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OBESITY AT THE MIRROR: CHANGES IN PSYCHOLOGICAL CHARACTERISTICS AFTER A PSYCHOEDUCATIONAL INTERVENTION FOR OBESE ADULTS

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Obesity is a pervasive condition, a risk factor for health issues including diabetes and heart diseases. The growing problem of obesity requires clinical attention and immediate interventions of prevention and care. Although little has been done thus far, the literature shows that the clinical population of obese patients is often characterized by the presence of eating habits linked to negative emotional experiences like anxiety, depression, anger and loneliness. Additionally, it seems that psychoeducational interventions aimed at changing eating habits can intervene on such psychological variables in order to help body-weight reduction.
The present study investigates the efficacy of a group psychoeducational intervention for obese patients in terms of both body weight loss and changes in relevant psychological variables such as binge eating, anxiety, depression, disturbed body image and sociocultural influences on body appearance. Gender differences will also be examined. The sample comprised 96 overweight and obese patients (32 males), $23 \leq$ age ≤ 65 years (M= 49.80, DS= 10.35), BMI ≥ 30, who participated in psychoeducational group interventions at the Clinical Dietetics and Metabolic Diseases Unit of the S. Orsola-Malpighi Hospital (Bologna). Each psychoeducational intervention consisted of 12 weekly group sessions run by a nutritionist, a psychologist and a physician. The aims of this treatment were: to motivate patients changing their eating habits and doing physical activity; to make aware of their condition of obese and the risks for physical and psychological health; to develop self-monitoring skills of their feeding habits, by using tools like food diary, counting calories and learning to read nutrition fact label. Independent assessments were performed pre-treatment (baseline, V0) and about two weeks after the end of the intervention (follow up, V1). Medical and sociodemographic variables were collected through medical records and data sheet, together with a set of self-report questionnaires including the Beck Depression Inventory, the State-Trait Anxiety Inventory, the Binge Eating Scale, the Sociocultural Attitudes Towards Appearance Questionnaire-3, and the Body Image Disturbance Questionnaire. The ethical norms were respected, in fact each patient has signed the form for informed consent to data processing, in respect of anonymity and privacy.

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At each time point body weight was also measured. Correlations and repeated measure ANOVAs were used as analytic strategy. The analyses showed significant positive correlations between binge eating and negative affectivity both pre- (r =.32, r=.34, p<.001, for depression and state anxiety, and r=.23, p<.05, for trait anxiety respectively) and post-treatment (r = .27, r = .38, and r = .39 all ps<.01 for depression, state and trait anxiety respectively). These analyses are consistent with the literature on the association between negative affectivity and binge eating. Women showed significantly higher depressive and anxious symptoms than men and these were related with a body image distortion, both pre- and post-treatment. After the treatment, there was a significant reduction of symptoms of depression (F (1, 65)= 4.254; p < .05), state anxiety (F (1, 62) =5.672; p<.05), trait anxiety (F (1, 61) =6.902; p<.05), binge eating (F (1, 65) = 25.757; p<.000), as well as of body wight (F (1, 64) =59.914; p<.000), irrespectively of gender (p=n.s.). In the post-treatment, only the levels of body image disturbance were improved, maybe because of weight loss.

Lastly, men had slightly higher levels of social-cultural influences than women. This study has several limitations that may impact the generalizability of these results. Particularly, the present study lacks of a control group of normal weighted adults, to assess whether these psychological characteristics are also present in this subjects, and the absence of a comparison group of obese that were not treated/treated differently, in order to assess the efficacy of psychoeducational interventions.

Further, the sample was small and mainly including female patients. Future studies are needed to replicate these findings with different samples. Lastly, it hasn't been considered a period of follow-up over 6 months for evaluate the stability of results and this study was correlational, which limits the conclusions that can be made. Longitudinal studies are needed to further assess the long-term relationships among psychological variables over time. The present findings emphasize the crucial role of both psychological variables and psychoeducational multidisciplinary interventions in the effectiveness of treatments aimed at improving eating habits, physical and psychological wellbeing of obese patients. Indeed, working on their thoughts and dysfunctional behaviors, on the psychological aspects of binge eating, on convictions, emotions, to develop coping strategies, to body image and prejudices and stereotypes of obese people, to improve self-esteem, it can somehow also improve eating behavior and body weight. This results also prove that it’s not just women who are possible “victim” of social expectations on appearance and beauty, but that it may also be affected men.

The group-format of psychoeducational interventions might be very important to facilitate the change of eating habits. Sharing experiences reduces loneliness and stimulates restructuring of

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thoughts, dysfunctional beliefs and changing behavior. The final purpose of this treatment is to help obese patients to develop all those skills that they probably have come less in the environment in which they grew up and lived, guaranteeing the change of their eating habits and substitute these with more functional and healthy.

MOTHER-CHILD AND FATHER-CHILD INTERACTIONS DURING FEEDING: AN EMPIRICAL STUDY ON THE PARENTAL PSYCHOPATHOLOGICAL RISK IN A NON-REFERRED SAMPLE

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International literature considers the role of fathers as risk factor or protection for the development of children's psychological difficulties and it has been proposed that a combination of maternal and paternal psychopathologies may create a style of coparenting characterized by negative interactions with children. Furthermore, several research have suggested that child's temperament can influence the quality of parent-infant interactions. The aim of this study was to explore the quality of interactions of mothers and fathers with their child at 18-24-month-olds during feeding, taking into account possible influences of parental psychopathological risk and child's temperament. Sample was composed by N=60 families with children of 18-24 months old, recruited in Italian preschool. After receiving written informed consent, have been administered (independently to mothers and fathers) the following measures: *Scala di Valutazione dell'Interazione Alimentare* (SVIA; Lucarelli et al., 2002). It is an observing procedure which identifies normal and/or risky relational modes between a parent and child during feeding exchanges. Parent-child interactions were observed in their homes during lunch and recorded (20-minute videos) and were observed separately, in two different days. The SVIA scores are evaluated on four subscales: 1) parents' affective states; 2) interactive conflict; 3) food-refusal behavior; and 4) affective state of the dyad. The instrument shows good reliability in terms of internal consistency (Cronbach's alpha = .79–.96); *Symptom Check-List* (SCL-90-R), a 90-item self-report questionnaire. It measures psychological symptoms and distress (Derogatis, 1994). It is composed by nine symptom dimensions and a Global Severity Index (GSI). The Italian validated version has been shown a good internal coherence (Cronbach's alpha=.70–.96; Prunas et al., 2012); *Questionari Italiani del temperamento* (QUIT; Axia, 2002) a

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report-form questionnaire that measure child temperament from the first month after birth to 11 years of age. The questionnaire shows good internal consistency (Cronbach's alpha = .59–.71). Before running the analyses, variables' normality was preventively ascertained. Has been carried out MANOVA to verify differences between parents' mean scores, considering child's sex and age, and linear regressions to evaluate the influence of parent's psychopathological risk and child's temperament on parents-child interaction and to evaluate whether mother-child and father-child interactions affect each other. All analyses were performed with SPSS software (Version 21.0). Results showed that the overall quality of mother-child interactions during feeding was similar than that of father-child. Results showed no differences between parents in psychopathological risk and no parents exceeded the clinical cut-off for SCL-90-R. Further, children's temperamental characteristics were in line with the normal population. Nevertheless, SVIA scores for mother-child and father-child interactions were similar than that of clinical population. Regression analysis showed that child's temperamental characteristics did not predict mother-child and father-child interactions. On the other hand, mothers' and fathers' psychopathological risks (paranoid ideation and anxiety respectively) predicted the general quality of their interactions with children during feeding in the direction of less contingent and less sensitive exchanges.
Results are shown on Table 1.

Table 1. Results and Values of the Regression Analyses

	Maternal Paranoid Ideation				Paternal Anxiety			
	R^2	β	t	p	R^2	β	t	p
Mother' affective state	Ns	Ns	Ns	Ns	.214	.704	2.32	<.05
Mother's Interactive Conflict	.202	.714	2.32	<.05	.231	.659	2.195	<.05
Mother's affective state of the dyad	.178	.643	2.06	<.05	.23	.609	2.03	<.05
Fathers' affective state	.236	.69	2.29	<.05	.169	.687	2.2	<.05
Fathers' Interactive Conflict	.219	.771	2.53	<.05	.200	.774	2.53	<.05
Fathers' affective state of the dyad	.174	.701	2.24	<.05	.160	.69	2.199	<.05

Note. The subscales that are not shown in this table are not statistically significant.

Regression analysis showed also that the quality of mother-child and father-child interactions affect each other. In particular, results showed that maternal Affective State of the Dyad predicted higher

scores on paternal Affective State of the Dyad (R^2=.664; β=1.013; t=2.97; p<.01). As reguard father-child interactions, results showed that paternal Affective State of the Dyad predicted higher scores on all maternal SVIA subscales (p<.05). This study shows that mothers and fathers have a similar relationship quality with their children during feeding, which is influenced by different difficulties originating from both individual psychological profiles of parents. These results are in line with those of Braungart-Rieker and colleagues (1999) that suggested that mothers and fathers do not differ in their level of sensitiveness and contingency toward their children. In this sample, parents-child interactions influenced one another: this result is coherent with family and ecological theories and with previous studies (Goodman, 2008), that highlighted how mother-infant and father-infant dyads are interconnected. This result stresses the importance to investigate the couple relationship between parents.

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THE ALTERNATIVE MODEL FOR DSM-5: BPD TRAITS IN NON-CLINICAL ADOLESCENTS

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Adolescence is a critical period for early identification and treatment of Borderline Personality Disorder (BPD), a common and severe condition with very high social and human burdens. Accordingly, the clinicians support the importance of studying borderline features in adolescence in order to develop effective treatment and prevention programs (Chanen, 2011; Crowell, Beauchaine & Linehan, 2009). Recently the DSM-5 (APA, 2013) introduced in Section III an alternative model for personality disorders that emphasizes the relevance of a trait assessment in distinguish personality disorders (Criteria B). The research on the validity of BPD in adolescence underlined the high heterogeneity of the disorder, suggesting that it could be better described using a dimensional approach (Miller et al., 2008). From this point of view, the Section III model of DSM-5 (APA, 2013) could be useful to better capture the core dysfunctional characteristics of BPD. Starting from these considerations, this study aims at investigating whether DSM-5 dysfunctional traits are able to discriminate participants with different risk levels for Borderline Personality Disorder in community dwelling adolescents. A two phases sampling approach was used: firstly the 11 items version of the Borderline Features Scale for Children (BPFSC-11) was administered to a nonclinical sample of 908 adolescents (females=71.4% , mean age=16.8, SD=1.79) recruited in different Italian secondary schools as initial screening of the BPD features and we identified the participants that showed an extreme BPFSC-11 total score (>95° percentile). Secondly, the BPD items of the SCID-II were administered both to the extreme group and a control group randomly selected by participants with BPFSC-11 total score lower than 95° percentile in order to select participants with high, low and moderate risk for BPD according to the number of SCID-II BPD criteria. In the final sample, composed by 115 community dwelling adolescents (females=73.9%, mean age=16.31, SD=1.67), the Personality Inventory for DSM-5 (PID-5) was administered. Independent sample multivariate ANOVA was used to assess whether PID-5 traits were able to capture different risk levels for BPD, testing three different models: 1) the DSM-5 BPD model

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which includes seven traits, namely Anxiousness, Emotional Lability, Separation Insecurity, Depressivity, Impulsivity, Risk Taking and Hostility; 2) a model with DSM-5 traits other than BPD ones; 3) a final model with the significant traits of the previous models. Finally, the possible gender influence was tested in the final model. For all the comparisons the nominal significance level was corrected according to Bonferroni's method. Our data showed that DSM-5 BPD model was able to explain a substantial amount of the variance (Pillai's Trace=.30, F=2.66, p<.001, $p\eta^2$=.15). Although most of the proposed traits showed a significant contribution in differentiating the three groups (effects sizes from moderate to high and p<.05), Separation insecurity did not result significant (p>.05). The second model did not result significant. However, some traits showed significant between groups differences: Irresponsibility (F=6.99, p<.001, $p\eta^2$=.11), Eccentricity (F=9.86, p<.001, $p\eta^2$=.15), Perceptual Dysregulation (F=14.70, p<.001, $p\eta^2$=.21) and Unusual Beliefs (F=11.00, p<.001, $p\eta^2$=.16). The final model, that included the six significant DSM-5 BPD traits found in the first model and the four traits that resulted significant in the second model, explained the higher portion of the variance (Pillai's Trace=.34, F=2.12, p<.005, $p\eta^2$=.17). All the traits showed a significant ability in differentiating the three groups with effect sizes from medium to high and: Irresponsibility (F=6.99, p<.001, $p\eta^2$=.11), Eccentricity (F=9.86, p<.001, $p\eta^2$=.15), Perceptual Dysregulation (F=14.70, p<.001, $p\eta^2$=.21), Unusual Beliefs (F=11.00, p<.001, $p\eta^2$=.16), Anxiousness (F=4.40, p<.05, $p\eta^2$=.07), Emotional Lability (F=4.52, p<.05, $p\eta^2$=.08), Hostility (F=9.48, p<.001, $p\eta^2$=.15), Depressivity (F=8.14, p<.01, $p\eta^2$=.15), Impulsivity (F=8.39, p<.001, $p\eta^2$=.13) and Risk Taking (F=5.08, p<.01, $p\eta^2$=.08). Finally, when we tested the potential influence of gender on the final model we did not find neither a significant effect of gender nor a interaction between gender and the groups. These results suggest that PID-5 traits are able to discriminate adolescents with different risk for BPD. However, the BPD model proposed in DSM-5 Section III does not seem to capture all the pathological aspects potentially involved in disorder, at least in our sample of nonclinical adolescents. More specifically, our data showed that in addition to the DSM-5 BPD traits (Anxiousness, Emotional Lability, Depressivity, Impulsivity, Risk Taking and Hostility) we should include other traits to better explain the differences among the three risk groups, namely Irresponsibility, Eccentricity, Perceptual Dysregulation and Unusual Beliefs. This means that some BPD aspects related to the Psychoticism and Disinhibition domains are not included in the DSM-5 proposed model. In our view, Psychoticism traits could be related to some dissociative features characterizing BPD that are not adequately represented in DSM-5 Section III, while Irresponsibility could be considered as secondary outcome of some nuclear BPD difficulties as identity instability, impulsivity, relational problems and anger. Interestingly, Separation Insecurity was the only DSM-5

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BPD trait that did not result significant in discriminating the groups. Such result is consistent with previous studies which found that this aspect is the less efficient in capturing BPD pathology (Fossati et al., 1999; McGlashan et al., 2005). Despite a number of limitations (e.g. nonclinical participants, small sample, lack of data of DSM-5 Section III Criteria A), we believe that our results could be useful in studying the BPD features and the DSM-5 Section III trait profile of BPD in adolescenc

PROMOTING POST-TRAUMATIC GROWTH IN CANCER PATIENTS: A STUDY PROTOCOL FOR A RANDOMIZED CONTROLLED TRIAL OF GUIDED WRITTEN DISCLOSURE

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Cancer diagnosis and related treatments represent a traumatic event for human beings. Their goals and priorities, taken for granted until that moment, are now potentially unattainable and uncertainty governs every aspect of the persons' existence. Cancer is, in fact, a shattering experience that violates the meaning system allowing people to perceive a coherent world (Fife, 2005). When a traumatic experience cannot be integrated into the person's meaning system, since it violates his/her believes and goals, it may trigger a new search for meaning. This elicit a meaning making process, restoring a more adaptive sense of the world and of themselves as worthy, thus allowing a better adjustment to cancer illness (Park, 2010). Post-Traumatic Growth (PTG) concerns the positive changes following traumatic events (Tedeschi & Calhoun, 1996). According to Park and George (2013), personal growth following trauma is a meaning made consequence implying the resolution of the discrepancy between the view of the self and the world, before and after trauma. The hypothesis of discrepant information with the person's world model following trauma was initially postulated by Post-Traumatic Stress Disorder (PTSD) theories suggesting that, in order to integrate new information, it is necessary to change preexisting schemas (Horowitz, 1990). Calhoun, Cann, Tedeschi, and McMillan (2000), stated that PTG implies an active effort to build new schemas and

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meanings through conscious thought, while PTSD derives from unconscious automatic rumination and intrusive thoughts, as the way memory works to rebuild pre-trauma schemas (Tedeschi & Calhoun, 1995; Janoff-Bulman & Franz, 1997). Literature on meaning and growth highlights the lack of interventions designed to increase meaning making and PTG in cancer patients (e.g. Henoch & Danielson, 2009). Expressive Writing (EW) interventions, implemented to promote well-being through deep thoughts and emotions disclosure in relation to trauma (Pennebaker & Beall, 1986), have produced health improvement (e.g. Pennebaker & Chung, 2007). However, EW has not found substantial corroboration among cancer patients (Merz, Fox and Malcarne, 2014; Zachariae & O'Toole, 2015). Notwithstanding, a writing intervention could facilitate the meaning making process leading to PTG if used to trigger both emotional expression and an adaptive narrative reconstruction of the traumatic event (Freda & Martino, 2014). Such intervention would trigger both an active cognitive reappraisal of the cancer experience and an emotional catharsis allowing more adaptive emotion regulation strategies (Pennebaker & Chung, 2007). The Guided Written Disclosure Protocol (GWDP, Duncan & Gidron, 1999) focuses on both emotional expression and cognitive processing of traumatic events. The benefits of GWDP are supported by initial evidence for symptoms reduction (Gidron et al., 2002; Martino, Freda & Camera, 2013; Martino, Onorato, D'Oriano, & Freda, 2012) and buffering effects on the distressing consequences of intrusive thoughts in cancer patients (Arden-Close et al., 2013).

Given its emotional and cognitive activation, GWDP could promote the active process leading to PTG as well as reduce distressing symptoms in oncological patients. The study is a multicenter randomized controlled trial including four oncological centers. 250 breast and colon cancer patients at the end of chemotherapy are randomized to GWDP or to an active control condition. Randomization is implemented through a central phone randomization using computer generated random numbers. Participants in both conditions will write at home every two weeks for three 20-minute sessions. GWDP participants are invited to (1) recall chronologically facts concerning the illness; (2) label the emotions related to those facts, appraise changes in priorities, reflect on their actual feelings and coping mechanisms; (3) reflect on how the illness have changed their view about life and themselves, teaching them to cope with possible future difficulties. Control participants write about their daily routine concerning the past week. Assessment instruments are administrated at three time points: pre-intervention, post-intervention and 6-month follow-up. We expect that, after the intervention, GWDP participants will have higher scores on the Post-Traumatic Growth Inventory (PTGI; Prati & Pietrantoni, 2006) as compared to the control group. Also, we expect that increased levels of PTG would be moderated by constructed meaning, measured by the Constructed

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Meaning Scale (CMS; Giorgi, Sguazzin, Fiammenghi, & Argentero, 2007). Furthermore, we hypothesize that, GWDP participants will have lower scores on the Impact of Events Scale (IES; Pietrantonio, De Gennaro, Di Paolo, & Solano, 2003) and on the Hospital Anxiety and Depression Scale (HADS; Costantini et al., 1999) as compared with the control group. GWDP is in line with the current research aimed at promoting well-being, rather than just reducing distressing symptoms. This intervention could ameliorate cancer patients' quality of life giving them the possibility to find new meaning in their existence and experience PTG as a consequence. Despite the increasing interest for PTG in positive psychology literature (Tedeschi, Calhoun, & Groleau, 2015), there is a lack of interventions specifically targeting this construct in cancer patients (Henoch & Danielson, 2009).

Results from this study will allow for an improved knowledge of whether and how GWDP could trigger PTG, and reduce distressing symptoms in cancer patients after adjuvant chemotherapy. Finally, the potential clinical benefits of the GWDP are associated with little effort requested for its implementation in hospital settings. Indeed, it is very efficient both in terms of economic resources and time requested to practitioners and patients.

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WHY I GOT ILL? THEORIES OF ADDICTION AMONG PEOPLE IN TREATMENT FOR THEIR ALCOHOL OR DRUG ABUSE.

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According to the current literature, addiction can be described as a persistent and maladaptive relationship with an object (gambling, internet, alcohol, drugs, working), associated to harmful consequences at the level of psychosocial health and the level of social relations. Typically, addictive behaviours are explained in one of these two different ways: that some people (i.e. 'addicts') have an addictive personality and/or there is a genetic basis for addiction (Larkin et al. 2006). Both the perspectives are embedded within an 'epistemology of sickness and disease' (Fingarette 1988) and converge in an image of the 'addicted person' as an individual who is at the same time free from cultural influences and fundamentally out of control. This kind of perspective justifies the propensity research has on intervention strategies focused on the individual (typically psychotherapy –psychoanalysis, behavioural-cognitive therapy, familiar therapy), perceived as ill and disempowered. On the other hand, the perspective supported in this work suggests to look at addictions as a part of a social system of meanings with which the individuals, their activities and their cultural environment are actively involved. Hence, according to this view, addictions become semiotic and cultural phenomena (Venuleo et al., 2016), which can be interpreted considering the symbolic dimension of meaning and its interactions within specific contexts of sense-making. Health services and self-help groups are among the major social arena wherein one becomes acculturated to particular ways of describing, understanding, and evaluating experiences associated with addiction. The aim of this study is to explore the way in which users of three different help services talk about their problem with alcohol or drug abuse, the help they have received and the (goal of) recovery process. The study material consists of 26 semi-structured interviews: 4 to the users of a rehabilitative community, 10 to the users of a public health service for the treatment of addiction, and 12 to the members of an Alcoholics Anonymous (A.A.) group. Most of them are men

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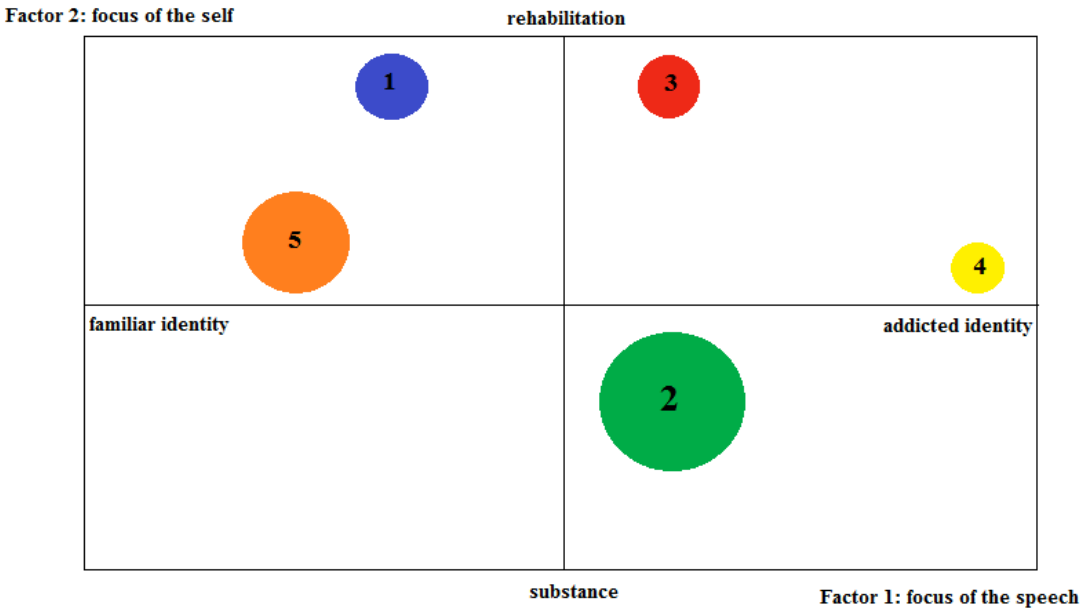
(69.2%), single (34.6%), unemployed or temporary workers (30.8%) and have a middle school education (42.3%). The mean age is 42.84. A Lexical Correspondence Analysis (LCA) and a Cluster Analysis (CA) were applied to the verbatim transcripts. LCA lead to 2 factorial dimensions: *focus of the speech* and *focus of the self* (figure 1). The first dimension refers to the main subject of the users' speeches and contrasts a focus on the *substance*, which seems to characterize users of public health services, to a focus on the *rehabilitation program*, which seems to characterize the members of the A.A.. The second dimension concerns the aspects to which the interviewed mostly refer to in order to describe themselves: *familiar identity* versus *addicted identity*. The former tends to characterize the users of the rehabilitation community; the latter refers to the users of the public health services. The cluster analysis allows us to identify 5 main thematic nucleus (Figure 1): 1) *I am addicted, why?* 2) *environment and addiction*; 3) *relationships and addiction*; 4) *rehabilitation program*; 5) *background of my addiction*.

Figure 1. The symbolic field



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The first nucleus "I am addicted, why?", represents 7.05% of the total and concerns theories about addiction -sometimes interpreted as a specific condition characterized by lack of freedom, danger, craving, some other times as illness, or a particular state of mind- and its origins from curiosity, particular life events and/or personality traits. The second nucleus, "environment and addiction", is the most representative, with a percentage of 56.88%. It refers to the context in which the phenomenon takes place: all conditions and situations that go with the use of a particular substance are mentioned, as well as those which co-occur with the recovery from it. The third, "Relationships and addiction" (2.08%), gathers all phrases related to social and interpersonal relationships of the interviewed. Here we can find an interesting focus on *others* as people connected with the use of substances or with the decision to stop taking them, and on the need to be recognized/appreciated by them. The fourth, "Rehabilitation program" (3.7%), specifically concerns the A.A. program, and all the aspects related to it, such as the group, the association and the rehabilitative path. Similarly to the first one, the fifth and last nucleus, "background of my addiction", describes the framework which surrounds the addiction. It represents the 30.29% of the total. In the whole, the results highlights how people from different *help contexts* attribute different meaning and sense to their experience. The common core seems to be the distinct description of *me as addicted* and *me as a family member*, as two separated and incompatible aspects of life, as well as the different focuses on rehabilitation and substance, that refer to different approaches and intervention strategies in addiction.

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RELATEDNESS ACROSS OVERSEAS BORDERS: CONCEIVING TRANSNATIONAL SURROGACY IN GAY FATHER FAMILIES

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Surrogacy is illegal in many European countries, including Italy, France, Germany and Spain. Some states in the USA allow *commercial* surrogacy, where the surrogate is paid by the intending parents. Other countries, like UK and Canada, allow only *altruistic* surrogacy, where only reasonable expenses related to the pregnancy may be paid to the surrogate.
Over the last decade, an increasing number of Italian gay men wishing to become parents have been forced by law to pursue surrogacy abroad. As a consequence, they experienced physical distance from the surrogate and their developing child during pregnancy. To date, surrogacy in gay father families has mainly been studied in relation to the changes associated with the transition to parenthood (Bergman et al., 2010), motivations for seeking transnational surrogacy (Norton et al., 2013), kinship, gender and economic implications (Murphy, 2015). The present study aims to fill this gap in the literature by exploring the experience of transnational surrogacy and the relationship with the surrogate during and after the birth in Italian gay father families. Participants were fifteen Italian gay couples who sought gestational surrogacy in California or in Canada. Fathers (M_{age} = 44.75; SD_{age} = 5.79) were recruited through snowball sampling within Rainbow Families; they were well-educated professionals and with middle to high socioeconomic status. Children were aged 2-6 years (M_{age} = 3.56; SD_{age} = 1.15).
Twelve couples used commercial surrogacy in California, whilst three couples used altruistic surrogacy in Canada. All couples did not know their surrogates and egg donors previously. None were in contact with the egg donor at the time of the study.
Couple and individual in-depth semi-structured interviews were carried out in Italian, audio-taped and transcribed verbatim. Interviews lasted 90−120 minutes. Qualitative data analysis was performed using the Interpretative Phenomenological Analysis (Smith et al., 2009) by a highly trained researcher in qualitative research. The consistency and the trustworthiness of the interpretative process were guaranteed through auditing by other two team researchers, who independently read the coding scheme and the transcripts giving their suggestions and criticisms.

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Findings indicated that three inter-related themes may be helpful to understand the experience of transnational surrogacy: 1) the perceived loss of control over the pregnancy; 2) the surrogate who helped fathers to feel connected with their developing child by sending ultrasounds and pictures of the growing belly; 3) the close relationship with the surrogate and her family during and after the birth. Fathers' emotional involvement throughout the pregnancy process was in contrast with the strategies of aloofness and emotional detachment found by Ziv and Freund-Eschar (2015) in their sample of Israeli intended fathers that pursued surrogacy in India. A possible explanation for this discrepancy is that in California and in Canada surrogacy is regulated and practiced quite differently from India, where socioeconomic and language barriers imply that the communication between fathers and Indian surrogates is mediated by the agencies. The positive relationship between fathers and their surrogates is unsurprising if considered in the broader context of transnational surrogacy and parents' language in disclosing origins to children. Maintaining contact with the surrogate during the pregnancy helped gay fathers to come to terms with the geographical distance. After the birth it enabled them to link disclosure of origins to the possibility that surrogates will be available to clarify potential doubts or questions posed by the children in the following years. This pattern has been found similar in heterosexual parent surrogacy families (MacCallum et al., 2003; Jadva et al., 2012).

Fathers did not mention at all the egg donor. It should be noted that participants had children who were aged between 2-6 years, so it is very likely that they will have to answer more detailed question about surrogacy and human reproduction in a short time, integrating the egg donors in the family narrative. In fact, studies carried out with donor conception families (Blake et al., 2010; Readings et al., 2011) and adoptive families (Solomon et al., 1996) found that children begin to show an understanding of their origins around the age of seven. However, the limitations of the study require its findings to be interpreted with caution.

As with any research on a contentious topic, the risk of socially desirable responding can not be ruled out, such that the negative attitudes towards surrogacy and gay parenting (Lingiardi et al., 2016) might have motivated fathers to present their experiences in a favorable light. In addition, participants with very different views about the surrogacy process may have been less willing to take part in the study. Bias may have also occurred due to the retrospective reporting of aspects related to the period of pregnancy. Overall, findings disconfirmed concerns that have been expressed about surrogates' exploitation or parents' fear of interference in bringing up the child (Golombok, 2015).

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The study sheds light on the impact of restrictive legislation on daily family experiences and enables both clinic staff and mental health professionals to support more adequately prospective gay fathers via transnational surrogacy. Especially considering that in Italy surrogacy is banned outright, studies such as this are fundamental to inspiring reflections in offshore fertility counsellors on how to tailor pre- and ongoing surrogacy counselling for prospective gay fathers, exploring their experience of pregnancy, bonding, contact with the surrogates and issues of disclosure to their children. In their resident country gay fathers could benefit from a psychological setting in which they share with their children and elaborate upon their meanings of surrogacy.

THE INTERPERSONAL GUILT RATING SCALE-15: THE FIRST VALIDATION DATA ABOUT A NEW CLINICIAN REPORT TOOL FOR THE ASSESSMENT OF INTERPERSONAL GUILT

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Guilt is a complex and distressing emotion with multiple determinants that can be experienced in a variety of different situations. The majority of psychoanalytic authors (Freud, 1923, 1924, 1939; Klein 1935, 1946) focused primarily on the intrapsychic origins of guilt, connecting it primarily with unconscious wishes to hurt others. This view suggests that people feel guilty because they have anti-social unconscious drives and wishes. According to Control-Mastery Theory (CMT), however, guilt is interpersonal in its origin, its aim is pro-social and its function is adaptive, but CMT stresses also how guilt may be also unconscious, excessive and irrational, especially when generalized and repeatedly linked to shame, or when it leads to distress, inhibitions and symptoms (O'Connor, Berry, Weiss, Bush, Sampson, 1997; Locke, Shilkret, Everett, Petry, 2013). A large body of theoretical and empirical studies shows the relationship between interpersonal guilt, self-sabotaging behaviors and psychological problems (Herbold, 1996; Berghold & Lock, 2002; Bruno, Lutwak, & Agin, 2009; Tilghman-Osborne, Cole, & Felton, 2010; Locke et al., 2013; Giammarco & Vernon, 2015). CMT identified four kinds of interpersonal guilt: survivor guilt, separation guilt,

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omnipotent responsibility guilt and self-hate. Survivor guilt (Lifton, 1968; Niederland, 1981) refers to a painful emotion that people may experience when they are surpassing important others, believing that they are hurting them by being more successful, happy, accomplished etc.. Separation guilt stems from the fear of harming others via one's own physical distance or psychological seperateness, while disloyalty guilt stems from the belief that having different values, appreciating a different way of life, supporting different political ideas or religious beliefs will be hurtful to loved ones (Modell, 1965; Asch, 1976). Omnipotent responsibility guilt involves an exaggerated sense of responsibility and concern for the happiness and well-being of other people, and it is based on the belief of having the duty and power to take care of loved ones in trouble. Self-hate guilt describes the feeling of being inherently wrong, bad and inadequate and not deserving acceptance, protection, love and happiness. These four kinds of guilt are substantially compatible with four of the six moral foundations of intuitive ethics identified by the evolutionary moral psychologist Jonathan Haidt (2012). In particular, Survivor guilt can be easily connected to the "fairness vs cheating" foundation; Separation/Disloyalty guilt to the "loyalty vs betrayal" foundation; Omnipotent responsibility guilt to the "care/harm" foundation.

Finally, Self-hate can be related to the "authority vs submission" foundation. The aim of this study is to introduce a brief clinician-rated report tool for a screening assessment of interpersonal guilt, the *Interpersonal Guilt Rating Scale-15* (IGRS-15 Gazzillo, Bush, Faccini, De Luca, Mellone, 2015), and its psychometric proprieties. The item set derived from the CMT literature and from the clinical experience of the authors. We asked to 28 clinicians to assess all their patients (N=154) with the IGRS-15, with the *Interpersonal Guilt Questionnaire-67* (IGQ-67; O'Connor, Berry, Weiss, Bush, Sampson, 1997), and with a *Clinical Data Form* (CDF; Westen, Shedler, 1999). Exploratory Factor Analysis on a random half of our sample (N=70) and a Confirmatory Factor Analyses on the other half (N=84) were performed. For the EFA was applied a Principal Component Analysis with Promax rotation and Kaiser normalization. 4-factor solution explaining 65.95% of the variance; the number of factors was extracted on the basis of both the scree plot procedure (point of inflexion of the curve) and factors with eigenvalue > 1 criterion. Subsequent CFA employed Diagonally Weighted Least Squares (DWLS).

The fit to the hypothesized model was excellent with a chi-square of 51.00, df = 84, p = .99, a goodness of fit index (gfi) of .98, and an RMSEA of 0.00. All the scales of the IGRS-15 have good internal consistency: the Cronbach alpha of the Survival Guilt scale was .80, the alpha of the Omnipotent Responsibility Guilt was .87, the alpha of the Self-hate was .84 and that of the

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Separation/Disloyalty guilt was .85. The alpha value of the overall scale was .82. Preliminary inter-rater reliability analysis were investigated. The ICC calculated on an item-per-item basis was .67, while the ICC of the scores of the four different IGRS-15 factors was .86. The *re-test reliability* was accettable with Pearson's values ranging from .52 to .69. The assessment of guilt with the IGRS-15 show a good concordant validity with guilt assessed with IGQ-67, the only existing validated measure for interpersonal guilt as thought in CMT. As hypothesized by CMT (Weiss, 1993), for example, IGRS-15 Self-hate correlated with the presence of physical abuse in anamnesis and with Cluster B personality disorders and with the overall level of personality functioning. Other than having good psychometric properties, the IGRS-15 is short-enough to be easily used in everyday real clinical practice, and its clinician-report format may help to identify also those kinds of guilt the patient are not fully aware of, and that for this reason could not be easily identified with self-report measures. The main limitations of this study are the limited number of clinicians (28) and patients (154) assessed, the fact that all the rater/clinicians were previously trained in CMT, and the fact that both IGRS-15 assessed guilt, and psychopathology rated with the CDF, are clinician-report measures. The IGRS-15 is a first step in the direction of supporting the clinical judgement about interpersonal guilt with an empirically sound and easy to use tool.

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ATTENTIONAL STYLES CAN HELP THE DETECTION OF SUBTLE SIGNS CONVERGING WITHIN AUTISM SPECTRUM DISORDERS

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In the last twenty years, methods for quantitatively measure looking behaviour have developed more precise and non-invasive techniques. From the beginning of the second decade of the new millennium, infrared cameras, assembled in remote or portable eye-tracking devices, have become a standard to fathom cognitive and affective development. Besides, eye-tracking technology fits research concerning subtle signs of psychopathology and atypical neurodevelopment, that are present before the diagnosis and/or imperceptibly mark the evolution of the disease. Between 2008 and 2013, that is only five years, more than 30 projects studied Autism Spectrum Disorders (ASD) with eye-tracking.

From the earliest depiction, the social characteristics of the disorders received major attention (Kanner, 1943), and they resound in the diagnostic criteria from DSM-V, as deficits in social reciprocity and communication (APA, 2013). The microstructure of gaze reveals atypicalities in the building blocks of attention sharing: less spontaneous attention to gaze and pointing (Klin et al, 2002), defective reacting to the gaze of others (Baron-Cohen et al,2006), correlation between sensitivity to declarative head movements and mental age (Leekam et al, 2003). The selective inattention for prototypical social areas of interest, like faces and eyes, has been challenged by contrasting experimental findings (Young et al, 2009). Even if the controversy can be partly ascribed to methodological differences, differential gaze patterns might help to differentiate subgroups within the unquestionably heterogeneous spectrum. The aim of the present study was to explore the correlates of attention distribution in different circumstances. Namely, we created three experimental conditions, that implied mentalizing, visual search and free-viewing, and tested the correlations with individual characteristics (e.g. anxiety, empathy and autistic traits). 42 healthy subjects completed the study.

Mean age was 22 years. We measured attention distribution calculating the fixations on a 17''-screen with an integrated eyetracking camera (Tobii T120). On the screen, 24 videos of a plain,

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social interaction were shown in randomized order. Before each video, one question was displayed: "Who is listening?" (social condition), "Who has the pen?" (non-social) "Just watch." (free-viewing). The participant answered the question through pressing a key. The participants completed four questionnaires: Autistic Quotient (AQ), Interpersonal-Reactivity-Index (IRI), Symptom Checklist 90 (SCL90), the Socioeconomic Score. We calculated the total duration of fixations in each of predefined areas of interest (AOIs: face, body and eyes of each of the two actors). The AOIs were assorted in groups (faces, bodies and eyes). According to our initial hypothesis, we expected an increase of duration on eyes and faces during the social condition and an increment of duration on the body in the non-social condition. What about the correlations? According to theoretical calculations, the extent of fixation on eyes and faces should be an esteem of social ability and be correlated with AQ.

According to our results, there is a significant difference in the watching tendencies across the three pairs of AOIs in the different conditions in the expected direction. Also, there are significant differences depending on sex: females tend to focus more on the upper part of the body and the difference is particularly striking for eyes. Fixation on faces in the social and non-social condition was correlated with The "Personal Distress" (PD) subscale of IRI. Fixation on the eyes in all the conditions was also correlated to PD. The most unexpected correlation was found in total fixation duration on the body in the non-social condition, which resulted positively connected to AQ, and negatively to "Empathic Concern" (EC), subscale of IRI. We performed a linear regression analysis: within this model, AQ resulted a significant predictor of the total fixation duration on the AOI. As we expected, when the subject was asked to answer to the question "Who is listening?", he or she looked more at face and eyes, relying on a very clear strategy of "reading in the eyes". On the other hand, the search-task increased the duration on body, where the object was more likely to be found. The gender differences are in line with previous findings: women tend to focus more on the face and eye region compared to men.

Our theory-based prediction was not fulfilled: our results are divergent but in line with newly ascending lines of research on ASD. In fact, an interesting and, especially, unexpected result is the correlation between AQ and the fixation duration on body in the non-social condition. Differences in the attentional style, distributed in correlation with the amount of autistic traits in the neuro-typical population, could explain this trend. In fact, a difficulty to disengage attention from a circumscribed area has been highlighted in patients with ASD (Sasson et al, 2008; 2011). The current result could be explained by a tendency to focus on the same AOI after the accomplishment of a search task. A persistent attentional style and a difficulty in disengagement is promising for

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revealing the intersection between low-level impairments and the broader clinical picture of autism. Until now, research failed to find a connection between AQ scores and measures of attention to a social scene watched passively, recorded or live, in typically developed adults. What we found shed a light on the possible manifestation of autistic traits in the typical population: a tendency to keep the focus of attention after the accomplishment of a task. More varied and ecological experiments could clarify the extent to which such a connection might shed a light on the subtle autistic traits.

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MEASURING EMPATHY WITH THE RORSCHACH-PERFORMANCE ASSESSMENT SYSTEM

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Empathy is commonly defined as the capability to understand other people's emotions and to react properly (Leiberg, & Anders, 2006). There is a general consensus about two basic components of empathy: cognitive empathy refers to the ability to recognize other's emotions; affective empathy refers to the ability to experience them (Rankin, Reiners, Corcoran, Drake, Shryane, & Völlm, 2011). Typically, the assessment of empathy occurs via self-reported questionnaires. However, self-reports are non-optimal to assess empathy, as they reflect what the respondent knows or thinks about him/herself and what s/he wants the examiner to know about him/herself, rather than their true ability to empathize with others. Because Rorschach scores are based on what people do, which is complement to the characteristics they consciously recognize and willingly endorse on a self-report instrument (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011), the Rorschach may be more suited than self-reports to measure empathy.
The aim of this study is to develop and validate a Rorschach-based scale for assessing empathy. First, the items of the Questionnaire of Cognitive and Affective Empathy (QCAE; Reiners et al., 2011), a relatively new tool to measure empathy, have been converted into 19 potentially measurable, Rorschach behaviors, i.e., our experimental Rorschach variables (e.g., QCAE Item27: "I am good at predicting what someone will do", Rorschach variable: the response includes actions that are about to happen or be experienced).
Next, two psychologists independently coded these 19 items on 25 Rorschach protocols, to test inter-rater reliability and evaluate their usability. This coding practice period also helped to reduce problems related to presentation clarity, overlapping, and redundancy of the items. Lastly, we proceeded with the selection of the items to be included in our final Rorschach Empathy Scale, which ultimately included 4 of these 19 experimental variables, and four pre-existing Rorschach scores. Items were selected if they correlated with QCAE at $p < .10$.
This nonconservative threshold was chosen to avoid missing potentially useful items. QCAE; Toronto Alexithyimia Scale-20 (TAS-20; Bagby, Parker, & Taylor, 1994), a 20 items self-reported questionnaire for evaluation of Alexithymia; Interpersonal Competence Questionnaire-Revised

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(ICQ-R; Buhrmester, 2002), a 40 items self-reported questionnaire for the evaluation of interpersonal competence; Reading the Mind in the Eyes Test (RME-T; Baron-Cohen et al., 1997), a performance-based test for the facial expression recognition; Sperimental Rorschach Items, Rorschach R-PAS (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011). *Sample*: N = 134; Male N = 32, Female N = 102 (76%), Age from 18 to 38 (*M* = 23; *SD* = 3.5). Tables 1 and 2 show significant (p < .10, see above) correlations of experimental (Table 1) and pre-existing (Table 2) Rorschach variables to QCAE. A total of 8 variables were selected for the Rorschach Empathy Scale.

TABLE 1. SIGNIFICANT PEARSON'S CORRELATIONS BETWEEN EXPERIMENTAL RORSCHACH ITEMS AND QCAE.

	QCAE		
	Total	Cognitive	Affective
Exp. Item 2	.15*	.14	.11
Exp. Item 4	.12	.18*	.00
Exp. Item 6	-.21**	-.23***	-.10
Exp. Item 11	.18**	.17*	.13

*** p < 0.01 level (2-tailed).
** p < (2-tailed).
* p < 0.10 level (2-tailed).

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TABLE 2. SIGNIFICANT PEARSON'S CORRELATIONS BETWEEN RORSCHACH VARIABLES AND QCAE.

	QCAE		
	Total	Cogntive	Affective
Card Turning (CT)	-.25***	-.18**	-.24***
Prompt (Pr)	-.17*	-.18**	-.01
Reflection (r)	-.20**	-.21**	-.12
Passive Human Movement Proportion (Mp/(Ma+Mp))	-.18*	-.19**	-.10

*** $p < 0.01$ level (2-tailed).
** $p <$ (2-tailed).
* $p < 0.10$ level (2-tailed).

EXPLANATION OF THE VARIABLES: As for the new experimental Rorschach items, Exp. Item2 is coded when the object of the response is described as expressing emotions or feelings; Exp. Item4 indicates that the object of the response is described as having intentions or desires. Exp. Item6 is coded when the respondent emphasizes his/her own perspective; Exp. Item11, the respondent sees gesture of compassion, help or support. As for the pre-existing Rorschach variables, CT and Pr may indicate a form of hostility towards the task. Reflection indicates that the person may be processing information in a self-centered way and MpPrp there is a propensity for passive engagement with the environment, a lack of purposeful problem-solving or personal initiative (Porcelli, Giromini, Parolin, Pineda, & Viglione, 2013). The mean of pre-existing Rorschach empathy variables, and the mean of our new, experimental Rorschach items correlated significantly with QCAE, as shown in Table 3.

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TABLE 3. PEARSON'S CORRELATION BETWEEN THE MEAN OF RORSCHACH EMPATHY VARIABLES AND THE MEAN OF EXPERIMENTAL RORSCHACH ITEMS WITH QCAE.

	QCAE		
	Total	Cognitive	Affective
Rorschach Empathy Index	.35***	.32***	.24***
Sperimental Rorschach Items	.25***	.28***	.16

*** $p < 0.01$ level (2-tailed).
** $p <$ (2-tailed).
* $p < 0.10$ level (2-tailed).

Finally, a hierarchical regression model tested whether the new pool of experimental items incremented over the pre-existing Rorschach scores in predicting QCAE. As shown in Table 4, the selected, experimental items did improve the prediction model. As such, the final, Rorschach Empathy Scale was generated by using the parameters of this multiple regression model.

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TABLE 4. MULTIPLE REGRESSION MODELS WITH RORSCHACH EMPATHY SCALE AND EXPERIMENTAL RORSCHACH ITEMS AS PREDICTORS (STEPWISE METHOD) AND QCAE TOTAL AS CRITERION.

Criterion/predictors entered by step	b1	b2	R	R^2	AdjR^2	DR^2
QCAE Total						
Step 1			.35	.12	.11	-
Ror. Empathy Index	.35**	.31**				
QCAE Total						
Step 2			.40	.16	.14	.04*
Ror. Empathy Index and Experimental Rorschach Items	-	.20*				

β1, β2 = standardized beta coefficients for steps 1 and 2.
* $p < 0.05$.
** $p < 0.01$.

The correlation of the Rorschach Empathy Scale to QCAE, RME, ICQ, and TAS-20 are reported in Table 5.

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TABLE 5. PEARSON'S CORRELATION BETWEEN THE RORSCHACH EMPATHY SCALE AND QCAE, RME, ICQ, AND TAS-20

	Rorschach Empathy Scale
QCAE TOTAL	.40***
QCAE Cognitive	.39***
QCAE Affective	.25***
RME sum	.20**
ICQ-R IR	.08
ICQ-R PES	.08
ICQ-R AI	.02
ICQ-R SD	.25***
ICQ-R CR	*.18**
TAS - Difficulties Identifying Feelings	.10
TAS - Difficulties Describing Feelings	-*.15**
TAS - Externally Oriented Thinking	-.25***
TAS Total	-.10

*** $p < 0.01$ level (2-tailed).
** $p <$ (2-tailed).
* $p < 0.10$ level (2-tailed).

The goal of this study was to develop and validate a Rorschach Empathy Scale. All in all, our findings show that our Rorschach Empathy Scale correlates with QCAE, RME, and some scales of ICQ-R and TAS-20, which suggests that our new index might help practitioners to assess empathy, with the Rorschach test. Currently, the Rorschach does not include variables that specifically target empathy. However, a number of Rorschach scores reflect features possibly associated to it, such as perspective taking (Reflection), tendency to oppositional behavior (Prompt, Card Turning), lack of

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initiative, (Mp) that could be crucial in those situations where someone is in difficulty and need someone's help. In addition, to these pre-existing Rorschach scores, the Rorschach Empathy Scale also includes some additional items measuring the ability to recognize other's people expressions (Exp. Item 2), the ability to make inferences about other's intentions or wishes (Exp. Item 4), cognitive flexibility (Exp. Item 6) and a sort of sensibility to the compassionate gesture (Exp. Item 11). We believe that the results of this research could pave the way in the attempt to improve the assessment of with the Rorschach test.

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IDENTIFING THE INFORMATIVE FUNCTIONS OF EMOTIONS IN THE DOCTOR – PATIENT RELATIONISHIP. AN INQUIRY IN PEDIATRIC PRIMARY CARE

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In this paper is presented an inquiry in pediatric primary care to propose a reflection about the role of the psychologist, as promoter of dialogue, in the Doctor-Patient Relationship.
Pediatric context can be described as a three-sided configuration; on its vertices are positioned the participants in the visit (Health Provider, Parent and Child). What happens in the relationship along each side can influence what happens on the other two sides (Freda & Dicé, 2016).
Dialogue in pediatrics is often characterized by anxieties about the health of the child, even if rarely emotions are treated during medical practices (Dicé & Savarese, 2014).

Figure1. The Three-sided Configuration.

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The inquiry aims to identify Dialogic Interaction Patterns based on the possibility to share emotions in the dialogue. In particular, the parent will be considered both as a user both as caregiver of the child. The inquiry took place in 8 Pediatric Primary Care Offices in Naples. 265 visits were recorded and transcribed verbatim (middle length 12,43 min); they were carried out by 19 pediatricians (12M, 7F) and aimed to 265 children (middle age 9.5 y/o) accompanied by 251 mothers and 34 fathers.

The Verona Coding Definitions of Emotional Sequences (VR-CoDES) is used to identify *cues* (expressions in which emotions are not clearly verbalized) and *concerns* (clear verbal expressions of unpleasant emotional states) expressed by patients during medical consultations, as well as the responses of health care providers to these signals (Del Piccolo et al., 2010). We used the classification proposed by Vatne et al. (2010) for cues/concerns among children and classified responses by pediatricians and parents.

The transcripts were analyzed by two independent judges. To analyze interdependence relationships between matrixes of cues/concerns and of responses, we use sparse canonical correlation analysis (SCCA) (Hastie et al., 2015). We extracted six pairs of canonical components, interpreted as characteristics of typical dialogues along each side. To describe the relational context, we assumed the three-sided configuration. The sides of the triangle are defined as Dialogic Interaction Axes (DIA).

Results:

Health Provider-Parent DIA

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Table 1. Parents' cues/concerns

	WEIGHT ON CANONICAL COMPONENTS	
	ξ_1	ξ_2
CUE A (vague words)	0	0
CUE B (metaphors)	0	0
CUE C (physiological correlates)	0	0
CUE D (neutral expressions)	0	0
CUE E (ripetitions)	0	0
CUE F (no verbal cues)	0	0
CUE G (past emotions)	**-1**	0
CONCERNS (explicit expressions)	0	**1**

Table 2. Health Providers' responses

	WEIGHT ON CANONICAL COMPONENTS	
	η_1	η_2
EPAAc (Acknowledgement)	**-0.961**	0
EPAEm (Empathy)	0	0
EPAEx (Acknowledgement)	0	0
EPCAc (Exploration)	0	0
EPCEx (Exploration)	0	0
ERIa (Information Advise)	0	**0,02**
ERSw (Switching)	0	0
ERPp (Post - Poning)	0	0
ERAb (Active Blocking)	0	**0,97**
NPAc (Post - Poning)	0	0
NPAi (Active Invitation)	0	**0,19**
NPBc (Black Channel)	**-0.276**	0
NPSi (Silence)	0	0
NPIm (Implicit Empathy)	0	0
NRIa (Information Advice)	0	0
NRIg (Ignore)	0	**0,04**
NRSd (Shutting Down)	0	0

- The first pair of canonical components is given by ξ_1, cues/concerns (the only variable with a weight other than 0 was CUE G), and η_1, responses (the only variables with weights other than 0 were EPAAc and NPBC). Their interaction can be interpreted as a dialogical dimension relative to pediatricians' latent tendency toward *providing space to past emotions*. The relationship between ξ_1 and η_1 (correlation coefficient = .726) is called EMOTIONS IN MEMORY.
- The second pair of canonical components is given by ξ_2, cues/concerns (the only variable with a weight other than 0 was CONCERN), and η_2, responses (the only variables with weights other than 0 were ERAB and NPAI). Their interaction can be interpreted as a dialogical dimension relative to pediatricians' latent tendency toward *open and close the dialogue*. The relationship between ξ_2 and η_2 (correlation coefficient = .810) is called AMBIVALENT TREATMENT OF EMOTIONS.

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Health Provider-Child DIA[1].

Table 3. Childrens' cues/concerns

	WEIGHT ON CANONICAL COMPONENTS	
	ξ_1	η_1
CUE A (vague words)	0	**1**
CUE B (metaphors)	0	0
CUE C (physiological correlates)	0	0
CUE D (neutral expressions)	0	0
CUE E (ripetitions)	0	0
CUE F (no verbal cues)	**-1**	0
CONCERNS (explicit expressions)	0	0

Table 4. Health Providers' responses

	WEIGHT ON CANONICAL COMPONENTS	
	ξ_2	η_2
EPAAc (Acknowledgement)	0	0
EPAEm (Empathy)	0	0
EPAEx (Acknowledgement)	0	0
EPCAc (Exploration)	0	**0,131**
EPCEx (Exploration)	0	0
ERIa (Information Advise)	0	0
ERSw (Switching)	**-0,131**	0
ERAb (Active Blocking)	0	0
NPAi (Active Invitation)	0	0
NPBc (Black Channel)	0	**0,991**
NPSi (Silence)	0	0
NRIa (Information Advice)	0	0
NRIg (Ignore)	**-0,991**	0
NRSd (Shutting Down)	0	0

- The first pair of canonical components is given by ξ_1, cues/concerns (the only variable with a weight other than 0 was CUE F), and η_1, responses (the only variables with weights other than 0 were NRIg and ERSw). Their interaction can be interpreted as a dialogical dimension relative to pediatricians' latent tendency toward *ignore the crying*. The relationship between ξ_1 and η_1 (correlation coefficient = .913) is called UNHEARDED CRIES.
- The second pair of canonical components is given by ξ_2, cues/concerns (in which the only variable with a weight other than 0 was CUE A), and η_2, responses (in which the only variables with weights other than 0 were NPBc and EPCAc). Their interaction can be interpreted as a dialogical dimension relative to pediatricians' latent tendency toward *providing space to vague emotions*. The relationship between ξ_2 and η_2 (correlation coefficient = .810) is called VAGUE EMOTIONS ACKNOWLEDGED.

[1] CUE G, ERPP, NPAC and NPIM, absents in the dialogue, were eliminated.

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Parent-Child DIA[2].

Table 5. Childrens' cues/concerns

	WEIGHT ON CANONICAL COMPONENTS	
	ξ_1	ξ_1
CUE A (vague words)	0	0
CUE B (metaphors)	0	0
CUE C (physiological correlates)	0	**-1**
CUE D (neutral expressions)	0	0
CUE E (ripetitions)	0	0
CUE F (no verbal cues)	**-1**	0
CONCERNS (explicit expressions)	0	0

Table 6. Parents' responses

	WEIGHT ON CANONICAL COMPONENTS	
	η_1	η_2
EPAAc (Acknowledgement)	0	0
EPAEm (Empathy)	0	0
EPAEx (Acknowledgement)	0	0
EPCAc (Exploration)	0	0
EPCEx (Exploration)	0	0
ERIa (Information Advise)	0	0
ERSw (Switching)	**-0,131**	0
ERPp (Post - Poning)	0	0
ERAb (Active Blocking)	0	0
NPAc (Post - Poning)	0	0
NPAi (Active Invitation)	0	0
NPBc (Black Channel)	0	**0,998**
NPSi (Silence)	0	0
NRIa (Information Advice)	0	0
NRIg (Ignore)	**0,974**	**0,043**
NRSd (Shutting Down)	0	0

- The first pair of canonical components is given by ξ_1, cues/concerns (the only variable with a weight other than 0 was CUE F), and η_1, responses (the only variables with weights other than 0 were NRIg and ERSw). Their interaction can be interpreted as a dialogical dimension relative to parents' latent tendency toward *ignore the crying*. The relationship between ξ_1 and η_1 (correlation coefficient = .864) is called UNHEARDED CRIES.
- The second pair of canonical components is given by ξ_2, cues/concerns (the only variable with a weight other than 0 was CUE C), and η_2, responses (the only variables with weights other than 0 were NPBC and NRIg). Their interaction can be interpreted as a dialogical dimension relative to parents' latent tendency toward *to let the child describe concerns about symptoms*. The relationship between ξ_2 and η_2 (correlation coefficient = .816) is called EMOTIONS ABOUT SYMPTOMS ACKNOWLEDGED.

[2] CUE G and NPIM, absents in the dialogue, were eliminated.

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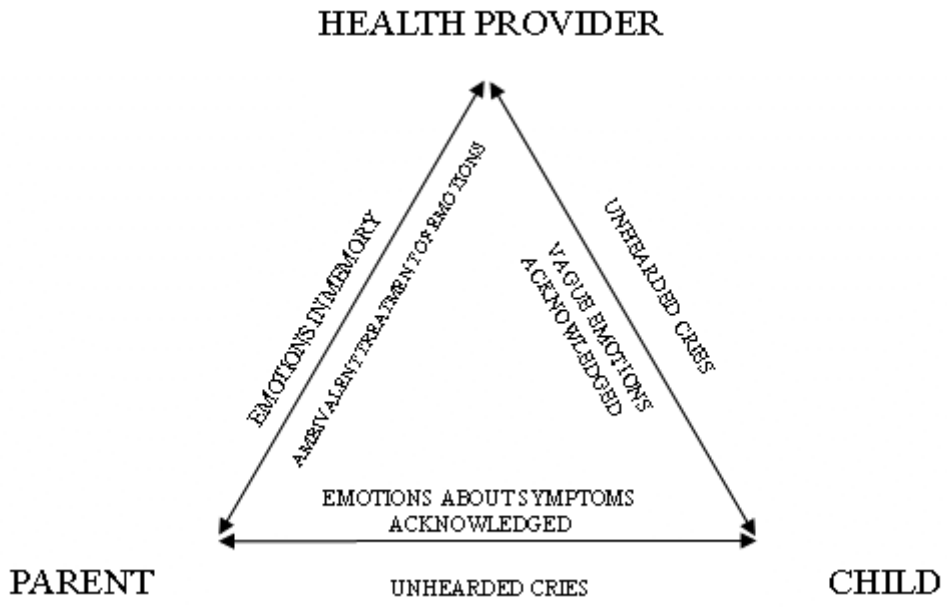
Discussions

Dialogic patterns seem to be characterized by reduced possibility to share explicit emotions; even the baby's crying seems to be not recognized as a distress signal.

Figure 2. Results.



Participants seem to limit dialogue about emotions, except when they are about symptoms and clinical conditions. The presence of a psychologist in a pediatric setting could promote dialogue and help participants to recognize emotions as information useful to the health care processes (e.g., subjective opinions of the users, their participation to the care, declination of the treatments in daily life) (Freda & Dicé, 2016)

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EATING DISORDERS IN FEMALE ADOLESCENTS: PSYCHOLOGICAL PROFILES AND FAMILY FUNCTIONING

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Literature in the field of Eating Disorders (EDs) pointed out an always greater spread of unhealthy eating behaviours among adolescents. Epidemiological data highlight a prevalence of 0.5%-1.0% for Anorexia Nervosa (AN) among adolescents, of 0.5%-3.0% for Bulimia Nervosa (BN) (Swanson et al., 2011) and of 1.0%-2.6% for Binge Eating Disorder (BED) (Watson et al., 2012). Moreover, the higher prevalence of eating disorders among girls was confirmed (5.7% of female and 1.2% of male adolescents showed EDs in a community sample, see Smink et al., 2014). These evidences suggest the relevance of the developmental phase of early adolescence (11-14 years of age) as particularly at risk for the onset of EDs (Smink et al., 2012), being a challenging period during which various changes occur, whit a re-organization of family functioning (Paciello et al., 2013). One of more investigated issue to better understanding the causes and the maintenance of EDs in adolescence is the family functioning and the quality of the relationships among family members. Several studies addressed associations between the onset of EDs in female adolescents, parental psychopathological risk (Haycraft et al., 2014) and damaged relationships among family members. But paternal psychopathological risk and its role in fostering ED in their daughters have been little studied until today. The problem under study was the representation of family functioning and female adolescents' psychological profiles, considering parents' possible psychopathological risk, in a sample of families with adolescents suffering of EDs. Following the transactional theoretical framework (Minuchin et al., 1978), that stress the role of adolescents' family members' characteristics in predicting the onset of EDs among their offspring, we conducted a cross-sectional study, in which we intended to assess the psychological profiles of female adolescents suffering of three forms of EDs and their parents' psychopathological risk. We aimed to verify whether adolescents' psychological features were associated with parental psychopathological risk and whether adolescents and their parents showed specific representations of family functioning, also examining possible association between adolescents' psychological profiles and perceived family running. Sample was constituted by Ntot=120 families of adolescents who addressed a network of

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public and private consultants in Central Italy requesting a clinical support for adolescents' disordered eating, diagnosed with AN (Group A), BN (Group B) and BED (Group C) (average age:14-17; s.d.:.769). Selected adolescents and their families completed self-report questionnaires assessing psychological symptoms and psychological distress *Symptom Check-List (SCL-90-R)* and adolescents' and parents' perceived family functioning *Family Adaptability and Cohesion Evaluation Scale (Faces IV)*. The three groups significantly differ each other as regard to both psychological profiles and perceived family functioning. With regards to adolescents' psychological profiles, a MANOVA showed a Group effect ($F = 207,183$; $p< 0.001$) and adolescents belonging to Group A, B and C show differences in all subscales of SCL-90/R, excepted on Anxiety. Adolescents with AN have more depression, hostility and obsessive-compulsive symptoms compared with peers with BN or BED; bulimic girls have more symptoms of somatization and paranoid ideation, whereas girls with BED have more symptoms of interpersonal sensitivity and psychoticism. With regards to parents' psychopathological risk, a MANOVA showed a Group Effect with reference to mothers ($F = 49.667$; $p< .001$) and to fathers ($F = 2,246$; $p< .05$). Mothers of anorexic adolescents have more depression symptoms compared with other mothers, while fathers have more paranoid ideation and psychoticism than other fathers. With regards to family functioning adolescents show different perceptions ($F = 31,83$; $p<0.001$): in group A they report low satisfaction with their family relationships than their parents, while in Group B they show lower scores than their parents on communication and in group C perceived their family less flexible and more rigid. Finally, parents' psychopathological risk is associated with their daughters' one, in particular as regards the following variables: adolescents' anxiety and mother's anxiety (.39*); adolescents' somatization, mothers' depression (-2.83*), psychoticism (-.412*) and fathers' interpersonal sensitivity (.195*). Moreover, the daughters' symptomatology is associated with their perceived family functioning: somatization with enmeshment in group A; psychoticism with enmeshment, paranoia with cohesion in B, somatization and depression with communication in C. Our principal findings showed that adolescents and parents in Group A, B and C present a specific psychopathological profiles and differ in their perception of family functioning. Adolescents with AN show the most severe psychopathological risk and perceive their family as highly disengaged, poorly interwoven and rigid. Adolescents' parents in the three groups showed high psychopathological risk, and each group presented a characteristic constellation of symptoms. The results suggest that specific maternal psychopathological symptoms can be associated with different clinical configurations in their offspring, whereas paternal psychopathological risk may be present in adolescents suffering from all types of eating disorders. Our data also find confirmation in

previous literature as they recognize that some family characteristics such as communication, flexibility and cohesion can be a protection or risk factor for adolescents' eating disorders. The results are in line with main evidences in literature upon which the description of anorexics and bulimics on their family remind to excessive Enmeshment, Rigidity, poorly Communicating and Conflict Avoidance, taking into account the fact that adolescents with BED have a negative perception and unsatisfying family functioning. It could be relevant, in future study with control sample or as a longitudinal research, to continue to evaluate the effect of adolescents' psychological profiles and parents' psychopathological risk on family functioning, considering the specific forms of adolescents' eating disorders and addressing even better paternal symptomatic characteristics.

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SHAME EXPERIENCES AND SOCIAL NETWORKING ADDICTION: AN UNEXPLORED ASSOCIATION

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In the last years, Internet addiction has been the subject of several studies, which have led to a growing consensus on the importance of distinguishing between different Internet applications when studying their addictive potential. As Griffiths (2000) points out, rather than becoming addicted to the medium per se, some individuals develop an addiction to specific online activities. Whereas Internet Gaming Disorder has been included in the appendix of the Diagnostic and Statistical Manual of Mental Disorder 5 (American Psychiatric Association, 2013), some scholars claim that more research is needed to ascertain the health-related impact of an excessive use of Internet communicative services. The use of social networking sites (SNS), in particular, has increased dramatically over the last few years, especially among young people, and it was found to be associated with dysfunctional Internet behavior and negative personal outcomes (EU NET ADB Consortium, 2012). Many scholars (e.g. Müller et al., 2016) argue that excessive SNS use may be addictive because some individuals experience symptoms similar to those experienced by individuals who suffer from other forms of addiction. Mood modification, salience, tolerance, withdrawal, conflict, and relapse appear to be present in people who use SNS excessively (Kuss & Griffiths, 2011). Such Internet problematic use has been called Social networks addiction (e.g. La Barbera, La Paglia, & Valsavoia, 2009). Concerning the etiological framework, it has been claimed that SNS addiction might derive from the perceived deficiency of social skills in face-to-face (FtF) relationships. Communicating with others online in a text-based manner allows users to avoid some of the more fearful aspects of social interaction, while at the same time meeting their needs for interpersonal contact and relationships (Erwin et al., 2004). The current study investigates the main and indirect effects of shame experiences and perceived benefits of computer-mediated communication (CMC) compared with FtF communication, on SNS addiction. In particular, a model in which perceived benefits of CMC (i.e. escapism, control over self-presentation, and approval/acceptance) mediate the association between shame and SNS problematic use was tested.
Undergraduate students (N = 590; mean age = 22.29 $\pm$ 2.079; F = 53.2%) were recruited from the University of Florence. Participation was voluntary, no rewards or extra-credit were provided. The following questionnaires were filled out in a classroom setting: the Generalized Problematic

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Internet Use-Scale 2 (GPIUS2; Caplan, 2010) -for the purpose of the present study, respondents were asked of referring to their use of SNS-; the Experience of Shame Scale (Andrews, Quian, & Valentine, 2002) and three brief scales, measuring the perceived benefits of CMC, i.e. Escapism (distraction from thinking about problems and responsibilities); Control over self-presentation (hiding negative attributes and experiencing different personalities); Approval/acceptance (being more socially accepted). Structural Equation Modeling (SEM) was performed. The structural model produced adequate fit to the data (χ^2 = 352.99; *df* = 92; *p* <.001; *RMSEA* [*90% CI*] =.07 [.06-.08]; *CFI* = .97; *SRMR* =.06). Variables accounted for 50% of the variance in SNS addiction. A partial mediation model in which shame predicted SNS addiction levels through the perceived benefits of CMC was found. A direct relationship between shame and problematic SNS use was also detected (Figure 1). The current results illustrated, for the first time, an association between shame experience and SNS addiction. Only one previous study (Craparo et al., 2014) found that shame was associated with a form of Internet addiction not specifically related to SNS use. A partial mediation model in which shame predicted SNS addiction levels through the perceived benefits of CMC was found. As for other types of addiction-as drug addictions (Tangney & Dearing, 2002)-, those people who experience shame could use SNS as a means of escaping from real life problems and negative emotions. Furthermore, in line with the social skill model (Caplan, 2005), SNS use might provide greater control over self-presentation (than face-to face interactions) for people who view oneself as having negative and unattractive characteristics. Finally, in accordance with recent studies, which evidenced the importance of relationship building and maintenance in motiving SNS use (e.g. Chen & Kim, 2013), the perception of being more socially accepted online could meet the need for interpersonal contacts among people who experience shame in offline social interactions.
Besides its limitations (e.g. cross-sectional data, self-reports), the current study highlights how feelings of shame can contribute to SNS addiction and emphasizes the necessity of taking into account the perceived benefits of CMC when exploring its psychological risk factors. CMC allowed people who struggle with feelings of shame to escape from negative emotions, to hide their supposedly negative attributes and to reduce the possibility to be rejected. For this reason, shame might be a specific risk factor in developing addiction to SNS.

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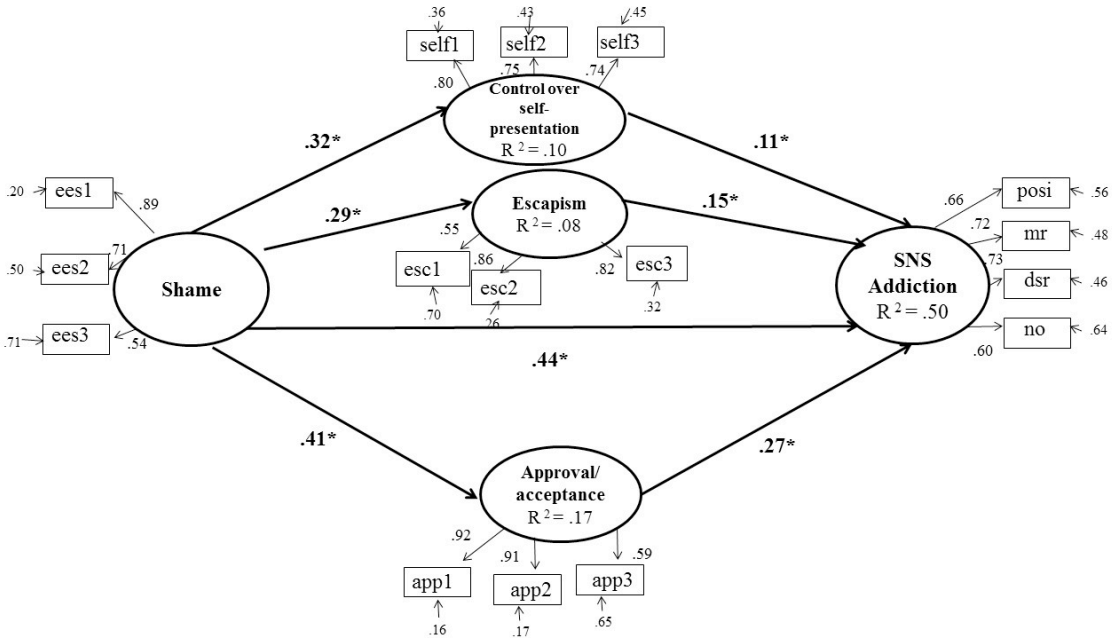

Figure 1. *Standardized estimates for structural model*
Note. ees1, ees2, ees3 = experience of shame scale subscales; self1, self2, self3 = control over self-presentation parcels; esc1, esc2, esc3 = escapism items; app1, app2, app3 = approval/acceptance parcels; posi = preference for online social interaction scale; mr = mood regulation scale; dsr = deficient self-regulation scale; no = negative outcomes scale; * p<.001

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CLINICIANS' EMOTIONAL RESPONSES AND PDM P AXIS PERSONALITY DISORDERS

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Countertransference is an important tool for understanding the patient, his personality and interpersonal style, and can help clinicians in planning, and monitoring, more patient-tailored and effective therapeutic interventions (Gabbard, 2009; Kernberg, 1984; PDM Task Force, 2006). Psychoanalytic theories suggest that patients may elicit in therapist feelings and emotions that reflect, in a more or less accurate way, their inner psychological world and their emotional, cognitive and interpersonal problems. These hypotheses seem to become more relevant with patients who suffer of pervasive and maladaptive patterns of motivations, thoughts, behaviors and emotions, i.e. with personality disorders.
Therefore, the emotional responses of treating clinicians may inform the diagnostic process providing information about patients' personality characteristics.
This theoretical and clinical view of countertransference has fostered, during the last 20 years, many research studies that showed the existence of specific relationships between personality disorders, assessed with DSM or SWAP, and emotions experienced by clinicians.
These empirical data confirm the diagnostic and prognostic value of countertransference. So far, only one study used the *Psychodynamic Diagnostic Manual's* (PDM Task Force, 2006; Gazzillo et al., 2015) for personality diagnoses. PDM is an empirically informed psychodynamic diagnostic manual that describes each disorder taking into account both symptoms and the intrapsychic dynamics underlying the disorder. PDM introduces a personality disorders' classification more rich and articulated that those ones of the other international diagnostic classifications, such as DSM or ICD, considering different subtypes and opposite and/or intermediate versions of the same personality disorders (e.g. the introjective and anaclitic versions of depressive personality disorder).
The aim of this study was to explore the relationship between patients' personality organization (PO) and personality disorders (PD), assessed with the categories of the PDM P Axis, and the emotional responses of treating clinicians. We asked to 232 clinicians to assess one of their adult patients with the revised version of *Psychodinamic Diagnostic Prototypes* (PDP-2; Gazzillo, Genova, Lingiardi, 2015), a version enriched with the descriptions of the different personality

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disorders subtypes and opposite and/or intermedie manifestations, as well as to complete the *Therapist Response Questionnaire* (TRQ; Betan, Heim, Zittel-Conklin, & Westen, 2005). For identifying which emotional responses (TRQ) were related to PO and to PDP patterns, we performed a series of multiple linear regression models, entering the PO and the PDP patterns as the dependent variables and the different TRQ factors as predictors. Then, when one or more clinicians' emotional reactions (TRQ factors) correlated with the PO as well as with one or more personality disorders, we performed a series of partial correlation for proving if, even after controlling the OP's level effect, the association between the TRQ's factors and the personality disorders remained significant.

Our data showed that patients with high level of PO tended to elicit positive emotions, while patients with low level of PO (borderline or psychotic) tended to elicit feelings of being overwhelmed and disorganized by emotions and the sense of being incompetent and inadequate. Moreover, our data showed that patients with the same personality diagnosis, but with different subtypes of this disorder, tended to evoke different kinds of emotional responses. The depressive/hypomanic disorders were predicted by parental/protective and disengaged reactions, but the disengaged one was specific of the introjective version of the depressive personality disorder. Differently, the hypomanic personality disorder seemed to show a typical pattern of emotional responses, characterized by sexualized and helpless/inadequate reactions.

The dependent/self-defeating disorders were associated with parental/protective, criticized/mistreated and disengaged reactions, but the parental/protective and disengaged were specific for dependent patients. The passive-aggressive version of dependent personality disorder was predicted by a parental/protective, overwhelmed/disorganized and criticized/mistreated reactions, while counter-dependent disorder by an overwhelmed/disorganized and parental/protective one, and the self-defeating disorder - in his relational version - just by an overwhelmed/disorganized response. The anxious disorder was connected to parental/protective and disengaged reactions, while the phobic disorder just by the parental/protective reaction. The obsessive-compulsive, somatizing and schizoid disorder were predicted by a disengaged reaction; the latter also by the parental/protective one.

Histeric/histrionic personality disorders were predicted by an overwhelmed/disorganized and sexualized reactions, while the narcissistic disorders by a parental/protective and criticized/mistreated reaction, even if the parental/protective one seems to be specific for the depressive/depleted subtypes of narcissistic patterns. Finally, the paranoid disorder was connected to helpless/inadequate and criticized/mistreated reactions, and the emotionally disregulated

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disorder by an overwhelmed/disorganized response. Herein, we choose to discuss just the associations between clinicians' emotional responses and personality disorders that are statistically significant also after controlling the PO level. In most cases, our results are coherent with PDM's indications about countertransference reactions usually felt by clinicians with patients with specific personality disorders and with other empirical studies on this topic (Colli et al., 2013; Tanzilli et al., 2015). Taken together, these results have clinically relevant implications because having information about the typical reactions that therapists can expect to feel working with a patient with a specific personality disorder may help them to avoid reacting in a way that unconsciously repeat patient's maladaptive patterns. Moreover, these empirical data confirm the diagnostic and prognostic value of the emotional responses of treating clinicians.

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PREDICTING COUPLE DYADIC ADJUSTMENT FROM ADULT ATTACHMENT STYLE AND INTERPERSONAL COMPETENCE: A PILOT STUDY

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Literature has largely showed that the quality of couple adjustment is related to the adult attachment style (Li & Chan, 2012; Meyers and Landsberger 2002). Adult attachment style has been conceptualized along two dimensions, namely attachment avoidance and attachment anxiety (Fraley and Shaver 2000). Individuals featured by avoidance attachment style tend to deny their need for other's love as well as to remain self-contained and self-reliant, trying to avoid closeness and interdependence (Fraley and Shaver 2000).

Individuals featured by anxiety attachment style tend to have doubts about their lovability and their value as a romantic partner, showing fear of rejection or abandonment, and a lack of confidence in one's capacity to regulate a partnership effectively (Fraley and Shaver 2000). Roughly speaking, people scoring high in both avoidant and anxious styles of attachment to their romantic partners are characterized by a lower relationship satisfaction and a higher breakup rate; by contrast, people low on both dimensions are characterized as securely attached individuals who are more successful in their relationships (Collins and Read 1990). Research has also showed the association between the adult attachment styles and interpersonal competence with respect to the individual differences in handling conflict (Castellano et al., 2014; Mikulincer and Shaver, 2012) and to provide emotional support for the partner (Epstein et al., 2015).

Individuals with secure attachment style are expected to cope more effectively with relationship conflict than those individuals with insecure attachment style (Mikulincer and Shaver, 2012). Indeed, secure adults are likely to show open communication and collaborative negotiation during conflict, and to rely on effective conflict-resolution strategies, such as compromising and integrating ones' own and a partner's needs and behaviors (Mikulincer and Shaver, 2012). For individuals with high score on attachment anxiety, interpersonal conflicts can reactivate their fears of rejection and abandonment. Adults characterized by attachment anxiety are more prone to experience a sense of decline in love, commitment, and relationship satisfaction; holding a more pessimistic beliefs about the future of their relationship (Campbell, Simpson, Boldry, & Kashy,

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2005; Gallo & Smith, 2001). For adults characterized by high score on attachment avoidant, interpersonal conflict could interfere with their need of independence and emotional distance leading them to dismiss a partner's complaints and downplay the significance of the conflict (Mikulincer and Shaver, 2012). Bartholomew and Allison (2006) found avoidant individuals acting violent when involved in an escalating series of conflicts, especially with an anxiously attached partner who demanded attention, care, and support. To the best of our knowledge the impact of interpersonal competences on the quality of romantic relationship has not been investigated. The current pilot study aimed to evaluate whether the couple dyadic adjustment can be predicted on the basis of attachment and interpersonal competence. A cross sectional research design has been set up. Participants were 70 cohabitant/married subject (35 males, and 35 females) (48 cohabitant, and 21 married). Mean age of male participants was 34.26 (SD = 6.05) while the mean age of female participants was 32.54 (SD = 5.56). At the time of data collection, all participants had been involved in a romantic relationship of at least 5 years duration. A mean relationship length of participants was 7,9 years (SD = 2,89). The attachment in close relationship was assessed using the Experience in Close Relationship-Revised (ECR-R), the couple dyadic adjustment was assessed using the Dyadic Adjustment Scale (DAS), and the interpersonal competence was assessed using the Interpersonal Competence Questionnaire-Revised (ICQ). The data analysis were conducted using the statistical program SPSS 21.

First, the relevant assumptions were tested. The assumption of singularity was met as the independent variables (Anxiety, Avoidance, Dyadic Adjustment, Conflict Management, and Emotional Support) were not a combination of other independent variables. Residual and scatter plots indicated the assumptions of normality, linearity and homoscedasticity were all satisfied. Second, a hierarchical multiple regression analysis was conducted to test whether the adult attachment style and interpersonal competence were able to predict the couple dyadic adjustment. A two-steps hierarchical multiple regression was conducted using the Dyadic Adjustment as dependent variable. The Attachment Style variable (Anxiety and Avoidance) was entered in step one; the Interpersonal Competence variable (Conflict Management and Emotional Support) was entered in step two. Results show that Avoidance in close relationship accounted for 28.2% of variance of couple dyadic adjustment, and significantly contributing to the regression model ($F (2, 67) = 14.53$, $p < .001$).

When the Interpersonal Competence variable was entered, an additional 6,7% of variance of couple dyadic adjustment was explained ($F (2, 65) = 4.483$, $p < .05$). Anxiety in close relationship did not

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show a significant correlation to the couple dyadic adjustment. Findings seem to confirm the hypothesis that the dyadic adjustment can be predicted on the basis of attachment in close relationship and interpersonal competence. The current pilot study provides a greater understanding of the association between couple adjustment, attachment in close relationship and interpersonal competence. Our data highlight that the attachment style, in particular avoidance in close relationship, as well as interpersonal competence - such as conflict management and emotional support - represents a valid perspective through which look at the quality of couple relationship. Further research is needed to deepen investigate the exchange between individual and couple dyadic features.

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VALIDATION AND PSYCHOMETRIC PROPERITES OF THE ITALIAN MORAL DISTRESS SCALE-REVISED (MDS-R)

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Caring for critically ill patients is an emotionally demanding job (1). Among the factors that affect clinicians' wellbeing, moral distress received an increasing attention (2). Moral distress was defined by Jameton (3) as the painful feeling that occurs when healthcare professionals cannot carry on what they believe is the ethically correct action either for internal or external constraints. The hallmark of moral distress is therefore a perceived violation of one's professional values and ethical integrity. Studies showed that clinicians who suffer from moral distress experience sadness, frustration and anger , and are at risk for burnout, withdrawal from patient care, or job leave (4). To date, two instruments have been developed to measure moral distress: the Moral Distress Scale (MDS) and its revised version (the MDS-R) (6,7).

Despite these scales constitutes a first effort to measure moral distress, their structural and concurrent validity have not been tested. Structural and concurrent validity are pivotal component of construct validity and are fundamental steps to validate an instrument. The aim of this study was develop and validate the Italian version of MDS-R on a sample of critical care clinicians through exploratory and confirmatory factor analysis. Convergent validity was assessed by exploring the relationship between moral distress and depression. Differences in moral distress related to socio-demographic characteristics were finally explored. *Data collection.* Data were collected in 8 adult medical-surgical Intensive Care Units (ICU) in the North of Italy. Physicians, residents and nurses were requested to fill in the MDS-R to measure moral distress and BDI-II to measure depression. The MDS-R is composed by 21 items that describes morally distressing situations. Each item is scored by clinicians in terms of frequency of occurrence and intensity of distress.

Responses are given on 5-point Likert scale varying from 0 (never) to 4 (very frequently) for the frequency scale and from 0 (none) to 4 (great extent) for the intensity scale. For each item a composite score is computed by multiplying the frequency and the intensity score. BDI-II is a self-report inventory to assess the severity of depressive symptoms. It is composed of 21 items

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describing physical/affective and cognitive symptoms. Each item is rated on a 4-point Likert-type scale ranging from 0 to 3 based on severity of the symptoms. *Data analysis.* Construct validity of the MDS-R was evaluated exploring its factorial structure. Exploratory Factor Analysis (EFA) was conducted using Mplus 6 to explore MDS-R factorial structure. The resulting model was tested through Confirmatory Factor Analysis (CFA). Convergent validity was assessed by exploring the correlations between the Italian MDS-R and BDI-II scores using Pearson. *Results.* 184 clinicians (64 physicians, 94 nurses and 14 residents) completed both MDS-R and BDI-II. Based on content validity checking, 4 items of the original MDS-R were eliminated. An initial EFA was conducted to explore the dimensionality of MDS-R. The best fit indices were obtained by a 4 factor model (RMSEA=.05; CFI=.97; TLI=.94; SRMR=.04). Upon inspection of the factor structure, additional 3 items were removed because they cross-loaded different factors or presented factor loadings smaller than .35. A follow-up factor analysis produced a 4 factor model with good fit indices (RMSEA=.01; CFI=.99; TLI=.99; SRMR=.03) and conceptual clarity. These factors were interpreted to represent the following dimensions: 1) Futile care, 2) Misconduct, 3) Deceptive communication, and 4) Poor teamwork. Overall, the factors extracted explained 59.21 % of total variance. This model was tested through CFA and showed good fit indices (RMSEA=.06; CFI=.95; TLI=.94; WRMR=.65). The internal consistency of the Italian MDS-R was good (Cronbach α =.81). The Italian MDS-R score positively correlated with BDI-II score (r=.293 p=.000). Among the Italian MDS-R subscales, the highest correlation was found between Deceptive communication and BDI-II (r=.268; p=.000). Moral distress score did not differ across age (F=.217; p=.805) nor across professional experience groups (F=.910; p=.404).

No differences were found in moral distress between physicians and nurses . However, nurses reported higher scores on Futile care than physicians (t=2.051; p=.042), and physicians presented higher score on Deceptive communication than nurses (t=3.617; p=.000). Moral distress was higher for those clinicians considering leaving their position (t=2.778; p=.006). *Discussion.* Our findings provide evidence that the Italian version of the MDS-R is a valid and reliable measure to assess moral distress among nurses, physicians and residents. Despite its brevity (14 items compared to 21 items of the MDS-R), the Italian MDS-R showed good internal consistency (α=.81). Factor analysis highlighted that there are four factors contributing to moral distress: Futile care, Deceptive communication, Misconduct and Poor teamwork. Within the most recent theoretical debate on the dimensionality of moral distress, the findings of this study provide empirical evidence that support the multidimensionality of the construct.

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The four-factor model that emerged confirms the complexity of clinical work in the ICU that relates not only to the biomedical domain, but also to the relational and ethical domains. The multi-dimensionality of the Italian MDS-R will allow a more accurate comprehension of moral distress among different professionals working in ICUs and will offer the base for tailored psychosocial interventions addressing the different dimensions of moral distress. Our study was the first to assess the relationship between moral distress and depression. We found a significant correlation between the Italian MDS-R and BDI-II suggesting that moral distress may be associated with depressive symptoms. Moral distress was higher in clinicians contemplating leaving their positions. These results suggest that moral distress could seriously impact critical care clinicians' wellbeing and should be addressed with psychological interventions.

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DIFFICULT REPRESENTATIONS IN THE WOMENS' NARRATIVES ON BREAST AND CERVICAL CANCER SCREENING

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The main objective of this study is to show a psychodynamic perspective on the preventive measures of women cancer. National and International Literature describe the role of different aspects related to the screening of breast and cervical cancer (i.e. cognitive, motivation, psyco-social). There is a need of integrating different aspects related to symbolic representations and to the meaning that women give to the taking care of themselves and to the risk of the diagnosis of cancer. The early diagnosis of diseases related to the intimate areas, female identity's symbol, leads to a conflict between life and death, health and disease, healthy body without symptoms and disease body with symptoms. The aim of research is understand how women tell their story about the prevention of breast and cervice cancer.
The narration is the meaning device (Margherita, 2009) that allows to focus the protoemotional aspects (Ferro, 2006) and it can represent events and thoughts (Freda, 2008), by constructing new meanings (Bruner, 1990) and by transforming the meaningless into an imaginable form (Barbieri, 2007). The hypothesis is that the risk of cancer leads to difficulties in the symbolic representation. Women can choose to write a story about the prevention of breast cancer or cervice cancer, or both. Fifty-eight women (26yo average) were enrolled in this study, and 29% of these had relatives (mother, aunt, grand-mother) with breast cancer. The narrations were collected altogether and were analyzied by a thematic analysis of multiple corrispondences by using T Lab. (Lancia, 2004, 2008; Reinert, 1995). The variables considered are familiarity (37% yes vs 63% no) and choice of the theme. Forty-five % wrote about prevention of breast cancer, 26% about cervice cancer and 20% about both themes. Women that have a familiarity with breast cancer are more prone to talk about prevention not only related to the breast cancer but also to the cervical cancer.
The results underline five thematic clusters. Factorial mapping of the clusters enables us to observe and interpret the relationship between the different threads that emerge and understand the factors that link them. Axis I, the horizontal axis, called *from the manifest to latent content*, it is related to the meaning of the prevention. On one side of this axis, the knowledge and the cognitive awareness are important aspects to take preventive. Women that have familiarity express their need of knowing. On the other side we found previous experiences, not easily accessible, related to the prevention and mostly expressed by women without familiarity. There is an idea related to not

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loving enough themselves, a feeling of guilty about sexuality and being women, and moreover the need of being brave to do tests to understand the possible disease state. I also considered a second axis (vertical) named from the concrete thought to the symbolic thoughts. Thinking about cancer prevention means thinking about illness, disease body, surgery, wounds, and lead to meaningless feelings. Women try to make sense to the prevention. It can be represented in experience, relations, thoughts and emotions set in the body. However, the idea of unwanted situations leads to confusion and lack of symbols generating a mental situation that it's hard to contain. This feeling builds primitive mechanisms such as the concrete thought. Therefore I considered a third axis, defined by the responsibility of the disease. On this axis it's possible identify different levels of responsibility identified by women that drive to the disease. The current study shows how young women deal with the prevention of cancer. Difficulties in representing the prevention and the consequences of the disease reduced the accessibility to each meaning and the transformation of the emotions in thought.

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STUDYHOLISM INVENTORY (SI): A TEST FOR A POSSIBLE NEW CLINICAL CONDITION

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It is since the 70s that researchers study workaholism, a work-related behavioral addiction. However, I assume that workaholism could be spread in the school context too, where it could be present towards study as it is the main activity for students, as well as work it is for workers. In line with this, Atroskzo, Andreassen, Griffiths, and Pallesen (2015) proposed the construct of study addiction and the Bergen Study Addiction Scale (BStAS), which is an adaptation of the Bergen Work Addiction Scale (BWAS; Andreassen, Griffiths, Hetland, & Pallesen, 2012). This scale was created by changing in the items of the BWAS the word "work" with "study", and it was already used in a previous research on behavioral addictions (Andreassen, Griffiths, Gjertsen, Krossbakken, Kvam, & Pallesen, 2013). More specifically, the BStAS is a 7-item instrument that conceptualizes study addiction as a pure addiction. The seven items reflect indeed the core components of addictions (salience, tolerance, mood modification, relapse, withdrawal, conflict, problems). Though, I believe, in accordance with Kardefelt-Winther (2015), that when proposing new potential behavioral addictions we should go beyond a priori assumptions of addiction, in order to identify the real manifestation of the problem behavior. For this reason, I suggested the construct of *Studyholism*, which is different from study addiction, even if it is related to the same behavior (i.e. studying). In particular, I aimed to define this potential new clinical disorder taking into account the possibility of the presence of both externalizing (i.e. addiction) and internalizing (i.e. obsessive-compulsive) symptoms. Moreover, since I believe that it is imperative not to overpathologize a common behavior such as studying, I suggest to differentiate between engaged and disengaged studyholics, and to keep in mind that there is also a third kind of heavy study investor, namely the engaged student. For these reasons, I aimed to create a test that allows distinguishing between these three kinds of heavy study investors. In addition, I aimed to better define the construct of *Studyholism* based on the results of the analysis on the preliminary version of the test. First, I created in collaboration with the Jagiellonian University of Krakow a pool of 68 items that, referring to workaholism literature, covered three hypothetical factors: addiction symptoms, obsessive-compulsive symptoms (also including perfectionism), and study engagement. Then, 340

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Italian University students filled out the pilot version of the Studyholism Inventory (SI). The participants (240 females, 100 males) were aged between 19 and 54 years. The 40.6% of the participants studied for the nursing profession, the 32.6% was a psychology student, and the remaining 26.8% attended some other courses (e.g. law, political sciences, medicine). Finally, most of them were at the first (50.6%) or second (36.8%) year of University. The Explorative Factor Analysis (EFA; Varimax Rotation) on the total sample (n = 340) showed that the best factor solution for the SI is a two-factor one: (1) obsessive-compulsive symptoms (or studyholism) and (2) study engagement. Hence, the final version of the SI is composed of 10 items, five for each factor, and it has any items related to addiction symptoms or perfectionism. In order to analyze further the SI, we run a Confirmatory Factor Analysis (CFA) on a sub-sample of the participants (n = 205). We selected randomly near the 60% of the participants and we done the CFA only on the 10 items of the final version of the SI. The fit index of the two-factor and one-factor solutions showed that the two-factor solution had better values, respectively: RMSEA = .11 and .21; GFI = .90 and .69; RMR = .12 and .23; NFI = .86 and .57; TLI = .86 and .47; CFI = .89 and .59.
Finally, I defined low and high Studyholism and Study Engagement (referring to the 25° and 75° percentile), in order to create four groups of students (n = 340): (1) Engaged Studyholics: high Studyholism and high Study Engagement (12.4% of the sample); (2) Disengaged Studyholics: high Studyholism and low Study Engagement (6.8% of the sample); (3) Engaged Students: high Study Engagement and low Studyholism (7.6% of the sample); (4) Detached Students: low Study Engagement and low Studyholism (9.7% of the sample). Given these results, I concluded that *Studyholism* may be more similar to a study-related obsession than to a study-related addiction. Moreover, it seems that *Studyholism* is characterized only by internalizing symptoms (and not by both internalizing and externalizing symptoms, as I hypothesized). Finally, it appears appropriate to distinguish between Engaged and Disengaged Studyholics, given the high proportion of students with both high studyholism and high study engagement. The main limit of this study is to have done the EFA and the CFA on the same sample. We used a sub-sample for the CFA, while it would have been more appropriate to gather new data for the 10-item version. The merit of this study is to have given some insights into the construct of S*tudyholism*, providing also an instrument to evaluate it; hence, future research could use it in order to analyze its antecedents and outcomes. Moreover, it highlights that many students experience high level of *Studyholism*. Regarding future perspectives, in order to deepening the analysis of the construct, I am collaborating with the Jagiellionan University and the University of Montana in order to validate the Polish and US version of the SI.

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EVALUATION OF THE IMPACT OF A CLINICAL SEMI-OPEN GROUP ON THE PHYSICAL AND PSYCHOLOGICAL HEALTH OF PATIENTS WITH HEART ATTACK

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According to World Health Organization data (2014) diseases related to the circulatory system are confirmed leading causes of death in the world, including Italy. The scientific literature of the past fifty years has shown considerable interest in the role played by psychological and psychosocial factors in the etiopathogenesis, the maintenance and the progression of the heart disease. Psychological intervention is now recognized internationally as part of cardiac rehabilitation programs. The study aims to assess the impact of a psychodynamic intervention group on clinic and psychological health of heart attack patients, functional to the recognition and the development of representational and emotional dimension of identity related to the disease and to changes in life it entails. The general assumption is that such intervention is able to promote the physical and psychological health of the subjects and a greater adherence to the rehabilitation program, as well as a reduction of the probability of new cardiac event and mortality. Heart attack (or myocardial infarction) patients were recruited consecutively in two hospitals (Brindisi and Copertino - Lecce) from September 2014 to November 2015: 22 for clinical intervention and 10 for the control group, with an age from 18 to 70 years.
The groups of the two hospitals were united in a single experimental sample after checking the initial homogeneity for all variables collected. The study involved: the collection of clinical, psychological and psychosocial variables at baseline, at the end of psychodynamic intervention group and 6 months after the end of it (follow-up); the collection of process variables at the end of each group session (participation, group climate, therapeutic alliance); the audio-recording and transcription of the sessions. Duration. The patients attended 12 meetings conducted by a clinic psychologist; the total duration was 6 months with twice-weekly meetings for the first structure and 3 months with weekly meetings for the second. The different duration between the two sites was due to dialogue with two different health care systems with two different organizational methods. ANOVA and Repeated Measures Analysis was applied to clinical, psychological and psychosocial data collected. At the end of the 12 sessions, there have been improvements for both groups - experimental and control - for clinical aspects (reduction of BMI, blood pressure, total cholesterol,

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LDL cholesterol, glycemia, antiplatelet drugs) and lifestyles (smoke reduction and increase of physical activity), besides worsening perception of the quality of the care system; for experimental group there was a trend of emotional reactivity (anger, depression and perceived social support) to shrink at follow-up. Process variables – participation, therapeutic alliance and group climate - were good with increase of scores over time for both total scales and their subscales. A Lexical Correspondence Analysis (LCA) and a Cluster Analysis (CA) were applied to the verbatim transcripts. LCA lead to 2 factorial dimensions. The first dimension refers to the nature of changes and opposites a focus on the behavior on lifestyles and a focus on the social condition of cardiac pathology. The second dimension concerns disease management: practical versus emotional. According to the positioning of the discourses produced in the symbolic space, the first meetings are centered on the emotional event management, intermediate meetings on the changes of habits and lifestyles, the final ones on the changes of social conditions and its external recognition. The CA allows to identify 4 main thematic nucleus: disease management; dialogue with the health care system; myocardial infarction; habits and lifestyles. The group expressed satisfaction for psychological intervention and considered it useful.

At the end of group intervention, clinical treatment it does not seem to influence the natural course of post-myocardial infarction (for both groups the physical/clinical indices and lifestyle improve); after other 6 months, there was the effects of the treatment: in the experimental group anger decrease while depression and social support of other significant increase. The outcome results suggest that at an initial phase in which patients experience anger and reactivity, it follows a phase in which the grief begins to be elaborated with depressive feelings (work of mourning, Bowlby 1988). So the group serves as a space and a container in which to express feelings that would otherwise remain unexpressed, and favorite the building of a new structure of meaning, while the long non-recognition can leave these emotions unresolved and adversely affect the disease outcome. About the content of speeches, the group focused both on practical aspects related to the management of the disease (changes in lifestyle), both on the emotional management, staying initially on a private dimension, and then moved, in last sessions, on pension issues, namely on a broader social dimension in which to expose themselves and to be recognized as "sick".

All this allows patients to cope with the transition from a first behavior of denial and then of emotional responsiveness until the attitude of taking charge of their condition, then accept and adapt to it. In conclusion, clinical group seems to have a facilitating role with respect to the ability to process the experience of illness and gives patients the opportunity to express their feelings on

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different aspects of disease management, from lifestyles changes to the awareness of a new social status.

AFFECTIVE REGULATION AND BRAIN DYNAMICS IN A SAMPLE OF SUBJECTS WITH A HISTORY OF CHILD MALTREATMENT

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The neurosciences have investigated the functional correlates of the "*Complex Trauma*" (Van der Kolk), resulting from a history of child maltreatment, by mean of EEG recordings stimuli related. The classical approach to investigate by EEG the brain activities related to problem solving, memory and emotional or attentive tasks, is the event related electrical deflections (ERP). This approach have resulted in the evidence of positive and negative "waves" in the averaged EEG activity after a stimulus. Another approach is the decomposition of the EEG signals in different oscillatory activities at different frequencies. Some authors have proposed that the ERPs resulted by the effect of changes in that band of frequencies (*Event Related Spectral Perturbations* - ERSP). Recently was found that in the EEG, the low frequency activity sustains the synchronization between different areas (Cross Frequency Modulation: CfM).
This synchronization may sustain in turn the emergence of high level mind functionalities as the consciousness. All these event related phenomena are expression of an integrated dynamic brain activity which does not occur in a sequential mode, but in a recursive systemic way where parallel processes harmonize each other or respond to dynamic perturbation risen by external or internal stimuli. In individuals with a history of childhood maltreatment may be present a different brain dynamic, detectable by a modified CfM and by EEG signs of functional overload.
In this study the EEG recordings are related to a Go/noGo modified task, in which subjects have to select appetitive or aversive images among a neutral set, when preceded by a cue. 400 images were presented to each subject, of which 40 were preceded by a wolf cartoon as cue, and 40 by a snoopy cartoon. 280 were neutral images, 20 (cued by wolf) with an aversive valence and 20 (cued by snoopy) with a appetitive valence. The task consisted in pressing a button if facing an appetitive image or another button if facing an aversive one. No press was requested if facing neutral images

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or cues. The study was performed on 26 subject (13 with child maltreatment [MCh] and 13 controls [Cnt]). Psychopathology was assessed by questionnaires (SCL-90, for psychopathology in general; DERS, for emotional dysregulation; TAS, for alexithymia; TSQ, for post traumatic reactions; SASS, for social adjustment; WHO-QOL Brief, for quality of life).
The CfM and behavioral parameters were computed. Subjects with a history of child maltreatment had similar global performance in the task as controls, but more hits on neutral images when not preceded by a cue (3.7 in Cnt e 20.9 in Mlt). No difference in response time in Go condition was detected between the two groups, while later responses occurred in MCh in noGo conditions (NoGo+: Mlt 972 ms, Cnt 708 ms; NoGo-: Mlt 1068 ms, Cnt 749 ms). Higher levels of CfM were found in the MCh group in the Medial Frontal Cortex (MFC: Mlt .096 rVL; Cnt .032 rVL), in the Superior Temporal Cortex (STC: Mlt .070 rVL; Cnt .045 rVL) and in the Uncus (Mlt: .076 rVL; Cnt: 0.44 rVL); on the other hand higher levels of CfM were found in the Anterior Cingulate (ACC: Mlt .036 rVL; Cnt .055 rVL)) in the Cnt group. Overall electrical activity was higher in the Uncus (Mlt 1036 mV*ms; Cnt: 267 mV*ms) in the MCh group and in the ACC (Mtl: 181 mV*ms; Cnt: 445 mV*ms) and in the Parahyppocampus (PHC; Mlt: 155 mV*ms; Cnt: 1695 mV*ms) in the Cnt group. The CfM in the Middle Temporal Cortex (**MTC**: r=.615;p=.001) is positively correlated with the Quality of *external world* Life factor (QoL Environment subscale & SASS Sociality Subscale), instead in the **PHC** (r= -.782; p<.001) and in **Cingulate** (r=-.511;p.001)
is negatively correlated; the CfM is also negatively correlated to the Quality of *internal world* Life factor (SASS Activity subscale, SASS Competence subscale, QOL psychological, low DERS Total Score, low SASS Social subscale) in **Fusiform Cortex** (FC: r=-.854; p<.001), in the **MTC** (r=-.821;p<.001) and in the **Uncus** (r=-.713;p<.001); the *Emotional Dysregulation* factor (DERS Impulse, DERS Goal, DERS Strategy, DERS Strategy, DERS Acceptance, DERS Clarity, TSQ) is positively correlated to CfM in the **FC** (r=.883;p<.001) and in the **MTC** (r=.609; p=.001) and negatively correlated in the **Cingulate** (r=-.820;p<.001); finally the *Alexithymia* factor is positively correlated to CfM in the **MTC** (r=.780;p<.001) and negatively correlated in the **Cingulate** (r=-.641;p<.001). The CfM in the **MTC** is related to an higher level of alexithymia, of emotional dysregulation, a better self reported quality of life in relation to the external world, but a worst one in relation to the inner world; moreover the CfM observed in the **Cingulate** Cortex is correlated to a lower quality of life in relation to the external world, and a lower emotional dysregulation and alexythimia; finally the CfM in the **PHC** was related to lower quality of life in general and related to the external world in particular, to an higher attention to inner world, to an higher risk of high scores in dissociation and to a lower quality in affective relationships. These data confirm the

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presence of a different brain dynamics in MCh then in Cnt, and the potential role of CfM in leading different process of brain integration in the two groups.

ILLNESS NARRATIVES AND MODAL ARTICULATION: AN INNOVATIVE METHODOLOGICAL AND CLINICAL PROPOSAL

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Within a psychological-semiotic perspective the modal verbs (must, can, will, and to know) are connection devices able to develop the sensemaking of a narrative. Modal verbs are verbal predicates that - in the construction of the phrase - add several meanings: possibility, will, duty, knowledge, need, or ability. From a syntactic point of view, a verb is defined as "modal" when it changes the sense of the following verb by positionally preceding it in the syntagmatic chain of the sentence (Marsciani e Zinna, 1991). In this sense, modalization is a semiotic interface that allow the emergence of subjectivity of the narrator (Greimas, 1983; Weizsacker, 1967) and it connects the experience with categories of possibilities, constraints, wishes, intentions to act, and interactions with others. Modal categorization directs the action in the context and it is not just a cognitive process but emotional as well (Greimas, 1983; Weizsäcker, 1956; Caston, 2011; Bertrand, 2002; Valsiner, 2014). Our proposal aim to highlight main modal use functions from a psychological perspective in narrative construction of meaning:
The connection function. Modals have a connective function between the affective primary matrix of the subject and its first discretization in a symbolic form. For example, through the linguistic use of modal verbs, the subject is connected with the text of the speech and the dynamic affective field which it involves. *The mediation function*. Modals make complex the relationships between social partners (in terms of reciprocity and/or complementariness).
They allow for the construction of a dialectic between subjectivity and alterity, the construction of a subject-in-relationship. The same relationship with the object of interest and the world is always mediated in modal terms. Therefore, modal articulation gives shape and direction to interpersonal relationships. *The vectorial function*. Modal operators contribute to the action orientation (by enabling and/or blocking) in space and time.

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They are inherently temporal, contextual and locally defined. Modal operators help build a sense of agency for the subject. We developed a method of analysis (De Luca Picione, Martino, Freda, in press *on Journal of Constructivist Psychology*) to study the modals within narrative texts. This methodology uses the quali-quantitative software T-Lab (Lancia, 2008). We analyzed six narratives of oncological illness, in order to highlight the presence of modals and their connections with verbal predicates. For this aim we defined two indices in order to compare the level of modalization of narratives: **Index of Textual Verbal Mass - TVM Index** - as the ratio of the sum of all verbs in a single narrative, and the total amount of words of that narrative; **Index of Modal Saliency - MS Index** - calculated as ratio of all modal occurrences and verbal mass of the whole narrative text. Next, in order to grasp the modal configuration (in terms of syntagmatic chain), we have done an analysis of the sequences (Markovian chain) of modal verbs (reintegrating modal verbs in the dictionary of T-Lab software) observing which entries occur in terms of probability in the position of predecessors and successors with respect to them. We posed as a keyword every single modal predicate. Results show several modal configurations in order to signify their own experience of illness: a first possible distinction is between the continuous reconfiguration and plasticity *versus* recurrence of a specific modal (such as rigid relational form that the person works to build her relational systems).

Modal stiffness can be read as a disadaptive clue/a symptomatic dimension specification (in the sense of a certain rigidity to signify their experience in a maladaptive way and little disposed to give rise to processes of development in the face of the changing nature of the illness experience). By contrast we observe that even the extreme volatility and the impossibility of pausing in a modal specific configuration could be indication of a signal of discomfort/pain. Indeed, the fragmented nature of the processes of signification and the compartmentalization of their experiences may prevent the achievement of its objectives and the construction of relational ties in which participate with a full sense of sharing and comparing.

Within this *continuum* (De Luca Picione, Martino & Freda, in submission) the extremes of which are total volubility/fragmentation and total stillness, we observe singular capability and the tendency to set up a specified modal experiences with degrees or more less stability and contingency. We propose this dialectics between stillness and dynamism of the modal articulation is fruitful of possibilities for the study of transformational processes of construction of the meaning of one's subjective experience.

Modal articulation study , as sensemaking process of subjective construction of experience, has three implications: 1) Theoretical level: to expand scientific reflection on human sensemaking

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processes and the interaction between affective, temporal, and agentive dimensions. 2) The methodological level: for idiographic framework studies on narratives, using these functions as markers for the positioning of the subject with respect to an event and as a way to signify relationships and expected future direction. 3) The clinical level: as a clinical marker of a subject's discomfort and at the same time as device to propose an intervention strategy that can be used dynamically and in a fluctuating mode to extend the intra/inter-psychological dialogue. As the subject recovers modal articulation and defines new modal relations, many possibilities can be think and realized.

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DEFICIT IN EMOTION RECOGNITION IN HIGH FUNCTIONING AUTISM SPECTRUM DISORDER (ASD): A COMPARISON BETWEEN FACIAL AND BODILY EXPRESSIONS

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Social information can be communicated by various channels, among which facial expression and body movement are pivotal. Difficulty in understanding other people in everyday interaction is widely reported in people with ASD, and it's one of the diagnostic criteria for the Autism Spectrum Disorder (American Psychiatric Association (APA), 2000, 2013). However, scientific findings on recognition of emotions in ASD - both with facial and bodily expression - are mixed (Harms et al., 2010; Kaiser and Shiffrar, 2009; Pavlova, 2011). Contradictory results may be due to several factors - such as IQ matching criteria, age, task demands and stimulus type (i.e. static or dynamic). Those might explain the variations in emotion recognition in ASD, especially among high-functioning individuals, as they can adopt different compensatory mechanisms according to the task and to the stimulus type. In the present study, we investigated the ability of individuals with high functioning Autism Spectrum Disorder (HF ASD) of recognizing emotions across a range of different social signals – such as facial and bodily expression. Furthermore, among the body movement, we explore differences in understanding the emotional content represented by implied (images) or explicit (videos) motion.

Finally, we investigated the relation between age and IQ level and the performance. 18 subjects with HF ASD (1 female, age: mean=18.56, sd= 8.03; IQ: mean=116.3, sd=20.11) and 18 controls matched for non-verbal IQ, age and gender (2 females, age: mean= 19.9, sd= 6.06; IQ: mean= 124.86, sd= 8.38) were asked to categorize 24 images of faces, 24 images of whole body (8 trials per emotional category), and 30 video clips of Full-light (FLDs) and 30 Point-light display (PLDs) of whole body movements (10 fearful, 10 happy and 10 neutral movements). The selected stimuli were rated for emotional intensity and quantity of movement in a prior pilot study and matched accordingly. None of the participant of the pilot study took part in the present study. The stimuli's duration was 3 seconds. Stimulus categories were presented in 4 separated blocks, each participant was administered all blocks. The order of block was counterbalanced between participants. Every

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experimental session started with 6 practice trials, to familiarize with the stimuli and with the task. Responses were collected by keyboard, the order of key-emotion correspondence was randomized across participants. Accuracy and response times (RT) were recorded. At the end of the experiment, participants were administered the Matrix of Raven test to assess the IQ level. **Accuracy**: Overall, TD were more accurate than HF ASD ($p < 0.001$).

We also compared the performance across the different class of stimuli: results showed that ASD participants were less accurate than TD in understanding facial expression, FLDs and PLDs (all comparisons $p>0.001$), but not different from TD's in recognizing static body images. Subsequently, within group logistic regressions were performed to compare the level of accuracy between stimulus type and emotional category in each group separately. In ASD group, fearful body images were recognized better than happy ($p=0,003$) or neutral ($p=0.001$). Fearful FLDs were recognized more accurately than happy FLDs ($p=0.035$). The accuracy for fearful PLDs were smaller than for neutral PLDs ($p=0.35$). Finally, we didn't find any difference in accuracy for faces across the emotional contents. In TD group there was not any difference across emotion nor for faces nor for bodies recognition. Neutral FLDs were recognized better than happy FLDs ($p=0.011$). Neutral PLDs were recognized better both than fearful ($p=0.046$) and happy ($p<0.000$) PLDs, and fearful PLDs better than happy PLDs ($p=0.003$). Finally, a linear model showed a significant interaction between IQ and age ($p<0.000$) in predicting the accuracy in ASD but not in TD group.

Response Times: A 2x3x4 repeated measure ANOVA with group as between factor and emotion and display as within factors was performed considering only the correct responses. Results showed a main effect of group ($p=0.042$), with TD faster than ASD; a main effect of emotion ($p=0.018$), and a main effect of display ($p<0.000$). Moreover, there was a significant interaction between group and display ($p=0.048$). Post hoc pairwise t-test revealed that in ASD faces were recognized faster both than FLDs and PLDs ($p<0.000$), and RTs for bodies were faster than PLDs ($p=0.001$). On the contrary, in TD the only significant difference was between faces and PLDs ($p=0.004$). Finally, a linear model showed a significant interaction between the IQ and the age in predicting the response times in ASD ($p<0.000$), and in TD group ($p<0.000$).

Our findings show that HF ASD are less accurate and slower than TD in recognizing emotion, their impairment is extended to all the stimulus categories and independent of the emotional content. Both TD and ASD recognise better the facial expression than the emotional body language. However, comparing the body stimuli, results revealed that ASD's difficulties was higher for videos (explicit) than for images (implied), and for PLDs than for FLDs. This findings suggest that the ASD impairment could be related to the movement rather than to the recognition of emotion.

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Finally, the IQ seems mediate the acquisition of compensatory mechanisms that improve with age, and which help ASD to recognize better and faster the meaning of facial and bodily expressions.

FROM SEXTING TO DATING VIOLENCE THROUGH AMBIVALENT SEXISM: THE PERPETRATOR'S PERSPECTIVE

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Sexting is a new trend among adolescents and young adults, defined by Chalfen (2009) as the exchange of provocative or sexually explicit content (text messages, photos and/or videos, also called "sexts") via smartphone, Internet and social networks. Literature described two categories: "experimental sexting," which has no harmful intentions and fits with typical adolescent development (flirting, joking) and "aggravated sexting," which involves harmful intentions and/or unwise misuse of sexual images of someone else (Wolak et al., 2012). Previous studies underlined the relationship between sexting misuse and risk for dating violence victimization. Conversely, our study aimed to investigate the perpetrator's perspective, focusing on a risky sexting behavior, the not-allowed sharing of sexts of someone else without his/her permission. We expected that those who make not-allowed sharing of sexts also perpetrate more dating violence. We also wanted to study this relationship within the theoretical framework of ambivalent sexism, as theorized by Glick and Fiske (1996). Specifically, we hypothesized that benevolent sexism could be a protective factor (Allen et al., 2009) in the relationship between not-allowed sharing of sexts and dating violence perpetration (at higher levels of benevolent sexism, the relationship would be weaker, and at lower levels of benevolent sexism, it would be stronger).
On the contrary, we expected hostile sexism to be a risk factor (Russell & Trigg, 2004; Valor-Segura et al., 2008; 2011) in the relationship between not-allowed sharing of sexts and dating violence perpetration (at higher levels of hostile sexism, the relationship would be stronger, and at lower levels of hostile sexism, it would be weaker). A survey composed by the Sexting Behavior

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Questionnaire (Morelli et al., 2016), the Conflict in Adolescent Dating Relationship Inventory (Wolfe et al., 2001) and the Ambivalent Sexism Inventory (Glick & Fiske, 1996) was administered to 715 adolescents and young adults from 13 to 30 years old (M_{age} = 22.01; SD_{age} = 4.01; 513 female participants, 71.7%).

Two moderation regression analyses tested the moderating role of both benevolent and hostile sexism, in the relationship between sexting and dating violence perpetration, controlling for age, gender and sexual orientation. Then, in order to interpret the direction of the interactions, two full simple slope analyses were conducted. At low levels of benevolent sexism, there was a significant positive relationship between sexting and dating violence perpetration, B = .30, t = 4.74, p < .001, whereas at high levels of benevolent sexism, this relationship vanished to a non-significant effect, B = .06, t = .05, *n.s.* On the contrary, at high levels of hostile sexism, there was a significant positive relationship between sexting and dating violence perpetration, B = .19, t = 4.25, p < .001, whereas at low levels of hostile sexism, this relationship was reduced to a non-significant effect, B = - .07, t = 1.56, *n.s.* Several studies found that sexting under pressure from partner/peers enhanced the possibility of dating violence victimization (Drouin et al., 2015;Tobin & Drouin, 2013). According with this literature, our study found a similar pattern from the perpetrator's perspective: Not-allowed sharing of sexts was weakly but significantly related to dating violence perpetration.

The weakness of this correlation suggested the presence of other moderating factors affecting this relationship. Thus, we tested the moderation roles of benevolent and hostile sexism because the literature showed them as a protective and a risk factor for dating violence, respectively (Allen et al., 2009; Forbes et al., 2005; Valor-Segura et al, 2011). As expected, our results suggested that in the relationship between sexting and dating violence perpetration, hostile sexism could be a risk factor while benevolent sexism could be a protective factor. In the presence of hostile sexism (i.e., a negative stereotyped vision of gender roles) sexting could be part of a wider pattern of violence in a dating relationship.

Both males and females with high hostile sexism are more tolerant toward intimate partner violence (Valor-Segura et al., 2011). Thus hostile sexism encourages in men an ideal of domination and overpowering of others, legitimating perpetration of violence (including sexting with harmful intention) in dating relationship. Likewise, hostile sexism encourages in women a perception of being submissive and unworthy that could lead them to be more aggressive because they perceive themselves as potentially under threat. Thus, women will be more disposed to engage in aggressions (including sexting with harmful intentions) in dating relationships. Similarly, benevolent sexism is based on a dichotomous gender vision: while hostile sexism is conceived on a

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"dominator/dominated" dimension that can lead to violence, benevolent sexism is based on a "protector/protected" dimension that encourages self-sacrifice rather than punishment. Thus, our findings suggest that benevolent sexism seems to be a protective factor in the relationship between not-allowed sharing of sexts and dating violence perpetration. A woman with high benevolent sexism can consider herself holy, pure and weak, within a gender perspective in which female violence could not be acceptable. Men with high benevolent sexism have more benign ideas of masculinity, linked to ideals of chivalry. The desire for domination is not acceptable, and the ideal man should be brave, virtuous and self-sacrificing in order to protect others. This conceptualization makes men's violent aggression unacceptable too. Therefore, these findings can have relevant implications for prevention programs that should be focused on decreasing and deconstructing gender stereotypes, in order to promote more healthy and safer dating relationships since adolescence.

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OBESITY AND SEXUAL HEALTH: RESULTS FROM A PRELIMINARY STUDY ON WOMEN ASKING FOR BARIATRIC SURGERY

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Obesity is an increasing epidemic affecting 300 million women worldwide (about 1/3 adults in USA and 1/10 in Italy). The WHO defines obesity as a body mass index (BMI) >30 kg/m^2, condition which can adversely produce physical, emotional and psychosocial problems [1-3]. Obesity is now the fifth leading cause of mortality worldwide and increases the risks of developing type 2 diabetes, hypertension, coronary artery disease, and stroke [4]. These risks do not cease when overweight and obese women become pregnant, but rather increase the risks for perinatal complications for mother and child than in normal weight women [5].

Moreover, it can also adversely affect sexual health, even if the effects on women have not been clearly defined [6]. Understanding the influence of body weight on sexual behaviour is critical for health-care professionals and patients. Although many have theorized that obese women are different from normal-weight women, current evidence based on unwanted-pregnancies rates seems to disprove this. Sexual behaviours and contraceptives use do not appear to vary by BMI in adult women, although obese adolescents may be more likely to engage in high-risk sexual behaviour or experience unintended pregnancy and STDs compared to normal-weight teens [1,7]. Bariatric surgery is one of the possibilities to contrast obesity. Weight loss is achieved by reducing the size of the stomach with a gastric band or through removal of a portion of the stomach (sleeve gastrectomy or biliopancreatic diversion with duodenal switch) or by resecting and re-routing the small intestine to a small stomach pouch (gastric bypass surgery).

Long-term studies show the procedures cause significant long-term loss of weight, recovery from diabetes, improvement in cardiovascular risk factors, and a reduction in mortality of 23% from 40% [8]. This study investigates the presence of psychological and sexual symptoms, alexithymia, sexual

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dysfunctional beliefs, body image and quality of life in a group of obese women, in order to improve general taking care, quality of life and sexual health. We focus our attention on the role played by the BMI level and the use of contraceptives to predict sexual health and quality of life in this group of obese women. Data were collected on 143 heterosexual women aged 40.46 ± 9.66 (range 19-45) asking for bariatric surgery at "Sapienza" University of Rome (Dept. of general surgery and "Bariatric Center of Excellence and Metabolic Surgery", U.O.C. "Sapienza" Polo Pontino, LT) from September 2015 to April 2016. Psychiatric condition and unfertile women were excluded from this study. A self-administered questionnaire was given during the psychological screening for surgery composed by: sociodemographic questionnaire, "Symptom Checklist 90 Revised" (SCL90-R), "Beck Depression Inventory II" (BDI-II), "State-trait Anxiety Inventory Y form" (STAI-Y), "Toronto Alexithymia Scale" (TAS-20), "Female Sexual Function Index" (FSFI), "Sexual Dysfunctional Beliefs Questionnaire" (SDBQ-W), "Body Uneasiness Test" (BUT) and "Test SIO for Obesity Disabilities Correlates" (TSD-OC) [9-16]. Women asking for surgery reported high levels of BMI (42.31 kg/m^2 ± 6.30) and low levels of education (41.3% and 46.9% respectively attended middle and high schools). More than half (n=79) did not use any contraceptive tool, even if they were fertile and they did not want to have a child at the moment of the study. Multiple regressions showed a relation between BMI and Hostility scale of SCL90-R (r=-.184). Results revealed a damaged sexuality due to a severe presence of sexual symptoms (FSFI total score ≤ 23) and high levels of sexual dysfunctional beliefs related to age and body, which were both independent from level of BMI. Sexual dysfunctional beliefs were strictly connected with the educational level ($F_{1,138}$= 22.49; p< .001). The most important result of this study is that women who used contraceptive methods (e.g., condoms, pills, etc.), compared with the non-users, reported better scores in sexual functioning scales. Except for sexual desire, obese women using contraceptives report better scores on arousal, lubrication, orgasm, satisfaction, sexual pain scales and less suffering from physical obesity-related pain during everyday life. This preliminary study found out a complex scenery in which sexual symptoms were extremely represented in women recruited. Sexuality is often forgotten in obesity conditions, even if a protective role of sexuality in chronic diseases is demonstrated in literature [6].

For instance, the use of contraceptives seems to be connected and to improve sexual health and quality of life. These results have important implications in both clinical and research field, showing the need for a deeper understanding and speaking about sexuality for a comprehensive taking care. It is therefore incumbent on healthcare practitioners to appropriately prescribe contraception for obese women and counsel them on correct and consistent use of contraception, not only to prevent

pregnancies and STDs, but to improve quality of life and sexual health [17]. An obese woman should be encouraged and motivated to make her decision about health and pleasure based on her own circumstances after all the risks and benefits of all the methods have been fully and appropriately addressed. While guidelines and warnings correctly attempt to portray risks, health professionals should also consider a patient-centred approach focused on encouraging women to communicate their needs and concerns and making efforts to address these as soon as possible. This will ultimately improve patient satisfaction and adherence, leading to early recognition of problems, and serve as guide for recommendations for appropriate interventions.

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CORONARY HEART DISEASE AND RORSCHACH REPRESENTATION OF THE SELF

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The experience of the disease, such as that of heart disease has value in the construction and representation of the self if it involves a bodily component; the latter at variance with the visible parts of the embodiment is formed in the moment in which the organ gives signals of its presence (in arythmia, for instance) or of its pathology (infarct). The Self-Representation is a key concept of personality and of its operation (Rausch de Traubenberg, 1984): it reflects the somatic pathology and the subjective experience. In terms of subjective phenomenology, the study of such phenomena relies on the use of the Rorschach, whose production base is linked to Pareidolia (Jaspers, 1913). This form of experience, prompting the projection of unconscious qualities regardless of the percept, allows a content analysis of the responses helped by the work of Rausch de Traubenberg. As suggested by Lin et al (2016), there are positive correlations with hostility, depression, anxiety, depressive rumination, highlighted in psychometric terms, not as images. As Mendoca et al (2015) pointed out, the psychological difficulties found agreement with the subjectivity, but the methodoloy used here, thanks to the features of projective methods, allows us a significantly deeper investigation.
The Grill of Representation of Self by Rausch de Traubenberg, finally, is the guarantor of understanding and deepening of a possible typical representation even for subjects with somatic problems. Thus, the production that symbolically shows the unconscious, becomes clinical evidence. In this study the authors want to verify the existence of archaic conflicts in relation to the amount of inanimate movement response and representation of the self through the anatomy contents, according to the psychoanalytic theory of Freud and Jung. The observation group is made up of 40 subjects aged between 32 and 76 years. The evaluation, rather than being carried out with one of the dominant methods of projective Rorschach (Passi Tognazzo, 1994 and Exner, 2007), makes use to the "Grill of self representation" of Rausch de Traubenberg (1984). With reference to this Grill, four columns are present, the first specifying the layout tied to Human, Animal and Inanimate categories. Assigning the contents of the responses to the Rorschach subcategories, a typical prevalence can be deduced, through which the representation that the subject has of his own

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Self emerges. The innervation of the organ and then of its energy investment is projected in the representation of the self. By analyzing the answers through the use of the Grid of self-representation, the following evidences were observed: a low frequency of inanimate movement response (m = 1%) in the inanimate category (21%); a high percentage of anatomy contents to (13%) of the whole human category (U = 25%); a high percentage of animals content (54%). Considering the body as the seat of psychic energy, in light of these results it is possible both to individuate, according to Freud (1926), that the body is perceived as devitalized in some parts, and to consider the latter as alienated parts of the self. In Jungian theory there was a disorganization of the image of the self. The psychic totality of the self is perceived, by people with heart disease, not as psychic unit that includes all human psychic phenomena, but as fragmented and devitalized. Similarly in study of Jung (1945) on patients with schizophrenia, the self is split. Thus, between schizophrenia and somatic disorders, even if different at clinical level, the root can be noted of an operational thinking which involves the alteration in representation of the self.
Concluding, the frequency of anatomy contents and of the root canal treatment phenomena show that the energy within the body is reduced, characterizing a somatic problem. The study allows for reflection between image, symbol and projection of the body in the psyche.

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SIMULATION OF PSYCHOLOGICAL SYMPTOMS OR "NOT GUILTY BY REASON OF INSANITY"? A MALINGERING STUDY IN ITALIAN PRISON INMATES

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Malingering consists of "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (APA, 2013, p.726). The external incentive and the deliberate, conscious production of symptoms are the key elements of malingering and differentiate malingering from conversion disorder or factitious disorder. The mere presence of feigned symptoms is insufficient to conclude malingering. Malingering is a significant concern in forensic/correctional settings and the identification of this phenomenon has important consequences in terms of clinical management of this population. Prior to the trial phase, malingerers may produce false symptoms to reduce culpability, to introduce mitigated circumstances, or to be absolved of responsibility. Prison inmates may also malinger psychopathological disorders to go to another prison or to avoid solitary confinement. Moreover, a person who is "Not Guilty by Reason of Insanity" undertake a therapeutic process in which the individual is housed in a community correctional setting, as opposed to institutional incarceration, or is placed under house arrest. In forensic and correctional settings, it is particularly important to detect malingering behaviors for the correct allocation of public funds and resources. Although malingering is widely examined in the U.S., only few studies have been published in Italy. Thus, our objective was to provide new data on this underinvestigated topic by evaluating how prison inmates simulate diffuse mental health symptoms. Eighty-seven male inmates were recruited from three Italian prisons. The mean age was 41.1 years (*SD* = 12.9), ranging from 19 to 78 years. We administered two self-reports for detecting malingering: (1) the *Structured Inventory of Malingered Symptomatology* (SIMS; Widows & Smith, 2005), a 75-item, true-or-false screening instrument investigating five groups of symptoms (Psychosis [P], Amnestic disorders [AM], Neurologic Impairment [NI], Affective Disorders [AF], and Low Intelligence [LI]), and (2) the *Inventory of Problems-29* (IOP-29; Viglione, Landis, & Giromini, 2013-2015), a 29-item self-report combining both self-attribution and performance-based items. The sample was randomly divided into two groups: (1) the control group (n = 41) was asked to complete honestly the self-reports, and (2) the simulation group (n = 46) was requested to feign a psychopathological disorders at the tests. Moreover, simulator group subjects were provided with a

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vignette describing a real-life scenario of mild traumatic brain injury (mTBI) and a list of physical (e.g., lack of energy and headache), cognitive (e.g., attention problems, difficulties in reading or planning), and affective (e.g., feeling sad, anxious, or concerned) symptoms that are commonly related to mTBI. Overall, both the SIMS and the IOP-29 detected most of the simulators (Table 1). The SIMS detected all the simulators (Sensitivity, SE = 1.00), but showed a low Specificity (SP = .37). The IOP-29, on the other hand, yielded a Sensitivity of .78 and a Specificity of .83. All in all, the findings revealed that both tests are valid as screening instruments of malingering.

Table 1. Diagnostic Efficiency Statistics for SIMS and IOP29 scores

	SE	SP	PPP	NPP	OCC
SIMS					
Psychosis (P)	.96	.37	.63	.88	.68
Amnestic disorders (AM)	.91	.59	.71	.86	.76
Neurologic Impairment (NI)	1.00	.51	.70	1.00	.77
Affective Disorders (AF)	.94	.49	.67	.87	.72
Low Intelligence (LI)	1.00	.20	.58	1.00	.62
Total	1.00	.37	.64	1.00	.70
IOP-29 Malingering Index	.78	.83	.84	.77	.81

Note. SE = Sensitivity, SP = Specificity, PPP = Positive Predictive Power, NPP = Negative Predictive Power, OCC = Overall Correct Classification.

Given that the vignette we provided to the simulator group mostly described symptoms related to affective disorders, neurological impairment, and amnestic disorders, we evaluated whether the SIMS scales related to these disorders were higher in the simulation group compared to the control group. As reported in Table 2, we found large, significant differences between the control group and the simulation group for both the SIMS and the IOP-29. Moreover, we found the highest effect sizes (i.e., Cohen's *d*) for the Neurologic Impairment (NI) and Affective Disorders (AF) of the SIMS, and the IOP-29 Malingering Index. Thus, the results indicated that the simulation group showed higher scores on both the SIMS and the IOP-29.

Table 2. Descriptive statistics and differences between groups.

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	Control Group		**Simulation Group**				
	M	*SD*	*M*	*SD*	*t*	*p*	Cohen's *d*
SIMS							
Psychosis (P)	2.82	2.55	7.88	3.85	-7.01	< .001	1.69
Amnestic Disorders (AM)	2.44	2.63	8.78	3.98	-8.37	< .001	1.47
Neurologic Impairment (NI)	3.50	3.21	8.76	3.03	-7.64	< .001	2.59
Affective Disorders (AF)	5.53	2.60	8.87	2.07	-6.26	< .001	1.86
Low Intelligence (LI)	3.80	1.86	7.29	2.74	-6.03	< .001	1.53
Total	15.70	8.80	42.42	11.53	-9.36	< .001	1.43
IOP-29 Malingering Index	.31	.20	.73	.22	-9.25	< .001	1.99

Given that our aim was to evaluate how prison inmates simulate symptoms related to mTBI, we conducted an in-depth analysis of the items of the SIMS. We computed median values of all the SIMS items in both the simulation and control groups. Then we compared the items and we considered only those items endorsed by at least 50% of the simulators but not by the control group to identify only those items commonly endorsed by simulators. As expected, we found that the simulators endorsed 73% of items of the Neurologic Impairment (NI) scale, 53% of items of the Amnestic Disorders (AM), 40% of items of the Affective Disorders (AF) scale, and 27% of items of the Low Intelligence (LI) scale. Surprisingly, the simulator group also endorsed 47% of items of the Psychosis (P) scale. Given that psychotic symptoms were not described in the vignette or in the list of symptoms provided to the simulation group, we hypothesized that prison inmates may have a tendency to include this type of symptoms even if they are not related to the vignette or situation asked to simulate. This result is consistent with the theory that malingerers often endorse severe, rare symptoms that are very infrequently endorsed by clinical populations (Rogers & Bender, 2003). In conclusion, the use of valid and accurate instruments is fundamental to detect malingering and to classify correctly simulators and honest subjects. Overall, our findings revealed that both the SIMS and the IOP-29 are valid instruments in detecting malingering and that prison inmates may use simulation strategies that are peculiar to their context. Finally, although malingering is widely investigated in other countries, more research is needed in Italy.

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ALPHA ASYMMETRY NEUROFEEDBACK FOR THE REDUCTION OF NEGATIVE AFFECT

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Frontal cortical regions have been long studied for their important role in the regulation of emotional behavior. Left and right frontal regions seem to contribute differently to the control of emotions and affect. A large number of studies have established that the left hemisphere holds an advantage in processing positive emotional information, whereas the right hemisphere holds an advantage in elaborating negative emotions (Cohen and Shaver, 2004). Electroencephalographic studies found that when the right frontal area is more active the left frontal area is stuck in alpha rhythm (which is inversely related to regional brain activation) and this leads to a deficit in positive affect. Also, alpha asymmetry (difference in alpha power between homologous regions in the right and left hemisphere) influence response to emotional stimuli, such as, individuals with greater right

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than left frontal activity report larger negative affective responses to negative emotion-inducing films and smaller positive affective responses to positive emotion-inducing films (Tomarken et al., 1990; Wheeler et al., 1993). A robust body of research, has documented that an increased activation of the right compared to the left prefrontal cortex at rest correlates with withdrawal related negative affect (Davidson et al., 1990), anxiety symptoms (Wiedermann et al., 1999) and depression (Thibodeau et al., 2006). On these basis neurofeedback has been proposed as a possible intervention aiming at reducing right and increasing left frontal activity in order to improve emotional and mood dysfunctions. Alpha asymmetry neurofeedback has been most frequently applied in order to modify emotional responses in non-clinical samples (Allen et al., 2001), and reduce depression in clinically depressed patients (Baehr et al., 2001; Rosenfeld et al., 1996; Choi et al., 2010).

The present study examined whether a neurofeedback training designed to increase the activity of the right relative to the left alpha frontal activity would modulate alpha asymmetry and, in turn, reduce negative affect in a non-clinical sample. 32 right-handed female students were randomly assigned to receive neurofeedback training designed to increase the right (F4) relative to the left (F3) frontal alpha (asymmetry group; N = 16) or to increase frontal (FZ) alpha activity (active control; N = 16). Both trainings consisted of seven biweekly 40 min sessions. The first and last sessions involved a psychophysiological assessment, including EEG recordings in resting conditions and completing the Positive and Negative Affect Score (PANAS), Beck Depression Inventory (BDI), and Beck Anxiety Inventory (BAI). During each training session, participants were trained with a visual feedback consisting of a histogram reflecting the level of alpha asymmetry. Participants were asked to keep the alpha asymmetry (difference in alpha power between right (F4) and left (F3) leads) over the threshold calculated during the baseline at rest. Participants in the active control condition had the same feedback, but alpha power in FZ was the signal connected to the feedback. The outcome was assessed as changes right alpha power (F4), left alpha power (F3) frontal alpha (FZ) activity and frontal alpha asymmetry (ln[F4] - ln[F3]) and in PANAS, BDI, and BAI scores from pre- to post-training. Asymmetry group showed a specific increase in right alpha power, but not in left alpha power, reflecting a significant increase in alpha asymmetry, while active control group showed no changes in EEG activity. No differences emerged in frontal central alpha in both groups from pre- to post-training. A reduction in BDI scores emerged in both groups.

PANAS negative scale and BAI scores were significantly reduced in the asymmetry group only from pre- to post-training. These preliminary findings confirm the effectiveness of frontal alpha asymmetry neurofeedback for modulating right alpha relative to left activity. Importantly, this study

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investigated whether alpha asymmetry modifications were induced by modification in the right or left frontal area activation, or both. Alpha asymmetry neurofeedback training specifically increased right alpha power, which is inversely associated with the activity of the corresponding brain area. Therefore, modification in alpha asymmetry was determined by a decrease in right frontal activity, that reflect a corresponding left frontal dominance. Furthermore, the asymmetry training decreased negative affect and anxiety symptoms reported by the participants, these changes were not found in the control group. Excessive right frontal activation has been linked to negative affect, depression and anxiety (Davidson et al., 1990; Thibodeau et al., 2006; Wiedermann et al., 1999), therefore, a reduction in the activity of the right frontal cortex may suggest a neurophysiological correlate of mitigated negative affect and anxiety.

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GENDER DIFFERENCES IN MINDFULNESS AND INFERTILITY-RELATED STRESS

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The international literature shows that infertile people react differently to a diagnosis of infertility and assisted reproduction technologies (ART), manifesting dysfunctional emotional responses, e.g.: stress, anxiety and depression. Moreover, previous research has shown that men and women with infertility significantly differ in the severity of infertility-related stress. Specifically, women usually report higher levels of stress. Recent studies on intervention based on mindfulness with women in ART have demonstrated its effectiveness in reducing psychopathological symptoms. Women showed a significant decrease in anxious and depressive symptoms, as avoiding of the negative experiences and the feelings of shame. Furthermore, they showed improvements in mindfulness skills without self-judgment.

In addition, some studies have shown the effectiveness of psychological interventions based on acceptance and awareness of emotions and thoughts. In order to contribute to develop a tailored psychological intervention, the main objective of this research is to analyze mindfulness and coping strategies and their associations with stress in a sample of infertile people.

The sample consists in 101 infertile people [49 men (years m=38,32 ; ds=6,15) and 52 women (years m=35,78 ; ds=5,46)]. Participants completed self-report questionnaires: 1. *Five Facet Mindfulness Questionnaire*, which measures the ability to observe and describe the emotional states and thoughts with awareness and without judgment and without react; 2. *Fertility Problem Inv*entory, analyze five first-order stressor factors: social concern, sexual concern, relationship concern, rejection of childfree lifestyle and need for parenthood; 3. *Coping Orientation Problems Experienced*, which assesses five coping strategies: social support, avoidance, positive attitude,

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problem focus, transcendence. All partecipants were in a heterosexual relationship and were married or cohabiting for at least 2 years. Partecipants were recruited from public and private clinics throughout the country. All procedures have been approved by the Ethical Review Board of Department of Dynamic and Clinical Psychology of Sapienza. The principal aims of this study were: 1. To test whether there were gender differences in mindfulness skills, fertility stress and coping strategies; 2. To analyze if there were associations between mindfulness and stress fertility problems and between coping strategies and stress fertility problems. The T test and multiple regression analysis were performed with SPSS Statistics software (version 21). The statistical analysis showed that women reported more infertility-related stress than men ($p = .002$) in all domains. There were not significant gender differences in mindfulness skills [table 1; 2]. Regarding coping strategies, women showed a significantly higher scores than men in social support ($p=.000$) and transcendence orientation ($p=.007$) [table 3; 4].

Regression analyses showed that coping strategies and mindfulness were related to infertility-related stress. In particular, among women, the Non Judge scale was negatively related to social concern ($\beta=-.539$) explaining 27% of total variance. Among men, Non Judge was negatively related to need for parenthood ($\beta=-.336$) explaining 29% of variance [table 5; 6]. In total sample, social support ($\beta=.204$), avoidance ($\beta=.420$) and transcendence ($\beta=.245$) were related to infertility-related stress explaining 28% of variance. Results represents one of the first contributions to study mindfulness and coping skills during ART, showing that mindfulness skills can minimize infertility-related stress. The study showed that women reported more stress than men, and that women could ask for social support and engage in transcendence orientation more than men. Perhaps women are more stressed because they are active agents of the intervention of ART and therefore they have more need of support from others.

Women could also rely on something transcendental to have more confidence in the eventual success of ART. The main limitations of this study were: 1) the choice of instruments; participants were given only self-report questionnaires; 2) the sample is composed of volunteer participants, about 65% of possible participants that were approached declined to participate. Future projects should investigate whether an intervention based on mindfulness in people with dysfunctional coping strategies can facilitate the management of stress during ART.

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Table 1. Test T of FPI

	t	df	sig	Diff tra medie
Social Concern	-2,108	100,691	**,037**	-2,88786
Sexual Concern	-1,991	99,110	**,049**	-2,58669
Relationship Concern	-2,717	99,929	**,008**	-3,47930
Rejection of childfree lifestyle	-1,733	95,149	**,086**	-2,91935
Need for parenthood	-2,183	100,502	**,031**	-4,30488
Total	-3,148	100,102	**,002**	-16,17807

Table 2.

	media	ds
Social Concern M	26,1883	6,55096
Social Concern F	29,0762	7,34476
Sexual Concern M	16,2827	5,92741
Sexual Concern F	18,8694	7,22876
Relationship Concern M	23,4126	5,96181
Relationship Concern F	26,8919	7,01810
Rejection of childfree lifestyle M	27,0542	9,29855
Rejection of childfree lifestyle F	29,9735	7,66955
Need for parenthood M	32,6072	9,35348
Need for parenthood F	36,9121	10,64689
Total M	125,5450	24,04090
Total F	141,7231	28,04858

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Table 3. test T of COPE

	t	**df**	**sig**	**Diff tra medie**
Social Support	-4,257	95,301	,**000**	-5,94639
Avoidance strategies	-,550	97,199	,583	-,75683
Problem focused	,990	95,024	,325	,84119
Trascendence orientation	-2,740	98,336	,**007**	-2,43132

Table 4.

	media	**ds**
Social Support M	25,9924	7,26496
Social Support F	31,9388	6,65283
Avoidance strategies M	24,5596	7,01817
Avoidance strategies F	25,3164	6,76931
Problem focused M	23,9115	4,47016
Problem focused F	23,0704	4,02270
Trascendence orientation M	22,1042	4,04885
Trascendence orientation F	24,5355	4,86152

Table 5. Regression analyses to examine associations between mindfulness facets and fertility related stress among men.

	Social Concern β	**Sexual Concern β**	**Relationship Concern β**	**Rejection of childfree lifestyle β**	**Need for parenthood β**
Observe	,119	,023	,144	,233	,169
Describe	-,449	,165	-,082	-,026	,095
Act with Awarness	,083	-,504	-,176	-,217	-,194
Non Judge	-,202	,005	-,140	,105	-,336
Non react	-,148	-,043	,033	-,175	-,060
R^2	**.257***	.189	.167	**.110***	**.290***

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Table 6. Regression analyses to examine associations between mindfulness facets and fertility related stress among women.

	Social Concern β	**Sexual Concern β**	**Relationship Concern β**	**Rejection of childfree lifestyle β**	**Need for parenthood β**
Observe	-,399	-,075	-,035	-,122	,147
Describe	-,063	-,214	-,185	,060	,175
Act with Awarness	-,151	-,095	-,176	,185	,042
Non Judge	-,539	-,352	-,202	-,342	-,286
Non react	-,099	-,192	-,044	-,387	-,070
R - quadrato	**.272***	**.209***	.144	**.207***	.173

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SEXISM AND ATTITUDES TOWARDS SAME-SEX PARENTHOOD: THE MEDIATION EFFECT OF SEXUAL STIGMA

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Several empirical contributions focused on negative attitudes towards same-sex marriage, parenting and family legalization given that these issues continue to generate controversy especially in Italy, where the recognition of civil rights proceeds more slowly than in other countries. Despite this legal gap, same-sex parenting is a phenomenon that is becoming increasingly visible in the Italian context (Baiamonte & Bastianoni, 2015). The present study intended to investigate negative attitudes towards same-sex parenting examining the impact of sexism and sexual stigma in heterosexual people and in lesbians and gay men. The aims of the research were to study the relationship between sexism and attitudes toward same-sex parenting exploring the possible mediated effect of sexual stigma, taking into account gender and sexual orientation. Participants were recruited through advertisements posted on websites and paper questionnaires. Data were collected on 79 gay, 87 lesbian and 330 heterosexual (based on the Kinsey Scale (Kinsey, Pomeroy, Martin, & Gebhard, 1948), with ages ranged from 17 to 63 (heterosexuals M = 27.86, SD = 7.95; sexual minorities M = 27.95, SD = 7.39).
A *Background Information Questionnaire* (BIQ) was completed by all the participants to collect data about demographic characteristics. The *D'Amore and Green Same-Sex Parenting Scale* (D'Amore & Green, 2014) is a 14-item questionnaire that measures supportiveness towards same-sex parenting. The *Ambivalent Sexism Inventory* (ASI*;* Glick & Fiske, 1996) is a 22-item measure designed to assess sexist attitudes towards women. The two scales of sexism, hostile (e.g., "Women seek to gain power by getting control over men") and benevolent (e.g., "Many women have a quality of purity that few men possess") are assessed separately. The *Measure of the Internalised Sexual Stigma for Lesbians and Gay Men* (MISS-LG; Lingiardi et al., 2012) is a 17-item questionnaire (e.g., "I would prefer to be heterosexual" or "At the University and/or at work, I pretend to be heterosexual") designed to assess negative attitudes that lesbian and gay people have towards homosexuality in general and towards such aspects of themselves. The *Modern Homophobia Scale-R* (MHS; Lingiardi et al., 2015) consists of two parallel versions, which enable the assessment attitudes of heterosexual people towards gay men (MHS-G, 22 item) and lesbian

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women (MHS-L, 21 item). In the heterosexual sample we found that positive attitudes towards same-sex parenting were negatively correlated with sexism (benevolent and hostile dimensions) and sexual prejudice towards LGB people. In the sexual minority sample, we found a similar pattern of correlations, but we noted a positive association between attitudes towards same-sex parenting and internalised sexual stigma. Heterosexual people showed stronger sexist tendencies (hostile sexism: $F_{1,492} = 21.83$; $p < .001$; benevolent sexism; $F_{1,492} = 8.44$; $p < .01$), and more negative attitudes towards same-sex parenting (gay parenting: $F_{1,492} = 49.40$; $p < .001$; lesbian parenting: $F_{1,492} = 51.92$; $p < .001$) than sexual minority people; likewise, men reported a higher degree of sexism (hostile sexism: $F_{1,492} = 11.62$; $p < .001$; benevolent sexism; $F_{1,492} = 0.70$; n.s.) than women. Moreover, the relationship between sexism and attitudes toward same-sex parenting was mediated both by sexual prejudice in heterosexual people (complete mediation; $\beta = –.08$, $t = –1.61$, $p \geq .05$), and internalised sexual stigma in lesbians and gay men (partial mediation; $\beta = –.24$, $t = –3.22$, $p \leq .01$).

This present study aimed to investigate attitudes towards same-sex parenting in heterosexual and sexual minority people while examining the impact of sexism and sexual stigma. This research intended to fill a gap in the literature and extend knowledge about attitudes towards same-sex parenting taking into account the perspective of lesbians and gay men, who have rarely been investigated in literature. In detail, as often reported in the previous studies (Davies, 2004; Glick & Fiske, 1996; Glick et al., 2000), we found only a significant effect of gender (men reported a higher level of sexism than women) and sexual orientation (heterosexual people showed an higher level of sexism then sexual minority people). Data seems to suggest that negative attitudes towards same-sex parenting can reflect the socio-cultural inequalities and discriminatory behaviors based on the traditional gender belief system and the ideology embodied in institutional practices that work to the disadvantage of sexual minority groups. In the heterosexual sample, the mediated effect of sexual prejudice on negative attitudes towards same-sex parenting was larger than the direct effect of sexism. This evidence suggests that sexual prejudice, more than sexism, was able to legitimate and perpetuate ideological systems that denigrated same-sex parenthood (Capezza, 2007; Lingiardi et al., 2015). In the sexual minorities' sample, the mediated effect of internalised sexual stigma was lower and partially influenced the relationship between sexism and attitudes towards same-sex parenting.

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PSYCHOLOGICAL IMPACT OF VIOLENCE, ADVERSITY AND SOCIAL MARGINALITY

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Discomfort, poverty and violence can take on different meanings, and may present using different facets, moving from the concrete to the symbolic. These conditions concern both the person's emotional aspects and identity. In particular, violence could manifest itself not only physically, but also through by the lack of economic, emotional, personal and social resources. Violence can have an extremely wide range of effect that vary as a function of the type of assault and is related with sociocultural variables (Briere&Jordan, 2004). A number of studies indicate that specific characteristics of a victimization are associated with the severity of subsequent psychological outcomes and the frequency, severity, chronicity are linked with psychological distress, including PTSD, anxiety, depression, and other psychological symptoms (Dutton, 1992). The study takes place at Centro di Prima Accoglienza San Fedele in Milan and, according to the model of Lewin's action-research(1946), the idea is to combine the research to the intervention. In fact this center is an organization born in 1948 that have particular attention on social aspects and sanitary education. It provide service to people who lives in different need conditions and social marginality: migrant, elderly or homeless people, children and their relatives. The majority of these services users are women. These are the reasons why the research focuses on psychologicalfemale experiences linked to social discomfort, poverty and violence.
For evaluating the psychological impact of adversity and social marginality it was used a test battery created ad hoc, composed bya particular registry paper, General Health Questionnaire (GHQ-12), Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM). GHQ-12 is a 12 items toll use for assess people's overall psychological well-being (Piccinelli et al, 1993) and CORE-OM is a 34-item generic measure of psychological distress, yielding scores for four components: Well-being (4 items), Symptoms (12 items), Functioning (12 items) and Risk (6 items) (Palmieri et al, 2009). The preliminary sample is composed by 72 women (mean age: 42,80±12,81): 38,89% are European, 13,89% Asian, 30,56% African, 15,28% Sud-American. Results show that 69,44% of them suffer the consequences of a violence form, more

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specifically the 47,22% concerns difficulty in economic independence, the 29,16% is "psychological violence" and the 25% is "physical violence". Data display relevant levels of psychophysical impairment (m=17,79;d.s=±5,29), moderate levels of personal well-being (m=18,76;d.s=±8,32), global and social functioning (m=16,66;d.s=±6,01), and psychopathological symptoms (m=15,65;d.s=±9,31). Risk subscale score (self-destructive and aggressive behavior) is under the clinical cut off (m=3,88;d.s=±5,81). Moreover who have suffered psychological violence has higher levels of these variables (t=-3,54;p=,001),(t=-2,47;p=,016), (t=-2,83;p=,006) (t=-2,76;p=,011),(t=-4,67;p=,000). Whereas who suffer the consequences of a violence form, show more higher risk perception (t=2,73;p=,008) and more impairment in global and social functioning (t=-3,00; p=,004) than who not. The results underline psychological consequences produced by a specific type of violence in women who evidence adversity and social marginality. Furthermore, the wide variety of trauma-specific, historic, victim, and sociocultural factors, confirming that the clinical presentation are unique for each persons. According to different authors (Briere&Jordan, 2004; Krantz&Garcia-Moreno, 2005; Krauss, 2006) work on these aspects could be relevant in order to identify the emergence of discomfort and provide preventive psychological interventions.

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EFFECTS OF TREATMENT MODEL AND PATIENTS' ATTENDANCE ON OUTCOME INDICATORS IN TWO STRUCTURED THERAPEUTIC PROGRAMS FOR BORDERLINE PERSONALITY DISORDER

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Dialectical Behavior Therapy (DBT; Linehan, 1993) and *Group Experience Therapy* (GET; Visintini *et al*., 2015) are structured therapeutic programs developed for patients with severe Borderline Personality Disorder (BPD) features: more specifically, targets of these treatments are a pervasive emotional dysregulation, self-harm behaviors, impulsivity and impairment in planning skills, relational instability. Despite the common targets, DBT and GET are quite different for theorical background (respectively, cognitive-behavioral *vs* psychodynamic), types of clinical intervention (focused on mindfulness and commitment *vs* focused on mentalizing and in-session "corrective emotional experiences"), modalities of group management (learning pre-defined skills *vs* exploring effective strategies in group setting), and treatment frequency (in the first phase, 4-5 hours a week *vs* 9 hours a week).

The aim of the study is to evaluate DBT and GET effectiveness over one year, which covers the first phase of treatment for both programs. Particularly, analysis were conducted considering the contribution of treatment model and patients' attendance. More specifically, the aims of the study are the following ones: evaluate treatments' effectiveness examining if the distributions of target variables change across times, despite baseline differences between subjects; investigate the role of other factors, such as treatment programs and patients' attendance, on outcome indexes. The study is a randomized and interventional trial with a longitudinal design. The sample is comprised by 40

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subjects (6 males, 15% of the total sample), with a mean age of 27 years (*SD* = 8.32). Subjects have severe BPD features (mean BPD traits = 5, *SD* = 1.98), and were consecutively admitted to DBT or GET at San Raffaele Turro Hospital (Milan, Italy). Dimensions of emotional (i.e., ways to cope with negative emotions, anger) and behavioral (i.e., self-harm, impulsivity) regulation skills, and attitudes toward experiences and toward others (i.e., mindfulness) were assessed at the admission and regularly during treatment, every three months. Statistical analyses were conducted with Repeated Measures ANOVA, adding age, sex, and baseline scores as covariates. No differences were found between patients admitted to DBT or GET for socio-anagraphic (i.e., age, sex, education level) and clinical variables (i.e., dysfunctional personality traits, diagnosis of personality disorders, severity of self-harmful behaviors and suicide attempts) at baseline (all *p*s = n.s.). Significant changes were found for both treatments in almost all dimensions over one year; changes were detachable since three months of therapy in emotion dysregulation and self-harm behaviors (all *p*s < .005).

More specifically, a main effect of time was found for all scales and subscales; this was confirmed keeping constant the baseline scores for the following dimensions: Emotion dysregulation under intense distress (non-acceptance, lack of goals, lack of strategies, lack of clarity, and total score); Mindfulness skills (observe, describe, acting with awareness, non-judgmental stance, small reactivity to experiences, and total score); Tendency to act impulsively without planning consequences; Physical and verbal aggressiveness, feelings of anger, hostility, and aggressiveness total score. Slightly differences were found between treatment programs: DBT demonstrate a stronger effect on anger expression and on a non-judgmental stance, while in GET the control of impulsiveness, the awareness of somatic sensations, the clarity and the ability to describe of inner feelings seemed to improve faster than in DBT. However, RM ANOVA with treatment program added as covariate confirmed an effect of the variable only for the describe mindfulness skills. Moreover, RM ANOVA showed an effect of three-months attendance on mindfulness total scores, no reactivity to experiences, physical and verbal aggressiveness, hostility, and aggressiveness total score.

The effect was better explained by the interaction with treatment program, since it was detachable only for DBT. An effect of one-year attendance was found for impulsivity. Both DBT and GET seemed to be effective on behavioral and emotional BPD difficulties. Even if their overall effectiveness seemed to be adequate, they showed specific areas of change, suggesting therapeutic mechanisms only partially overlapping. Treatment programs and patients' attendance seemed to be

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distinguishable effects, indicating that differences between DBT and GET go beyond treatment frequency. Therapeutic action in DBT and GET need to be examined deeper for the implications for clinical practice regarding to common and specific factors in these BPD therapies. Other goals for further studies are examining the trend of change, the impact of patients' severity at baseline on the amount of change (i.e., suicide attempts in the last year, dimensions of personality such as self-directness or antagonism), the impact of personality profile or symptoms (i.e., alcohol/drugs abuse) on treatment completion.

Keywords: borderline personality disorder, psychotherapy, effectiveness

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TRAUMATIC EVENTS AND DISSOCIATIVE EXPERIENCES IN FIBROMYALGIA SYNDROME

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Fibromyalgia Syndrome (FM) is a chronic disease characterized by widespread pain and fatigue with an unknown etiology. Moreover, FM is characterized by a heterogeneous group of non-specific symptoms, such as sleep disturbances, mood disorders and neurocognitive impairment. A history of physical or psychological trauma [1,2] has been observed in FM patients. Although there are no studies confirming that trauma may causes FM, this could be an initiating and perpetuating factor in this syndrome. The high level of stress during and after a trauma may lead also to dissociation.
Dissociation refers to a mechanism allowing individuals to temporarily avoid emotional distress and to protect them from negative stimuli [3]. Individuals, who were exposed to traumatic experiences of emotional abuse and neglect in the context of child-caregiver interactions, consequently had less opportunity to process experiences with their feelings. Pedrosa[4] founded a higher lifetime prevalence rate for psychosocial victimization during childhood and adolescence (maternal abuse and paternal indifference) in patients with FM, which predicted higher scores on difficulty identifying feelings, a facet of alexithymia. The main objective of this study was to investigate the frequency of traumatic and dissociative experiences, and parental style in FM patients compared to healthy controls (HC).The current study moved from the hypothesis that FM patients tend to present higher level of dissociation and greater traumatic events than HC.
The participants were recruited in the Fibromyalgia Integrated Outpatients Unit of the "Città della Salute e della Scienza" Hospital of Turin. All participants completed, in the presence of a clinical psychologist, the informed consent and self-report questionnaires, which took approximately 20 minutes to complete. Traumatic events were assessed by the Traumatic Experience Checklist (TEC)[5], dissociative experiences was assessed using the Dissociative Experiences Scale (DES-II) [6]; the parental style was assessed using the Parental Bonding Instrument (PBI) [7].The TEC is a self-report questionnaire inquiring 29 types of traumatic events. Specifically,TEC addresses the setting and the age in which trauma occurred, the duration and the severity of trauma.The DES-II is

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a 28-item self-report measure of dissociative experiences. Items assess the percentage of time that individuals experience these symptoms. The PBI consists of 25 items, 12 of which refer to "care" and 13 to "overprotection" that subjects recall to have received from mother and father during their first 16 years of life. The study involved 112 participant, 57 women with a diagnosis of FM, mean (SD) age 50.2(10.5), and 55healthy women, mean (SD) age 43.6 (12.3). With respect to results, patients with FM reported significantly higher level of traumatic events than HC in particular in the area of emotive neglect and abuse ($p < .001$). The prevalence of dissociative experiences was significantly higher in FM patients compared to HC ($p < .001$) and a possible dissociative disorder seemed to be present in 19.3% of the patients with FM vs. 1.8% of HC. In patients with FM, but not in HC, there was a significant correlation between the amountof traumatic events and dissociative symptoms ($r = .351$; $p=.008$). As well as parental styles concerned, FM patients showed the following parental pattern: both mother and father showed lower care and higher protection scores than HC. These data highlight the presence of an "affectionless control" style in FM patients' parents compared to HC (55.3% vs. 18.5% father; 66.7% vs. 27.8% mother,respectively). On the contrary, results showed the limited presence of "optimal parenting" style, characterized by high care and low protection, in FM patients' parents compared to HC (16% vs. 39% father; 14% vs. 41% mother, respectively). The results, confirming our hypothesis, suggest that women with FM tend to present more traumatic events and more dissociative experiences than HC. Moreover, FM patients seem to have mostly experienced a parental style defined as "affectionless control". The identification of psychological variables could be an important key in realizing tailored psychological treatments focused on traumatic events of FM patients.

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THE INTERPERSONAL EXPRESSION OF PERFECTIONISM AMONG GRANDIOSE AND VULNERABLE NARCISSISTS: PERFECTIONISTIC SELF-PRESENTATION, EFFORTLESS PERFECTION, AND THE ABILITY TO SEEM PERFECT

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Trait perfectionism dimensions and narcissism have been extensively linked (for a review, see Flett et al., 2014). A growing interest has been directed to a particular type of perfectionist, "the narcissistic perfectionist", that is, people with grandiose ambitions and standards and associated attributes who feel like they are perfect or they could be perfect (Sorotzkin, 1985, 1998). The current research wants to focus on a different perspective of perfectionism, that is, on perfectionistic self-presentation, in keeping with recent work that takes an extended approach by conceptualizing the perfectionism construct not only in terms of trait perfectionism but also in terms of perfectionistic self-presentation (Hewitt et al., 2003). Perfectionistic self-presentation (PSP) involves the public interpersonal expression of perfectionism and includes three distinct dimensions: perfectionistic self-promotion (proactively promoting a perfect image), non-disclosure of imperfections (concerns over verbal disclosure of imperfections), and non-display of imperfections (concern over behavioral displays of imperfection).
Recently, this model has been expanded by adding two new dimensions: the need to appear perfect with apparent ease (Effortless perfectionism) and the self-confidence in the ability to present a perfect image (PSP capability). Individual differences in the self-perceived ability to seem perfect and the need to appear effortlessly perfect should be an important supplement to perfectionistic self-presentation and a potentially useful way of distinguishing *narcissistic grandiosity* versus *narcissistic vulnerability*. The existence of these two forms of narcissism was first conceptualized and examined by Wink (1991) and a considerable body of psychology literature has confirmed the existence of two orthogonal constructs of narcissism. Grandiose (or overt) and vulnerable (or covert) narcissism share some core traits, such as a sense of entitlement and grandiose fantasies. However, vulnerable narcissism, but not grandiose narcissism, is largely marked by hypersensitivity, defensiveness, and insecurity (Dickinson & Pincus, 2003). Previous research suggests that overt and covert narcissists are motivated to give others an image of perfection (Sherry et al., 2014).

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The present research aims to build upon previous results on the association between the two forms of narcissism and perfectionistic self-presentation by including a) the perception of one's ability to display an image of perfection; and b) the tendency to appear perfect by hiding effort. We investigated whether these two new elements of perfectionistic self-presentation could account for additional variance in grandiose and vulnerable narcissism beyond that explained by the other three facets of PSP. A sample of 305 undergraduates (54.2% F; mean age: 22.62 $\pm$ 3.081) was recruited. The following self-report were administered: Narcissistic Personality Inventory (NPI), Hypersensitive Narcissism Scale (HSNS), Perfectionistic Self-Presentation Scale (PSPS), Perfectionistic Self- Presentational Capability Scale (PSPCS) and the Effortless Perfectionism Scale (EPS). Two hierarchical regression analyses were conducted.

The inclusion of the PSPCS and the EPS accounted for an additional statistically significant amount of variance of overt narcissism scores (respectively 2.3% and 2.8%) beyond the 5.3% of variance explained by PSPS subscales. The higher the overt narcissism the higher the tendency to promote a perfect image, the perception to have the ability to appear perfect and the feeling of pressure to be perfect without visible effort. On the other hand, the final model explained 29% of the variance of covert narcissism. The inclusion of PSPCS added a significant amount of variance to the model (2.7%) whereas a significant effect of EPS was not found. The higher the covert narcissism, the higher the tendency to proactively promoting a perfect image, the concerns over behavioral displays of imperfection and the lower the self-confidence in the ability to appear perfect. The overall pattern of results highlighted the importance of distinguishing narcissistic grandiosity and narcissistic vulnerability and the usefulness of an extended conceptualization of the perfectionism construct. First, it was evident that the concept of perfectionistic self-presentation is much more relevant in vulnerable narcissism relative to grandiose narcissism.

Grandiose narcissism was associated weakly - but significantly - with perfectionistic self-promotion and effortless perfection. There was also evidence suggesting that this form of narcissism was associated with more positive appraisals of the capability to seem perfect. In contrast, stronger and more pervasive links between perfectionistic self-presentation and narcissism were found for vulnerable narcissism. Students with high levels of vulnerable narcissism had desires to seem perfect but they had negative self-appraisals of their capability of seeming perfect.

The results of our regression analysis showed that effortless perfection did not predict unique variance in narcissistic vulnerability beyond the three PSP facets, but it was clearly the case that individual differences in the capability to seem perfect was a unique predictor. Collectively, these findings suggest that vulnerable narcissists might be attuned to their public image, but this might be

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a defensive process that reflects a core sense of inadequacy that extends to but is not limited to a sense of inefficacy about being able to project and maintain a positive public image. Besides the limitations of the study (e.g. the cross-sectional design, the use of self-reports), the current findings have theoretical and practical implications. The findings illustrate the need for a broader focus on self-presentational concerns in models of narcissistic personality. At the practical level, vulnerable young people who are both perfectionistic and narcissistic may be hiding their distress and underlying sense of inadequacy and lack of efficacy. It is important for clinicians to address the core self and identity issues that underscore their outward narcissism.

CHILD RUMINATION INTERVIEW VALIDATION: A CHILD-FRIENDLY TOOL TO ASSESS RUMINATION IN KIDS

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Rumination is a cognitive process characterized by an abstract, repetitive, and negative thinking style. In spite of its crucial role for the prevention of distress and the promotion of well being in children, the construct of rumination in childhood has received little attention in the scientific literature. One of the possible causes of such neglect may rely in the absence of appropriate tools to assess rumination in this age group. To overcome this limitation, the present study first aimed at validating a child-friendly tool (Children Rumination Interview; CRI) to be used in a sample of aged 6-12 years. **Methods.** The sample was composed of 49 males and 51 females, aged between 7 and 12 years (N = 100; average age =9.35 ± 1.13 years) in medium-high socioeconomic status, attended school in Italy's central regions.
Children/preadolescent's rumination was assessed through a semi-structured interview developed ad hoc for this study. In addition to the interview, participants were individually administered a battery of self-report standardized questionnaires. We used Children's Response Style Questionnaire to examine concurrent and discriminant validity. The average time needed to complete the session was 20-30 minutes. *Children Rumination Interview*. The Children Rumination Interview (CRI) is a children-friendly instrument that uses vignettes and cartoons to assess rumination tendencies in

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children and preadolescents aged 7 to 12 years. Compared to other self-report linguistic instruments, this illustrated tool has the advantage to be usable with samples speaking any language. The CRI has two comparable versions, one for males and one for females, and depicts four unpleasant prototypical events that may trigger ruminative thoughts: 1) alone (i.e., looking at his/her broken toy); 2) with his/her parents (i.e., being reproached because his/her room is a mess); 3) with friends (i.e., being teased by his/her mates); 4) at school (receiving a bad grade from the teacher). For each of these cartoons, the child is first asked to describe the scene to ensure accurate understanding, then to report if the depicted event has ever occurred to him/her.

As an important feature of rumination is the persistence of unpleasant thoughts over time, well beyond the occurrence of the event itself, each situation also includes three further vignettes in which the same event is represented as a cartoon in the children's head. Three different times after the occurrence of the event are depicted: a few hours after, before going to sleep, and the next day. For each of these three vignettes, the participant is asked to report on a 5-point Likert scale (from 1 = never to 5 = always), how often he/she happened to think about the unpleasant event. Levels of sadness, happiness and anger may be optionally assessed at the beginning and the end of the task by the use of cartoons representing a Likert scale (from 0 = not at all to 5 = very much). *Children's Response Style Questionnaire*.

The Children's Response Style Questionnaire (CRSQ; Abela et al. 2000) has been derived from the adults' Response Style Questionnaire (Nolen-Hoeksema and Morrow 1991). It is a self-report instrument consisting of 25 items divided into three subscales: rumination, distraction and problem solving. Respondents are asked to indicate how often (from 0 = almost never to 3 = almost always) they engage a specific behavior when they experience sadness. Cronbach's alpha in the present study ranged from .73 to .81 for the different subscales. An explorative factor analysis was conducted on the initial set of 13 items, using the PAF. Factor analysis yielded two main factors: personal life-related rumination (31.1% of the total variance) and school-related rumination (12.9% of the total variance).

Cronbach's α was .80 for the first and .74 for the second dimension. A 2x2 factorial MANOVA was performed to test for the effect of gender and age (7-9 years vs. 10-12 years) on the two CRI factors and the total score. Significant gender (Wilks' $\lambda = 0.88$; $F(3,94) = 4.14$, $p < .01$, $\eta 2 = 0.12$) and age (Wilks' $\lambda = 0.82$; $F(3,94) = 6.87$, $p < .01$, $\eta 2 = 0.18$) effects emerged. The analysis did not yield any gender X age interaction effect. Older (10-12 years) and female participants showed higher tendencies to ruminate about school issues compared to their younger (7-9 years) and male counterparts. A positive correlation emerged between total score CRI and Rumination scale CRSQ

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(r= .45; p<.01), proving the concurrent and discriminant validity. There wasn't correlation between total score CRI and Distraction and Problem solving scale CRSQ (r=.04; p<.01; r=-.06; p<.01). It was checked the reliability both subscale identified in the factor analysis. For the first subscale (personal life-related rumination) α Cronbach =.80; for the second subscale (school-related rumination) α di Cronbach =. 74. The effect of age is not surprising if we consider that our age range encompasses the transition from elementary to middle school (at 11 years). As to gender differences, a meta-analysis found small but significant differences in rumination between boys and girls in childhood (d = .14) and adolescence (d = .36), with girls more likely to ruminate than boys (Johnson & Whisman 2013). Our data suggests that such effect sizes may increase if different types of rumination are taken into account. Overall, results point to the fact that gender disparities in rumination may emerge early during the development. The CRI appears as a promising tool to assess rumination in children/preadolescents and suggests partially different pathways to specific forms of ruminative thoughts.

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MOTHER-TODDLER FEEDING INTERACTIONS IN PRETERM AND FULL-TERM DYADS: THE INFLUENCE OF MATERNAL AND INFANT FACTORS

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The literature has highlighted that feeding disorders of infancy and early childhood are associated with the mother-child relationship (Ammaniti et al., 2004, 2006; Chatoor, 1996, 2002, 2009; Satter, 1990; Trombini & Trombini, 2006, 2007; Trombini, 2010). Both the mother's and the child's characteristics may influence the development of feeding issues in the child (Chatoor, 1996; Farrow and Blisset, 2006). Premature children seem exceptionally vulnerable for the development of feeding difficulties, particularly those born with very low birth weight and very low gestational age (Pierrehumbert et al., 2003; Thoyre, 2007). They can experience difficulties in breastfeeding (Zanardo et al., 2011; Torola et al., 2012) and weaning (Mathisen et al., 2000; Burklow et al., 2002), and mismatched interactions with their mothers (Reyna, 2012). However, mother-child feeding interactions have been poorly explored in the preterm population, especially during toddlerhood, which represents a vulnerable time for the onset of feeding disorders connected to the child's emerging autonomy (Lichtenberg, 1989; Lucarelli et al., 2003; Trombini & Trombini 2006, 2007; Trombini, 2010).

Aim of the study was to expand on the literature and to explore, through a longitudinal, transactional and multi-risk model, the quality of mother-child feeding interactions from 18 to 30 months, an important time-frame form the development of the child's self-feeding skills, comparing preterm and full-term dyads. The contribution of maternal affective state (depression, anxiety) and of several child's risk factors associated with prematurity (global level of development, breastfeeding, weaning, and reflux) was considered. A total of 69 mother-child dyads participated in the study: 44 preterm dyads (18 males and 26 females; born with birth weight $\leq$ 1500 grams and gestational age $\leq$ 32 weeks, and without neonatal major cerebral complications or genetic syndromes) and 25 full-term dyads (15 males and 10 females; born with birth weight > 2500 grams and gestational age > 36 weeks, and without neonatal major cerebral complications or genetic syndromes). Most of the mothers were Italian, married or cohabiting with the father of the child,

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employed and with middle-high school education. All dyads were assessed at 18, 24 and 30 months (corrected age for preterm children) at the Psychodynamic Laboratory of the Department of Psychology, University of Bologna (Cesena, Italy). During each assessment 20 minutes of mother-child feeding interaction were video recorded during the meal from behind a one-way mirror and later coded by two trained and blind raters through the Scala di Valutazione dell'Interazione Alimentare (SVIA; Ammaniti et al., 2006). The child's global level of development was assessed through the Griffiths scales (Griffith, 1996) and mothers were administered the Beck Depression Inventory-II (BDI-II; Beck & Steer, 1996) and the State-Trait Anxiety Inventory (STAI; Spielberger, 1983) to screen for maternal depressive and anxious symptomatology.

Data on the child's breastfeeding, weaning, and reflux were gathered through an ad hoc questionnaire administered to the mothers. First, Pearson's Chi-Square and Student's t test were run to investigate differences between the preterm and the full-term group in demographic and obstetric variables. Second, the effect of group (prematurity), time of assessment, and their interaction on mother-child feeding interactions were tested through two-levels Linear Mixed Models (LMMs) with random intercept, controlling for maternal affective state (depression and anxiety) and child's factors (development, breastfeeding, weaning, reflux). Last, when necessary, Bonferroni post hoc test was used for multiple comparisons. The two groups resulted homogeneous for what concerns the child's gender and maternal socio-demographic characteristics. Regarding feeding interactions in preterm and full-term dyads, a significant effect of group emerged, with more problematic interactions in the preterm group. In particular, preterm dyads showed greater negative maternal affective state (anger, sadness and distress during the child's meal), greater interactional conflict (maternal high intrusiveness, child's oppositional behavior and food refusal), and less dyadic reciprocity (maternal difficulties in supporting the child's autonomy and child's distress) than full-term dyads during meals.

Moreover, for what concerns the effect of maternal and infant factors, interactional conflict and maternal affective state during meals were negatively influenced by maternal depression, while low dyadic reciprocity was associated with low child's development. Last, poor child's food intake was related to low child's development, lack of breastfeeding, and presence of reflux. For what concerns the effect of time of assessment, the level of interactional conflict during meals decreased significantly from 18 to 30 months, independently of the group, as emerged at Bonferroni post hoc test. However, scores of preterm dyads remained higher, thus indicating greater conflicts during meals, than in full-term dyads. No interaction between group and time of assessment emerged. These findings suggest that attention should be paid to support mother-child feeding interactions

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during toddlerhood in the preterm population in order to foster the mother-child relationship and to promote the child's healthy eating behaviour. Moreover, results confirm the importance of monitoring maternal affective state, especially maternal depression, and the child's development when evaluating mother-child feeding interactions.

STRESSFUL LIFE EVENTS AND PSYCHOSOMATIC SYMPTOMS IN FIBROMYALGIA: A CASE-CONTROL STUDY

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Fibromyalgia Syndrome (FM) is a chronic musculoskeletal pain disorder
characterized by widespread pain and muscle tenderness. The prevalence of FM is estimated between 2.9% and 4.7% in the general population and it is more common in women than in men. Even if the etiology and the evolution of FM are still unclear, the development and maintenance of the syndrome may be due to a complexity of factors ranging from genetic to psychological factors. What is more, FM is often associated with a heterogeneous group of other symptoms, i.e. fatigue, disrupted or non-restorative sleep, hyperalgesia and allodynia, cognitive disorders, alexithymia, depressive and anxiety disorders and stressful life events.
Objective: The purpose of the study is to evaluate the prevalence of psychological distress, alexithymia, psychosomatic symptoms and stressful life events in a group of patients with FM, compared to a sample of patients with Rheumatoid Arthritis (RA). RA is a chronic, systemic, inflammatory, autoimmune disorder affecting the synovial membrane of multiple and symmetrical joints. The causes are still not completely understood, but complex interactions of genetic susceptibility, immunological and inflammatory processes, as well as environmental factors, contribute to the risk for and course of RA. Since RA is a chronic pain condition, but with minor psychosomatic symptoms, we hypothesized that the psychological components could be more elevated in FM. Sixty-one consecutive female with FM, attending the "*Città della Salute e della Scienza*" Hospital of Turin (Clinical Psychology Unit, Prof. Torta) and 75 consecutive female with a diagnosis of RA (Rheumatology Unit) were enrolled in the study, after giving written informed consent.
Psychological distress was assessed by the Italian version of the Hospital Anxiety and Depression Scale (HADS), a self-reported questionnaire. It is divided into two subscales: anxiety (HADS-A) and depression (HADS-D). Alexithymia was measured using the Italian version of the 20-Item Toronto Alexithymia Scale (TAS-20), the most commonly used measure for this construct. TAS-20

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has a three factors structure which reflect the three main facets of the alexithymia construct: a difficulty in identifying between subjective feelings and bodily sensations (DIF), a difficulty describing one's emotions to other people and (DDF) and an externally oriented thinking (EOT). Psychosomatic symptoms were assessed by the Diagnostic Criteria for Psychosomatic Research (DCPR), a semi-structured interview that includes various diagnostic types: abnormal illness behavior (disease phobia, thanatophobia, health anxiety, and illness denial), somatization syndromes (persistent somatization, functional somatic symptoms secondary to a psychiatric disorder, conversion symptoms, and anniversary reactions), irritability (irritable mood and type A behavior), demoralization, and alexithymia. TEC is a self-report questionnaire about 25 types of potential trauma, including criterion A events of PTSD, as well as other potentially traumatic events. The study involved 136 participants, 61 women with a diagnosis of FM, mean (±SD) age 50.2 (±10.5), and 75 women with a diagnosis of RA, mean (±SD) age 53.8 (±9.7). There were no significant differences between the FM and AR neither in age not in the years of education. FM patients reported significantly higher levels ($p < .001$) of psychological distress (HADS), both in the subscale of anxiety and depression. As well as alexithymia as concerned, FM patients reported significantly higher levels ($p < .001$) of difficulty in identifying emotions (TAS-20, DIF subscale), compared to RA patients. On DCPR, FM patients showed a significantly higher prevalence ($p < .001$) of persistence somatization, demoralization, conversion symptoms and anniversary reaction, compared to patients with RA. What is more, TEC results highlighted that FM patients reported significantly more traumatic events than RA patients on total score ($p < .001$).
Particularly, FM patients reported significantly higher scores on the composite subscales of emotional neglect and emotional abuse in childhood ($p < .001$). The present study revealed not only a higher presence of psychological distress, but also a higher prevalence of psychosomatic symptoms and a greater number of lifetime trauma in patients with FM, compared to RA patients. Moreover, emotional abuse and neglect in childhood were more often reported in FM than in RA patients. Further studies are needed to better clarify if the exposure to trauma in the past could predispose to the development of FM, with a reduction in the stress responsiveness and an increase of the symptomatology. In conclusion, these results highlight the importance of a multidisciplinary approach, which takes into account also the psychological aspects in the treatment of FM.

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THE LAUSANNE TRILOGUE PLAY IN THE EVALUATION OF ADOPTIVE PARENTS: A QUALITATIVE RESEARCH

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Between the 2009-2016 a research group has been established in a public sanitary service to develop a procedure able to integrate narrative tools, based on a psychodynamic approach, with the Lausanne Trilogue Play (Fivaz Depeursinge, Corboz Warnery, 2000) based on a role playing simulation with the goal to explore the co-parental functioning. The hypothesis at the basis of this integration was born during a clinical application of this observational tool with some adoptive families in difficulty with their sons. During the observation of these families, we discovered some recurring dysfunctions related to specific alliance systems: child centred or characterized by the involvement of a unique parent with his/her adoptive son (Mazzoni, Lubrano Lavadera, Di Benedetto, Criscuolo, Mangano, 2015). The research has been realised through a qualitative method, since we have not found standardised procedures in the literature on the use of LTP prenatal in the pre adoption evaluation. Besides, the narrative procedures in use in our sanitary service were not homogeneous within the psychologist referents for the evaluation. The protocol of the research had been organized in two phases. First phase: **(1) Constitution of a team research** based on six participants, three psychologist referents for the evaluation and three psychologists trained on the LTP, but not belonging to the evaluation group; The team research had the task to define: the delivery, the space organization, the possible media useful for the role play simulation with a doll, the greed to codify the expected behaviours; **(2) Process consensus** realized by the comparison with an expert of LTP Prenatal (Dr. A.Simonelli); **(3) Network** with all the social workers and psychologists who had the task to evaluate pre adoptive couples. Second phase: **(1) Application of the LTP prenatal to 30 couples** at their first offer of adoption; **(2) Systematization of the contents** emerging from the anticipation phase: “Imagine a possible mate with a child. How old is he/she, which is his/her history? Does she/he has a special need?”, of the data from the simulation with a doll and of the contents in the phase of the sharing process(reflective phase) : “How has been the game? How have you seen each other in the parent role?”; **(3) Follow up after a child enters** in the family through a new LTP administration. While the teamwork was adapting the setting of the LTP Prenatal to the pre adoptive evaluation, some knots had been solved: (a) In the

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pre adoptive phase, differently of the pregnancy, there is not a baby. The couples are in a desire situation; (b) The child that could be combined is unknown; (c) The grid elaborated by Fivaz and her team was structured on a new born; (d) The context was stressful because of the evaluation context. The 48% of the couple we have evaluated for their first adoption were in the age range 40-49. The 8% were in the range 50-55, while the 44% had an age between 30 and 39. In the *anticipation phase*, the 48% have imagined to be mated with children between 3-4 years old, the 32% to be mated with younger children between 1-2, the 20% with children in the range 6-8. In practice, despite the majority of our sample was more the 40 years old, the couples imagined themselves in a context of primary care with a little child. The 75% of the couples presented a good *co-parental alliance*, while the 25 entered in a dysfunctional area. In the networking with the referents for the couple often a variance emerged between the narrative evaluation and the interactive one. The interactive let emerge a better image on the couple's competence. The interpretation of this variance is that the LTP projected the couple toward the future and that the triadic situation let emerge the resources instead of what was negative in the past. In the reflective phase, nobody criticized the game, but all appreciated it. Some of them underlined the difficulty to interact with a doll and most of them were emotional looking each other in a parental character. All of them were aware that the game was a simulation and not a guarantee of a real mating. Since the time for a mating process is very long in Italy, we have had only three couples back with a child. Therefore, we do not have data for establish a specific prognosis for the adoption respect what is in literature on the predictive ability of the LTP prenatal. The application of LTP prenatal to the pre-adoption has required the manufacturing of different dolls to adapt the setting to the different age of the adoptive children. The definition of a disclosure phase, in which the couple could define the profile of a baby to play their intuitive abilities, and a *reflective phase* through which the coupe could return to the reality of the evaluation context, has been necessary to favour a good performance. Two positive aspects of this research have been: 1-the LTP has put the couple in more active position in the evaluation process (reflective phase);2- it has reduced the referents subjectivity thanks to the use of an intersubjectively validated tool and of the possibility to share opinions with colleagues not involved emotionally with the couple.

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A PILOT RANDOMIZED CONTROLLED TRIAL OF RELAXATION TRAINING FOR PATIENTS WITH STABLE SYMPTOMATIC MODERATE/SEVERE COPD

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Chronic Obstructive Pulmonary Disease (COPD) is a complex, debilitating and preventable lung condition, characterized by a persistent airway obstruction with different degrees of impairment (GOLD, 2016). The clinical symptoms can be increased by short-term depressive symptoms, dysthymia or clinical depression, affecting also the treatment adherence (Maurer, 2008) and activating a sensation of anxiety. Relaxation techniques, which are widely used in rehabilitation or in the mainframe of Cognitive Behavioral Therapy (CBT), improve coping skills, with a moderate impact on well-being, respiratory functions and QoL. The aim of this study was to investigate the feasibility and the short-term effects of one-session relaxation training, based on natural breathing, on stable symptomatic moderate/severe COPD patients. We conducted a two-arms, single-blind (participants), Randomized Controlled Trial (RCT) on a convenience sample of 38 COPD patients. They were recruited from the HD Respiratory Unit of Fondazione Don Carlo Gnocchi, in Milan, Italy. *Inclusion criteria*: diagnosis of COPD; age ≥18 years; basal FEV_1<70%, using the standards established by Global Initiative For Chronic Obstructive Lung Disease (GOLD)(GOLD, 2016); British Medical Research Council questionnaire (mMRC) ≥2 (Bestall et al., 1999); COPD Assessment Test (CAT) ≥10 (P. W. Jones et al., 2009). *Exclusion criteria*: pregnancy, psychiatric disturbances, oncological diseases, immunosuppressive condition. Patients were randomly allocated 1:1 to one of two groups with a computer-generated list.
The study was approved by the Ethical Committee of the IRCCS Santa Maria Nascente and the Ethical Committee IRCCS Regione Lombardia. It was registered in clinicaltrials.gov: NCT02698904. **Intervention:** participants in the experimental group (EG) listened to a relaxing audio track, based on natural breathing, for eleven minutes. They lied down on a rigid bed with a

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pillow to facilitate muscle release and listened to the audio track with a pair of headphones. The control group (CG) watched a documentary that included neutral contents and which had the same duration as the relaxation audio in a similar setting to that explained above. At the baseline assessment, and after the intervention, participants were assessed on: *Pulmonary and physiological functions*: The modified British Medical Research Council (mMRC) (Bestall et al., 1999), the COPD Assessment Test (CAT) (P. Jones et al., 2009), the BORG scale (Kendrick, Baxi, & Smith, 2000) to assess the health status impairment and the degree of dyspnoea. We detected Forced Vital Capacity (FVC), Forced Expiratory Volume in the First Second (FEV_1), FEV_1/FVC. the measurement of airway resistance (kPa/l/s), the heart rate and oxygen saturation. *Psychological state*: The Visual Analogue Scales (VAS) ; the State-Trait Anxiety Inventory - Y1 (STAI) (Spielberger C, 1970) and the Positive and Negative Affective Schedule (PANAS) (Watson, Clark, & Tellegen, 1988). Data analysis was conducted with the SPSS software. Given the relatively small sample and the expectation of a non-normal distribution, we opted for the use of non-parametric tests (Mann-Whitney U Test and Wilcoxon Test). The significance level was set to .05, two-tailed. We recruited 38 participants (mean age 72.66; SD=8.68). All participants had moderately severe chronic airflow limitations with an average FEV_1 of 54.21%. We found a significant increase in SpO_2 within EG (z = -2.672, p =0.008) as well as an improvement in the heart rate (z = -3.576, p <0.001; U = 95, z = -2.504, p =.012) and a significant change in the level of dyspnoea intensity within EG (z = -3.002, p = 0.003). The state anxiety denoted a significant change in the EG (z = -3.771, p <.001; U = 104.5, z = 2.223, p =.026). Finally, there was a significant change about the negative affects in both groups (EG: z = -3.127, p =.002; CG: z = -3.186, p =.001) and about the positive affects only in the EG (z = -2.581, p =.010). There were also significant differences between groups about emotional states, assessed by VAS (U = 108, z = -2.129, p =.033). This study showed that a relaxation technique has the potential to induce significant improvements in physiological functions, as well as a positive emotional effect and a reduction in anxiety levels. However, it is short-term and its conclusions must be confirmed by further studies.

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