondly to standardize the use of the LTP in adolescents. This paper describes the project design and the preliminary results so far arisen. **Results:** Preliminary data confirm a link between psychological disorders in developmental age and family dynamics, but this relationship does not appear to be linear. It will be further clarified when we follow up these families and see how their children's psychological disorders develop in relation to the evolution of their family dynamics. **Discussion/Conclusion:** Data alight the value of the LTP as part of the diagnostic and therapeutic armamentarium in developmental psychopathology, for identifying a family's dysfunctional and functional characteristics with a view to offering them early and efficacy interventions.

Keywords: Lausanne Trilogue Play, psychopathology, children, adolescents.

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Introduction

Family characteristics strongly predict mental health in childhood, making it increasingly necessary to use appropriate tools for investigating and supporting the role of parental figures in parallel with psychotherapy for a child. Then, it is essential to identify a family's dysfunctional and functional characteristics in order to offer early and right interventions.

This research project is consistent with recent models for interpreting children's development in the setting of their families as a whole. The family is a structured system that can be defined on the basis of different functions, such as conjugal relations (the relationship between the partners as a couple), parenthood (each parent's relationship with the child), and parenting (the relationship between the partners as parents). Within this approach, the most noteworthy changes have been prompted by the work of Fivaz-Depeursinge and Corboz Warnery (1999). Their systemic-evolutionary model is helping to create new opportunities for studying mother-father-child interactions, referring to a triadic system that evolves from the earliest stages of life. According to that, the Lausanne Trilogue Play (LTP) is a semi-structured interview procedure developed by the Centre for Studies and Research on Family Group in Lausanne in the 1980s. This tool uses video recordings of a family involved in an activity. It is very useful for assessing family systems and can help develop the alliance with the clinician and thus enable the family's functional or dysfunctional characteristics to be identified. Moreover, using video feedback (a shared and guided viewing of the movie together with the parents) gives parents an opportunity to improve their strategic skills and increase their parenting resources. So far, the LTP has been mainly used in research with babies (Bighin, De Palo, & Simonelli, 2011; Carneiro, Corboz-Warnery, & Fivaz-Depeursinge, 2006; Gargano, & Lubrano-Lavadera, 2006; Simonelli, Bighin, & De Palo, 2012; Simonelli, Fava-Vizziello, Bighin, & Petch, 2010), but it had yet to be tested as a clinical application in a structured, continuous usage. Based on these premises, this paper's aims are:

- To use the LTP as a diagnostic tool and a help to identify a targeted, effective therapy tailored to each family.
- To support and validate the use of the LTP as a clinical and therapeutic tool capable of recognizing and improving family's strategic interactions and parenting skills.
- To gain a better understanding of the value of the LTP in predicting how the quality of triadic interactions relates to patient outcomes.
- To standardize the LTP tool for use in adolescents and in different clinical groups.

Method

Participants

The research involves a longitudinal study lasting 36 months. The sample is being recruited at the Neuropsychiatry Unit for Children and Adolescents, Azienda-ULSS 16 in Padua, and consists of patients aged between 3 and 18 years, and their parents, referred for a psycho-diagnostic assessment due to emotional or behavioral problems. The neuropsychiatric consultation is scheduled with separate diagnostic interviews with the children or adolescents and their parents, and it is conducted by a developmental neuro-psychiatrist and a trained psychodynamic psychologist.

The study sample aims to be of about 100 families, divided into two groups: Group 1 (n = 50) contains families whose children are assigned to a course of individual psychotherapy for maximum two years (it depends on sessions, conducted weekly or fortnightly); in Group 2 (n = 50) the child's treatment is associated with intervention to support parenting (sessions conducted monthly or bimonthly).

Instruments

Child Behavior Checklist (CBCL) and *Youth Self Report (YSR)* (Achenbach, & Rescorla, 2001). They are in the form of a questionnaire completed by parents (the CBCL) and adolescents (the YSR), and yield two profiles: one for competences (activities, social functioning, school performance) and one for behavioral and emotional problems, which can be assessed as "normal", "borderline" or "clinical". The problems are grouped into: 'internalizing problems' (anxiety, depression and withdrawal, somatization); 'externalizing problems' (aggressive and rule-breaking behavior); and 'other problems' (social problems, thought-related problems, attention problems).

Symptom Check List revised (SCL-90 R) (Derogatis, 1994). This is a 90-item self-report questionnaire for assessing psychopathological traits. This instrument sheds light on a broad range of psychological issues and psychopathological symptoms. The instrument is also useful for measuring patients' progress or treatment outcomes. The various items assess 9 symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Toronto Alexithymia Scale (TAS 20) (Rieffe, Oosterveld, & Terwogt, 2006). The TAS-20 is a self-report questionnaire that measures the three defining factors of alexithymia: "difficulty in identifying feelings", "difficulty in communicating feelings to others", and "externally oriented thinking". Respondents are classified as non-alexithymic (scores <51), borderline (scores 51-60), or alexithymic (scores >61).

Family Empowerment Scale (FES) (Koren, De Chillo, & Friesen, 1992). It is a questionnaire measuring the level of empowerment. This tool is a 34 item self-report scale, which are divided into three subscales, *Family*, *Community* and *Service System*. The continuum of rating extends over a 5-point range. In the present study we used the sub scale Family only, given our interest in exploring the parental perception of self efficacy in managing children in everyday life.

Lausanne Triogue Play (LTP) (Fivaz-Depeursinge, & Corboz-Warnery, 1999). It enables the monitoring and assessment of triadic family interactions. The LTP procedure aims to monitor the dynamics of a family in an interactive fun- and stress-free condition. The LTP is administered by a trained professional and the family is asked to organize a game in a sequence of four stages: in Part I, one parent interacts with the child while the other looks on (2 + 1); in Part II, the parent previously acting as a third party observer plays with the child while the other parent looks on (2 + 1); in Part III, all three participants interact with each other (3); and in Part IV, the parents interact with each other while the child looks on (2 + 1).

The switches from one stage to another are transitions that demand a good coordination between the partners in managing the negotiations and sharing in the family game. The encoding scheme used in the LTP procedure comprises 10 scales, each defining an observational variable defining behavior such as: body language, direction of gaze, coparenting coordination, role organization, parental scaffolding, the

child's involvement, sensitivity and affect regulation, shared activities, and family warmth. The scores obtained on each of the scales are added together and lead to a total score that assesses the quality of the family's interactive skills.

Procedures

The following tests are administered to the parties involved (as appropriate) during the diagnostic workup: YSR 11-18; SCL 90 R; 20 TAS; CBCL, FES and LTP. Each test is repeated every six months, except for the LTP (see below). Groups 1 and 2 are being randomly divided into 2 subgroups (1a, 1b, and 2a, 2b).

The LTP is administered every 6 months for 2 years after starting therapy in subgroups 1a and 2a, associated with video feedback for the family on each occasion, while in subgroups 1b and 2b the LTP is repeated every 12 months for 2 years and participants are given no video feedback.

After 24 months, the resulting data will be reworked to test the short-term efficacy of the therapy (on the child or adolescent and the parents), and of the LTP as a therapeutic and diagnostic tool. The follow-up will then continue up to 36 months, using the YSR 11-18, the SCL 90 R, the 20 TAS, the CBCL, the FES and the LTP.

Psychodiagnostic assessment. At the Neuropsychiatry Unit where this research is underway, it is standard procedure to ask parents to sign documents giving their consent on matters of privacy, public health and research activities, and the possible use of video or sound recordings as part of diagnostic and/or therapeutic procedures. The psychodiagnostic assessment is based on the following protocol:

- with the child or adolescent: the neuropsychiatrist conducts a first interview to obtain their acceptance, then two clinical interviews and any associated tests, then a final interview to communicate the diagnosis and therapeutic recommendations;
- in parallel with the parents: the psychologist conducts a first interview to obtain their acceptance, two clinical interviews to collect their child's clinical history and complete any tests, and a final interview to communicate the diagnosis and therapeutic recommendations.

The final interview is held with patients and their parents together, and led by both the operators. It is used to explain the diagnosis and suggest treatment(s). This is also when the research project is explained and the young patients and their parents or guardians sign to give their informed consent to take part.

Therapeutic interventions. After the diagnostic process and according to the therapeutic indication, the recruited families are divided into two groups: Group 1 contains families whose children are assigned to a course of individual psychodynamic psychotherapy for about two years (30-50 sessions, conducted weekly or fortnightly); in Group 2 the child's treatment is associated with intervention to support parenting taking a psycho-educational approach (20-35 sessions, conducted monthly or bimonthly).

In the subgroups b's families LTP was associated with videofeedback. The use of videofeedback aims to promote the effectiveness of treatments in term of improvement of family interactions, especially those linked to parenting. Monitoring and sharing videos interactions with parents can allow to support offsprings' treatment in case of dysfunctional interactions.

Design

This is a longitudinal research study, lasting three years, within which a case control study is meant to be run in terms of treatment (between groups with and without videofeedback association).

Results

So far we have assessed 155 children and adolescents at the baseline (T0), 83 males and 72 females, with a mean age of 14 years. Of these 155 cases, 78 were taken into care at our Neuropsychiatry unit, excluding 11 dropouts. Eighty-nine of the parents had an average-to-low cultural level (school attendance up to grades 5 or 8), while for 209 it was average-to-high (up to grade 13 or university). The parents were divorced/separated in 24 cases.

Discussion

The first round of analyses conducted on our current sample focused on answering the following questions:

Are there any differences in the capacity to manage the various family configurations between clinical/borderline subjects and nonclinical subjects?

To assess this aspect, we studied the differences between the clinical/borderline group and the nonclinical group (based on the CBCL and YSR scores) in the trends of the various parts of the LTP. We used a generalized linear model to assess any differences in the trends of the scores obtained in the various parts of the LTP (the independent variable) by the two groups (clinical/borderline versus nonclinical; first factor) for each subscale of the YSR /CBCL (second factor).

Are there any differences within a given family configuration (focusing on the single parts of the LTP) between the group of clinical/borderline subjects and the group of nonclinical subjects?

To assess this issue we studied the differences between the clinical/borderline group and the nonclinical group (CBCL and YSR) in the scores for the variables involved in each stage of the LTP.

Briefly, the first analyses on the relationship between the psychopathological issues and the family dynamics in the sample of clinical subjects suggested that clinical/borderline YSR and CBCL scores corresponded to families with very high levels of conflict between the parents in Part IV of the LTP, and of interference in Parts I and II, especially when externalizing, and social problems are concerned. These findings confirm the hypothesis that coparenting difficulties (when mother and father have trouble interacting and cooperating) correlate with their child's structuring and symptoms.

On the other hand, it does not always seem to hold that more severe psychological disorders coincide with more dysfunctional family dynamics, especially as far as internalizing problems (anxiety, depression, somatization) are concerned. In interpreting these results, we need to consider variables such as the transgenerational aspects of the anxiety-depression domain, and the possibility of a greater degree of sensitivity and empathy in families with a child who has internalizing problems.

Thus, on our results so far, we can say that a link exists between developmental psychological disorders and family dynamics, but this relationship does not appear to be linear. We have not found that more severe disorders coinciding with low levels of family functioning. These aspects will be further analyzed and clarified when we follow

up these families and see how their children's psychological disorders develop in relation to the evolution of their family dynamics.

Close to scientific results, the value of our project from the clinical and care-providing standpoint is clear from several aspects: the assessment phase involves examining the whole family system, identifying its functional and dysfunctional aspects, and the traits of each of its members; the treatment phase involves structured and intensive measures that public services are increasingly rarely able to offer; the follow-up enables us to monitor how the disorders evolve, keeping patients connected to the service, in this sense it also serves as a tertiary prevention measure.

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