

## Parent-therapist therapeutic alliance - a neglected factor in pediatric speech-language intervention: A longitudinal study

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### ABSTRACT

**Background:** The therapeutic alliance (TA) has been widely used to explain variations in psychotherapy, but its role in pediatric speech-language therapy remains underexplored.

**Aims:** This longitudinal study examined whether the TA between speech-language therapists (SLTs) and parents of children undergoing speech-language intervention predicted therapeutic outcomes and whether it moderated the effects of parental psychological factors.

**Methods:** Forty-one parents of children aged 3–12 years and 12 SLTs participated in a 12-week intervention. SLTs rated child disorder severity at onset, TA after two sessions, and therapeutic outcomes at completion. At the onset of therapy, parents completed measures of caregiving style, perceptions of their child, and child-related emotions. Hierarchical regression models assessed predictors of therapeutic outcomes, and moderation analyses tested interactions between TA and parental variables.

**Results:** Background variables explained 18% of the variance in therapeutic outcomes. Adding parental psychological variables increased the explained variance to 40%, and including TA significantly increased it to 50%. Stronger TA predicted better therapeutic outcomes, while greater disorder severity, compulsive caregiving, and highly positive parental perceptions of the child predicted poorer outcomes. Importantly, the moderation analysis indicated that a strong TA buffered the negative impact of compulsive caregiving on therapeutic outcomes.

**Conclusions:** Findings underscore the role of early parent-SLT alliance in promoting therapeutic success and mitigating the negative effects of intrusive parenting. Clinicians should prioritize building a strong TA with parents and address parental psychological factors as part of pediatric speech-language therapy. Future research should include parent-reported alliance and independent outcome measures, in longitudinal multi-informant designs.

In recent decades, both research and clinical practice have increasingly focused on the positive role of therapeutic alliance (TA), a

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*collaborative relationship between therapist and patient*, in achieving treatment goals. Although the impact of the TA in psychotherapy has been extensively studied (see Horvath et al., 2011), relatively fewer studies have explored this topic in the context of speech-language therapy. Even fewer have focused on pediatric speech-language therapy (e.g., Ebert, 2017; Fourie et al., 2011). Most studies emphasize subjective experiences, without systematically exploring how TA may predict the attainment of pediatric speech-language therapy's goals (Hansen et al., 2024). Moreover, these few studies have primarily focused on the child-therapist alliance and have not addressed the parent-therapist relationship. The current study aims to address this gap through a longitudinal design, examining the predictive value of the parent-therapist TA on outcomes over a 12-week course of pediatric speech-language intervention.

## 1. Therapeutic alliance in psychotherapy

*Therapeutic alliance* (TA) has been found to be a key component of effective therapy and to facilitate the achievement of treatment goals (Safran et al., 2006). Bordin (1979) outlined three core components of strong TA. First, client-therapist agreement on treatment tasks; that is, a mutual understanding of the activities the clients must engage in to progress in treatment. Second, client-therapist agreement on treatment goals; that is, a shared vision of the intended outcomes of the therapy. Third, client-therapist emotional bond; that is, the extent to which the client is emotionally connected to the therapist, and feels close and secure on the therapist's goodwill, responsiveness, and support in times of need.

A literature review by Feinstein et al. (2009) broadened the scope of research on TA by highlighting that a strong alliance between parents of children in psychotherapy and the children's therapist is associated with positive clinical outcomes. They further propose that this TA not only supports the child's therapy but also serves as an active mechanism of change within the therapeutic process. This parent-therapist relationship, regarded as a "facilitative condition" (Alexander & Dore, 1999), was associated with higher treatment retention (Hawley & Weisz, 2005), stronger treatment engagement, and reduced symptom severity (Joshi, 2006). Finally, a recent review by De Greef et al. (2017) identified child age and diagnosis as key factors that may moderate the association between parent-therapist alliance and therapeutic outcomes. In the current study, we controlled for these factors.

Recently, the strength of TA has also been found to contribute to clinical outcomes in other kinds of therapy beyond psychotherapy. For example, Thomas et al. (2023) highlighted the capacity of General Practitioners to build deep, trusting relationships with their patients, thereby fostering a sense of safety and security during moments of vulnerability – a hallmark of a strong TA. Indeed, a systematic review found this supportive patient-therapist relationship to be associated with better medical health outcomes (Baier, Kline & Feeny, 2020. See also: Starfield et al., 2005). However, less evidence is available on other therapeutic fields, such as speech-language therapy, and on the parent-therapist alliance in the context of pediatric speech-language therapy.

## 2. Therapeutic alliance in speech-language therapy

The therapeutic process for children with speech and language difficulties is multifaceted and often demanding, requiring consistent practice, openness, and adherence to recommendations (ASHA, 2022). Effective intervention requires speech-language therapists (SLTs) to address each child's unique strengths and challenges, tailoring plans to empower the child and support parental behaviors. By creating repeated opportunities to explore effective communication in diverse contexts, including at home (i.e., therapeutic continuity), SLTs can facilitate therapeutic progress and improve clinical outcomes (Ebbels et al., 2019; Siu, 2015).

Although TA has been extensively studied in psychotherapy, its role in speech-language therapy is only recently gaining empirical attention (Connery et al., 2022). Evidence is beginning to emerge that TA may influence outcomes in diverse populations, including children who stutter and individuals with acquired communication disorders such as aphasia (Hansen et al., 2024). These findings suggest that the relational aspects of therapy, particularly the alliance between SLTs and caregivers or clients, warrant closer examination in the context of pediatric speech-language interventions.

More generally, the literature has underemphasized the parent-SLT relationship, despite its central role in treatment adherence, and therapeutic progress (Sønsterud et al., 2019; Rustin, 1995). Beyond accompanying their children to sessions, parents are key agents in therapy, responsible for implementing strategies at home and supporting practice beyond the clinical setting, thereby directly influencing treatment intensity and outcomes (Siedlik et al., 2023; Sugden et al., 2019). Indeed, parents often view themselves as co-workers in their child's communication development (Davies et al., 2017).

Recent research highlights that effective parent-SLT collaboration depends on mutual trust, clear communication, responsiveness to family needs and constraints, shared decision-making and goals (Melvin, Meyer & Scarinci, 2020; Pritchard et al., 2025). Klatte et al. (2020, 2024) emphasize fostering continuity between clinic and home-based practices, and urge consideration of the perspectives of both therapists and parents alike. In this respect, contextual factors, such as parental confidence, time demands, and cultural expectations, shape how parents engage with SLTs and enact therapeutic recommendations (Leafe et al., 2025). Together, this literature suggests that the formation of a collaborative relationship between parents and SLTs (a strong parent-SLT therapeutic alliance) may support parental engagement and optimize children's speech and language outcomes (Division for Early Childhood 2014).

Given the unique child-parent-SLT triad, the strength of the parent-SLT therapeutic alliance is essential for supporting the child's progress. The SLT can function as a supportive figure for parents as well, offering guidance, reassurance, and expertise that empower them to engage confidently in their child's care. This kind of support (*secure-base* provision; Mikulincer & Shaver, 2023) enables parents to explore new strategies and support their child's communication and emotional needs outside the clinic. The SLT can also provide what Mikulincer and Shaver (2023) called a *safe haven* – a non-judgmental, supportive space where parents can express concerns, process challenges, and seek advice related to raising a child with communication difficulties.

### 3. Parental characteristics and parent-SLT therapeutic alliance

In pediatric therapy, whether psychological or medical, clinical outcomes are influenced not only by the strength of TA with the therapist but also by other parental factors. Although a broad range of parent-related factors may influence engagement in pediatric interventions (e.g., parents' capabilities, external opportunities, motivation, see [Michie et al.'s, 2011](#), COM-B model), we focus on a more circumscribed set of parental factors that are theoretically and clinically proximal to the quality of parent-child relationship and the formation of the parent-SLT alliance. Specifically, we focus on parents' caregiving style and their emotions toward, and perceptions of, the child. These are relatively stable relational factors that shape parents' availability, flexibility, and tolerance of uncertainty in caregiving contexts, as well as their capacity to collaborate with professionals under conditions of concern about the child ([Dix, 1991](#); [Mikulincer & Shaver, 2023](#); [Taubman-Ben-Ari, 2022](#)). In contrast to more distal contextual constraints (e.g., time, resources, or access), these relational factors are directly enacted within therapy sessions and in parent-child interactions at home. Accordingly, these theoretically grounded, alliance-relevant factors are likely to shape both collaboration with the SLT and the translation of therapeutic recommendations into everyday practice.

Research has shown that parental caregiving characterized by compulsive or anxious over-involvement (in contrast to responsive caregiving style) seems to be associated with worries about their self-worth and competence ([Shaver et al., 2011](#); [Stern et al., 2018](#)) and can negatively impact the child's mental health, self-image, coping abilities, and sense of competence (e.g., [Segrin et al., 2013](#); [Schiffman et al., 2014](#)). In addition, parents' positive emotional experiences while interacting with, or thinking about, their child (e.g., joy, pride, and affection) are associated with more parental engagement and a stronger sense of parental competence. Conversely, parents' negative child-related emotional experiences (e.g., frustration, guilt, and anxiety) seem to hinder parental engagement, availability, and supportiveness ([Dix, 1991](#); [Taubman-Ben-Ari, 2022](#)). Similarly, perceiving the child as warm and affectionate, in contrast to demanding or invasive, is associated with positive child-parent interactions and a greater sense of parental efficacy ([Chasson et al., 2021](#); [Oates et al., 2018](#); [Taubman-Ben-Ari, 2022](#)).

Taken together, these parental factors might improve or hinder the child's progress within speech-language therapy. Parents who adopt a sensitive pattern of parenting, who perceive their child as affectionate, and experience related positive emotions, might better collaborate with both the SLT and the child in therapeutic tasks and contribute to better clinical outcomes. By contrast, adopting an over-involved style of parenting, perceiving the child as demanding, and experiencing child-related negative emotions, might create relational tensions and conflicts, thereby impeding therapeutic progress. On this basis, we decided to include these parental factors in the current study, examining their contribution to parent-SLT therapeutic alliance and clinical outcomes in pediatric speech-language therapy.

### 4. The current study

The existing literature highlights the need for a dedicated longitudinal investigation into how parent-SLT therapeutic alliance contributes to clinical outcomes in pediatric speech-language therapy. To address this issue, the current study followed 41 child-parent-therapist triads over a 12-week intervention period, examining whether parent-SLT therapeutic alliance, alongside demographic and parental psychological factors, predicted therapeutic outcomes. Our hypotheses were:

1. A stronger parent-SLT therapeutic alliance, as rated by the SLTs at the early stages of the intervention, would predict greater therapeutic improvement at the end of the intervention
2. Parents' endorsement of a responsive/sensitive caregiving style, report of positive emotions while thinking about their child, and positive perceptions of the child would be predictive of better clinical outcomes at the end of the intervention. In contrast, parents' endorsement of a compulsive/over-involved caregiving style, report of negative emotions while thinking about their child, and negative perceptions of the child would be predictive of worse clinical outcomes.
3. Parent-SLT therapeutic alliance would moderate the association between parental psychological variables and clinical outcomes, potentially buffering the adverse effects of parents' compulsive/over-involved caregiving style, negative child-related emotions, and negative perceptions of the child.

**Table 1**  
Background information on the SLTs.

| Background variable                        | Mean (SD)    | Range |
|--------------------------------------------|--------------|-------|
| Age (years)                                | 30.35 (5.23) | 24–47 |
| Religious affiliation                      |              |       |
| Haredi (ultra-Orthodox Jewish)             | 7            |       |
| National Religious                         | 2            |       |
| Secular                                    | 3            |       |
| Years of education*                        | 14.54 (1.93) | 16–22 |
| Professional seniority (years)             | 5.57 (1.95)  | 2–12  |
| Number of annual training courses attended | 6.57 (4.23)  | 1–12  |

\* Years of education:  $\leq 16$  = BA,  $>16$  = MA or PhD.

## 5. Method

### 5.1. Participants

**Speech-Language Therapists.** The study included 12 licensed SLTs, employed by community-based large Child Development Units. All participating SLTs were part of a larger professional development program that provided in-service training on evidence-based clinical assessment and intervention. This background ensured a relatively high and consistent level of professional competence across sites. Each therapist treated between two to 12 patients whose parents consented to participate in the study.

Background information on the SLTs is summarized in [Table 1](#): All were female, 88% reported receiving workplace training, and 65% worked for a single employer. Seven identified as Haredi (ultra-Orthodox Jewish), two as National Religious, and the remaining three as secular. Nine clinicians were native Hebrew speakers, three were fluent Hebrew-speaking immigrants from France. All conducted their sessions in Hebrew.

**Parents of Patients.** The study included 41 parents of children receiving speech-language therapy. A total of 59 parents were initially recruited. Of these, 18 dropped out: Two parents asked to discontinue participation, two parents terminated therapy prematurely, and 14 parents failed to complete the questionnaires within the designated timeframe. Forty percent of the 41 parents were mothers, and approximately half of the parents identified as belonging to the Jewish ultra-Orthodox community.

**Patients.** Regarding clinical presentation, 23 children (56%) were referred for speech-related difficulties, including articulation and/or oral-motor concerns (13 with articulation difficulties, one with oral function difficulties, and nine with combined difficulties). The remaining 18 children (44%) were treated for language difficulties, including expressive and/or receptive language delays (of which, five with combined language and articulation difficulties). Inclusion criteria were: (a) Normal cognitive functioning, as assessed by the treating team and confirmed by educational placement in a regular classroom (not a special education setting), (b) No diagnosis of complex developmental disabilities, such as autism or other conditions affecting cognitive/behavioral functioning (e.g., epilepsy), (c) No speech fluency disorders (e.g., stuttering), and (d) No sensory impairment (e.g., hearing loss or visual impairment). These criteria were chosen to reduce the potential confounding effects of comorbidities such as intellectual disability ([Goorhuis-Brouwer & Knijff, 2002](#); [Shakuf et al., 2025](#)). The final sample included children in the age range of 36 – 132 months,  $M = 79.4$ ,  $SD = 25.8$  months.

### 5.2. Tools

#### 5.2.1. SLTs questionnaires

To increase SLT retention and protocol compliance, we selected short questionnaire versions and, when possible, single item measures (e.g., the performance score in [Icht, 2021](#)).

**Professional background questionnaire.** SLTs completed a 6-item questionnaire covering the therapist's professional experience and training at the beginning of the study to ensure adequate level of professionalism, see Appendix A1.

**Patient (child) Assessment Questionnaire.** At the beginning of the treatment, SLTs rated their patients' difficulties on a single-item 5-point scale, ranging from 1 (minimal difficulty) to 5 (severe difficulty), see Appendix A2.

**Shortened Parent-SLT Therapeutic Alliance Questionnaire.** After the second session, SLTs completed the 12-item Working Alliance Inventory-Short Revised (WAI-SR; [Hatcher & Gillaspay, 2006](#)). This scale, developed from the original 36-item WAI ([Horvath & Greenberg, 1986](#)), assesses a therapist's perceived quality of the working alliance with a client. In the current study, we tailored the instructions and wording of the items to tap SLT's perceived quality of the TA with the client's parents. It includes 12 items measuring the Task, Goal, and Bond dimensions of the parent-SLT therapeutic alliance (4 items per dimension). SLTs rated the extent to which each item described their relationship with the parents of their client on a 7-point scale, ranging from 1 (strongly disagree) to 7 (strongly agree), see Appendix A3. In the current sample, Cronbach  $\alpha$  for the 12 items was 0.90. On this basis, a total score was computed for each parent-SLT dyad by averaging the 12 items. Higher scores indicated a stronger parent-SLT therapeutic alliance.

**Therapeutic Outcomes.** After the last session of the treatment, SLTs rated the extent to which treatment goals were met on a single-item 5-point scale, ranging from 1 (goals were not met) to 5 (goals were fully met).

#### 5.2.2. Parental psychological factors

At the beginning of the treatment, the parent who attended most sessions completed three questionnaires tapping their caregiving style, their perception of the child, and the emotions that thinking about the child elicited in them.

**Caregiving style** was assessed with a 24-item version of the *Caregiving Questionnaire* ([Kunce & Shaver, 1994](#)). This scale comprises two subscales (12 items per subscale) tapping caregiving responsiveness/sensitivity (e.g., "When my child seems to want or need a hug, I'm glad to provide it", "I am very attentive to my child's nonverbal signals for help and support") and controlling/compulsive caregiving (e.g., "I tend to be too domineering when trying to help my child," "I tend to get overinvolved in my child's problems and difficulties"). Parents were asked to focus on their current relationship with their child and to rate the extent to which each item was descriptive of their thoughts and behavior within this relationship. Ratings were made on a 7-point scale ranging from 1 (*not at all*) to 7 (*very much*). Reliability and validity for this measure have both been deemed excellent ([Kunce & Shaver, 1994](#)). In the current sample, Cronbach's  $\alpha$ s were acceptable for the two subscales (0.78 for responsive/sensitive caregiving and 0.82 for controlling/compulsive caregiving). On this basis, we computed two scores for each parent by averaging items in each subscale, with higher scores indicating higher sensitive or compulsive caregiving.

**Parents' emotions toward their child** were assessed with the Positive and Negative Affect Scale (PANAS, [Watson et al., 1988](#)). The scale consists of 10 items tapping positive mood (e.g., "excited", "proud", "strong") and 10 items tapping negative mood (e.g., "irritable",

"guilty", "scared"). Participants were asked to think about their child and to rate the extent to which each item described the feelings elicited by this thinking exercise. Ratings were made on a 5-point scale ranging from 1 (*not at all*) to 5 (*very much*). The PANAS has been found to be a highly reliable and valid scale for assessing positive and negative transient emotions (Watson et al., 1988). In the current study, Cronbach's  $\alpha$ s were acceptable for both positive emotion items (0.75) and negative emotion items (0.85). Then, two scores were computed for each participant by averaging the relevant items of each subscale. Higher scores reflect higher levels of positive mood and negative mood, respectively.

Parents' perception of their child was assessed with the 14-item Mothers' Object Relations Scale-Short Form (MORS-SF; Oates et al., 2018). This questionnaire was developed to identify potential areas of difficulty in the early parent-child relationship by measuring two factors: child's perceived emotional warmth (e.g., "My child is affectionate towards me"), and child's perceived intrusiveness (e.g., "My child wants too much attention"). Responses were indicated on a 7-point scale, ranging from 1 (*never*) to 7 (*always*). In the current study, Cronbach's  $\alpha$ s were acceptable for the two subscales (0.75 for perceived emotional warmth and 0.77 for perceived intrusiveness). On this basis, two total scores were computed for each parent by averaging items belonging to a subscale. Higher scores indicate greater perceptions of the child's warmth and the child's intrusiveness (1-lowest to 7-highest).

### 5.3. Procedure

To recruit participants, the second author (SLT) reached out to colleagues, presented the study, and invited participation. Additionally, a recruitment advertisement was distributed to various social media SLT groups. SLTs who learned about the study through these channels voluntarily contacted the first or second author to express their willingness to participate. At the beginning of the study and throughout its duration, each participating SLT reached out to the parents of eligible patients and invited them to participate. SLTs and parents completed the abovementioned questionnaires, which were analyzed at the end of the study data collection period. This was a convenience sample. Data collection for the study took place between April 2022 and July 2023, following a structured longitudinal protocol over a 12-week speech-language therapy period for each participant. The data collection process included three key timepoints:

- (1) T1 - Baseline (Week 0): Upon recruitment and prior to the start of therapy, each participating SLT rated the severity of the child's communication disorder using a 7-point Likert scale. Parents completed a battery of baseline questionnaires assessing: (a) Caregiving style (e.g., compulsive caregiving, Kuncé & Shaver, 1994), (b) Perceptions of their child (e.g., idealization; MORS-SF, Oates et al., 2018), and (c) Child-related emotions (e.g., concern, anxiety, and pride; PANAS, Watson et al., 1988).
- (2) T2 - Early Alliance Assessment (After 2 Sessions): Following the second therapy session, each SLT completed the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspay, 2006), adapted to assess the therapeutic alliance (TA) specifically between the SLT and the parent. This time point was selected to capture early alliance formation, consistent with prior literature demonstrating the predictive value of early TA in therapeutic processes (Zilcha-Mano, 2017).
- (3) T3 - Outcome Evaluation (Week 12): After 12 weeks of treatment, SLTs completed a final evaluation of therapeutic outcomes, again using a 7-point Likert scale indicating the extent to which treatment goals were achieved. Parents who completed the therapy also repeated the WAI-SR as part of a broader feedback collection, though this follow-up measure was not the focus of the current analysis.

Participant recruitment and retention were monitored throughout this period. A total of 58 parents were initially enrolled, with 41 completing the full protocol.

Parents were informed that the questionnaires would not include identifying details about their children and that SLTs would not have access to the completed questionnaires. Participation was entirely voluntary, and the decision to participate or decline did not impact the child's treatment in any way. All participants signed a consent form before data collection. The study received ethics approval from the relevant institutional review board [name erased for peer review] (Approval No 10-29-01-20).

All therapy sessions were delivered in person (face-to-face) in community-based clinics, with both the child and at least one parent present throughout the 12-week intervention period. No remote (online) sessions were included in the study. Sessions were held once per week and followed the standard clinical routine of each therapist. The therapeutic content, materials, and techniques were not identical across patients, allowing clinicians to tailor the intervention to the child's individual needs and therapeutic goals based on clinical judgment. This flexible approach reflects real-world conditions, promotes ecological validity, thus supporting the generalizability of findings to routine clinical contexts.

### 5.4. Data analysis

Data were analyzed using SPSS Statistics, version 27. The outcome factor was the attainment of the therapeutic goals as assessed by the SLT after the last meeting (Therapeutic Outcomes, a continuous variable, from [1], minimal, to [5], maximal). The following predictor groups were tested:

- A. Background variables – Gender (X2), Age (X2, < 6 years old vs.  $\geq$  6 years old) and Disorder Severity (X2, minimal-mild vs moderate-severe). Diagnosis was not included in the model because it was confounded with age in this sample.
- B. Parents' Psychological variables (all continuous) – Responsive caregiving, compulsive caregiving, positive child perception, negative child perception, child-related positive emotions, child-related negative emotions; and

### C. Strength of parent-SLT therapeutic alliance as reported by the therapist after two sessions of the treatment (continuous).

In the first stage, we conducted a stepwise hierarchical logistic regression, adding each predictor group in a separate step to assess their unique and combined contribution to Therapeutic Outcomes, as measured at the end of treatment (three months after collecting data about the predictors). In the second stage, we tested the addition of interactions of parent-SLT therapeutic alliance and parental variables.

## 6. Results

The stepwise regression model is presented in Table 2. Step 1, with only background variables as predictors, resulted in  $r = 0.429$ ,  $F(3, 37) = 2.78$ ,  $p = .05$ , accounting for approximately 18.4% of the variance. In Step 2, the addition of the six parents' psychological variables led to a significant model with  $r = 0.639$ ,  $F(9, 31) = 2.38$ ,  $p = .04$ , accounting for approximately 40.1% of the variance. However, the increase in explained variance from step 1 to step 2 was not significant,  $F(6, 31) = 2.38$ ,  $p = .10$ . The addition of a single variable, parent-SLT therapeutic alliance (as gauged by the therapist) in step 3 significantly increased the explained variance,  $F(1, 30) = 5.32$ ,  $p = .03$ , with  $r = 0.706$ ,  $F(10, 30) = 2.98$ ,  $p = .01$ , accounting for approximately half of the variance.

The final model in Step 3 revealed that disorder severity (rated by SLTs at the beginning of the treatment) was predictive of a 33 % ( $\beta = -.333$ ,  $t = 2.11$ ,  $p = .04$ ) reduction in Therapeutic Outcomes (post-treatment). Among parents' psychological variables, compulsive caregiving and parents' perception of the child's warmth were both predictive of a *reduction* in Therapeutic Outcomes (gauged 3 months later),  $\beta = -.333$ ,  $t = 2.23$ ,  $p = .034$ ; and  $\beta = -.375$ ,  $t = 2.35$ ,  $p = .026$ , respectively. However, an increase in parent-SLT therapeutic alliance (at the second session of treatment) was predictive of an *increase* in Therapeutic Outcomes (post-treatment),  $\beta = 0.329$ ,  $t = 2.31$ ,  $p = .028$ .

From all six interactions between parental psychological variables and parent-SLT therapeutic alliance we tested in Step 4, only one interaction was found to be statistically significant (see Appendix B for full results). As shown in Table 2, the interaction of parental compulsive caregiving and parent-SLT therapeutic alliance on Therapeutic Outcomes led to a significant increase in explained variance,  $\Delta r^2 = 0.061$ ,  $F(1, 29) = 4.03$ ,  $p = .05$ , yielding a significant model,  $r = 0.748$  ( $r^2 = 0.56$ ),  $F(11, 29) = 3.34$ ,  $p = .005$ . A simple slope analysis, visually depicted in Fig. 1, shows that parental compulsive caregiving was associated with worse Therapeutic Outcomes for patients whose parent-SLT therapeutic alliance was low ( $-1$  SD),  $\beta = -.694$  [ $-1.16$  -  $-.23$ ],  $t = 3.03$ ,  $p = .005$ , or medium (average),  $\beta = -.356$  [ $-0.55$  -  $-0.05$ ],  $t = 2.41$ ,  $p = .022$ . However, for patients with high TA ( $+1$  SD), parental compulsive caregiving was not significantly associated with Therapeutic Outcomes,  $\beta = -.051$  [ $-0.48$  -  $0.37$ ],  $t = 0.25$ ,  $p = .81$ . Note that parent-SLT TA did not differ significantly between parents scoring below versus above the midpoint on compulsive parenting,  $t(39) = 0.697$ ,  $p = .49$ , suggesting that group differences in alliance are unlikely to account for the interaction effect. Similarly, the following key variables were not unevenly distributed across therapists (all  $\chi^2$  tests were non-significant): parent gender, child age ( $< 6$  vs.  $\geq 6$  years), disorder severity (mild vs. moderate to severe), and therapeutic alliance (TA score  $\leq 6$  vs.  $> 6$ ).

**Post-hoc power analysis.** A post-hoc power analysis was conducted using G\*Power (v3.1) for multiple regression models at each step

**Table 2**

Hierarchical Regression: Standardized Betas [with 95 % CIs], in four steps. The first column presents Means (SD) and percentages for the sample.

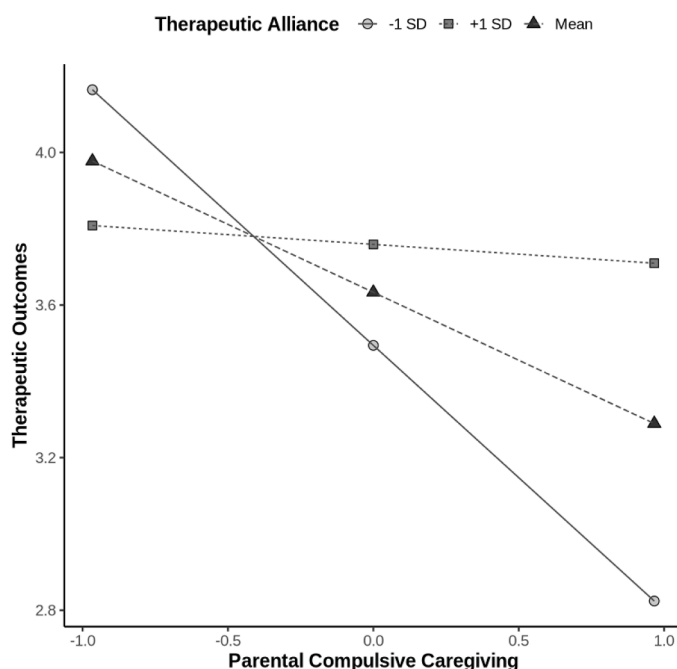
| Predictor                                      | M(SD)/<br>% | Step 1<br>Background             | Step 2<br>Psychological Variables<br>(Parent) | Step 3<br>Therapeutic Alliance<br>(Therapist) | Step 4<br>Interaction Model      |
|------------------------------------------------|-------------|----------------------------------|-----------------------------------------------|-----------------------------------------------|----------------------------------|
|                                                |             | $r = 0.429^*$                    | $r = 0.639^*$                                 | $r = 0.706^*$                                 | $r = 0.748^{**}$                 |
| Parent Gender (female)                         | 41 %        | .218 [-.39, 1.07]                | .271 [-.06, 1.14]                             | .215 [-.38, 1.02]                             | .385 [.17, 0.94]                 |
| Disorder Severity (moderate-severe)            | 68 %        | -.368 [-1.44, -.12] <sup>*</sup> | -.376 [-1.52, -.16] <sup>*</sup>              | -.333 [-1.39, -.02] <sup>*</sup>              | -.951 [-1.65, -.25] <sup>*</sup> |
| Age ( $\geq 6$ years)                          | 51 %        | .254 [-.07, 1.07]                | .220 [-.08, 1.02]                             | .184 [-.18, 0.91]                             | .429 [-.13, 0.98]                |
| Responsive Care Style <sup>a</sup>             | 5.8 (0.7)   |                                  | -.029 [-.52, 0.26]                            | -.090 [-.58, 0.33]                            | -.200 [-.65, 0.25]               |
| Compulsive Care Style <sup>a</sup>             | 3.4 (1.0)   |                                  | -.373 [-.70, -.05] <sup>*</sup>               | -.333 [-.65, -.03] <sup>*</sup>               | -.356 [-.66, -.05] <sup>*</sup>  |
| Child Perceived Affectionate <sup>a</sup>      | 6.3 (0.8)   |                                  | -.408 [-1.04, -.07] <sup>*</sup>              | -.375 [-.94, -.06] <sup>*</sup>               | -.466 [-.88, -.05] <sup>*</sup>  |
| Child Perceived Demanding <sup>a</sup>         | 2.5 (1.1)   |                                  | .201 [-.09, 0.47]                             | .276 [-.02, 0.56]                             | .287 [.00, 0.57] <sup>*</sup>    |
| Child-related positive emotions <sup>b</sup>   | 4.0 (0.5)   |                                  | .077 [-.55, 0.84]                             | .147 [-.38, 0.84]                             | .447 [-.22, 1.12]                |
| Child-related negative emotions <sup>b</sup>   | 1.6 (0.6)   |                                  | -.146 [-.77, 0.30]                            | -.188 [-.82, 0.22]                            | -.263 [-.78, 0.25]               |
| Therapeutic Alliance <sup>a</sup>              | 6.2 (0.8)   |                                  |                                               | .329 [.03, 0.75] <sup>*</sup>                 | .167 [-.24, 0.57]                |
| Interaction: Therapeutic Alliance X Compulsive |             |                                  |                                               |                                               | .405 [0, 0.82] <sup>*</sup>      |

<sup>\*</sup>  $p \leq 0.05$ .

<sup>\*\*</sup>  $p \leq 0.005$ .

<sup>a</sup> Means are presented on a 7-point (1–7) Likert scale.

<sup>b</sup> Means are presented on a 5-point (1–5) Likert scale.



**Fig. 1.** Moderation of the relationship between Parental Compulsive Caregiving (Z scores) and Therapeutic Outcomes by parent-SLT Therapeutic Alliance.

of the analysis ( $\alpha = 0.05$ ,  $N = 41$ ). For Step 1, which included 3 predictors and yielded an observed correlation of  $r = 0.429$  ( $f^2 = 0.23$ ), the achieved power was 0.68. However, for Steps 2 through 4, which included between 9 and 11 predictors and yielded correlations ranging from  $r = 0.639$  to  $r = 0.748$  ( $f^2 = 0.69$  to  $1.27$ ), the achieved power exceeded 0.99.

## 7. Discussion

The current longitudinal study examined the contribution of the parent-SLT therapeutic alliance to therapeutic outcomes in pediatric speech-language therapy, alongside the role of parental psychological factors. Over 12 weeks, we followed 41 child–parent–therapist triads, collecting measures from both therapists and parents. The results showed that the strength of parent-therapist TA (assessed at the second session of the treatment by the SLT) was the most notable predictor of better therapy outcomes at the end of treatment (as assessed again by SLT). Unsurprisingly, disorder severity was associated with worse therapy outcomes. Parental compulsive caregiving and parents' positive perceptions of their child as warm and affectionate were also predictive of less favorable therapeutic outcomes. Notably, in a moderation analysis, TA was found to buffer the negative effect of parental compulsive caregiving, suggesting its unique role in supporting progress, with important implications for SLTs' clinical practice and training.

### 7.1. Parent-SLT therapeutic alliance

In accordance with our first research hypothesis, one of the most important findings of the current study is the role of parent-SLT therapeutic alliance, which was related to an increase of about 33 % in therapeutic outcomes. According to Bordin (1979), TA reflects an emotional fit between the therapist and the patient (or the patient's parent in our case), built on respect, trust, reciprocity, and shared agreement on treatment goals. Our results echo the association between TA and treatment outcomes observed in psychotherapy research. A meta-analysis of over 200 studies demonstrated that a stronger alliance is consistently associated with better outcomes across various mental health conditions, including major depressive disorder and psychotic disorders (Horvath et al., 2011). Beyond facilitating the attainment of treatment goals, TA has also been linked to broader measures of patients' well-being and life satisfaction (Prusiński, 2022).

The current study joins a growing body of evidence regarding the role of TA in the speech-language therapy field. In adult populations, much of the existing work highlights how the quality of the relationship between SLT and client shapes treatment success (Manning, 2010; Plexico et al., 2010). For example, studies in stuttering and voice therapy in adults have found strong links between TA and improvements in motivation, engagement, and therapy outcomes months after intervention (Pasternak et al., 2022; Subramanian, 2015). The current findings are novel, as in pediatric speech-language therapy, much of the research remains limited and largely descriptive (Hansen et al., 2024). Most studies have explored the experiences of children, parents, and clinicians, identifying empathy, warmth, and flexibility (key components of TA) as critical for fostering trust and engagement (Fourie et al., 2011; Ebert, 2018). Direct empirical investigations into how these relationships predict therapy outcomes are still scarce (Freckmann et al., 2017).

Our study highlights the importance of parent-SLT therapeutic alliance as a part of a successful child-parent-therapist triad in speech-language therapy. The current findings support the model proposed by Accurso et al. (2013), highlighting that a solid parent-SLT relationship fosters greater parental engagement and satisfaction, which in turn promotes more positive intervention outcomes. When parents feel supported, competent, and actively involved in the therapeutic process, they are more likely to contribute meaningfully to their child's progress.

Our findings underscore the predictive value of early parent-SLT therapeutic alliance, yet low early alliance should not be interpreted as a definitive indicator of poor treatment outcome. The process of alliance-building evolves through ongoing role adjustment and may strengthen over the course of intervention (Klatte et al., 2024; Melvin et al., 2020). Therefore, early challenges in establishing a strong alliance should not be taken as grounds to discontinue therapy, but rather as an opportunity for alliance repair.

## 7.2. Parental characteristics

As the current study focuses on the unique role of parent-SLT therapeutic alliance, key parental psychological factors were also assessed. In accordance with our second research hypothesis, parental compulsive caregiving was significantly predictive of worse therapeutic outcomes (as assessed by the SLT three months later). This parenting style is characterized by parents who become overly involved, controlling, or anxious in their attempts to help or protect their child (Shaver et al., 2011). Instead of responding flexibly and sensitively to the child's needs, the parent may act in a way that reflects their own anxiety or need for control, often interrupting the child's autonomy. This caregiving pattern is thought to reflect insecure attachment patterns in the caregiver, particularly anxious attachment, where the parent feels responsible for constantly managing the relationship or ensuring the child is okay, sometimes at the expense of the child's development (Stern et al., 2018).

In the context of speech-language therapy, parental compulsive caregiving might manifest in interrupting the child during therapeutic tasks, answering on behalf of the child, pressuring the child to perform, or expressing anxiety or frustration during or between sessions (Klatte et al., 2019). Such behaviors may interfere with the child's ability to engage, take risks, and build confidence in therapy. These behaviors can impair the therapeutic process and outcomes. For example, parents who frequently interrupt their children can disrupt the flow of communication, making it difficult for the child to practice their speech and language skills effectively. Pressuring children to perform can lead to anxiety, which may further inhibit their willingness to participate in therapy. Expressing frustration from the child can create a negative atmosphere, hindering the child's engagement in therapeutic tasks (Klatte et al., 2019).

A central finding of the current study is that a strong parent-SLT therapeutic alliance can *buffer* the abovementioned negative effects of compulsive parenting. This finding partially confirms our third research hypothesis. Namely, when the SLT establishes a strong TA with the parent, parental compulsive caregiving might not necessarily impair therapeutic outcomes. These results underscore the strength of collaborative and supportive relationships between clinicians and parents, irrespective of the parents' parenting style. In the context of speech-language therapy, when SLTs develop a strong TA with the parent, they may counteract parental frustration and anxiety and then probably mitigate over-involved, compulsive parenting behaviors. One must note, however, that this interpretation should be made cautiously, given the sample size. Even so, parent-SLT therapeutic alliance was comparably high among parents scoring below versus above the midpoint on compulsive parenting, supporting the possibility that alliance may buffer the association between compulsive parenting and outcomes. Broadly, data echoes past findings on the strength of a supportive figure to generate changes regardless of personality (Nagar et al., 2022; Ben-David and Mikulincer, 2025).

At odds with our hypothesis, parents' positive perceptions of the child were associated with worse therapeutic outcomes. This finding was somewhat unexpected, given that previous studies have generally shown that such positive perceptions support improved treatment outcomes (e.g., Hemphill & Littlefield, 2006; Tharinger et al., 2009). Typically, positive parental perceptions are associated with greater understanding and engagement in the child's treatment, thereby enhancing therapeutic outcomes. However, excessively positive perceptions may lead parents to underestimate the child's difficulties, hold unrealistic expectations, or struggle to accept slow or limited progress (Wenger & Fowers, 2008). Indeed, in the current study, 61 % of the parents provided a score of at least 6.5/7, indicating an extremely high perception of their child (as compared to previous studies; Oates et al., 2018).

In the context of speech-language therapy, these extremely positive perceptions may sometimes hinder parental engagement and flexibility during treatment. It is possible that in our study, extremely high agreement with statements like "my child is gifted and talented" and "my child likes doing things with me" led to disappointment and frustration when confronted with the child's actual pace and limitations, ultimately hampering progress. This interpretation aligns with Liber et al.'s (2008) findings that heightened positive parental affect may lead to emotional overinvolvement and poorer treatment outcomes for children with anxiety disorders.

We note that about half of the participating families and of the SLTs belong to the Israeli Jewish ultra-orthodox community. This community is characterized by lower SES, high birth rates, limited prenatal testing, a greater incidence of developmental conditions, and strong faith-based acceptance of children's challenges as divinely ordained (Roer-Strier & Avieli, 2022). These cultural characteristics may influence how parents perceive their child's difficulties, engage in therapy, and relate to the speech-language therapist. It may also help explain the high levels of parental idealization reported in the current study. While such positive perceptions can foster a supportive family environment, they may also lead to unrealistic expectations regarding the child's progress and limit parental flexibility during intervention. These findings underscore the importance of culturally sensitive approaches in pediatric speech-language therapy, particularly when working with religious communities.

## 7.3. Caveats and future recommendations

Several limitations of the current study warrant consideration. Typical for longitudinal field studies, the sample size was modest,

which may limit the generalizability of the findings. Although post-hoc power analyses indicated sufficient power and the sample matched previous studies (e.g., [Sønsterud et al., 2019](#) - 18 adults; [Fourie et al., 2011](#) - 6 children; [Ebert, 2017](#) - 14 SLTs, 22 children, 20 parents), more research is called for to replicate and extend these findings with larger samples. Another limitation concerns therapist-level clustering. Because multiple children were treated by the same SLT, observations were not fully independent. Clients treated by the same therapist may share therapist-related influences (e.g., therapeutic style, interpersonal approach, clinical experience), which can induce intra-class correlation. As therapist-level variance was not explicitly modeled using multilevel analyses, standard errors may have been underestimated, potentially increasing the likelihood of Type I errors. Future studies with larger samples should employ hierarchical or mixed-effects modeling to account for therapist-level clustering and more precisely estimate alliance-outcome associations. In addition, the study relied on self-report questionnaires for assessing psychological variables. Even though these were valid and widely used tools, they may be subject to social desirability biases (e.g., [Icht et al., 2023](#)).

Although SLT-rated TA offers valuable insights, it may introduce bias by representing the therapist's perspective on the clinical relationship. Indeed, both the predictor (parent-therapist TA) and the outcome (therapeutic outcomes) were reported by the same therapist. Prior reviews have noted that informant overlap may strengthen alliance-outcome associations due to shared method variance ([De Greef et al., 2017](#)) and increase the risk of common method bias. To partially mitigate this concern, the assessments of parent-therapist TA was conducted early in treatment (after two sessions), whereas therapeutic outcomes were assessed only after 12 sessions. This introduced a two-month temporal separation between predictor and outcome measurement, a procedural strategy recommended to reduce common method variance ([Podsakoff et al., 2003](#)). Moreover, therapists were not made aware of the study's hypothesis, which further limits potential expectancy effects. Future research should consider a multi-informant approach.

An additional limitation of the present study concerns the age range of the participating children, spanning from early childhood (age 3) to preadolescence (age 12). This range encompasses substantial developmental stages in cognition, language and parental-child interactions that may have influenced the tested variables (see, [Icht et al., 2025](#)). To mitigate these effects, age was included in our models and was not found to have a statistically significant effect (see [Table 2](#)). However, future studies should directly examine the effects of age-specific patterns on parental factors, alliance, and therapeutic outcomes.

Finally, although several parental psychological factors were included, other contextual variables, such as culture (e.g., [Icht & Ben-David, 2014](#)), therapist characteristics (e.g., [Freud et al., 2021](#)), and therapy settings (e.g., [Schertz et al., 2025](#)), were not assessed and may also influence outcomes. Specifically, a large proportion of the participating families and SLTs belonged to the ultra-Orthodox Jewish community. This population is characterized by larger family sizes, which often lead to increased caregiving demands and limited parental availability per child. On the other hand, strong religious beliefs were found to foster greater tolerance and emotional resilience in parenting children with developmental difficulties ([Bartl et al., 2020](#); [Ganz, 2024](#)). These factors may influence how parents engage with their children's therapy. Given the specific sociocultural context in which the study was conducted, some caution is warranted when generalizing the findings to different cultural, demographic, or service characteristics. Future research should further explore how these characteristics intersect with parental attitudes in the context of pediatric speech-language therapy.

## 8. Summary and clinical implications

This longitudinal study focuses on the parent-therapist-child triad in pediatric speech-language therapy. Current findings underscore the critical role of the parent-SLT therapeutic alliance in predicting treatment outcomes in pediatric speech-language therapy and buffering the negative effects of a compulsive/over-involved parental style. SLTs should be encouraged to foster strong, collaborative relationships with parents from the outset of therapy. Integrating the critical role of TA into SLTs' training and supervision may also enhance therapeutic effectiveness. Strategies may include dedicating time to building rapport, acknowledging parental perspectives, agreeing on therapy goals, and setting realistic parental expectations for progress.

Importantly, the study highlights that certain parental psychological factors, such as compulsive caregiving or overly positive perceptions of the child, may hinder treatment progress when not properly addressed. These findings suggest the need for SLTs to assess and monitor not only the child's communication profile but also parental attitudes, expectations, and interaction styles. When appropriate, offering parental support or referral to psychoeducational resources (e.g., using simulation-based training; [Golombick et al., 2024](#)) may enhance engagement and ultimately improve therapy outcomes. Broadly speaking, a successful speech-language therapy must encompass emotional and interpersonal aspects as well as speech, language, and communication targets.

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## Ethics

The study received ethics approval from the relevant institutional review board [name erased for peer review] (Approval No 10–29–01–20). Written informed consent was obtained from all participants prior to data collection.

## AI usage declaration

AI tools (ChatGPT 5 and 4o) were used to improve grammar and style. All suggestions were reviewed and edited by the authors, and no AI was used for data analysis, interpretation, or drawing conclusions.

## CRediT authorship contribution statement

**Michal Icht:** Writing – review & editing, Writing – original draft, Supervision, Conceptualization. **Maayan Tayar:** Writing – review & editing, Data curation. **Mario Mikulincer:** Writing – review & editing, Conceptualization. **Riki Taitelbaum-Swead:** Writing – review & editing, Conceptualization. **Boaz M. Ben-David:** Writing – review & editing, Writing – original draft, Formal analysis, Conceptualization.

## Declaration of competing interest

The authors declare no competing interests.

## Appendix A. Unpublished/ Adapted Questionnaires

### A1). Professional Background Questionnaire (translated from the original Hebrew version)

#### Instructions:

Please answer the following questions to provide background information. All responses will be kept confidential and used for research purposes only.

#### Questions:

1. Age. \_ years old (Please write your age in years)
2. Gender. M / F
3. Religious Affiliation. Please select the option that best describes your religious identification: Haredi (Ultra-Orthodox Jewish) / National Religious / Secular / Other: \_\_\_\_\_
4. Years of Education. > 16 years (equivalent to Bachelor's degree) / < 16 years (equivalent to MA or PhD) / Other (please specify): \_\_\_\_\_ (Or fill in exact number of years: \_\_)
5. Professional Seniority. How many years have you been practicing as an SLT? \_ years
6. Number of Annual Training Courses Attended. (In the past year, how many professional development or training courses did you attend?) \_ courses

### A2). Patient (child) Assessment Questionnaire (translated from the original Hebrew version)

#### Instructions:

Please indicate your clinical impression of the patient's current level of communication difficulty, based on your diagnostic assessment, on a 5-point scale, ranging from 1 (minimal difficulty) to 5 (severe difficulty):

1. Minimal difficulty: Communication is largely age-appropriate; minor concerns observed.
2. Mild difficulty: Noticeable but limited difficulties that slightly impact communication.
3. Moderate difficulty: Clear communication challenges that require structured intervention.
4. Moderately severe difficulty: Significant impairments that substantially interfere with communication in daily settings.
5. Severe difficulty: Profound communication deficits requiring intensive, ongoing support.

### A3). Shortened Parent-SLT Therapeutic Alliance Questionnaire (adapted from WAI-SR; Hatcher & Gillasp, 2006 and translated from the Hebrew version)

#### Instructions.

The following sentences describe feelings or thoughts that may arise for a parent in relation to their child's therapist. We are interested in how you experience the current parent's responses to the therapy you provide for their child. Please respond to each statement by rating the extent to which you agree or disagree with it, using a 7-point scale, ranging from 1 (strongly disagree) to 7 (strongly agree).

#### Questions:

1. The parent and I agree about the things s/he needs to do during therapy to improve the child's condition.
2. During therapy, the parent has begun to see the child's difficulties in new ways.
3. The parent feels that I like her/him.
4. The parent does not understand what I am trying to achieve in therapy.
5. The parent trusts my ability to help the child.
6. The parent and I are working toward goals that we both agree on.
7. The parent feels that I appreciate her/him.
8. The parent and I agree on what is important for her/him to work on with the child.
9. The parent and I trust each other.

10. The parent and I have different views about what the child's problems are.
11. The parent and I have developed a good understanding of the kind of changes that would be good for the child.
12. The parent believes that the way I work on the child's difficulties is correct.

## Appendix B. models examining all possible interactions between parental psychological variables and parent-SLT therapeutic alliance. Model 2 was chosen for the manuscript

| Variable                             | Model 1                  | Model 2               | Model 3                  | Model 4                  | Model 5                  | Model 6                  |
|--------------------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Parent Gender (female)               | 0.218 [−0.076, 0.512]    | .385 [.17, 0.94]      | 0.218 [−0.081, 0.517]    | 0.206 [−0.088, 0.500]    | 0.205 [−0.089, 0.499]    | 0.218 [−0.066, 0.502]    |
| Disorder Severity (moderate-severe)  | −0.335* [−0.662, −0.008] | −0.951* [−1.65, −.25] | −0.333* [−0.661, −0.005] | −0.381* [−0.732, −0.030] | −0.374* [−0.723, −0.025] | −0.381* [−0.704, −0.058] |
| Age (≥6 years)                       | 0.188 [−0.109, 0.485]    | .429 [−.13, 0.98]     | 0.189 [−0.123, 0.501]    | 0.196 [−0.101, 0.493]    | 0.199 [−0.100, 0.498]    | 0.221 [−0.071, 0.513]    |
| Responsive Care Style                | 0.343 [−1.493, 2.179]    | −0.200 [−.65, 0.25]   | −0.095 [−0.447, 0.257]   | −0.082 [−0.417, 0.253]   | −0.088 [−0.424, 0.248]   | −0.080 [−0.406, 0.246]   |
| Compulsive Care Style                | −0.316 [−0.633, 0.001]   | −0.356* [−.66, −.05]  | −0.326 [−0.659, 0.007]   | −0.307 [−0.623, 0.009]   | −0.304 [−0.626, 0.018]   | −0.302 [−0.605, 0.001]   |
| Child Perceived Affectionate         | −0.363* [−0.698, −0.028] | −0.466* [−.88, −.05]  | −0.564 [−3.841, 2.713]   | −0.391* [−0.723, −0.059] | −0.405* [−0.747, −0.063] | −0.346* [−0.669, −0.023] |
| Child Perceived Demanding            | 0.273 [−0.045, 0.591]    | .287* [.00, 0.57]     | 0.276 [−0.043, 0.595]    | −0.773 [−3.679, 2.133]   | 0.289 [−0.030, 0.608]    | 0.258 [−0.051, 0.567]    |
| Child-related positive emotions      | 0.164 [−0.209, 0.537]    | .447 [−.22, 1.12]     | 0.146 [−0.222, 0.514]    | 0.182 [−0.194, 0.558]    | −0.757 [−3.567, 2.053]   | 0.176 [−0.179, 0.531]    |
| Child-related negative emotions      | −0.196 [−0.537, 0.145]   | −0.263 [−.78, 0.25]   | −0.188 [−0.529, 0.153]   | −0.195 [−0.533, 0.143]   | −0.181 [−0.521, 0.159]   | −3.005 [−6.902, 0.892]   |
| Therapeutic Alliance (TA)            | 0.826 [−1.270, 2.922]    | .167 [−.24, 0.57]     | 0.117 [−3.564, 3.798]    | −0.084 [−1.261, 1.093]   | −0.660 [−3.721, 2.401]   | −0.604 [−1.921, 0.713]   |
| TA X Responsive Care                 | −0.699 [−3.617, 2.219]   |                       |                          |                          |                          |                          |
| TA X Compulsive Care                 |                          | .405* [0, 0.82]       |                          |                          |                          |                          |
| TA X Child Perceived Affectionate    |                          |                       | 0.281 [−4.589, 5.151]    |                          |                          |                          |
| TA X Child Perceived Demanding       |                          |                       |                          | 1.040 [−1.827, 3.907]    |                          |                          |
| TA X Child-related positive emotions |                          |                       |                          |                          | 1.294 [−2.692, 5.280]    |                          |
| TA X Child-related negative emotions |                          |                       |                          |                          |                          | 2.982 [−1.131, 7.095]    |

## Data availability

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

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