

**PROGRAMA DE INTERVENCIÓN POST-DIVORCIO:
EVALUACIÓN DEL PROCESO A TRAVÉS DE LA
ALIANZA TERAPÉUTICA**

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*A mis padres,
por guiarme en el camino*

*A mi pareja,
por formar el mejor equipo juntos*

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INTRODUCCIÓN

INTRODUCCIÓN

El objetivo principal de esta tesis doctoral consiste en comprender el papel de la alianza terapéutica en el programa de intervención grupal post-divorcio Egokitzen. Este proyecto se ha desarrollado en contexto comunitario y a nivel nacional (en Puntos de Encuentro Familiar a los cuales los progenitores acudían por derivación judicial). La alianza será evaluada desde el modelo SOFTA (*System for Observing Family Therapy Alliances*) (Friedlander, Escudero, & Heatherington, 2006).

El divorcio ha acaparado gran atención en las investigaciones en el ámbito familiar debido a su importante impacto en la salud mental de todos los miembros de la familia (Barumandzadeh, Martin-Lebrun, Barumandzadeh, & Poussin, 2016; Martínez-Pampliega, Cormenzana, Corral, Iraurgi, & Sanz, 2019; Pendry, Carr, Papp, & Antles, 2013; Rosenfield, Jouriles, McDonald, & Mueller, 2014; Sturge-Apple, Davies, Cicchetti, & Fittoria, 2014). Dada esta situación, se han desarrollado múltiples servicios y programas con el fin facilitar la adaptación al divorcio, disminuyendo la sintomatología psicológica y reduciendo el impacto psicológico del divorcio en todos los miembros de la familia (Malcore, Windell, Seyuin, & Hill, 2010; Vélez, Wolchick, & Sandler, 2012). No obstante, los estudios de eficacia de los programas de intervención post-divorcio ha sido un foco de interés a posteriori. En los últimos años en el ámbito internacional se han desarrollado investigaciones al respecto (Becher et al., 2018; Braver, Sandler, Cohen Hita, & Wheeler, 2016; Jewell, Schmittl, McCobin, Hupp, & Pomerantz, 2017; McIntosh & Tan, 2017; Philip & O'Brien, 2017), pero a nivel nacional solamente el programa Egokitzen cuenta con estudios de eficacia y eficiencia (Apraiz, Ugarte, Aguado, & Martínez-Pampliega, 2015; Martínez-Pampliega et al., 2015, 2020).

Otro de los esfuerzos importantes en el ámbito de las intervenciones terapéuticas se ha centrado en analizar los mecanismos explicativos de la eficacia de las

intervenciones. Entre las variables más estudiadas se encuentra la alianza terapéutica y se ha revelado como una variable de proceso necesaria para comprender la eficacia de las intervenciones (Welmers-Van de Poll et al., 2018). En concreto, se estima que la alianza terapéutica explica entre un siete y un veintiún por ciento del cambio terapéutico (Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Flückiger, Del Re, Wampold, & Horvath, 2018; Karver, De Nadai, Monahan, & Shirk, 2018; Wampold & Imel, 2015; Welmers-Van de Poll et al., 2018), y ha demostrado su influencia en el éxito terapéutico en diferentes modalidades de terapia (Flückiger et al., 2018; Friedlander, Escudero, Welmers-van de Poll, & Heatherington, 2018; Karver et al., 2018).

No obstante, a pesar de que la literatura subraya la importancia de la alianza terapéutica como factor clave para el éxito de las intervenciones terapéuticas, no existen estudios en los que se haya analizado la alianza terapéutica en un programa de intervención grupal post-divorcio, en gran medida debido a la complejidad añadida que supone la modalidad grupal, frente a otras modalidades como la terapia individual o la terapia de pareja. Además, entre las problemáticas de estudio, no se encuentran investigaciones específicas sobre las situaciones de divorcio. Esto quizá haya sido debido a la dificultad emocional de las personas que atraviesan por este periodo.

Por todo ello, el objetivo principal de esta tesis doctoral consiste en comprender el papel de la alianza terapéutica en el programa de intervención grupal post-divorcio Egokitzen. Para poder dar respuesta a este objetivo, el contenido de la presente tesis doctoral se divide en tres capítulos.

En el primer capítulo se presenta la fundamentación teórica de la tesis doctoral. En dicho capítulo se realiza una revisión de la literatura existente sobre el divorcio y la alianza terapéutica.

En el segundo capítulo se recogen los tres estudios empíricos que conforman la presente tesis doctoral. En el primer estudio, se analiza la validez estructural de la escala SOFTA-s desarrollada por Friedlander, Escudero, & Heatherington, (2006) con el fin de evaluar la alianza terapéutica. En el segundo estudio empírico, se presenta un análisis multinivel del impacto de la regulación emocional en el establecimiento de la alianza terapéutica, teniendo en cuenta la percepción del paciente y del terapeuta. En el tercer estudio, se presenta el análisis de la influencia del proceso de la alianza terapéutica en la eficacia del programa Egokitzen, lo cual se realizará analizando la sintomatología de los progenitores, y considerando la regulación emocional como variable mediadora.

Finalmente, en el tercer capítulo se presenta y discute las conclusiones generales de la tesis doctoral junto con sus implicaciones a nivel teórico y clínico. Además, se señalan las futuras líneas de investigación y las limitaciones de la presente tesis doctoral.

CAPÍTULO I:

FUNDAMENTACIÓN TEÓRICA

1. EL DIVORCIO-SEPARACIÓN

Según las últimas estadísticas publicadas, aproximadamente un millón de familias experimenta el divorcio en Europa (Instituto de Política Familiar, 2018). En España, anualmente se producen más de 100.000 rupturas familiares, de las cuales el 96% son divorcios y el 4% separaciones (INE, 2019; Instituto de Política Familiar, 2019). La tasa de ruptura con relación al número de matrimonios se sitúa aproximadamente en el 60% (Instituto de Política Familiar, 2019). Estas estadísticas sobre el divorcio también reportan datos sobre los hijos/as. Concretamente, estas tasas suponen que anualmente 90.000 hijos/as experimenten el divorcio de sus padres, de los cuales 75.000 (85%) son menores de edad (INE, 2019; Instituto de Política Familiar, 2019).

A la luz de las estadísticas, el 65% de los matrimonios se rompen tras 10 años de duración (INE, 2019). Por otro lado, los datos revelan que la edad media de las personas que deciden divorciarse es de 46 años (INE, 2019; Instituto de Política Familiar, 2019).

1.1. Impacto del divorcio-separación

En la literatura se encuentra ampliamente documentado el gran impacto que el divorcio tiene no sólo sobre el ajuste psicológico de los padres y madres, sino también en el resto de los miembros del sistema familiar (Barumandzadeh et al., 2016; Martínez-Pampliega et al., 2019; Pendry et al., 2013; Rosenfield et al., 2014; Sturge-Apple et al., 2014). Entre las repercusiones de este proceso en los progenitores, la literatura ha enfatizado su impacto a nivel emocional así como la sintomatología psicológica (Braver et al., 2016; Sandler et al., 2020), sobre todo de tipo depresivo (Stack & Scourfield, 2015; Zulkarnain & Korenman, 2019). En lo que respecta al impacto en los hijos/as, se destacan los problemas psicológicos, comportamentales y sociales de estos/as, con manifestaciones tanto externalizantes como internalizantes (Emery & Tornello, 2014; Mahrer, O'Hara, Sandler, & Wolchik, 2018; Martínez-Pampliega et al., 2019).

Dadas las implicaciones que el divorcio tiene en el bienestar psicológico, a lo largo de las últimas décadas han surgido programas de intervención con el propósito de facilitar la adaptación al divorcio de los progenitores, disminuyendo la sintomatología psicológica y reduciendo el impacto psicológico del divorcio en todos los miembros de la familia (Malcore et al., 2010; Vélez et al., 2012).

1.2. Programas de intervención

Como ha sido indicado, debido a la repercusión que el divorcio tiene en el ajuste psicológico de las personas que pasan por esta situación, se han diseñado múltiples programas de intervención. La mayoría de estos programas están dirigidos a los progenitores, entre otros, *Children in the middle* (Arbuthnot & Gordon, 1994; Kramer, 1997), *New Beginning* (Sandler et al., 2018; Wolchik et al., 2000, 1993) y *Parenting Through Change* (Forgach, 1994; Forgatch, Patterson, De Garmo, & Beldavs, 2009). Algunos de los programas de intervención existentes cuentan con estudios de eficacia (Arbuthnot & Gordon, 2005; Martínez-Pampliega et al., 2015; Owen & Rhoades, 2012; Pedro-Carroll, Nakhnikian, & Montes, 2005; Sigal, Wolchik, Tein, & Sandler, 2012; Wolchik, Sandler, Winslow, & Smith-Daniels, 2005).

Estos programas de intervención surgieron inicialmente en EEUU a finales de 1970 y se extendieron en la década de los 90 (Ramírez, 2003). Las revisiones realizadas por diversos autores indican que en su mayoría son intervenciones estructuradas grupales con un enfoque psicoeducativo y terapéutico (Blaisure & Geasler, 2005; Grych, Fincham, Jouriles, & McDonald, 2000). Los objetivos de estos programas de intervención estadounidenses son diversos, desde crear un ambiente que facilite la expresión de las vivencias, aliviar el estrés derivado de la separación y elaborar el proceso de ruptura del vínculo emocional con la expareja, hasta proporcionar un espacio para desarrollar

habilidades de afrontamiento que ayude a las personas a manejar sus emociones (Blaisure & Geasler, 2005; Geasler & Blaisure, 1999; Wolchik et al., 2000).

En su momento, debido a lo prometedor de los programas de intervención para progenitores en Estados Unidos y a la ausencia de programas en castellano, el equipo de investigación Deusto FamilyPsych desarrolló Egokitzen, un programa de intervención para padres/madres divorciados que se presenta más detalladamente a continuación.

1.3. Programa de intervención post-divorcio Egokitzen

Este programa está dirigido a progenitores separados o divorciados y aborda los factores relevantes en el conflicto interparental en situaciones de divorcio centrándose en aquellos que minimizan el impacto del divorcio y que fomentan la resiliencia. Este programa de intervención se desarrolló tras una extensa y minuciosa revisión de la literatura y de los programas más relevantes de Estados Unidos (Martínez-Pampliega, Sanz, Iraurgi, & Iriarte, 2009; Merino et al., 2017).

El programa de intervención Egokitzen está compuesto de 11 sesiones de 90 minutos de duración, a implementar con frecuencia semanal. El programa aborda desde un enfoque sistémico del funcionamiento familiar, tres áreas fundamentales: el divorcio y su impacto, el conflicto interparental y la crianza de los hijos. Las sesiones del programa de intervención están diseñadas para involucrar activamente a los participantes a través de role-playings, debates y actividades grupales. En la Tabla 1 se amplía la información sobre el programa Egokitzen.

Si bien a nivel internacional existen estudios de análisis de eficacia de algunos de los programas de intervención, en España, el programa Egokitzen es el único que cuenta con estudios con este objetivo (Apraiz et al., 2015; Martínez-Pampliega et al., 2015, 2020). Ahora bien, ¿a qué se deben los cambios logrados en el programa de intervención Egokitzen? Es decir, si bien es clara la eficacia de las intervenciones, es menos clara la

comprensión sobre las variables subyacentes que explicarían la eficacia de los diferentes programas. En los últimos años, ha habido un creciente desarrollo de estudios en esta dirección, tratando de identificar los mecanismos a través de los cuales se producen los cambios obtenidos en las intervenciones terapéuticas. Una de las variables más respaldadas por la literatura con el fin de entender cómo y a qué se debe el éxito terapéutico ha sido la alianza terapéutica (Friedlander, Escudero, Heatherington, & Diamond, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011), la cual ha sido destacada como una variable de proceso necesaria para comprender la eficacia de las intervenciones (Welmers-Van de Poll et al., 2018).

Tabla 1

El programa Egokitzen

Sección	Sesión y título	Objetivos
1. Presentación del proceso de divorcio	0. Presentación del proceso de divorcio.	• Integración del grupo. • Establecer las bases del funcionamiento y las normas del programa. • Conocer las expectativas de los/as participantes acerca del programa. • Motivar a los padres y madres para conseguir su participación dentro del grupo y la realización de las tareas para casa.
		• Desarrollar la cohesión grupal, la confianza y la compenetración. • Establecer la credibilidad del conductor/a.
		• Normalizar el divorcio. • Detectar y analizar los mitos respecto al divorcio y las reacciones ante ellos.
		• Comprender el impacto del divorcio en padres/madres e hijos/as y detectarlo en ambos.
	1. Frecuencia, mitos y reacciones ante el divorcio.	• Analizar las reacciones diferentes de los hijos/as en función de la edad ante el divorcio. • Ofrecer ciertas pautas de actuación ante las reacciones de los hijos/as al divorcio.
		• Trabajar el manejo y afrontamiento de las situaciones de conflicto.
		• Identificar situaciones en las cuales los hijos/as son colocados en medio de los conflictos parentales.
		• Desarrollar habilidades para el manejo de conflictos sin la utilización de los hijos/as.
		• Mejorar la capacidad para identificar los sentimientos experimentados en las diferentes situaciones.
		• Desarrollar la capacidad para el control de los sentimientos de ira.
2. Conflictos interparentales. Manejo y afrontamiento de situaciones de conflicto	2. Hijos/as en medio del conflicto.	• Tomar conciencia de los pensamientos, imágenes y sentimientos que acompañan a las situaciones estresantes.
		• Cuestionar y sustituir los pensamientos negativos por otros más positivos.
	3. Reconocer los disparadores de la ira.	• Mejorar la capacidad para controlar los sentimientos de ira.
		• Adquirir y practicar estrategias de relajación.
	4. Reduciendo la ira.	• Identificar las habilidades de comunicación para solucionar los conflictos.
		• Entrenar las habilidades de escucha activa.
	5. Resolución de conflictos.	• Formular mensajes Yo.

3. Crianza	6. El continuo de crianza y pautas generales.	• Poner en práctica las habilidades de resolución de conflictos aprendidas con el objetivo de fijar los conocimientos y aumentar la seguridad de los padres y madres en sus propias capacidades.
	7. Mitos y realidades sobre el mal comportamiento.	• Diferenciar los conceptos de crianza en paralelo y cooperativa. • Identificar los casos en los que es aplicable cada uno de ellos. • Señalar las pautas generales de crianza. • Señalar las pautas específicas para cada tipo de crianza. • Discernir entre mitos y realidades en relación a la conducta negativa de los hijos/as. • Comprender y manejar el sentimiento de rechazo y alejamiento de los hijos/as. • Identificar y romper los ciclos negativos de relación padres/madres-hijos/as. • Poner en práctica las habilidades adquiridas para alcanzar ciclos positivos de relación. • Fortalecer el vínculo padre/madre-hijo/a.
	8. Escucha activa.	• Adquirir las estrategias y habilidades necesarias para lograr un cambio. • Adquirir algunos conocimientos básicos sobre habilidades de comunicación y, más especialmente, sobre la escucha activa. • Analizar la importancia de desarrollar estas habilidades para ayudar a los hijos/as a reducir el estrés provocado por la separación.
	9. Claves para una disciplina positiva y eficaz.	• Poner en práctica las habilidades aprendidas con el objetivo de fijar los conocimientos y aumentar la seguridad de las madres y los padres en sus propias capacidades. • Poner en práctica estrategias de manejo de conducta de los hijos/as. • Desarrollar expectativas de cambio claras y realistas. • Conocer la forma adecuada de emplear las consecuencias, tanto positivas como negativas, para modificar la conducta de los hijos/as.
	10. Mantener los cambios aprendidos y desarrollar identidad familiar.	• Planificar el uso consistente de las consecuencias para modificar una conducta específica. • Reconocer y reflexionar sobre los cambios obtenidos. • Reflexionar sobre las dificultades presentadas al poner en práctica las habilidades del programa. • Reforzar la motivación necesaria para continuar practicando las habilidades del programa.

2. LA ALIANZA TERAPÉUTICA

2.1. Definición conceptual de la alianza terapéutica

Consensuar qué es alianza terapéutica no ha resultado una tarea sencilla desde que Freud (1912) introdujera la idea, no el concepto como tal, en su propuesta sobre los aspectos transferenciales en el psicoanálisis. Freud a lo largo de varias de sus obras, desarrolló conceptos como la transferencia positiva o el pacto analítico que han tenido gran repercusión en la concepción actual de alianza terapéutica. El concepto de transferencia positiva es considerado como la motivación necesaria del paciente para el trabajo terapéutico (Freud, 1912), mientras que el pacto analítico hace referencia a la colaboración necesaria entre el paciente y el terapeuta para el desarrollo de una buena relación terapéutica (Freud, 1937). Es importante señalar que se emplean los términos alianza terapéutica y alianza de trabajo para hacer referencia al mismo constructo (Kapit, 1968).

Hasta la fecha, la definición de alianza que propuso Bordin (1979) es la más empleada (Doran, 2016), la más heurística y la que mayor influencia ha tenido en la psicoterapia (Escudero, 2009). Ésta se considera transteórica y está conceptualizada como una actitud colaborativa entre el paciente y el terapeuta. El énfasis en la colaboración y el consenso entre terapeuta y cliente son las características diferenciales de esta conceptualización de la alianza (Horvath et al., 2011), la cual se desarrolla a través de tres elementos interrelacionados (Bordin, 1994; Bordin, 1979): (1) el acuerdo entre el terapeuta y el cliente acerca de las metas del tratamiento, (2) el acuerdo entre terapeuta y cliente sobre las tareas necesarias para alcanzar las metas y (3) el vínculo entre terapeuta y cliente. Por tanto, esta conceptualización incide sobre la multidimensionalidad y la complejidad de la alianza terapéutica (Safran & Muran, 2000).

A pesar de la dificultad de establecer un consenso sobre el constructo de alianza terapéutica, Corbella & Botella (2003) afirman que, a día de hoy, es reconocido por la mayoría de las escuelas psicoterapéuticas, lo que ha incrementado la trascendencia del constructo (Andrade, 2005).

2.2. La alianza terapéutica en terapia grupal

Si bien la literatura sobre el establecimiento de la alianza terapéutica en terapia grupal es escasa, las investigaciones coinciden en señalar la complejidad que entraña la construcción de la alianza terapéutica en esta modalidad de terapia (Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002; Holmes & Kivlighan, 2000; Tasca, Compare, Zarbo, & Brugnera, 2016). El estudio realizado por Gillaspy et al., (2002) defiende que la alianza terapéutica como individuo de un grupo y la alianza terapéutica como grupo pueden jugar un papel diferente como predictores del éxito terapéutico. Esto implica que en terapia grupal el profesional debe prestar especial atención tanto a la alianza terapéutica que se establece a nivel individual como a nivel grupal.

Uno de los motivos principales por los que resulta complicado el establecimiento de la alianza terapéutica en terapia grupal es la numerosidad de las personas involucradas. En este contexto la alianza terapéutica se va a establecer en función por un lado, de la relación que el terapeuta construya con los miembros del grupo, y por otro lado, de las relaciones que se generen entre los miembros del grupo (Friedlander, Escudero, & Heatherington, 2006; Pinsof, 1994; Rait, 1998). Además, el proceso terapéutico puede ser percibido de forma diferente por cada miembro del grupo (Beck, Friedlander, & Escudero, 2006; Glebova et al., 2011) debido a las diferentes expectativas y motivaciones de las personas involucradas en la terapia, lo que supone una dificultad añadida para el desarrollo de una relación de colaboración necesaria para el proceso terapéutico

(Escudero, 2009). Esta situación conlleva la creación de múltiples niveles de relación que el terapeuta debe tener en cuenta y ser capaz de manejar adecuadamente (Escudero, 2009).

El único modelo, como se explicará a continuación, aplicable en contexto familiar y de pareja pero que puede también ser aplicable en contexto grupal es el SOFTA.

2.3. El modelo SOFTA

El modelo conceptual sobre la alianza terapéutica SOFTA (System for Observing Family Therapy Alliances) (Friedlander, Escudero, & Heatherington, 2006) refleja las características comunes de los diversos contextos terapéuticos, lo que permite su aplicación no solo en terapia individual, familiar o de pareja, sino también en terapia grupal (Escudero, 2009). Se articula en torno a cuatro dimensiones: (1) Enganche en el proceso terapéutico, (2) Conexión emocional con el terapeuta, (3) Seguridad dentro del sistema terapéutico y (4) Sentido de compartir el propósito en la familia. Las dos primeras dimensiones reflejan la clásica definición de la alianza terapéutica del modelo de Bordin y las otras dos dimensiones recogen aspectos sistémicos de la terapia conjunta (Friedlander, Escudero, & Heatherington, 2009). A continuación, se presentan las definiciones de las dimensiones según Friedlander et al., (2009).

La dimensión Enganche en el proceso terapéutico se refiere a la implicación del cliente en la terapia y en la consecución de los objetivos. Se considera indispensable la cooperación del cliente en la psicoterapia para lograr que sea una parte activa del tratamiento.

La dimensión Conexión emocional con el terapeuta se refiere a la percepción, por parte del cliente, de una verdadera preocupación y deseo de ayudar del terapeuta. El cliente valora al terapeuta como una persona importante en su vida y siente que la relación construida es de confianza y afecto.

La dimensión Seguridad dentro del sistema terapéutico recoge la sensación de comodidad y apertura a nuevas perspectivas por parte del cliente.

Y, como cuarta dimensión, estaría el Sentido de compartir el propósito en la familia, la cual refleja el grado en que los miembros de la familia participan unidos en la terapia.

Es importante destacar que las dimensiones se consideran procesos dinámicos y fluidos, que están interrelacionadas entre sí (Friedlander et al., 2009). En la Figura 1 se muestra de manera gráfica el modelo SOFTA propuesto por Escudero, (2009).

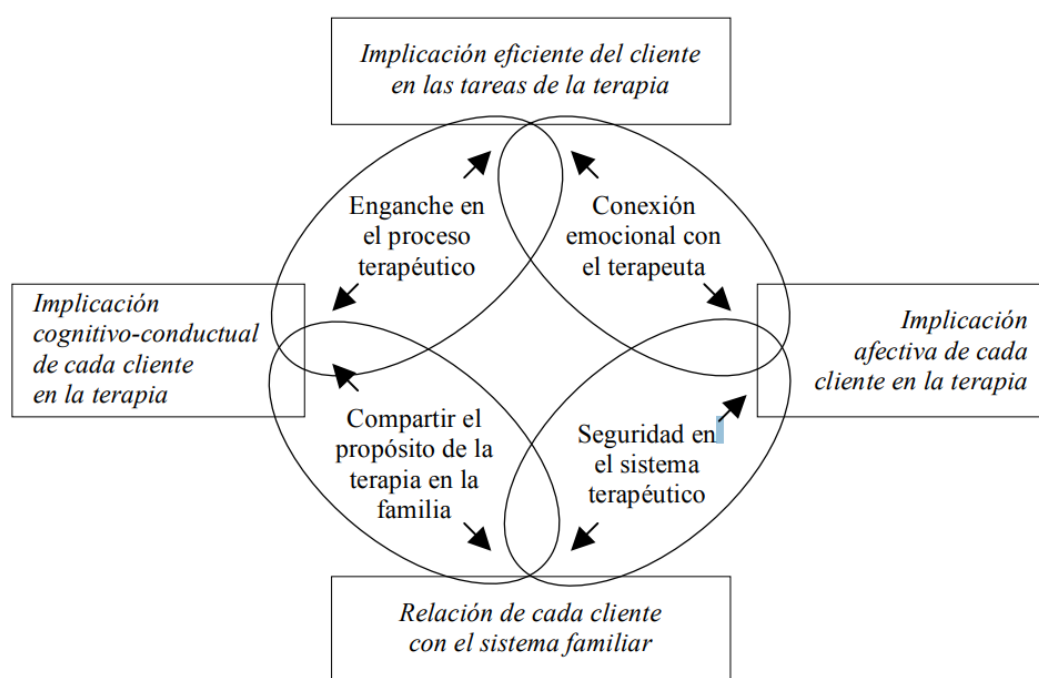


Figura 1. Representación del modelo SOFTA (Escudero, 2009, p.255).

El modelo SOFTA se caracteriza por ser (1) transteórico, (2) observable, (3) interpersonal y (4) multidimensional (Friedlander et al., 2009) y a día de hoy, es considerado como una de las conceptualizaciones multidimensionales más actuales en terapia familiar (Günther, 2017).

Trasteórico en cuanto a que los autores desarrollaron los instrumentos inductivamente para que no se limitase a un enfoque teórico único ni a una única escuela.

Observable, en la medida que asume que “las conductas sociales manifiestan pensamientos y sentimientos de fondo acerca de las relaciones interpersonales” (Friedlander et al., 2009, p.54), de manera que las conductas verbales y no verbales observadas a través del instrumento observacional “son manifestaciones de la contribución cognitiva y emocional que hace el terapeuta al Enganche, la Conexión, la Seguridad y el Sentido de compartir el propósito de la familia acerca de la terapia” (Friedlander et al., 2009, p.55).

Interpersonal dado que los ítems hacen referencia a “conductas interactivas entre los miembros de la familia, y entre cada cliente y terapeuta. Las sesiones de terapia son por definición contextos interpersonales de un gran valor comunicativo” (Friedlander et al., 2009, p.58), haciendo referencia al axioma “no es posible no comunicar” de Watzlawick, Jackson, & Beavin, (1967).

Y, multidimensional, por dos motivos. Por un lado, porque ambos sistemas, cliente y terapeuta, está representados y, por otro lado, porque el constructo alianza terapéutica se conforma en base a cuatro dimensiones. “Cada dimensión está compuesta de ítems, tanto positivos como negativos, que ejemplifican las contribuciones favorables y desfavorables a la alianza terapéutica” (Friedlander et al., 2009, p.59).

2.4. Investigación en alianza terapéutica

2.4.1. Relación entre la alianza terapéutica y el resultado de la intervención

La alianza terapéutica ha sido destacada como una variable de proceso necesaria para comprender la eficacia de las intervenciones (Welmers-Van de Poll et al., 2018), dado que ha demostrado la influencia que tiene en el éxito de la psicoterapia, tanto en el ámbito de la psicoterapia de adultos (Flückiger et al., 2018) como en psicoterapia de niños

y adolescentes (Karver et al., 2018), y en terapia familiar y de pareja (Friedlander et al., 2018). La literatura apunta a que la alianza terapéutica explica entre un 7 y un 21% del cambio terapéutico (Crits-Christoph et al., 2011; Flückiger et al., 2018; Karver et al., 2018; Wampold & Imel, 2015; Welmers-Van de Poll et al., 2018).

Tratando de profundizar en el conocimiento sobre cómo es el proceso de la alianza terapéutica, se han desarrollado investigaciones que han puesto el foco en los momentos de la evaluación de la alianza terapéutica. Por un lado, contamos con investigaciones que han evaluado la alianza terapéutica en fases iniciales de la intervención. En este sentido, los resultados revelan la relevancia de establecer una buena alianza terapéutica en las primeras sesiones del tratamiento para el buen pronóstico del mismo (Castonguay, Constantino, & Holtforth, 2006; Glebova et al., 2011; Wampold & Imel, 2015; Yoo, Bartle-Haring, & Gangamma, 2016). Por otro lado, las investigaciones con más de una medida de la alianza terapéutica han generado cierta controversia acerca de cuál es la mejor trayectoria de la alianza terapéutica para alcanzar el éxito. Parte de la literatura apunta a la importancia de mantener estable la alianza establecida en las primeras sesiones durante el proceso terapéutico para obtener mejores resultados (Glebova et al., 2011; Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015; Wampold & Imel, 2015; Yoo et al., 2016), mientras que otros estudios defienden el incremento de la alianza a lo largo de la intervención para alcanzar el cambio terapéutico (Chu, Skriner, & Zandberg, 2014; Kramer, de Roten, Beretta, Michel, & Despland, 2009; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005).

Cabe destacar que la literatura también ha dedicado grandes esfuerzos en estudiar las perspectivas de clientes y terapeutas de la alianza terapéutica y su relación con el resultado de la intervención. En las investigaciones realizadas se han encontrado diferencias entre la percepción del cliente y la del terapeuta (Fitzpatrick, Iwakabe, &

Stalikas, 2005; Meier & Donmall, 2006). Algunas investigaciones encontraron una relación más fuerte entre la percepción del cliente y el resultado terapéutico (Horvath & Symonds, 1991; Piper, Azim, Joyce, & Mccallum, 1991), mientras que investigaciones más recientes defienden que es la percepción del terapeuta de la alianza terapéutica la más relacionada con el resultado de la terapia (Baldwin, Wampold, & Imel, 2007; Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012).

2.4.2. Factores que influyen en la construcción de la alianza terapéutica

Como se ha comentado previamente, el éxito de la intervención terapéutica dependerá en gran medida de la alianza terapéutica que se establezca (Friedlander et al., 2018; Wampold & Imel, 2015; Yoo et al., 2016). Por ello, se han desarrollado investigaciones centradas en identificar qué factores influyen en la construcción de la alianza terapéutica, tanto del paciente como del terapeuta.

En lo que respecta al estudio de las características del cliente, se ha encontrado que establecen una fuerte alianza terapéutica aquellos con (1) niveles altos de regulación emocional (Burt, 2013; Knerr et al., 2011; Owens, Haddock, & Berry, 2013; Whitehead, Jones, Bilms, Lavner, & Suveg, 2019), (2) alta autoestima (Saunders, 2001), (3) bajos niveles de estrés (Knerr & Bartle-Haring, 2010; Knerr et al., 2011) y (4) alta calidad en las relaciones sociales (Connolly Gibbons et al., 2003; Eltz, Shirk, & Sarlin, 1995; Hersoug, Monsen, Havik, & Høglend, 2002; Saunders, 2001). Por otro lado, evidencia recogida hasta el momento sugiere que la sintomatología psicológica de los pacientes al inicio del tratamiento no guarda relación con el establecimiento de la alianza terapéutica. Este resultado ha sido identificado en diversos contextos terapéuticos, como la terapia individual (Hersoug et al., 2002; Horvath, Gaston, & Luborsky, 1993; Saunders, 2001), y la terapia conjunta (Knobloch-Fedders, Pinsof, & Mann, 2007; Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005). Todas estas características tienen una influencia en

la construcción de la alianza terapéutica, por lo que los profesionales deben tener especial cuidado ante este tipo de características en los clientes y emplear estrategias para amoldarse.

En cuanto a las características de los terapeutas que pueden influir en el establecimiento de la alianza terapéutica, sus actitudes y comportamientos han sido las variables identificadas por su importante papel, tal y como se refleja en la Tabla 2.

Tabla 2

Actitudes y comportamientos del terapeuta que influyen en la alianza terapéutica

Actitudes y comportamientos del terapeuta	Autores
• Generar un ambiente de seguridad para alcanzar una buena alianza terapéutica, mostrando comprensión, calidez, apoyo y colaboración a cada uno de los miembros de la terapia.	Escudero, Boogmans, Loots, & Friedlander, 2012; Escudero, Friedlander, Varela, & Abascal, 2008; Friedlander et al., 2009. Escudero, 2009.
• Mostrarse comprometido con la terapia, haciendo referencias que integren como un equipo al profesional y al paciente (ej. el uso del plural a la hora de abordar los retrocesos) o empleando un tono firme y seguro, pero cercano y afectivo.	
• Fomentar el compromiso con la terapia entre los miembros del grupo a través del apoyo mutuo, la comunicación abierta y el énfasis en las perspectivas compartidas.	Lambert, Skinner, & Friedlander, 2012.
• Contribuir a que se sientan cómodos en sesión.	Friedlander et al., 2011; Lambert et al., 2012.
• Ser versátil para posibilitar situaciones que favorezcan el desarrollo de una buena alianza terapéutica.	Carpenter, Escudero, & Rivett, 2008; Rait, 2000.

Otra variable objeto de investigación ha sido los años de experiencia. En este sentido, los resultados de dichas investigaciones han mostrado que no existe relación entre la experiencia del terapeuta y la alianza terapéutica (Corbella & Botella, 2003).

2.5. Instrumentos para evaluar la alianza terapéutica

Tratando de operativizar el constructo de alianza terapéutica, a lo largo de los años se han construido diversos instrumentos para evaluar la alianza terapéutica en los diferentes formatos de terapia. La mayoría de los instrumentos son de carácter autoinformante y los menos siguen un método observacional.

Dos meta-análisis son especialmente ilustrativos de las medidas existentes más prominentes. Por un lado, el meta-análisis realizado por Horvath et al. (2011), el cual se centra en aquellas medidas aplicables a la terapia individual. Los cuatro instrumentos más empleados son los siguientes: (1) California Psychotherapy Alliance Scale (CALPAS; Marmar, Weiss, & Gaston, 1989), (2) Helping Alliance Questionnaire (HAQ; Alexander, & Luborsky, 1986), (3) Vanderbilt Psychotherapy Process Scale (VPPS; Gomes-Schwartz, 1978); O'Malley, Suh, & Strupp, 1983) y (4) Working Alliance Inventory (WAI; Horvath & Greenberg, 1986; Horvath & Greenberg, 1989). Por otro lado, el reciente meta-análisis publicado por Friedlander et al. (2018) señala los siguientes instrumentos en la terapia conjunta: la Couple Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986), la Family Therapy Alliance Scale (FTAS; Pinsof & Catherall, 1986), el Working Alliance Inventory (WAI-Co; Symonds & Horvath, 2004), la Vanderbilt Therapeutic Alliance Scale (VTAS-R; Shelef & Diamond, 2008) y el System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero & Heatherington, 2006).

Entre todos los instrumentos, aquellos vinculados al modelo SOFTA son especialmente destacables al ser los únicos que incorporan la dimensión de Seguridad dentro del sistema terapéutico. Además, como se ha indicado previamente, el modelo SOFTA destaca por su creación específica para el ámbito de terapia familiar y de pareja, y por ofrecer la posibilidad de ser aplicado tanto en terapias individuales como grupales

(Friedlander et al., 2009). El SOFTA cuenta con dos instrumentos de evaluación para la alianza terapéutica, uno de ellos observacional (SOFTA-o) y el otro de carácter autoinformante (SOFTA-s). Estos instrumentos cuentan con versiones para los clientes y para los terapeutas, y son apropiados para ser aplicados tanto en contexto americano como español (Friedlander et al., 2009). El SOFTA-s está muy vinculado al instrumento observacional (SOFTA-o) en la medida que surgió a partir del instrumento observacional. No obstante, si bien la fiabilidad y validez predictiva del instrumento observacional ha sido respaldada a través de diversos estudios (Beck et al., 2006; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, et al., 2006; Friedlander, Lambert, & Muñiz de la Peña, 2008; Sheehan & Friedlander, 2015), no existen análisis estructurales del instrumento SOFTA-s.

3. CONCLUSIONES TEÓRICAS

Teniendo en cuenta lo anteriormente expuesto en el marco teórico, se evidencia la relevancia del estudio de los mecanismos explicativos de la eficacia de las intervenciones post-divorcio.

La literatura ha señalado la alianza terapéutica como una variable importante de estudio, reflejando que establecer una fuerte alianza terapéutica permite que el contexto terapéutico sea vivido como un espacio seguro en el que se establece una conexión emocional entre cliente y terapeuta y proporciona un sentimiento de enganche con el proceso terapéutico que permite alcanzar un mayor cambio terapéutico. En definitiva, múltiples investigaciones han recogido lo perjudicial que puede resultar la falta de esta alianza terapéutica para un buen proceso terapéutico y, por lo tanto, para el éxito de la terapia.

Debido a la importancia que la alianza terapéutica tiene para el éxito de las intervenciones, las investigaciones tratan de identificar cuáles son los factores que

influyen en el establecimiento de la alianza terapéutica y cuál es la mejor trayectoria de la alianza terapéutica para alcanzar el éxito terapéutico. Además, se ha evidenciado la necesidad de un instrumento de evaluación que permita recoger ambas perspectivas de la alianza terapéutica (cliente y terapeuta) y pueda ser empleado en diferentes contextos terapéuticos. Por otro lado, la alianza terapéutica no ha sido estudiada en relación a la problemática de divorcio y en contexto de intervención grupal. Por lo que se ha evidenciado la necesidad del estudio de esta variable, que la literatura recoge como sumamente importante, en una modalidad de intervención grupal y en la problemática de divorcio.

Por todo ello, la presente tesis doctoral tiene como objetivo analizar el papel de la alianza terapéutica en el programa de intervención grupal post-divorcio Egokitzen. Con el fin de dar respuesta a este objetivo, se plantean tres estudios empíricos.

El primer estudio tiene como objetivo analizar la estructura multidimensional de la escala SOFTA-s para evaluar la alianza terapéutica desarrollada por Friedlander, Escudero, & Heatherington, (2006) en tres modalidades terapéuticas (individual, familiar y grupal) y en sus dos versiones, para el cliente y para el terapeuta. Se centra en investigar la estructura de cuatro factores de primer orden (Enganche en el proceso terapéutico, Conexión Emocional con el terapeuta, Seguridad en el sistema terapéutico y Sentido de compartir el propósito en la familia) agrupados en un factor de segundo orden (Alianza Terapéutica) originalmente teorizada por los autores.

En el segundo estudio empírico se realiza un análisis multinivel del impacto de la regulación emocional en el establecimiento de la alianza terapéutica, teniendo en cuenta la percepción del paciente y el terapeuta. De acuerdo con los resultados de la literatura, se presenta el modelo hipotetizado en la Figura 2.

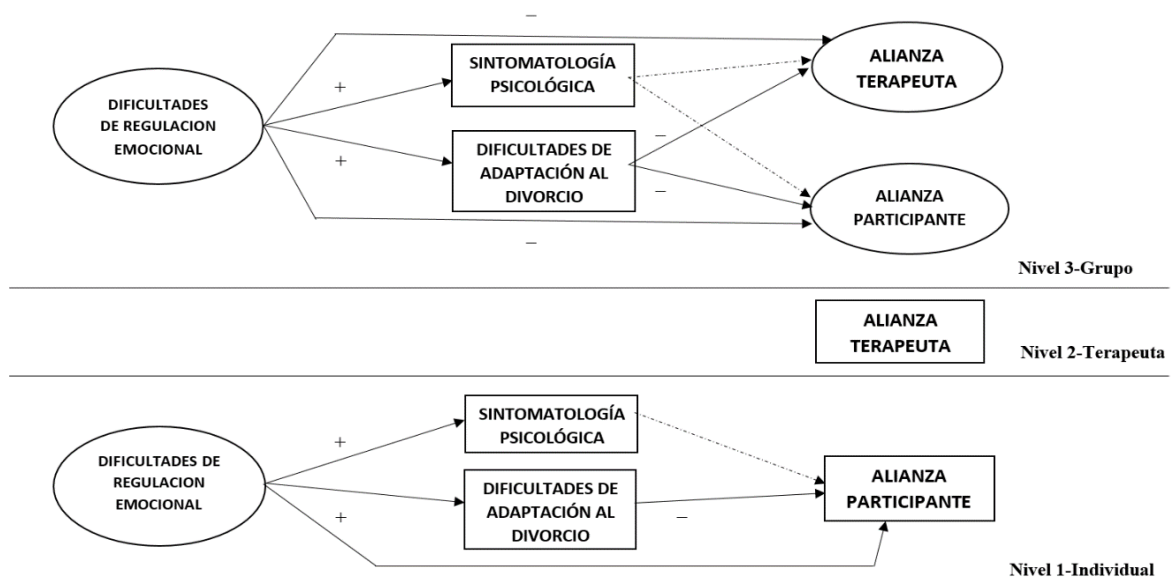


Figura 2. Modelo hipotetizado Estudio 2.

El tercer estudio analiza la influencia del proceso de la alianza terapéutica en la eficacia del programa Egokitzen, a través de la sintomatología de los progenitores, considerando la regulación emocional como variable mediadora. La hipótesis de este tercer estudio es que el desarrollo temprano de la alianza terapéutica, y su mantenimiento a lo largo de la intervención se asociará con una reducción de la sintomatología psicológica de los progenitores, a través de su asociación con el incremento en la regulación emocional de los progenitores. A continuación, se presenta el modelo hipotetizado en la Figura 3.



Figura 3. Modelo hipotetizado Estudio 3.

CAPÍTULO II: ESTUDIOS EMPÍRICOS

4. ESTUDIO I

Measuring Perceptions of the Therapeutic Alliance in Individual, Family and Group Therapy from a Systemic Perspective: Structural Validity of the SOFTA-s

Alvarez, I., Herrero, M., Martínez-Pampliega, A., & Escudero, V. (2020). Measuring Perceptions of the Therapeutic Alliance in Individual, Family, and Group Therapy from a Systemic Perspective: Structural Validity of the SOFTA-s. *Family Process*, 1–14. <https://doi.org/10.1111/famp.12565>

**Measuring Perceptions of the Therapeutic Alliance in Individual, Family and
Group Therapy from a Systemic Perspective: Structural Validity of the SOFTA-s**

Abstract

This study examined the multidimensional structure of the client and therapist versions of the self-report measure, *System for Observing Family Therapy Alliances* (SOFTA-s; Friedlander, Escudero, & Heatherington, 2006) across three distinct therapeutic modalities (individual, family, group). Specifically, we investigated whether the originally theorized model of four first-order factors (Engagement in the Therapeutic Process, Emotional Connection with the Therapist, Safety within the Therapeutic System, and Shared Sense of Purpose within the Family) would be reflected in a second-order factor (Therapeutic Alliance). The sample included 105 therapists who worked with 858 clients (165 individuals, 233 families, and 43 groups) in several Spanish community agencies. To control for dependent data, we used multilevel modeling. Results of the multilevel confirmatory factor analyses showed adequate reliabilities, fit indices and factor loadings across the three therapy contexts for both versions of the measure (client and therapist). Adequate measurement invariance was also found across respondents and therapy modalities. Taken together, these results support the structural validity of the SOFTA-s, a brief and flexible self-report alliance measure that can be used reliably in clinical practice as well as in studies of individual, family, and group therapy.

Keywords: Therapeutic Alliance, Group Therapy, Family Therapy, Individual Therapy, Multilevel Confirmatory Factor Analysis.

The influence of a strong therapeutic alliance has been clearly supported in the successful psychotherapy of adults (Flückiger et al., 2018), children and adolescents (Karver et al., 2018), couples and families (Friedlander, Escudero, et al., 2018). To date, Bordin's (1979) original conceptualization of the working alliance as a common factor in psychotherapy is the most widely used definition (Doran, 2016).

Bordin's (1979) conceptualization emphasizes the complex, dynamic, and multidimensional nature of the working alliance (Safran & Muran, 2000). In this conceptual model, the alliance refers to a collaboration between patient and therapist, that is, a two-way relationship. Indeed, the emphasis on collaboration and consensus are essential characteristics of this conceptualization (Horvath et al., 2011), which has three interrelated elements: (1) agreement between therapist and client about the goals of the treatment, (2) agreement between therapist and client about the necessary tasks to achieve the goals, and (3) a bond between therapist and client (Bordin, 1979, 1994).

In order to obtain a full picture of the therapeutic process, both therapist and client perspectives need to be evaluated (Bachelor, 2013; Nissen-Lie et al., 2015). In conjoint therapies (couple, family, and group), however, evaluation of the alliance is particularly complex (Friedlander, Escudero, & Heatherington, 2006). Unlike individual therapy, the conjoint context requires developing and balancing alliances with multiple members of the family or group. Moreover, alliances are formed between each individual client and the therapist as well as between and among the clients in a family unit (Pinsof, 1994). The concepts *intra-system alliance* and *within-family alliance*, which refer to collaboration among family members (Friedlander et al., 2018), are key to understanding and researching the alliance from a systemic perspective.

Among the various instruments for evaluating the strength of the therapeutic alliance, the multidimensional System for Observing Family Therapy Alliances (SOFTA)

(Escudero & Friedlander, 2017; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, et al., 2006), which was simultaneously developed in both English and Spanish (Friedlander, Escudero, & Heatherington, 2006), stands out because it was specifically developed to study conjoint family therapy. Moreover, a recent meta-analysis found that of the various alliance measures used in couple and family therapy research, the SOFTA system had the strongest correlation with clinical outcomes (Friedlander et al., 2018). The trans-theoretical conceptualization of the SOFTA, its meaningfulness for both clients and therapists, and its use in individual (Friedlander et al., 2018) as well as conjoint therapy, have made it one of the foremost instruments for studying the alliance from a systemic perspective (Günther, 2017).

The SOFTA model is operationalized by a set of observational (SOFTA-o) and self-report (SOFTA-s) instruments, which are articulated around four interdependent dimensions. Whereas the clients' behaviors in the SOFTA-o are assumed to reflect their positive and negative thoughts and feelings about each dimension of the alliance, the therapists' behaviors are assumed to reflect behaviors that either contribute to or detract from the various alliance dimensions (Friedlander, Escudero, & Heatherington, 2006). In parallel versions of the SOFTA-s, clients rate their own levels of engagement, emotional connection and safety, as well as the degree to which family members share a sense of purpose about the problems, goals and value of therapy for achieving those goals; therapists rate their perceptions of all family members' level of engagement, connection, safety, and shared sense of purpose.

Two of the four SOFTA dimensions reflect Bordin's (1979, 1994) classic definition of alliance (*Engagement in the Therapeutic Process* and *Emotional Connection with the Therapist*), while the other two dimensions reflect the systemic aspects of family therapy (*Safety within the Therapeutic System* and *Shared Sense of Purpose within the*

Family). The Engagement dimension, broader than agreement on goals and tasks, refers to the client's active involvement in the therapy. The Emotional Connection dimension refers to the client's perception of the therapist's genuine concern and desire to help. Safety within the Therapeutic System captures individuals' feelings of comfort and openness as well as their level of comfort interacting with other family members. Shared Sense of Purpose, the within-system aspect of alliance (Pinsof, 1994), refers to the level of productive family collaboration on therapy goals and tasks and is operationally defined as: "family members seeing themselves as working collaboratively in therapy to improve family relations and achieve family goals; a sense of solidarity in relation to the therapy ('we're in this together') and valuing their time with each other in therapy; essentially, a felt unity within the family in relation to the therapy" (Friedlander, Escudero, & Heatherington, 2006, p. 126).

The first of the SOFTA instruments to be developed was the SOFTA-o, the observational version. Its reliability and predictive validity have been supported in various studies (Beck et al., 2006; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, et al., 2006; Friedlander et al., 2008; Sheehan & Friedlander, 2015). The 16-item self-report SOFTA-s (Friedlander, Escudero, & Heatherington, 2006), which was developed from behavioral items in the SOFTA-o, has been shown to align closely with the observer version (Escudero et al., 2008; Muñoz de la Peña, Friedlander, & Escudero, 2009), supporting its ecological content validity.

Although clients' SOFTA-o ratings of alliance were found to comprise a higher order construct, the *Therapeutic Alliance* (Friedlander, Escudero, Horvath et al., 2006) (see Figure 1), no such structural analysis has been conducted with the self-report measures (SOFTA-s), prompting the present study. In addition, although the authors of the measures suggested the potential applicability of the SOFTA to group therapy

(Friedlander, Escudero, & Heatherington, 2006), to date no such research has been conducted. A few studies on the therapeutic group alliance in treatments for cancer, eating disorders, and substance abuse (Gillaspy et al., 2002; Schnur & Montgomery, 2010; Tasca et al., 2016) support the importance of the alliance in this treatment modality, prompting our decision to test the structural validity of the SOFTA-s in the group context.

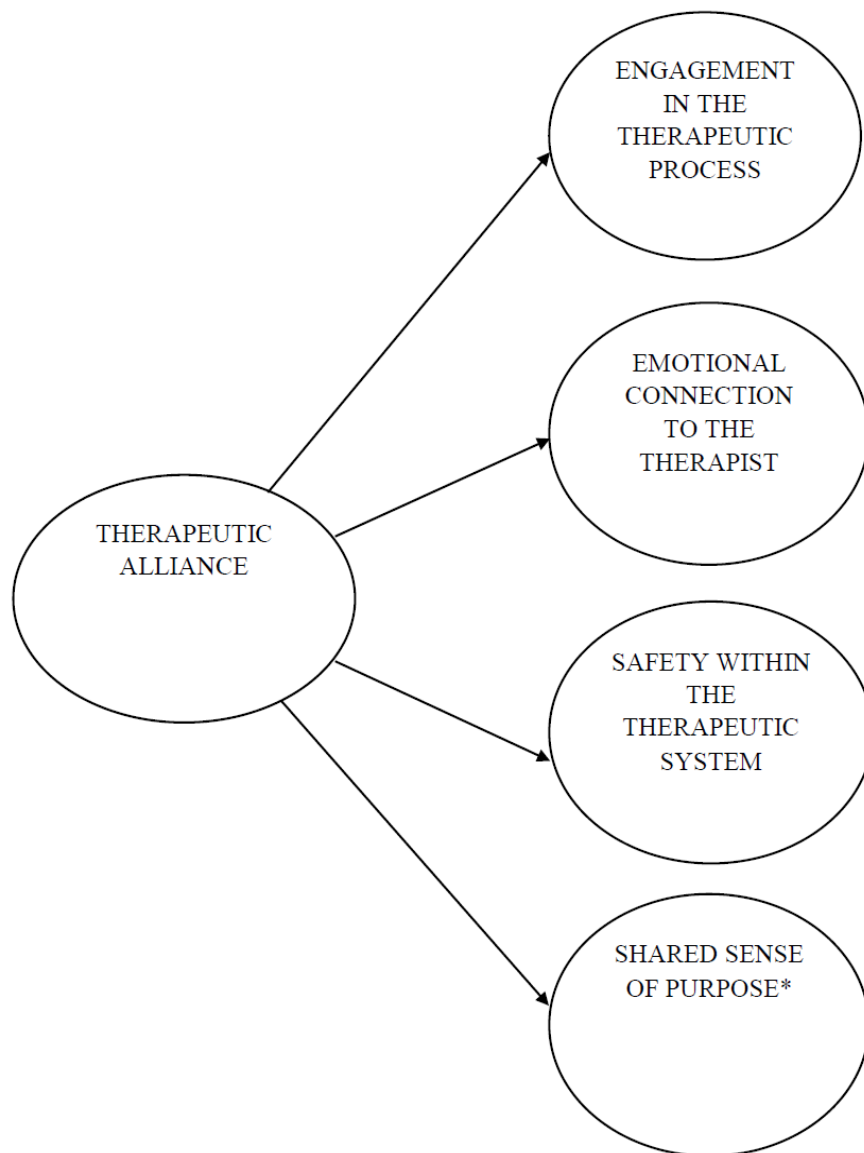


Figure 1. Theoretical model. * Shared Sense of Purpose is only defined as part of the therapeutic alliance in group and family contexts, not an individual contexts.

The SOFTA-s, administered to clients after a session, reflects their private experience of the alliance with the therapist and their experience of safety and a shared sense of purpose with the other clients in the conjoint treatment context (Escudero & Friedlander, 2017). In this way, administration of the SOFTA-s can provide therapists with regular feedback (after each session or across stages of therapy) about how individual clients are experiencing the unfolding therapeutic process. Armed with this information, the therapist could address, for example, a faltering engagement of an adolescent in conjoint sessions with his parents, or a husband's relative lack of safety in sessions with his wife, or a lack of shared sense of purpose among clients in group therapy.

Indeed, use of the SOFTA-s in a few previous case studies has shown its sensitivity to shifts in specific alliance dimensions, particularly Safety and Shared Sense of Purpose, when the discussion changes from outside influences to within-family conflicts. In one evidence-based case study (Friedlander et al., 2008), for example, a mother and daughter exhibited (SOFTA-o) and reported (SOFTA-s) particularly strong alliances during the first six sessions when they were discussing the father's drug use and absence due to incarceration, but when the topic shifted to a conflict between them, the daughter's self-reported perception of Safety plummeted, as did her view of the family's Shared Sense of Purpose.

This article summarizes our analysis of the structural validity of the SOFTA-s across three distinct therapeutic contexts —individual, family and group therapy. In doing so, we compared the multidimensional structure of the measure as completed by both clients and therapists.

Method

Participants

Clients. All clients who were seen in either individual, family or group therapy at one of several community agencies in Spain were recruited for the study. The sample included 858 clients (62% women, 38% men) with a mean age = 36.03 years ($SD = 14.21$); 165 (19%) were seen in individual therapy, 481 (56%) were seen in family therapy ($N = 233$ families, with $M = 2.06$ members per family), and 212 (25%) were seen in group therapy ($N = 43$ groups, with $M = 4.93$ members per group). Of the family therapy cases, 20% were couples who were seen for family problems (e.g., parenting concerns, coping with risky adolescent behavior). In general, the presenting problems included intrafamily conflict, poor communication/ intimacy, adjustment to separation/divorce or parental death.

Therapists. All 105 therapists who participated in the study (81% women, 19% men; M age = 40.85 years, $SD = 9.17$) had received specific training in systemic family therapy, mostly at the master's or doctoral level. On average, the therapists had 10.71 years of professional experience ($SD = 7.44$).

In total, 428 SOFTA-s questionnaires were completed by the 105 therapists: 54% were completed by the family therapists, 26% by the individual therapists, and 20% were by the group therapists. Specifically, 21 therapists completed the SOFTA-s with reference to 111 individual therapy clients ($M = 5.29$ per therapist); 39 therapists completed the measure with reference to 231 families ($M = 5.92$ per therapist); and 45 therapists completed the measure with reference to 86 groups ($M = 1.93$ questionnaires per therapist).

An integrative systems approach to therapy was used in the family and individual modalities, with interventions derived from various systemic orientations, including

structural, strategic, narrative and solution focused. In the group context, a similar integrative approach was used, although the sessions were more structured.

Instruments

System for Observing Family Therapy Alliances-self report (SOFTA-s; (Friedlander, Escudero, & Heatherington, 2006). Six versions of the measure were administered, two per therapy context (one for clients, one for therapists).

The SOFTA-s versions for the family and group modalities¹ contain 16 items reflecting each of the four alliance dimensions: Engagement in the Therapeutic Process (E), e.g., “What happens in this therapy can solve our problems;” Emotional Connection with the Therapist (C), e.g., “The therapist is doing everything possible to help me,” Safety within the Therapeutic System (S), e.g., “The therapy sessions help me open up (share my feelings, try new things...);” and Shared Sense of Purpose (SSP), e.g., “All my family members who come for therapy want the best for our family and to resolve our problems”). The therapist versions are parallel to the client versions, e.g., “What happens in therapy can solve this family’s problems” (E). Each dimension consists of 4 items rated on a 5-point Likert-type scale (1 = *not at all*, 2 = *a little*, 3 = *moderately*, 4 = *a lot*, and 5 = *very much*); summed scores can range from 4 to 20 per dimension, with 16 to 80 for the total alliance score.

In the individual therapy versions of the measure, clients and therapists respond to 12 items about the perceived strength of their alliance in terms of Engagement, Emotional Connection and Safety (3 items per dimension, e.g., “I feel comfortable and relaxed in the sessions” and “I think the client feels comfortable and relaxed in the

¹ As this was the first use of the SOFTA-s in group therapy, we modified the items to reflect this treatment context by simply changing the word “family” to “group.”

sessions”). Since this version of the SOFTA-s does not include Shared Sense of Purpose, the 12-item total score for the individual therapy modality can range from 12 to 60.

Procedure

After approval was obtained by the Ethics Commissions of the University of Deusto and the University of A Coruña, we administered the questionnaires to clients and therapists at the end of the third session of treatment. Participants signed an informed consent which indicated that participation was voluntary, anonymity was ensured, and participants had the right to withdraw from the study at any time.

Analytic Strategy

The fit of the data to the theoretical model was examined using multilevel confirmatory factor analyses (CFAs) and analysis of invariance. The analyses were carried out using MPlus 7.0 (Muthén & Muthén, 2012) with weighted least squares estimation, which is considered suitable for categorical variables and is robust for a lack of normality (Wang & Wang, 2012). The framework of the structural equations through which the CFAs were carried out allows for the estimation of factors and their relationships to the items, taking into account and eliminating measurement errors from the estimate (Wang & Wang, 2012).

With the exception of the individual therapy sample, all the collected data had a hierarchical structure, so the confirmatory factor analyses (CFA) were performed using multilevel modeling (clients nested within families or groups), which takes dependent data into account, avoiding errors in the estimates (Heck & Thomas, 2015). Therefore, the client data were modeled at Level 1, controlling for the variability due to the family or group at Level 2 for the corresponding samples.

For cases in which a therapist completed multiple questionnaires (for different clients, families, or groups), the data were modeled by client at Level 1 and grouped by

therapist at Level 2. This structure was used in all three therapy contexts—individual, family, and group. For all cases where the data were analyzed by multilevel analysis, the adequacy of this strategy was examined. For this purpose, the presence of significant systematic variance at Level 2 was examined in the null model that justified the need to consider this hierarchical level (Heck & Thomas, 2015).

First, separate CFAs were carried out for the client and therapist self-report versions in the global sample and the subsamples of the three therapy contexts (individual, family, and group) in order to study the adequacy of the theorized model for the pool of 16 items. The theoretical model represents four first-order factors (E, C, S, and SSP) grouped into a second-order factor (Therapeutic Alliance). (For the individual therapy cases, the pool was only 12 items, since the Shared Sense of Purpose dimension was not applicable in this treatment modality.)

The model fit was evaluated according to the ratio of chi-square/degrees of freedom (χ^2/df), the comparative fit index (CFI), the Tucker-Lewis index (TLI), and the root mean square error of approximation (RMSEA). Values of $\chi^2/df < 3$, CFI, and TLI > 0.90 , and RMSEA $< .08$ were considered acceptable fit values; and values of $\chi^2/df < 2$, CFI, and TLI > 0.95 , and RMSEA $< .05$ were considered excellent fit indicators (Hu & Bentler, 1999). In addition, in order to establish the base model, only factor loadings of that exceeded .30 were retained, i.e., items whose loadings did not meet this criterion value were removed from the final pool (Hair, Black, Babin, & Anderson, 2014).

Second, once the base model was established, the measurement invariance between therapeutic contexts for clients and therapists was analyzed. Specifically, independent invariance procedures were used to test (a) the invariance of the three dimensions, E, C, and S, the common structure for all three treatment modalities; and (b)

the invariance of the global structure (E, C, S, and SSP, which only pertains to the family and group therapy) and the second-order factor, Therapeutic Alliance.

For all of the measurement invariance procedures, four nested models were evaluated based on parameter equality constraints between groups (Wang & Wang, 2012). The first model was the configural model in which all parameters were unconstrained, that is, no parameter equality between groups was imposed. This model analyzes the invariance of factor loading patterns by simultaneously testing the baseline model without equality restrictions in each sample. The presence of configural invariance denotes that the proposed structure (number of factors and indicators per factor) is adequate for all groups, without assuming that they are equal. The second model was the metric invariance model in which the factor loadings were set to be equal between groups. The presence of metric invariance indicates that relationships between each item and each factor are equal in all the groups, so that the relationship between factors and other external variables can be compared between groups. The third model was the scalar model in which, in addition to the factor loadings, the intercepts were constrained to be equal between groups. The presence of scalar invariance allows comparing the means of the factors between samples (Dimitrov, 2010).

When either type of total invariance was not met, we proceeded to establish models of partial invariance, as proposed by Putnick and Bornstein (2016). In other words, whereas total invariance assumes perfect equality, partial invariance indicates some degree of equality but for all the parameters. In this way, partial invariance allows some differences by freeing parameters, although the number of freed parameters should not exceed 20% of the total number of parameters (Dimitrov, 2010). At each step, invariance between the compared samples was assumed if each constraint did not result in a reduction of the CFI $> .10$ (Wang & Wang, 2012).

Results

First, we analyzed the data structure based on the presence or absence of significant variance at Level 2 for each sample. The data indicated that, in both full samples of clients and therapists, there were items (56% and 75% of the items, respectively) with significant variance at Level 2. In the surveys filled out by clients, we found that 38% of items in the family therapy subsample and 19% of items in the group therapy subsample showed significant variance at Level 2. In the surveys filled out by therapists, 13% of the items showed significant variance at Level 2 in the family therapy subsample. The presence of significant variance at Level 2 indicated the adequacy of multilevel analyses in all of these subsamples. In contrast, because the therapist subsamples in the contexts of individual therapy and group therapy did not show significant variance at Level 2 in any of the items, these samples were analyzed with non-hierarchical models.

First, we computed CFAs with the original item pools (see Table 1). This original version showed inadequate values of the fit indexes CFI, TLI, and RMSEA in the client subsample for individual therapy, in the therapist subsample for group therapy, and in the full sample of the client version, where, additionally, all values above the cut-off point in χ^2/df were observed.

In several of the subsamples, four items (one from each alliance dimension) consistently had factor loadings below .30: “It is hard for me to discuss with the therapist what we should work on in therapy” (E), “The therapist lacks the knowledge and skills to help me” (C), “At times I feel on the defensive in therapy” (S), and “Some members of the family don’t agree with others about the goals of the therapy” (SSP). Therefore, we removed these items and re-tested the model with the remaining 12 items, 3 per dimension.

Table 1 shows the fit indices for this set of re-analyses. Results indicated very good fit indexes for all three therapy contexts (individual, family, and group) both for clients and therapists. Also shown in Table 2, all factor loadings had values greater than .30. Due to the adequacy of this factor structure in all the subsamples, the 12-item revised model was used as the base model for the subsequent invariance tests.

Second, measurement invariance in the three therapeutic contexts for both clients and therapists was analyzed (see Table 3). We determined whether the common structure (dimensions E, C, and S) was invariant in all therapy contexts and whether the complete structure (dimensions E, C, S and SSP, along with the second-order factor Therapeutic Alliance) was invariant in the family and group contexts.

Since a good fit to the configural model was found for all subsamples, we tested the full metric invariance model. Results showed that full metric invariance was met in all cases except for the common model for therapists, where partial metric invariance was obtained. Scalar invariance was calculated from each metric invariance model. Although in no case was full scalar invariance fulfilled, partial scalar invariance was met in all cases. Taken together, these data indicated that for both the client and therapist versions of the SOFTA-s, measurement invariance for the two structures was found across the three therapeutic contexts.

Finally, as shown in Table 4, we computed the reliabilities of the scale dimensions (E, C, S, and SSP) and the second-order factor (Therapeutic Alliance) for the full samples of clients and therapists and for each subsamples as a function of therapeutic context. For this purpose, McDonald's (1999) omega (Zinbarg, Yovel, Revelle, & McDonald, 2006) and Cronbach's (1951) alpha indices (George & Mallery, 2010) were used. The internal reliability indicators of all the dimensions and the total scale were acceptable, for both

the total client sample and the total therapist sample. In addition, reliabilities levels for the second-order factor were acceptable in all the samples.

The 12-items of the revised versions of the measure (client and therapist) are shown in Figure S1.

Table 1

Model Fit Indexes of Confirmatory Factor Analyses by Therapy Context for Client and Therapist Scales

				Model fit indexes					
	Scale subject	Therapy context	<i>n</i>	χ^2	<i>df</i>	χ^2/df	CFI	TLI	RMSEA
Original version	Client	Individual	165	223.53	51	4.38	.87	.83	.14
		Family	481	292.14	220	1.33	.91	.90	.03
		Group	212	294.93	220	1.34	.91	.91	.04
		Total clients	858	561.19	220	2.55	.86	.84	.04
	Therapist	Individual	111	97.95	51	1.92	.93	.91	.09
		Family	231	210.79	220	0.96	1.00	1.01	< .01
		Group	86	231.65	100	0.96	.76	.71	.12
		Total therapists	428	267.88	220	1.22	.97	.97	.02
Final version	Client	Individual	165	32.57	24	1.57	.99	.99	.05
		Family	481	148.96	116	1.28	.96	.95	.02
		Group	212	159.13	116	1.37	.95	.94	.04
		Total clients	858	282.08	116	2.43	.91	.90	.04
	Therapist	Individual	111	33.75	24	1.41	.98	.97	.06
		Family	231	109.89	116	0.95	1.00	1.01	< .01
		Group	86	72.86	50	1.46	.95	.94	.07
		Total therapists	428	154.91	116	1.34	.97	.97	.03

Note. Original version = pool of 4 items per dimension; final version = pool of 3 items per dimension; *df* = degrees of freedom;; CFI = Comparative Fit Index; TLI = Tucker-Lewis Index; RMSEA = Root Mean Square Error of Approximation.

Table 2

Factorial Loadings by Therapy Context for Client and Therapist Scales

Factor Loadings by Context									
Factor	Item	Client				Therapist			
		Ind	Fam	Group	Total	Ind	Fam	Group	Total
E	1	.69	.61	.54	.59	.64	.71	.58	.69
	5	.78	.81	.78	.79	.85	.87	.70	.80
	9	.72	.68	.53	.64	.54	.74	.94	.67
C	2	.90	.74	.70	.75	.39	.51	.68	.48
	6	.73	.70	.85	.73	.38	.53	.84	.52
	10	.79	.77	.83	.75	.70	.70	.62	.69
S	3	.75	.71	.69	.71	.91	.73	.82	.76
	7	.68	.72	.64	.68	.84	.88	.70	.89
	11	.38	.30	.40	.37	.65	.69	.44	.63
SSP	4	--	.77	.76	.77	--	.96	.81	.97
	8	--	.75	.72	.72	--	.85	.84	.82
	12	--	.60	.78	.65	--	.82	.51	.78

Note. The contents of the items can be found with the same numbering in Figure S1. E = Engagement in the therapeutic process; C = Emotional connection to the therapist; S = Safety within the therapeutic system; SSP = Shared Sense of Purpose; Ind = Individual; Fam= Family; Total = Joint sample of the three therapy contexts, namely individual, family, and group.

Table 3

Measurement Invariance Indicators

Invariance model	Common Structure								Full structure							
	Client				Therapist				Client				Therapist			
	χ^2	<i>df</i>	CFI	Δ CFI	χ^2	<i>df</i>	CFI	Δ CFI	χ^2	<i>df</i>	CFI	Δ CFI	χ^2	<i>df</i>	CFI	Δ CFI
Configural	208.47	95	.978	---	120.84	87	.981	---	228.92	100	.976	---	156.75	100	.985	---
Full metric	203.21	101	.980	-.002	153.92	93	.966	.015	211.97	108	.981	-.005	188.78	108	.979	.006
Partial metric	NA				130.15	91	.978	.003	NA				NA			
Full scalar	298.47	127	.966	.012	328.69	109	.878	.103	369.94	132	.956	.020	460.29	132	.915	.070
Partial scalar	269.07	123	.971	.007	139.54	99	.978	< .001	287.22	126	.971	.005	202.58	119	.978	.007

Note. NA - Not Applicable; CFI = Comparative Fit Index; Δ CFI = Difference of CFI between the configural model and the corresponding invariance model. The invariance of the common structure is that of the three dimensions (Engagement in the therapeutic process; Emotional connection, and Safety within the therapeutic system) common to the three therapeutic contexts. The complete structure compares the complete four-dimensional structure (including Shared sense of purpose) and a second-order factor (Therapeutic Alliance) in the family and group therapeutic contexts.

Table 4

Reliability Indexes

Scale subject	Therapy context	E		C		S		SSP		Therapeutic alliance	
		α	ω	α	ω	α	ω	α	ω	α	ω
Client	Individual	.77	.78	.84	.84	.65	.69	--	--	.90	.90
	Family	.78	.79	.81	.81	.61	.68	.83	.83	.90	.90
	Group	.71	.72	.85	.86	.66	.68	.83	.83	.91	.92
	Total	.76	.76	.82	.82	.61	.68	.82	.82	.90	.90
Therapist	Individual	.71	.73	.50	.51	.84	.85	--	--	.83	.84
	Family	.75	.76	.64	.64	.79	.80	.88	.88	.91	.91
	Group	.75	.76	.76	.76	.67	.68	.73	.76	.67	.63
	Total	.77	.78	.65	.65	.76	.78	.86	.86	.90	.91

Note. E = Engagement in the therapeutic process; C = Emotional connection to the therapist; S = Safety within the therapeutic system; SSP = Shared Sense of Purpose. α = Cronbach's alpha; ω = McDonald's omega.

SOFTA-s / FAMILY AND GROUP THERAPEUTIC ALLIANCE	
CLIENT VERSION	THERAPIST VERSION
1. What happens in therapy can solve our problems / Lo que hacemos en terapia puede solucionar nuestros problemas. 2. The therapist understands me / El terapeuta me comprende. 3. The therapy sessions help me open up (share my feelings, try new things...) / Las sesiones me sirven para abrirme (por ejemplo: expresar sentimientos o probar cosas nuevas). 4. All my family members (of us) who come for therapy want the best for our family (the group) and to resolve our problems / Los que venimos a terapia queremos conseguir lo mejor para nuestra familia (grupo) y resolver los problemas. 5. The therapist and I work together as a team / Siento que estoy trabajando en equipo con el terapeuta. 6. The therapist is doing everything possible to help me / El terapeuta está haciendo todo lo posible por ayudarme. 7. I feel comfortable and relaxed in the therapy sessions / Me siento cómodo/a y relajado/a en las sesiones. 8. All of us who come for therapy sessions value the time and effort we all put in / Todos los que venimos a terapia valoramos el esfuerzo y el tiempo invertido por los demás aquí. 9. I understand what is being done in therapy / Entiendo el sentido de lo que se hace en terapia. 10. The therapist has become an important person in my life / Considero que el terapeuta se ha convertido en una persona importante para mí. 11. There are some topics I am afraid to discuss in therapy / Hay algún tema del que no me atrevo a hablar en terapia. 12. Each of us in the family (group) helps the others get what they want out of therapy / Todos en la familia (grupo) intentamos ayudar a que los demás consigan en terapia lo que necesitan.	1. What happens in therapy can solve this family's (group's) problems / Lo que hacemos en terapia puede solucionar los problemas de el/los clientes. 2. I understand this family (group) / Comprendo a esta familia (grupo). 3. The therapy sessions are helping the clients to open up (share feelings, try new things ...) / Las sesiones les sirven a los clientes para abrirse (por ejemplo: expresar sentimientos o probar cosas nuevas). 4. All of the family members (group members) who are coming for therapy want the best for the family (group) and to resolve their problems / Los que vienen a terapia quieren conseguir lo mejor para su familia (grupo) y resolver los problemas. 5. The family (group) and I are working together as a team / Siento que estoy trabajando en equipo con mis clientes. 6. I am doing everything possible to help this family (group) / Estoy haciendo todo lo posible por ayudar a esta familia (grupo). 7. Family (group) members feel comfortable and relaxed in the therapy sessions / Creo que los clientes se sienten cómodos y relajados en las sesiones. 8. All of those who come for therapy sessions value the time and effort the others put in / Todos los que vienen a terapia valoran el esfuerzo y el tiempo invertido por los demás aquí. 9. What this family (group) and I are doing in therapy makes sense to them / Los clientes entienden el sentido de lo que se hace aquí. 10. I have become an important person in this family's (group's) life / Creo que me he convertido en una persona importante para mis clientes. 11. There are some topics that the family (group) members are afraid to discuss in therapy / Hay algunos temas de los que los clientes no se atreven a hablar en terapia. 12. Each person in the family (group) helps the others get what they want out of therapy / Todos en la familia (grupo) se ayudan entre sí para conseguir en terapia lo que necesitan.
<u>Dimensions:</u> - Engagement in the therapeutic process = 1, 5, 9. - Emotional connection to the therapist = 2, 6, 10. - Safety within the therapeutic system = 3, 7, 11. - Shared Sense of Purpose* = 4, 8, 12. * To use the self-report with only one client (individual format) the items 4, 8 and 12 should be removed. The content of the items must be adapted to the context. This version is available on request.	

Figure S1. Final version of SOFTA-s.

Discussion

The objective of this study was to assess the structural validity of the SOFTA-s in three distinct therapeutic contexts (individual, family, and group). Overall, multilevel confirmatory factor analyses supported the revised 12- and 9-item (individual therapy) versions of the measure (renamed SOFTA-sR) as psychometrically sound for evaluating clients' as well as therapists' perceptions of the working alliance in all three contexts. The good fit indices of the obtained factor structure, consistently supported the complex, multidimensional nature of the therapeutic alliance, as originally theorized (Friedlander, Escudero, & Heatherington, 2006). Specifically, this structure involves a higher-order alliance factor that subsumes four interrelated dimensions: Engagement in the Therapeutic Process, Emotional Connection with the Therapist, Safety within the Therapeutic System, and Shared Sense of Purpose.

The therapeutic alliance measured by the SOFTA-s reflects alliance characteristics common across therapeutic contexts (Friedlander, Escudero, & Heatherington, 2006) as well as the specific systemic nature of work with families. The systemic aspect of alliance is most clearly reflected in the Shared Sense of Purpose dimension, which refers to collaboration between and among clients seen conjointly irrespective of each one's individual relationship with the therapist. Notably, in a recent meta-analysis of all alliance research in couple and family therapy, measures of the within-system alliance had a stronger correlation with outcome than did measures of other alliance aspects (Friedlander, Escudero, et al., 2018).

In addition, the present results reaffirm the importance of Safety across therapeutic contexts, as well as its importance as a distinct aspect of the alliance, particularly in conjoint treatment contexts due to the presence of multiple clients and the explicitly relational nature of these treatments (Escudero & Friedlander, 2017).

It is noteworthy that our measure invariance results showed that the SOFTA's Safety and Shared Purpose dimensions emerged as important in the group context as they did in the family context. Due to the limited attention to alliance in the literature on group therapy, the present study not only supports the use of the SOFTA-s for studying this treatment modality but also the importance of the two conjoint aspects of alliance in the SOFTA framework, Safety and Shared Purpose.

Furthermore, the similar results obtained in our comparative analysis of the client and therapist versions of the measure support its structural validity. We assessed both perspectives, which might differ from one another but are necessary to understand the therapeutic alliance construct in its entirety (Fitzpatrick et al., 2005; Hersoug, Høglend, Monsen, & Havik, 2001; Kramer, de Roten, Beretta, Michel, & Despland, 2008; Meier & Donmall, 2006; Nissen-Lie et al., 2015).

In terms of limitations, although the full sample size was large, the subsample of therapists in individual therapy was comparatively small. Therefore, replication should be done with an increased number of individual therapists. In future studies, it would also be interesting to test the convergent validity of the SOFTA-s with other self-report alliance measures as well as with the observational SOFTA-o. Additionally, the inclusion of variables at different points of an intervention could provide evidence regarding the predictive validity of the SOFTA-sR. Finally, future research could consider how problems specific to couple therapy, such as romantic relationship distress or intimacy dissatisfaction, contribute to the various alliance dimensions as measured by the SOFTA-sR.

In short, the SOFTA-s is a versatile and flexible measure for evaluating the strength of the therapeutic alliance in individual, family, and group contexts as perceived by both

clients and therapists. The brevity of this instrument and its ease of application facilitate its use in practice as well as in research.

5. ESTUDIO II

The impact of emotion regulation on the establishment of the therapeutic alliance in post-divorce group intervention: A multilevel approach

Alvarez, I., Herrero, M., & Martínez-Pampliega, A. (under review). *The impact of emotion regulation on the establishment of the therapeutic alliance in post-divorce group intervention: A multilevel approach.*

**The impact of emotion regulation on the establishment of the therapeutic alliance
in post-divorce group intervention: A multilevel approach**

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Abstract

Objective: The present study focuses on the impact of emotion regulation on the establishment of the therapeutic alliance in a context of post-divorce group intervention.

Method: The study involved 177 divorced parents and 60 therapists and was developed through multilevel path analysis.

Results: The data showed an association between emotion regulation and therapeutic alliance across the difficulties of adaptation to divorce, although the results were different from the perspective of the participant and of the therapist and between the individual and the group level. **Conclusions:** The study highlights the relevant role of emotion regulation in post-divorce adaptation and in the success of the establishment of the therapeutic alliance, while clarifying the formation of the alliance from the viewpoints of the individual and the therapist. The study also highlights the need to understand the alliance at both the individual and the group level, in order to design therapeutic interventions.

Keywords: emotion regulation, therapeutic alliance, symptomatology, divorce, multilevel.

In recent decades, divorce cases have increased internationally. In Europe, it is estimated that around 1 million families go through a situation of divorce, while in Spain, a divorce rate of 58% is estimated, and specifically, Spain is one of the European countries with the highest divorce rate (Instituto de Política Familiar, 2018). In addition, 60% of parents who decide to divorce have children in their care (OECD-27_Family_Database, 2015). Along with these statistics, there is an extensive bibliography that includes the impact of divorce on the mental health of parents and children (Kiecolt-Glaser, 2018; Mahrer et al., 2018; Zulkarnain & Korenman, 2019). All of this has promoted the development of intervention programs aimed at facilitating parents' adaptation to divorce in order to decrease their symptoms and reduce the psychological impact of divorce on all members of the family (Malcore et al., 2010; Vélez et al., 2012).

Multiple intervention programs have been designed with this aim, some of which have efficacy studies (Owen & Rhoades, 2012; Sigal et al., 2012). In Spain, only the Egokitzen program has efficacy studies (Martínez-Pampliega et al., 2015; Merino et al., 2017). In order to understand the impact of these therapeutic interventions, research has sought to identify the relevant variables, among which the therapeutic alliance has been highlighted (Welmers-Van de Poll et al., 2018).

The most widely employed conceptualization of therapeutic alliance (Doran, 2016) that has the most influence in psychotherapy (Escudero, 2009) is the trans-theoretical proposal of Bordin (1979), which is characterized by establishing a collaborative attitude between patient and therapist in the agreement on the tasks and objectives of the therapy. It is widely recognized the influence of the therapeutic alliance in intervention outcomes (Flückiger et al., 2018; Friedlander et al., 2018; Karver et al., 2018).

After the initial decades of research on the relationship between the therapeutic alliance and the outcome of interventions, the current focus is on exploring the establishment of the therapeutic alliance in greater depth.

In this sense, there is emerging evidence of associations between therapeutic alliance and emotion regulation (Owens et al., 2013; Whitehead et al., 2019). The emotion regulation refers to the process through which individuals modulate their emotions and modify their behavior to achieve goals, adapt to the context, or promote their well-being (Gross, 2015). Higher levels of difficulties in emotion regulation are associated with lower therapeutic alliance (Burt, 2013; Knerr et al., 2011; Owens et al., 2013; Whitehead et al., 2019). Thus, the ability to regulate emotions might influence the establishment of therapeutic alliance (Lewandowski, D'iuso, Blake, Fitzpatrick, & Drapeau, 2011). Concretely, a person who is overwhelmed by their emotional experience may not be prepared to establish a relationship with the therapist (Whitehead et al., 2019).

Understanding the relation between these variables is especially relevant in the context of divorce, which has often been described as a process of stress (Amato & Hohmann-Marriott, 2007; Yárnoz-Yaben, Guerra, Comino, Plazaola, & Biurrun, 2008) and seems to be linked to emotional dysregulation (Johnston & Campbell, 1988; Willén, 2015; Yárnoz-Yaben et al., 2008). That is, those people with greater emotion regulation abilities seem to cope better with the stress of divorce, suffer lower levels of symptomatology (Estévez Gutiérrez, Herrero Fernández, Sarabia Gonzalvo, & Jáuregui Bilbao, 2014; Garnefski & Kraaij, 2006; Gross & Feldman Barrett, 2011), and have better post-divorce relations (Willén, 2015).

However, despite that the consideration of divorce as a very emotionally intense process is clearly accepted, research focused on understanding this emotional experience is scarce and there is even less research on its connection with the comprehension of the

therapeutic alliance. Thus, the need to continue to deepen the study of emotion regulation in relation to therapeutic alliance, the process of adaptation to divorce and symptomatology in post-divorce group interventions seems obvious.

In the literature review, it is noteworthy that most of the research on the therapeutic alliance has focused on individual therapies (Coyne, Constantino, Ravitz, & McBride, 2018; Mallinckrodt & Jeong, 2015; Probst, Lambert, Loew, Dahlbender, & Tritt, 2015) and, although less frequent, also on family and couple therapies (Knobloch-Fedders, Pinsof, & Mann, 2004; Lambert et al., 2012; Mamodhoussen et al., 2005). However, there are practically no studies analyzing the establishment of the therapeutic alliance in group settings (Tasca et al., 2016) and none concerning divorce.

The present study

The literature review has highlighted the relevance of some variables such as the therapeutic alliance in post-divorce intervention programs. As divorce is a stressful process, emotional regulation could play a key role in establishing the alliance. In addition, our comprehension of the alliance in a group context needs to be examined in further depth.

Thus, the objective of this study is to understand the impact of emotion regulation on the establishment of the therapeutic alliance in a context of post-divorce group intervention. In accordance with the results of the literature, the hypothesized model is presented in Figure 1.

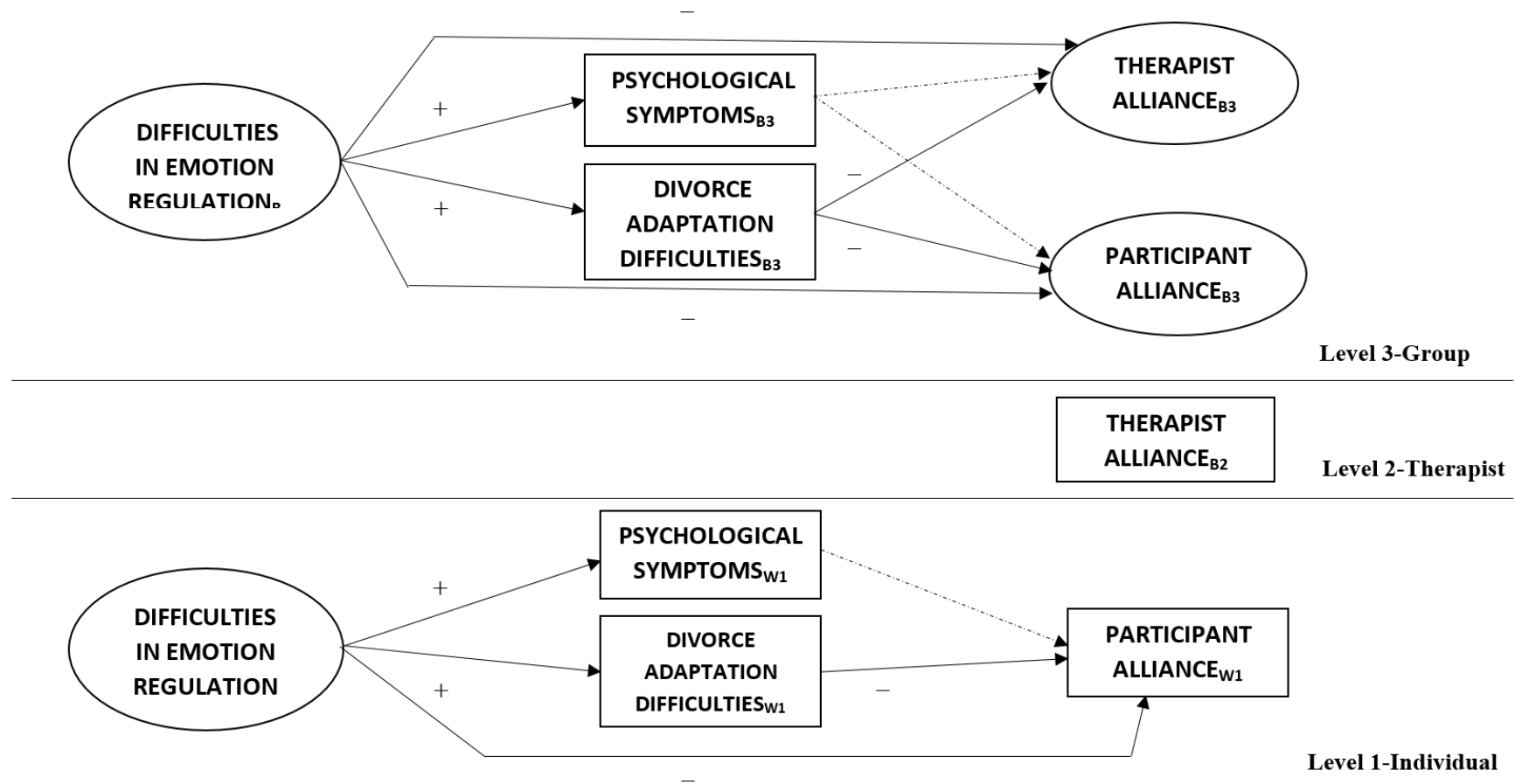


Figure 1. Hypothesized model. B3 = variable modeled at Level 3, B2 = variable modeled at Level 2, W1= variable modeled at Level 1.

This proposal has been operationalized through 1) the System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, & Heatherington, 2006) due to its wide recognition and the possibility to apply it in individual, family, couple, and group therapies (Friedlander et al., 2009) 2) multilevel analysis because it is appropriate to handle the nested structure of the data (Muthén & Muthén, 2012) 3) with parents participating in the post-divorce intervention program Egokitzen, which, as mentioned, has studies of efficacy and efficiency in Spain (Apraiz et al., 2015; Martínez-Pampliega et al., 2015; Merino et al., 2017).

Method

Participants

The participants in the study are 177 parents involved in 30 intervention groups for separated or divorced parents, who attended 12 visitation centers (specialized resource to support families after their break-up), and their therapists, a total of 60. In order to clarify the terms, the parents attending the groups are hereinafter called “participants” and their therapists are named “therapists”.

With regard to the participants, the inclusion criteria for parents were: a) motivation to participate in a post-divorce intervention; b) to be divorced or separated c) not live with their ex-partner; d) not have a psychological disorder diagnosed; e) completing the questionnaires at two moments (pre-intervention questionnaires and alliance at the 3rd session of the intervention).

Participants' average age was 40.32 years ($SD = 7.14$) and there were more women than men (63 vs. 37%, respectively). These parents had been married for an average of 10.44 years ($SD = 6.51$). Concerning time since divorce, 48% of the parents reported having separated/divorced more than three years ago, 24% between one and two years ago, 11% from two to three years ago, and the remaining 17% less than one year ago. The

relations with the ex-partner were mainly non-existent or limited (40 vs. 26%, respectively), in 16%, they were very scarce, and in 9%, they were variable. Only 8% considered their relationship to be fluid.

The parents' average number of children was 1.59 (SD = 0.85), and the presence of a single child (57%) or of two children (33%) was very frequent. The children's mean age was 8.24 years (SD = 4.35). In 71% of the cases, the participating parent was the custodial parent, with 67% of the cases presenting exclusive maternal custody, 21% shared custody, and only in 9% exclusive paternal custody.

With regard to the therapists, their mean age was 40.05 years (SD = 8.96) and they were mostly women (86% female vs. 14% male). According to the inclusion criteria, they all had experience in addressing post-divorce problems and had participated in the specific training of the program.

Pre-intervention measures

Adaptation to Divorce. Adaptation to divorce was measured by the "Cuestionario de Adaptación al Divorcio-Separación" (CAD-S; Yárnoz-Yaben & Comino-González, 2010). This instrument evaluates the adaptation to divorce-separation and consists of four dimensions. In the present study, only the dimension of Psychological and Emotional Difficulties in the adaptation to divorce-separation was administered. It refers to feelings of anger towards the ex-partner, thoughts about never being able to overcome the breakup of the relationship, or never really believing in the separation, also describing obsessive interest in the ex-partner. The dimension is made up of 6 items rated on a Likert-type response format. In the present study, Cronbach's alpha for the mentioned dimension was $\alpha = .74$, and McDonald's omega was $\omega = .77$, indicating acceptable reliability.

Parental psychological symptomatology. Psychological symptomatology was measured by the *Symptom Checklist-90* (SCL-90; Derogatis, Lipman, & Covi, 1973), adapted and validated in Spanish by González de Rivera, De las Cuevas, Rodríguez, & Rodríguez (2002). This questionnaire consists of nine dimensions evaluating clinical symptoms in adults. Four dimensions were used in this study: Interpersonal sensitivity, Depression, Anxiety, and Somatization. These four dimensions are rated on 44 Likert-type items. In this study, the alpha for these four subscales taken together was $\alpha = .96$ and the omega was $\omega = .97$, indicating very high internal consistency.

Emotion regulation. Emotion regulation was measured through the *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004), in the Spanish adaptation by Hervás and Jódar (2008). This scale examines the difficulties that may emerge in the process of emotion regulation and consists of 25 Likert-type items, grouped in five dimensions: Non-acceptance, Lack of objectives, Impulsiveness, Lack of strategies, and Lack of clarity. It also has a global score for Emotion regulation. In this study, the reliability of the global scale was very high ($\alpha = .95$, $\omega = .95$).

Intervention measures

Therapeutic Alliance. Therapeutic alliance was measured through the *System for Observing Family Therapy Alliances* (SOFTA; Friedlander, Escudero, & Heatherington, 2006). This consists of 16 Likert-type items grouped in four dimensions: Engagement in the therapeutic process, Emotional connection with the therapist, Safety within the therapeutic system, and Shared sense of purpose within the family. In addition, the questionnaire provides of a global score of Therapeutic alliance. The questionnaire is presented in two versions: one to be answered by the patients and the other to be completed by the therapists. In the patient version, the respondent must respond to the content of each item referring to their alliance with the therapist, and in the version for

the therapists, the items are completed according to their perception of alliance with the group. In this study, for patients' therapeutic alliance, the internal consistency of the scale was high ($\alpha = .84$, $\omega = .86$) and for therapists' therapeutic alliance, the mean reliability among therapists was acceptable ($\alpha = .66$, $\omega = .71$).

Procedure of the present study

The present study was performed at 12 nationwide visitation centers. We contacted 1538 people to ask them about their interest in participating in the intervention program, of whom 428 reported being interested and were summoned to a personal interview. This personal interview was attended by 360 people, who were informed about the program and who signed the informed consent. However, 107 could not meet the conditions of participation and be included in the experimental group (due to working hours, shift work, family conciliation, etc.). Two hundred twenty people completed the questionnaires on the pre-intervention variables of this study, but 20% ($n = 43$) did not complete the second step in the 3rd session, either due to not attending this particular session or to dropping out of the intervention group because of their job. So finally, 177 parents completed pre-intervention and intervention measures of the study. A flow chart of the parents participating in the study is presented in Figure 2.

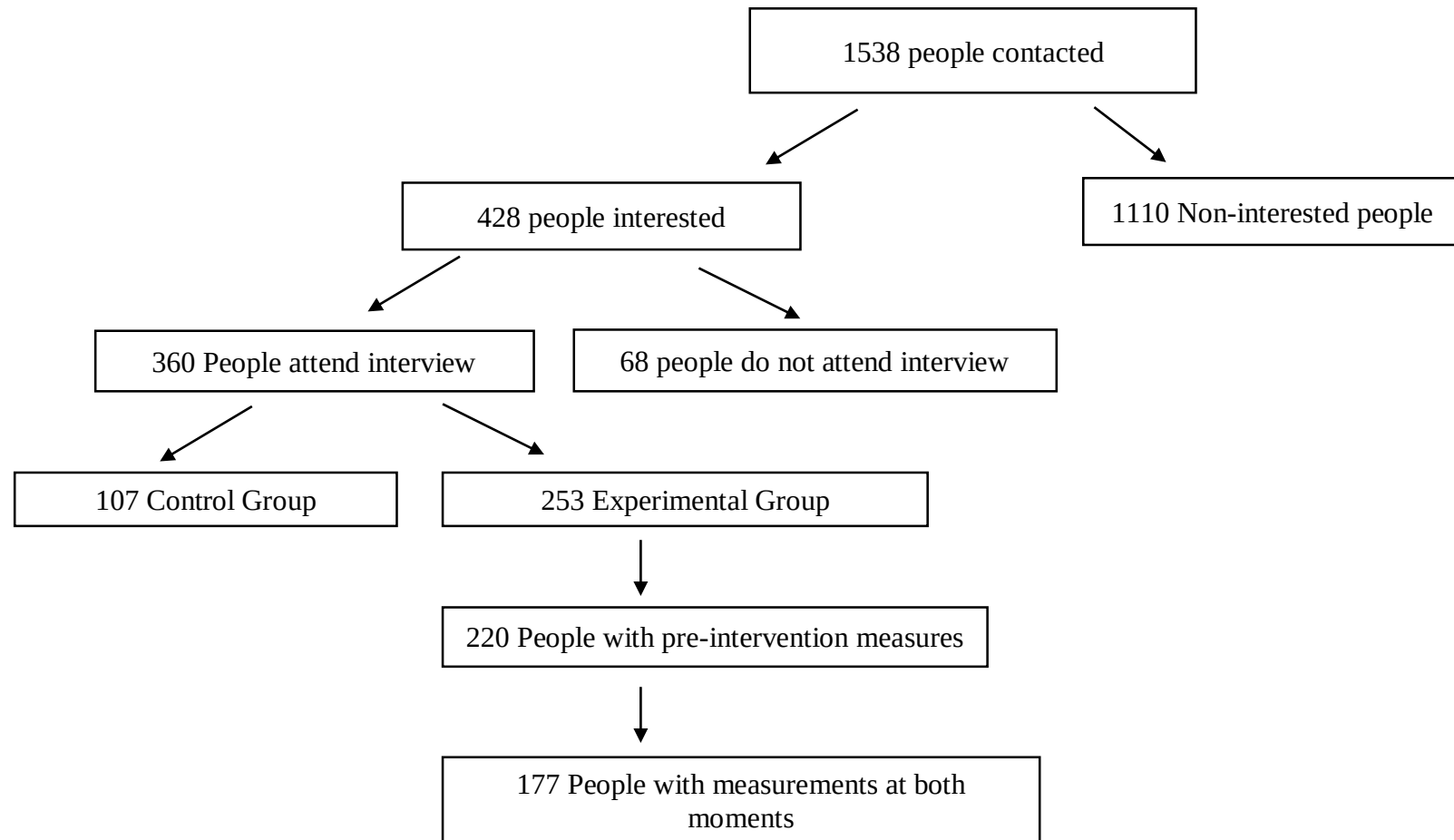


Figure 2. Flow chart of study sample.

The professionals in these visitation centers were trained by the members of the research team to evaluate and implement the intervention program. We applied the Egokitzen program (Apraiz et al., 2015; Martínez-Pampliega et al., 2015), which is a program focuses on the relevant factors of interparental conflict in divorce situations, especially those that minimize the impact of divorce and promote resilience. It consists of 11 sessions of 1.5 h, which address three thematic areas from a systemic approach to family functioning: divorce and its impact, interparental conflict, and parenting. The sessions are designed to actively engage participants through role-playing, debates, and group activities. Each intervention group was led by two trained professionals, at least one of whom was a psychologist, and the average number of participants in the groups was 5.9.

Regarding data collection, participants and therapists both completed the questionnaires. With regard to the participants, before starting the intervention group, they completed three instruments individually (DERS, SCL-90, and CAD-S). After the third session, (session identified as relevant for the establishment of the therapeutic alliance; Wampold & Imel, 2015; Yoo et al., 2016), the patient version of the SOFTA questionnaire was administered. The therapists only completed their version of the SOFTA questionnaire after the third session.

Participation in the investigation was voluntary, and participants were ensured about the anonymity of the responses to the questionnaires. Participants were also informed of the possibility of dropping out of the investigation if they wished to do so. The investigation was approved by the ethics commission of the authors' university.

Analysis procedure

As a preliminary analysis, we verified the absence of significant differences in sociodemographic and target predictive variables between the participating group and

those not included for lack of the second measurement. Data loss was small, about 6% maximum in most indicators. In addition, Little's MCAR test indicated that the missing value patterns were completely random, $\chi^2(5531) = 5147.15$, $p > .999$, so pairwise analysis was carried out.

After the preliminary analyses, the hypothesized model was tested (see Figure 1). For this purpose, we used multilevel path analysis in a structural equation framework with Mplus 7.0 (Muthén & Muthén, 2012) with Robust Maximum Likelihood. Specifically, we analyzed a model with three levels in which the individual data (Level 1) were nested within therapists (Level 2) and intervention groups (Level 3).

To perform the analysis, two models were compared: (1) the null model, and (2) the model with all the predictors (Model 1). The null model estimates the variance attributable to each level of analysis and establishes the base model for the comparison of subsequent models. From this model, we estimated the Intraclass Correlation Coefficient (ICC) of the alliance from the viewpoint of the participant and of the therapist to determine the degree of similarity between the data within each "cluster" or grouping level (i.e., therapists and/or group clusters) (Hox & Roberts, 2011).

Model 1 included the relationships shown in Figure 1. Based on the variance observed in the null model, participant alliance was modeled as a dependent variable at Level 1-Individual and Level 3-Group, while the therapist alliance was modeled at Level 2-Therapist and Level 3-Group. The variable difficulties in emotion regulation was modeled as a latent factor with the five dimensions as indicators. To control for Level 1, the match between the participant's and the therapist's gender was included and, at Level 2, therapeutic experience.

Following the recommendations of Aguinis, Gottfredson, and Culpepper (2013), the variables measured at Levels 2 or 3 were grand-mean centered at the corresponding

level and the variables modeled to Level 1 were group-mean centered. To test these indirect effects, we followed the recommendations of Preacher, Zyphur, and Zhang (2010).

For the comparison between models, the following absolute indicators of good fit were considered: the ratio of chi-square (χ^2) and degrees of freedom lower than 3, Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) greater than .90, and Root Mean Squared Error of Approximation (RMSEA) below .08. As relative fit indicators, lower values of Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC) were considered to be indicators of better fit (Hu & Bentler, 1999). The likelihood ratio test was used to determine whether the alternative model led to a significant increase in fit (Twisk, 2010).

The data set of the study is available at <http://dx.doi.org/10.17632/jmppy4h8k2.1>

Results

The descriptive statistics and correlations between the variables under study are included in Table 1.

Null model

This first model showed that the ICC of the therapeutic alliance reported by the therapists was .33 at Level 2, whereas, at Level 3, it was .67. This indicates that 67% of the variance of the therapist's alliance was related to differences between groups, and 33% to differences between therapists.

This model showed that the ICC of the therapeutic alliance reported by participants at the level of therapists was $< .01$ and, at the group level, it was .30. This information indicates that the participant's alliance presented 70% variability among participants, and 30% among groups, while it presented a near-zero variability among therapists. Therefore, the participant's alliance was modeled only at Levels 1 and 3.

Table 1

Descriptive Statistics and Correlations between Study Variables

Study variable	M	SD			Correlations				
		Level 1	Level 2	Level 3	1	2	3	4	5
1. Divorce adaptation difficulties	1.84	0.78	--	0.40	(.74)	.51***	.54***	.11	
2. Psychological symptoms	40.12	29.11	--	14.39	.51**	(.96)	.62***	-.10	
3. Difficulties in emotion regulation	8.83	3.38	--	1.74	.48**	.76***	(.95)	-.13	
4. Patient alliance	4.29	0.33	--	0.22	< .01	.23	.16	(.84)	
5. Therapist alliance	4.24	--	0.20	0.28	-.21	.22	.25	.47**	(.66)

Note. Correlations above the diagonal are Level 1 correlations (i.e., Participants, $n = 177$), and Level 3 correlation are shown below the diagonal (i.e., Groups, $n = 30$). Correlations for Level 2 (i.e., therapist units, $n = 60$) are not provided because only therapist alliance was modeled at this level. Alpha coefficients are displayed in parentheses.

** $p < .01$. *** $p < .001$.

Likewise, the psychological and emotional difficulties of adaptation to divorce had an ICC < .01 at the therapist level, and .07 and .14, respectively, at the group level. Therefore, the remainder of the variability was distributed between the individual and group levels. Specifically, psychological symptomatology showed a variability of 93% at the individual and of 7% in the groups, whereas the emotional and mental difficulties of adaptation to divorce showed a variability of 86% at the individual and of 14% in the groups. As in both variables, the variance at Level 2-therapists was close to zero, they were not modeled at that level but at Levels 1 and 3.

The likelihood ratio test indicated that the null model significantly increased the fit with respect to a non-multilevel model, $\chi^2(89) = 5010.97$, $p < .001$, or a model with only two levels, $\chi^2(8) = 471.73$, $p < .001$. The zero-model fit indicators were poor, $\chi^2(83) = 923.69$; $\chi^2/df = 11.26$; AIC = 15927.13; BIC = 16081.90; CFI < .01; TLI = < .01; RMSEA = .17.

These data indicate that the variance due to the hierarchical structure of the data was important and that, therefore, multilevel analysis is an adequate method of analysis. This model was established as the base model of comparison.

Model 1: Direct effects on therapeutic alliance

Model 1 (see Figure 3) significantly increased the fit with regard to the null model, $\chi^2(30) = 2534.60$, $p < .001$. In fact, all the fit indicators of this model were very good and better than those of the null model, $\chi^2(52) = 93.18$; $\chi^2/df = 1.79$; AIC = 13438.53; BIC = 13682.30; CFI = .95; TLI = .93; RMSEA = .05.

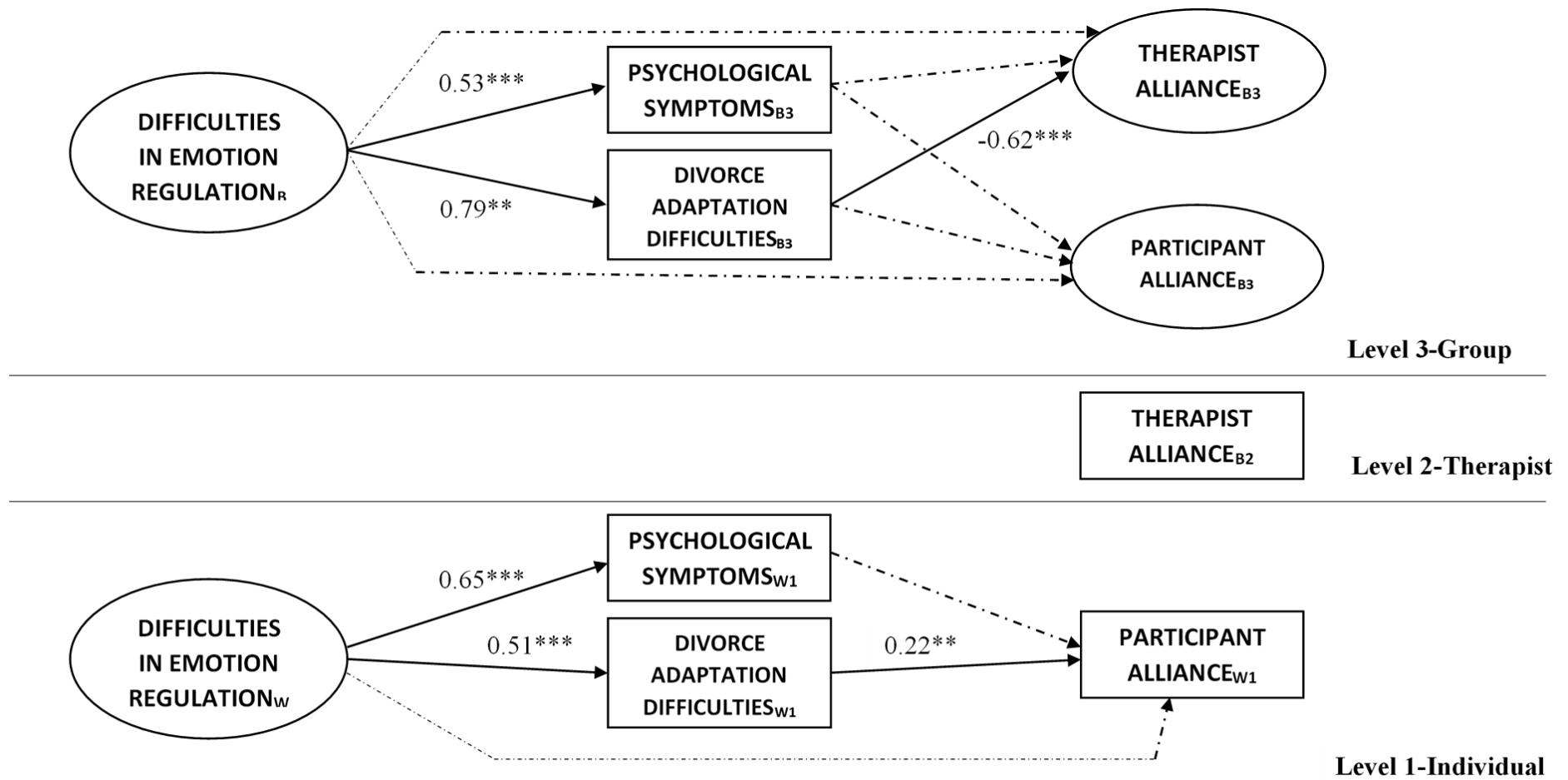


Figure 3. Multilevel standardized coefficients of significant Model 1 paths. Dashed lines represent non-significant paths. B3 = variable modeled at Level 3, B2 = variable modeled at Level 2, W1= variable modeled at Level 1.

** $p < .01$, *** $p < .001$.

As shown in Table 2, the participants' emotion regulation difficulties were related to higher levels of psychological symptomatology and emotional and mental difficulties of adaptation to divorce at Levels 1 and 3. That is, the people and groups of participants with more emotion regulation difficulties tended to present more symptomatology and more psychological difficulties of adaptation to divorce.

In the prediction of the alliance, it was observed that the psychological symptomatology had no significant effect on the alliance either of the participant or of the therapist, at any level. However, the psychological and emotional difficulties of adaptation to divorce did show a significant effect, although different in relation to the alliance perceived by the participant or by the therapist. With regard to the participants' alliance, it was observed that its effect on alliance of the psychological and emotional difficulties of adaptation to divorce was significant at Level 1 but not at Level 3.

With regard to the therapist's alliance, it was observed at Level 3 that the psychological and emotional difficulties of adaptation to divorce were related to lower therapeutic alliance, in the opposite direction as that observed in relation to the participants' alliance. Likewise, as seen in Table 2, none of the control variables had a significant effect.

This model explained 6% of the variance of participant-perceived therapeutic alliance at Level 1 and 6% at Level 3. Likewise, model explained 35% of the variance of therapist-perceived therapeutic alliance at Level 3.

Table 2

Standardized Multilevel Model Estimates of Direct Effects on Participant and Therapist's Alliance

Level	Independent variable	Dependent variable					
		Participant alliance			Therapist alliance		
		β	SE	95% CI	β	SE	95% CI
Level 1 – Participant	Same gender	0.08	0.15	[-0.14, 0.30]			
	Different gender	0.13	0.13	[-0.10, 0.25]			
	Divorce adaptation difficulties	0.22**	0.08	[0.03, 0.18]			
	Psychological symptoms	-0.11	0.39	[<-0.01, <0.01]			
	Difficulties in emotion regulation	-0.17	0.12	[-0.04, <0.01]			
Level 2 – Therapist	Therapeutic experience				0.20	0.16	[-0.02, 0.12]
Level 3 – Group	Divorce adaptation difficulties	-0.04	0.26	[-0.31, 0.26]	-0.62***	0.17	[-0.78, -0.12]
	Psychological symptoms	0.08	0.38	[-0.01, 0.01]	0.03	0.30	[-0.01, 0.01]
	Difficulties in emotion regulation	0.19	0.38	[-0.07, 0.12]	0.58	0.31	[-0.01, 0.19]

Note. Participant-therapist match on gender was modeled as two dummy variables (i.e., same gender and different gender). ** $p < .01$, *** $p < .001$.

Model 1: Indirect effects on the therapeutic alliance

Based on the observations in Model 1, the indirect effect of emotion regulation difficulties in participants' and therapists' therapeutic alliance was tested through the psychological and emotional difficulties of adaptation to divorce. The indirect effects were not tested through psychological symptomatology because it had no effect on the therapeutic alliance.

The results of these analyses showed that the indirect effects of emotion regulation on the participant's therapeutic alliance ($\beta = 0.01$, $SE < .01$, $p = .021$, 95% CI (Confidence Interval) [<0.01 , 0.02]) and on that of the therapist ($\beta = -0.05$, $SE = 0.02$, $p = .003$, 95% CI [-0.08 , -0.02]) were both significant, although with the opposite sign.

Discussion

The present study, whose main objective was to analyze the impact of emotion regulation on the establishment of the therapeutic alliance in a post-divorce group intervention, has provided relevant results in support of emotion regulation. The results have shown the importance of differentially understanding alliance in a group setting and the need to take into account both participants' and therapists' perceptions. However, the data have not fully confirmed the initial approach, insofar as the relationship between emotion regulation difficulties and the therapeutic alliance were only indirect. The results will be presented in detail.

Firstly, regarding the impact of emotion regulation, the data underline the importance of understanding this variable in relation with family conflicts, as well as in interventions, people's well-being, and post-divorce interpersonal relationships. These relationships, mainly verified in other contexts (Fresco, Mennin, Heimberg, & Ritter, 2013; Peña-Sarrionandia, Mikolajczak, & Gross, 2015; Willén, 2015), have been supported in the context of high interparental post-divorce conflict, thus contributing to

understanding the adaptation to divorce and the impact of interventions on the therapeutic alliance. However, this relationship was not direct, but occurred instead through its association with the psychological and emotional difficulties related to adaptation to divorce. Hence, these explanatory mechanisms could be addressed to achieve greater therapeutic Alliance. Therefore, it is relevant to study a variable of the divorce context, that is, the specific psychological and emotional difficulties undergone by parents who decide to divorce.

Secondly, the data showed that the relationship between emotion regulation and the therapeutic alliance occurred both from the perspective of the participant and of the therapist, although differentially. That is, parents and groups with more emotion regulation difficulties and also with greater psychological and emotional difficulties of adaptation to divorce achieve a greater therapeutic alliance with the therapist. However, in such situations, therapists perceive a lower therapeutic alliance at the group level. As the existing literature shows, the divorce process is a stressful situation for parents (Amato & Hohmann-Marriott, 2007), and the need for help felt by the parents with the greatest difficulties when facing such stress could lead them establish a greater therapeutic alliance. On the contrary, for therapists, it may be overwhelming to stand before a group with serious difficulties both in emotion regulation and adaptation to divorce, which may lead them to perceive a lower therapeutic alliance with this kind of groups. The differences between the two perceptions found in our study are in accordance with the results of other studies (Fitzpatrick et al., 2005; Meier & Donmall, 2006). Therefore, we emphasize the need to take into account both perspectives (participant and therapist), and not only those of individual modalities, couples, or family interventions, as has been the rule to date (Bachelor, 2013; Nissen-Lie et al., 2015). We should also consider the

therapeutic alliance when planning the design and evaluation of interventions carried out in groups.

Thirdly, the results obtained also seem to show that there are differences between the processes observed at the individual and group level. Thus, the data are consistent with the approach of Gillaspy et al., (2002) to the relevance of taking into account not only the individual perspective but also that of the group to understand the processes of therapeutic alliance. The results of this study are also in line with those found by Holmes & Kivlighan, (2000), which pointed out that the therapeutic alliance as an individual within a group and the therapeutic alliance as a group may play different roles as predictors of therapeutic success. In our research, at the individual level, intraindividual processes were predictors of the participant's alliance, but not of the group's alliance. This implies that these intrapersonal processes explain the differences in alliance between participants, but not the alliance between groups. This reinforces the value of self-regulating processes for individual adaptation and could indicate that the key variables of group alliance are contextual and interpersonal factors. For example, authors such as Frey and Fontana (1991), and Paulus, Kenworthy, and Coskun (2012) point out that certain group characteristics like cohesion, communication, and group size can affect the interaction between group members. We have also observed that emotion regulation and the difficulties of adaptation to divorce seem to affect the alliance of the therapist at the group level, reaffirming, therefore, the importance of these variables at both levels (individual and group) but with a differential character depending on who perceives the alliance (participant or therapist).

Finally, the present study also confirms, as already reported for other therapeutic modalities, that the participants' symptomatology does not seem to be related to the therapeutic alliance (Connolly Gibbons et al., 2003; Knobloch-Fedders et al., 2007). In

this case, the symptomatology was related to emotion regulation, but had no mediating effect on the establishment of the therapeutic alliance, either from the perspective of the participant or of the therapist. This result is maintained in the individual and group alliance.

In short, the results of this study have relevant clinical implications for therapists, insofar as they emphasize the need to take into account patients' emotion regulation due to its relevant role in establishing the alliance therapeutic when there are severe interparental conflicts. Paying attention to patients' emotion regulation in a therapeutic context could involve the therapist's conscious effort to generate, through the therapeutic relationship, a corrective emotional experience that may contribute to the decline of the patient's emotional arousal.

In post-divorce group interventions, it seems relevant to keep in mind that patients can initiate therapy with varying levels of emotion regulation, which also involves different therapeutic processes. This variability is a challenge for the therapist who, as noted, may feel overwhelmed. However, being aware of this will allow the therapist to direct efforts towards the acquisition of the patients' emotion regulation strategies and favor the success of the interventions, as well as the reduction of therapeutic dropout.

Indirectly, the conscious approach of emotion regulation in therapy will have a fundamental impact on parenting (Morris, Silk, Steinberg, Myers, & Robinson, 2007), which could influence the children's post-divorce adaptation.

We note several limitations in this study. The first is the small size of the sample. Although the sample is not negligible considering its specificity, a larger number of participants in the study would allow us to incorporate additional variables of the therapist or participants to the model without losing statistical robustness and would favor a greater generalization of the findings. A second limitation is the self-reported data. The SOFTA-

o model allows an observational analysis (Friedlander et al., 2005) both of the therapist's and the participant's interventions, and its employment would help to understand the alliance in greater detail.

Future research could contemplate the incorporation of different moments throughout the process and after its completion, contributing to our understanding of the role of post-divorce emotion regulation in the results of the intervention. Also, the inclusion of contextual and interpersonal variables could further our understanding of group therapeutic alliance.

In conclusion, the study underlines the important role of emotion regulation for the mental health and well-being of parents who are going through post-divorce difficulties with their ex-partners. This aspect should be considered when designing an adequate therapeutic alliance that favors the psychological adjustment not only of the parents but also of their children. This study makes an important contribution to the literature by providing preliminary evidence to suggest that parents' emotion regulation and the psychological and emotional difficulties of adaptation to divorce can condition the therapeutic alliance, so it is necessary to consider these variables when designing post-divorce group intervention programs. In addition, the present study has highlighted the relevance of considering both the perspective of alliance of the therapist and of the participant and of addressing alliance from a group setting, which has proven to be a different context from the simple sum of its participants.

6. ESTUDIO III

Does the therapeutic alliance process explain the results of the Egokitzen post-divorce intervention program?

Alvarez, I., Herrero, M., & Martínez-Pampliega, A. (under review). *Does the therapeutic alliance process explain the results of the Egokitzen post-divorce intervention program?*

Does the therapeutic alliance process explain the results of the Egokitzen post-divorce intervention program?

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Abstract

Objective: The objective of this study was to explain the relationship between therapeutic alliance and the changes observed in the parents' psychological symptomatology after participation in the Egokitzen program, analyzing the mediating role of emotion regulation. **Method:** The study involved 177 divorced parents and 40 therapists. **Results:** It has been observed that the early development and maintenance of the therapeutic alliance influence the parents' psychological symptomatology after the intervention, through emotion regulation. **Conclusions:** The study reinforces the role of the therapeutic alliance as a determining factor in the success of group interventions. This effect has turned out to be indirect through emotion regulation, highlighting the importance of managing emotions.

Keywords: therapeutic alliance, emotion regulation, symptomatology, divorce, group.

Nowadays, destructive divorce is considered a complex, stressful, and emotionally very intense process (Amato & Hohmann-Marriott, 2007; Bodenmann et al., 2007), with repercussions in the mental health of the people who face it (Kiecolt-Glaser, 2018; Sbarra, 2015; Stack & Scourfield, 2015; Zulkarnain & Korenman, 2019). Among the consequences of this process, the literature has emphasized its impact at an emotional level as well as psychological symptomatology, (Braver et al., 2016; Sandler et al., 2020), especially of a depressive type (Stack & Scourfield, 2015; Zulkarnain & Korenman, 2019).

Given the significant impact of destructive divorce on mental health, over the years, many group intervention programs have emerged that address emotion regulation and the associated symptomatology to facilitate the process of adaption of the people involved in this process (Malcore et al., 2010; Vélez et al., 2012). The objectives of these preventive programs include: a) generating an environment of support that encourages the cathartic expression of the experiences concerning divorce, b) providing the opportunity to solve problems and develop coping skills that help them manage their emotions, c) relieving the stress arising from separation, and d) developing the process of breaking the emotional bond with the ex-partner (Blaisure & Geasler, 2005; Geasler & Blaisure, 1999; Grych, 2005; Pedro-Carroll & Jones, 2006; Wolchik et al., 2000).

In recent years, studies at the international level on the effectiveness of these programs have proliferated (Becher et al., 2018; Braver et al., 2016; Jewell et al., 2017; McIntosh & Tan, 2017; Philip & O'Brien, 2017) although, in Spain, they remain scarce, with the sole exception of the Egokitzen program (Apraiz et al., 2015; Martínez-Pampliega et al., 2015, 2020). However, despite progress in the verification of its effectiveness, research is still far from knowing its explanatory mechanisms.

This interest has not been linked exclusively to preventive programs but also to psychotherapeutic intervention in general, with the therapeutic alliance being one of the most frequently studied factors (Friedlander et al., 2011; Horvath et al., 2011). This interest is attested by recent meta-analyses that have gathered extensive evidence of the influence of the therapeutic alliance in therapeutic success, regardless of the modality of the therapy (Flückiger et al., 2018; Friedlander et al., 2018; Karver et al., 2018). Specifically, it is suggested that the therapeutic alliance explains between 7 and 21% of therapeutic change (Crits-Christoph et al., 2011; Flückiger et al., 2018; Karver et al., 2018; Wampold & Imel, 2015; Welmers-Van de Poll et al., 2018).

Therapeutic alliance and emotion regulation

Therapeutic alliance refers to the collaborative relationship established between client and therapist (Bordin, 1979). This conceptualization has three main components: the link between therapist and client, mutual agreement on treatment goals, and mutual agreement on the tasks necessary to achieve the established goals (Bordin, 1979). To date, many investigations have identified the relevance of establishing a strong alliance in the first sessions of psychological treatment (Wampold & Imel, 2015; Yoo et al., 2016) and of maintaining this alliance during the therapeutic process for its good prognosis (Glebova et al., 2011; Nissen-Lie et al., 2015; Wampold & Imel, 2015). Establishing a strong therapeutic alliance allows the therapeutic context to be experienced as a safe space in which an emotional connection is established between the client and the therapist (Escudero & Friedlander, 2017). In addition, a strong therapeutic alliance provides a feeling of connection with the therapeutic process and unity between the client and the therapy (Escudero & Friedlander, 2017; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, et al., 2006). By achieving a context of trust and safety,

the therapist will be able to confront the client to produce greater therapeutic change (Wampold & Imel, 2015).

The specific mechanisms through which the therapeutic alliance influences the effectiveness of interventions are not yet clear. In this sense, there is emerging evidence of associations between the therapeutic alliance and emotion regulation (Owens et al., 2013; Ronningstam, 2017; Whitehead et al., 2019). Higher levels of therapeutic alliance are associated with lower levels of difficulties in regulating emotions (Burt, 2013; Knerr et al., 2011; Owens et al., 2013; Whitehead et al., 2019), understanding emotion regulation as the process through which individuals modulate their emotions and modify their behavior to achieve goals, adapt to the context or promote their well-being (Gross, 2015). Therefore, the establishment of a strong therapeutic alliance can enhance their ability to regulate emotions. In turn, the existing literature indicates that people's emotion regulation is related to their symptomatology (Estévez Gutiérrez et al., 2014; Garnefski & Kraaij, 2006). That is, those with greater abilities to regulate emotions suffer lower levels of symptomatology (Gross & Feldman Barrett, 2011). Recently, Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, and Peri (2016) integrated both emotion regulation and the therapeutic alliance in their study and identified the relevant role of both variables as determinants of the therapeutic process and the prediction of the clients' functioning.

The present study

The review of the literature has highlighted, on the one hand, the relevance of the therapeutic alliance for the success of the psychotherapeutic intervention and its increasingly evident association with emotion regulation; on the other hand, the need to understand the effectiveness of post-divorce intervention programs has been identified, with divorce being regarded as an emotionally very intense process. Understanding the effectiveness of post-divorce group interventions could benefit from deepening the

therapeutic alliance and its impact on emotion regulation. To date, we know of no studies in this regard.

This study is proposed to analyze, through a longitudinal study, the development of the alliance throughout the implementation of a post-divorce intervention program, and to deepen the relationship of the alliance with parents' emotion regulation and symptomatology. The program implemented will be the Egokitzen program, which, as indicated, is the only one that currently has studies of efficacy and effectiveness in Spain (Martínez-Pampliega et al., 2015, 2020). The data of the therapeutic alliance will be collected from the therapist's perception because it is more related to the outcome of the therapy than the client's perception (Baldwin et al., 2007; Del Re et al., 2012).

Research question

1. Does the evolution of the therapeutic alliance in the course of therapy explain the direct change in emotion regulation and the indirect change in the parents' psychological symptomatology?

Hypothesis

1. The early development of the therapeutic alliance and its maintenance throughout the intervention will be associated with a reduction of the parents' symptomatology, through its relationship with the parents' increased emotion regulation.

Method

Participants

The final sample was made up of 117 parents aged 41.88 years ($SD = 6.30$). Of these, 36% were fathers and 64% mothers. These parents had on average 1.57 children ($SD = 0.71$) with an average age of 9.00 years ($SD = 4.47$). Forty-six percent of the participants had been divorced for more than three years, 13% from two to three years,

20% from one to two years, 9% from six months to one year, 10% from two to six months, and 2% less than two months. With regard to the level of education, 35% reported having primary studies, 34% high school or vocational training, 11% a middle career, 17% a higher career, and 3% a master's degree or Ph.D.

The parents participated in 34 intervention groups supervised by two therapists. This research involved 40 therapists. The average age of the pairs of therapists was 43.43 years ($SD = 8.88$), and their professional experience was 16.84 years ($SD = 5.72$). Thirty-six percent of the pairs of therapists were made up of one man and one woman, 59% of the pairs were two women, and 5% of the pairs of therapists were made up of two men.

Intervention

The Egokitzen post-divorce intervention program (Apraiz et al., 2015; Martínez-Pampliega et al., 2015), developed from a systemic approach to family functioning, was implemented. It is aimed at minimizing the impact of interparental conflict and building the resilience of the participants and their children. It consists of 10 sessions of 90 minutes (plus a previous framing session), implemented on a weekly basis, and structured around divorce and its impact, interparental conflict, and parenting. Special emphasis is placed on the emotional impact of the breakup, helping the participants to better manage their emotions. The sessions are designed to actively engage the participants through role-playing, debates, and group activities.

Client measures

Emotion regulation. Emotion regulation was measured through the Spanish adaptation of the *Difficulties in Emotion Regulation Scale* (DERS; Gratz & Roemer, 2004) of Hervás and Jódar, (2008). This scale examines the difficulties that can appear in the process of emotion regulation and is composed of 25 five-point Likert-type items ranging from 1 (*almost never*) to 5 (*almost always*), grouped into five dimensions: Non-

Acceptance, Lack of Objectives, Impulsivity, Lack of Strategies, and Lack of Clarity. The internal consistency of the global scale was .95 at pre- and posttreatment. Cronbach's alpha index was adequate in all the dimensions both at pre- and posttreatment (Non-acceptance: .87 and .93; Lack of clear objectives: .90 and .84; Impulsivity: .84 and .78; Lack of strategies: .91 and .89; Lack of Clarity: .71 and .67, respectively).

Parental psychological symptomatology. Psychological symptomatology was measured with the adaptation and validation in Spanish of the *Symptom Checklist-90* (SCL-90; Derogatis et al., 1973) of González de Rivera et al., (2002). The scale has 44 Likert-like items rated from 1 (*nothing or not at all*) to 4 (*very much or extremely*), with a global score contemplating Interpersonal Sensitivity, Depression, Anxiety, and Somatization. The Cronbach alpha in this study was .96 at the pre- and posttreatment.

Therapists' measures

Therapeutic Alliance. Therapeutic alliance was measured through the *System for Observing Family Therapy Alliances* (SOFTA-s; Alvarez, Herrero, Martínez-Pampliega, & Escudero, (2020). It consists of 12 Likert-type items, ranging from 1 (*not at all*) to 5 (*very much*) grouped into four dimensions: Engaging in the therapeutic process, Emotional Connection with the therapist, Safety within the therapeutic system, and Sense of Sharing the purpose in the family. The questionnaire is completed via the therapists' perception of the therapeutic alliance with the group. The reliability of the scale in the third session was .65, in the sixth session, it was .76, and in the ninth session, it was .84. So, the overall mean of the scale's reliability was .75.

Procedure

This longitudinal study was developed at 12 family visitation centers nationwide. We contacted 1538 people to ask them if they were interested in participating in the intervention program, of whom 428 reported being interested and were summoned to a

personal interview. This personal interview was attended by 360 people, who were informed about the program and who signed the informed consent. However, 107 could not meet the conditions of participation for various reasons (working hours, work shift, family reconciliation, etc.) and become part of the experimental group. Finally, 117 parents completed the questionnaires on the variables of this study.

The 40 participating therapists were formed by the members of the research team in both the evaluation and implementation of the intervention program. Each intervention group was led by two professionals, with at least one being a psychologist. The average of participants in the groups was 3.47.

Regarding data collection, to measure therapeutic change, the participants completed the DERS and SCL-90 instruments individually before the intervention group began and again at the end. The therapists, meanwhile, completed the Therapeutic Partnership Questionnaire (SOFTA-s) at the end of sessions 3, 6, and 9. The literature has shown the need to collect therapeutic alliance measurements at various times throughout the treatment in order to explain the outcome of an intervention (Crits-Christoph et al., 2011).

Participation in the investigation was voluntary and participants were ensured about the anonymity of the responses to the questionnaires. Participants were also informed of the possibility of dropping out of the investigation if they wished to do so. The investigation was approved by the ethics committee of the University of Deusto (ETK-7/16-17).

Data analysis

The hypothesis was tested using growth curve analysis in a structural equation (SEM) framework with Mplus 7.0 (Muthén & Muthén, 2012) with the maximum likelihood estimator. Following the indications of Wang and Wang (2012), we began

testing the growth model of the therapeutic alliance. In this sense, growth curve analyses allow SEM to be applied to longitudinal data analysis with repeated measures for the same subjects over time. As the therapeutic alliance was measured at three moments (i.e., in the third, sixth, and ninth sessions), two models were compared based on the possible slopes (the maximum degree of the polynomial cannot exceed the number of time points $- 1 = 3 - 1 = 2$): the linear slope model and the quadratic slope model. In both cases, to facilitate interpretation, the first measure (i.e., the third session) was set to zero as the centering point. In this way, we compared whether the therapeutic alliance had a linear or curved evolution from the beginning to the end of the intervention. At the same time, the intercept was modeled, fixing the first collected value (third session) to facilitate interpretation. Therefore, the intercept can be understood as the initial level of the therapeutic alliance.

After analyzing the growth model of the therapeutic alliance, we tested the complete model, which included the intercept and the slope of the therapeutic alliance as independent variables, changes in emotion regulation difficulties as a mediator, and changes in symptomatology as the dependent variable. For this purpose, the changes were computed as differential variables in which the pre-intervention value was subtracted from the post-intervention value to represent the changes over the course of the program. In addition, gender, age, and intervention group were included as control variables in the model.

To assess the level of fit of the model, the following goodness-of-fit indicators were considered: non-significant chi-square (χ^2), Comparative Fit Index (CFI), and Tucker-Lewis Index (TLI) greater than .90, and Root Mean Squared Error of Approximation (RMSEA) and Standardized Root Mean Square Residual (SRMR) below .08 (Hu & Bentler, 1999).

Results

First, we calculated the descriptive statistics of the observed variables of the study shown in Table 1. Secondly, the models were tested according to the hypothesis, starting by analyzing the evolution of the alliance throughout the intervention sessions.

Table 1

Descriptive Statistics

Study variable	Pre		Session 3		Session 6		Session 9		Post	
	M	SD	M	SD	M	SD	M	SD	M	SD
Therapeutic alliance			4.23	0.26	4.31	0.33	4.41	0.35		
Emotion regulation difficulties										
Non-acceptance	10.43	4.99							9.30	4.82
Lack of clear objectives	7.46	3.67							6.90	2.93
Impulsivity	7.82	3.46							7.14	2.86
Lack of strategies	11.63	5.36							11.03	4.95
Lack of clarity	7.24	3.03							7.04	2.78
Psychological symptomatology	41.07	31.61							32.42	27.70

The results of the hypothesized quadratic model led to estimation warnings that indicated problems in the specification of the model. Therefore, the quadratic function was considered inappropriate for modeling the growth curve of the therapeutic alliance (Wang & Wang, 2012). Based on this, the model was tested with the linear slope, which showed a good fit to the data, ($\chi^2[1] = 1.50$, $p = .221$, CFI = 1.00, TLI = .99, RMSEA = .055, SRMR = .132), so it was established as a growth model of therapeutic alliance. This model indicated that both the mean ($M = 4.24$, $SE = 0.02$, $p < .001$) and the variance ($\sigma = 0.05$, $SE = 0.01$, $p < .001$) of the intercept were significant, yielding significant differences in the initial levels of therapeutic alliance among participants. Also, the mean

($M = 0.08$, $SE = 0.03$, $p = .004$) and variance ($\sigma = 0.02$, $SE = 0.01$, $p = .006$) of the linear slope were significant. We therefore note that the therapeutic alliance tended to increase in a linear and non-quadratic way throughout the intervention process, and that the participants differed significantly in the increase of alliance across the program sessions.

From the growth model of therapeutic alliance, we tested the final model, including the change in the difficulties of emotion regulation as a mediator, the change in psychological symptomatology as a dependent variable, and the control variables. This final model showed a good fit to the data ($\chi^2[45] = 58.33$, $p = .087$, $CFI = .95$, $TLI = .94$, $RMSEA = .050$, $SRMR = .070$). The correlations between the model variables are shown in Table 2.

Table 2

Bivariate Correlations of the Model Variables

Variables	Correlations				
	1	2	3	4	5
1. Gender					
2. Age	-.04				
Therapeutic alliance					
3. Intercept	< .01	< .01			
4. Slope	< .01	< .01	< .01		
5. Δ Emotion regulation difficulties	-.01	-.01	-.35***	.03	
6. Δ Psychological symptomatology	-.18	.04	-.15	.03	.35***

Note. *** $p < .001$.

As shown in Figure 1, the results of the final model indicated that the intercept of therapeutic alliance was significantly and negatively related to the increase in emotion regulation difficulties, but the slope of the therapeutic alliance showed a nonsignificant relationship with the changes in emotion regulation difficulties. Therefore, higher levels of therapeutic alliance, and not its increase across the sessions, were related to the decrease in emotion regulation difficulties from pre to post intervention.

With regard to changes in symptomatology, we noted that the therapeutic alliance showed no significant direct relationship either with the intercept or with the slope. However, changes in the difficulty of emotion regulation showed a significant and positive relationship with changes in symptomatology. Thus, those who experienced a reduction in their emotion regulation difficulties tended to reduce their symptomatology.

Finally, the indirect effect of the intercept of the therapeutic alliance on symptomatology was analyzed, finding that it was significant (-10.07 , $SE = 5.14$, $p = .050$), such that higher levels of therapeutic alliance as of the first sessions were related to a greater reduction of symptomatology due to the effect on emotion regulation difficulties. This model explained 18% of the variance of emotion regulation difficulties and 15% of psychological symptomatology.

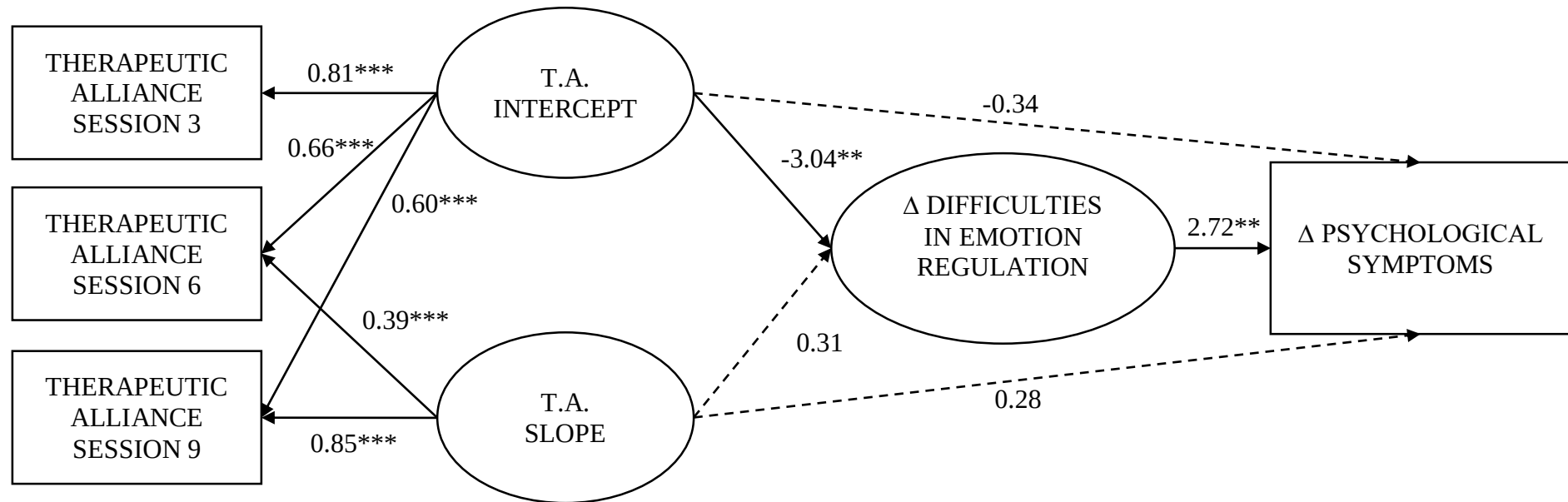


Figure 1. Standardized growth model coefficients. T.A. = Therapeutic alliance. Dashed lines represent non-significant coefficients.

** $p < .01$, *** $p < .001$.

Discussion

The objective of this study was to explain the relationship between therapeutic alliance and the changes observed in the parents' psychological symptomatology after participation in the Egokitzen program, analyzing the mediating role of emotion regulation. The results support the hypothesis: it has been observed that the early development and maintenance of the therapeutic alliance influence the parents' psychological symptomatology after the intervention, through emotion regulation.

With regard to the research question focused on the role of the therapeutic alliance, we can highlight two aspects: 1) we found that a strong construction of the therapeutic alliance at the beginning of the intervention, together with its maintenance throughout the treatment, explains the change in the parents' symptomatology; 2) this impact on symptomatology occurred through the observed change in the parents' emotion regulation. These two points will be addressed in more detail below.

On the one hand, the results are relevant because, in this area of research, there is some controversy about the best trajectory of the therapeutic alliance to achieve therapeutic success. The findings of this study confirm the importance of building a strong therapeutic alliance in the first sessions of treatment and maintaining it during the process to achieve therapeutic change. Therefore, it provides additional data to the evidence provided by Nissen-Lie et al. (2015) or Yoo et al. (2016), among others, compared to other studies (Chu et al., 2014; Kramer et al., 2009; Piper et al., 2005) that, on the contrary, found support for the increase of the therapeutic alliance throughout the intervention as a more favorable condition to obtain better therapeutic results. Although in clinical practice, it is a challenge for therapists to maintain a stable therapeutic alliance during the intervention and avoid breakdowns in it, the results obtained highlight the special care that therapists must exert. Finding strategies to achieve this may have to be

the goal. In this sense, the studies of Aron (2006) and Larsson, Falkenström, Andersson, and Holmqvist (2018) directed attention toward meta-communication about disagreements and impasses in the therapeutic relationship, that is, how to take advantage of breakdowns in the therapeutic alliance and turn them into opportunities for the benefit of the therapeutic process.

On the other hand, our research has helped to clarify the mechanisms through which the therapeutic alliance can be related to the success of interventions, as measured in this study through the parents' symptomatology. Specifically, we identified emotion regulation as a mediating variable. Although this variable had shown its relevance in other contexts (Fresco et al., 2013; Peña-Sarrionandia et al., 2015), no research had been developed till now that reflected its importance in preventive post-divorce intervention programs. These results seem to be consistent with the literature carried out in clinical context, which has emphasized the relationship between therapist and client as a corrective emotional experience (Alexander & French, 1946; Castonguay & Hill, 2012; Safran & Muran, 2000), allowing clients to acquire better management of their emotions throughout the intervention, and reducing the associated psychological symptomatology. Despite the promising results obtained, the specificity of the intervention in this study will require further research to analyze the role of emotion regulation in other therapeutic modalities.

In this sense, we emphasize the fact that this research has identified the relevance of the therapeutic alliance in a group context, a modality scarcely researched so far, identifying its role in the therapeutic success, as in other modalities (Baldwin et al., 2007; Del Re et al., 2012; Nissen-Lie et al., 2015). The results of the study allow us to affirm the importance of the therapists' directing their efforts in the first sessions to achieve

therapeutic engagement and working in collaboration with the members of the group to achieve the objectives, also in group interventions and even preventive interventions.

Finally, the study has provided support to those researchers who have emphasized the need to address the design, analyzing the therapeutic alliance process through different sessions, to better understand its relationship with the results of the therapeutic interventions (Sexton, Ridley, & Kleiner, 2004). In fact, it should be noted that this research, with three moments of measurement of the therapeutic alliance, has allowed us to explain a fairly acceptable percentage (15-18%) of therapeutic change (Crits-Christoph et al., 2011; Flückiger et al., 2018; Karver et al., 2018; Wampold & Imel, 2015; Welmers-Van de Poll et al., 2018).

However, this study has several limitations that suggest a cautious interpretation of the results. First, the therapist sample is small. Although the specificity of the sample shows the values of the participation of these professionals in the study, a greater number of participating therapists would favor a greater generalization of the findings obtained. Another limitation of the study is the self-reported nature of the measures or the limitation of the variables considered in the model. In this sense, for future research, the therapists' characteristics (e.g., personality), aspects that have not yet been addressed in post-divorce group interventions, could be considered as additional variables. It would also be important, from the point of view of the design, to take follow-up measures to enable the collection of data required to understand causal relationships.

In short, to our knowledge, this research is the first study that addresses the explanatory mechanisms of the therapeutic alliance in a group context with post-divorce interventions. The study has helped to reinforce the role of the therapeutic alliance as a determining factor in the success of group interventions, because of its relationship with the participants' symptomatology. This effect has turned out to be indirect through

emotion regulation, highlighting the importance of managing emotional processes for therapeutic success, also in post-divorce group interventions. The generalization of this result to other modalities and therapeutic objectives remains to be analyzed.

CAPÍTULO III: CONCLUSIONES GENERALES

7. CONCLUSIONES Y REFLEXIONES GENERALES

7.1. Conclusiones e implicaciones teóricas y clínicas

Como se ha señalado en la revisión teórica, ha sido claramente demostrada la influencia que la alianza terapéutica tiene en el éxito de la psicoterapia, tanto en el ámbito de la psicoterapia de adultos (Flückiger et al., 2018) como en la psicoterapia de niños y adolescentes (Karver et al., 2018), así como en el ámbito de terapia familiar y de pareja (Friedlander, Escudero, et al., 2018).

Los resultados del presente trabajo, dirigido a comprender el papel de la alianza terapéutica en el programa de intervención grupal post-divorcio Egokitzen, han contribuido a comprender los mecanismos subyacentes, al mismo tiempo que ha permitido dotar de validez estructural a un instrumento muy valioso para la evaluación de la alianza terapéutica. Las implicaciones teóricas y clínicas se estructuran según las cinco principales conclusiones alcanzadas en esta tesis doctoral:

- I. La utilidad del instrumento SOFTA-s (System for Observing Family Therapy Alliance) como una breve y sencilla herramienta de auto-informe para evaluar el constructo alianza terapéutica en tres contextos terapéuticos (individual, familiar y grupal) tanto para la percepción de los clientes como para los terapeutas.

Pese a la importancia de la alianza terapéutica en diferentes modalidades terapéuticas (Flückiger et al., 2018; Friedlander et al., 2018; Karver et al., 2018), no existía un instrumento versátil que pudiera ser empleado en diferentes contextos terapéuticos. Los autores del instrumento SOFTA-s señalaban la posibilidad de aplicarlo en terapia individual, familiar y grupal (Friedlander et al., 2009), pero, hasta la fecha, no se habían desarrollado análisis estructurales del instrumento y tampoco se había aplicado en contexto grupal. Por este motivo, se analizó la validez estructural del instrumento

SOFTA-s para evaluar la alianza terapéutica tanto de clientes como de terapeutas en las tres modalidades terapéuticas señaladas (individual, familiar y grupal).

El resultado del estudio realizado al respecto (estudio I) en esta tesis doctoral ha confirmado la validez estructural del SOFTA-s. El SOFTA-s ha demostrado ser una herramienta breve, sencilla y de fácil aplicación para evaluar la alianza terapéutica en la práctica clínica y en investigación, de manera fiable y válida en tres contextos terapéuticos. Asimismo, este instrumento permite recoger ambas perspectivas de la alianza terapéutica (cliente y terapeuta), favoreciendo su uso para la realización de análisis comparativos. El uso de análisis multinivel permitió apoyar estos resultados aportando rigor a los resultados obtenidos.

- II. La regulación emocional de los pacientes debe ser considerada si queremos desarrollar una adecuada alianza terapéutica que favorezca el ajuste psicológico de los progenitores tras el divorcio.

Como se identificó en la revisión teórica, la regulación emocional es un factor importante para la comprensión del bienestar de las personas (Fresco et al., 2013; Gross & Feldman Barrett, 2011; Peña-Sarrionandia et al., 2015; Willén, 2015). Además, evidencia emergente apunta que la alianza terapéutica y la regulación emocional están relacionadas (Owens et al., 2013; Ronningstam, 2017; Whitehead et al., 2019), encontrando que niveles más altos de alianza terapéutica se asocian con niveles más bajos de dificultades en la regulación de las emociones (Burt, 2013; Knerr et al., 2011; Owens et al., 2013; Whitehead et al., 2019). También, la regulación emocional de las personas está relacionada con la sintomatología que estas experimentan (Estévez Gutiérrez et al., 2014; Garnefski & Kraaij, 2006), en el sentido de que aquellas personas con mayores capacidades de regulación de las emociones sufren niveles más bajos de sintomatología (Gross & Feldman Barrett, 2011). De hecho, recientemente, Fisher et al., (2016)

incluyeron en su investigación tanto la regulación emocional como la alianza terapéutica e identificaron el importante papel de ambas variables como determinantes del proceso terapéutico y como predictoras del funcionamiento de los clientes, apoyando una línea prometedora de estudios para seguir profundizando en la alianza terapéutica.

No obstante, a pesar de la relevancia de la regulación emocional para el bienestar psicológico y de la consideración del divorcio como un proceso emocionalmente intenso, son escasos los estudios existentes que han tratado de comprender dicha experiencia emocional en el ámbito del divorcio. Por todo ello, los hallazgos de los estudios realizados en la presente tesis doctoral suponen un apoyo empírico a la regulación emocional como un factor importante a considerar en el ámbito clínico.

Por un lado, la presente tesis doctoral ha reflejado el impacto de la regulación emocional en el establecimiento de la alianza terapéutica (estudio II) y, por otro lado, ha evidenciado la relevancia de la regulación emocional como mediadora entre la alianza terapéutica y la sintomatología de los progenitores (estudio III). En definitiva, la presente tesis doctoral ha evidenciado el importante rol que la regulación emocional presenta en relación a la salud mental y al bienestar de los progenitores que están atravesando dificultades post-divorcio con sus ex-parejas. Por lo que, en esta línea, y siguiendo los resultados de la presente tesis doctoral parece evidente la necesidad de incorporar el trabajo en regulación emocional en los programas de intervención post-divorcio, con la finalidad de que los clientes adquieran un mejor manejo de sus emociones a lo largo de la intervención, y reduzcan la sintomatología psicológica asociada.

III. La relevancia de las primeras sesiones de la alianza terapéutica y del mantenimiento de la misma durante el proceso terapéutico para alcanzar el éxito terapéutico en intervenciones grupales post-divorcio.

A pesar de que en la actualidad es evidente la influencia que la alianza terapéutica tiene sobre el éxito terapéutico (Flückiger et al., 2018; Friedlander et al., 2018; Karver et al., 2018), a día de hoy, no está claro cómo debe ser la trayectoria de la alianza terapéutica a lo largo de la intervención para aumentar la eficacia de las intervenciones, lo que se convirtió en el objetivo del estudio III.

En este sentido, los resultados obtenidos en la presente tesis doctoral corroboran la importancia de construir una fuerte alianza terapéutica al inicio de la intervención y mantener la alianza terapéutica durante el proceso para alcanzar un cambio terapéutico, proporcionando datos adicionales a las evidencias aportadas por Nissen-Lie et al., (2015) y Yoo et al., (2016). Construir una fuerte alianza terapéutica supone lograr que el cliente se sienta seguro en terapia, enganchado al proceso terapéutico y que exista una conexión emocional entre cliente y terapeuta (Escudero & Friedlander, 2017; Friedlander, Escudero, & Heatherington, 2006; Friedlander, Escudero, Horvath, et al., 2006).

En cuanto a las implicaciones clínicas de los resultados observados para los programas de intervención post-divorcio, resulta evidente que los terapeutas deben poner especial énfasis en trabajar la alianza terapéutica con los clientes, es decir, trabajar el enganche en el proceso terapéutico, la conexión emocional, que los miembros del grupo compartan el propósito y la seguridad dentro del sistema terapéutico con el fin de favorecer el éxito terapéutico, al igual que hasta la fecha había sido identificado en contextos clínicos de terapia individual, grupal o de pareja. Asimismo, resulta esencial destacar el papel que los profesionales desempeñan en el desarrollo de esta alianza terapéutica en programas de intervención grupales post-divorcio.

IV. La relevancia de considerar la percepción de la alianza terapéutica tanto del paciente como del terapeuta en intervenciones grupales post-divorcio.

Con el fin de obtener una panorámica completa del proceso terapéutico, la literatura señala la necesidad de evaluar tanto la percepción de pacientes como de terapeutas (Bachelor, 2013; Nissen-Lie et al., 2015). En la presente tesis doctoral, se ha realizado dicho análisis, encontrándose diferencias en la percepción de la alianza terapéutica entre ambos, paciente y terapeuta (estudio II). Estos resultados también han sido recogidos en otras investigaciones (Fitzpatrick et al., 2005; Meier & Donmall, 2006).

Estos resultados son de gran relevancia para el ámbito clínico. A la hora de establecer una buena alianza terapéutica los profesionales deben trabajar coordinadamente con el cliente, poniendo en común cuáles son sus percepciones sobre la alianza terapéutica (Friedlander et al., 2009). Es importante evaluar ambas perspectivas de la alianza terapéutica, de forma que, en caso de diferencias, el terapeuta pueda abordarlas con el cliente, es decir, discutir las, negociarlas, trabajar la implicación en terapia, etc., con el fin último de obtener unos mejores resultados terapéuticos (Larsson et al., 2018).

Por tanto, la presente tesis doctoral pone de manifiesto la necesidad de tener en cuenta ambas perspectivas (paciente y terapeuta) también en la comprensión de la alianza terapéutica en contexto de intervención grupal post-divorcio, en la planificación del diseño y evaluación de intervenciones desarrolladas con modalidades grupales, y no sólo en modalidades individuales, de pareja o familia, como ha sido habitual hasta la fecha (Bachelor, 2013; Nissen-Lie et al., 2015).

V. La relevancia de comprender de forma diferencial la alianza terapéutica en contexto grupal.

Es de destacar que si bien los hallazgos de las investigaciones sobre alianza terapéutica subrayan su importancia, la mayoría de las investigaciones se han centrado en otras modalidades terapéuticas (Coyne et al., 2018; Lambert et al., 2012; Mallinckrodt & Jeong, 2015; Probst et al., 2015), siendo prácticamente ausentes los estudios que analizan el establecimiento de la alianza terapéutica en contexto grupal (Tasca et al., 2016). Teniendo en cuenta esto, junto al hecho de que la alianza terapéutica como individuo de un grupo y la alianza terapéutica como grupo pueden jugar un papel diferente como predictores del éxito terapéutico (Gillaspay et al., 2002; Holmes & Kivlighan, 2000), los resultados del presente trabajo doctoral ha aportado datos relevantes para clarificar la comprensión de estos procesos en contexto grupal post-divorcio.

Los resultados observados en el estudio II indican que los procesos intraindividuales fueron predictores de la alianza terapéutica del paciente, pero no de la alianza terapéutica grupal. Esto implica que estos procesos intrapersonales permiten explicar las diferencias en alianza terapéutica entre pacientes, pero no la alianza entre grupos, lo que refuerza el valor de los procesos de autoregulación para el ajuste individual y podría indicar que las variables clave de la alianza terapéutica grupal recaen en factores contextuales e interpersonales. En este sentido, algunos autores señalan que ciertas características grupales como la cohesión, la comunicación y el tamaño grupal pueden afectar a la interacción entre los miembros de grupos (Burlingame et al., 2011; Frey & Fontana, 1991; Paulus et al., 2012).

A nivel clínico, a la hora de llevar a cabo un grupo de intervención, resulta imprescindible tener en cuenta las particularidades de esta modalidad de terapia con el fin de lograr establecer una buena alianza terapéutica, la cual debe establecerse tanto con

cada miembro del grupo como con el grupo en su conjunto. Esto hace que las situaciones de alianzas divididas que se pueden dar durante el proceso terapéutico requieran especial atención. Por todo esto, resulta esencial destacar el complejo papel desempeñado por los profesionales con el fin de desarrollar la alianza terapéutica en programas de intervención grupales post-divorcio. Para lograr el éxito terapéutico deben atender tanto al grupo en su conjunto como a las diferencias individuales de las personas que lo conforman.

7.2. Limitaciones y líneas futuras de investigación

Esta tesis doctoral presenta varias limitaciones que deben tenerse en cuenta al interpretar los resultados. A su vez, se establecerán las futuras líneas de investigación en este campo.

Por un lado, la muestra de terapeutas participantes en los estudios, entre 40 y 60, es pequeña. Aunque la especificidad de la muestra pone en valor la participación de estos profesionales en el estudio, un mayor número de terapeutas participantes favorecería una mayor generalización de los hallazgos obtenidos. En cuanto a los terapeutas, de cara a futuras investigaciones podría considerarse explorar ciertas características de personalidad que podrían influir en el establecimiento de la alianza terapéutica, aspectos que todavía no han sido abordados en intervenciones grupales post-divorcio.

Por otro lado, desde el punto de vista del diseño, sería interesante tomar medidas de seguimiento que permitan la recopilación de datos necesarios para ampliar la comprensión de las relaciones causales. Asimismo, con respecto a la evaluación, las herramientas de evaluación utilizadas han sido cuestionarios de autoinforme, lo que ha limitado la información recogida. Por ello, para futuros estudios, sería interesante combinar la administración de cuestionarios de autoinforme con otras técnicas cualitativas, de observación, como podría ser el SOFTA-o. De esta manera, podría ser analizada la consistencia de la información obtenida a través de cuestionarios de

autoinforme con las observaciones realizadas de la alianza terapéutica durante el proceso terapéutico.

Por último, debido a que la presente tesis doctoral se ha desarrollado en Puntos de Encuentro Familiar, los participantes en el estudio fueron progenitores divorciados que hacían uso de este recurso especializado por derivación judicial, lo que implica ser cautelosos con los resultados observados. Para futuros estudios, sería interesante obtener una muestra de población general como participante en el programa Egokitzen, con el fin de generalizar los resultados observados.

7.3. Consideraciones finales

La influencia de la alianza terapéutica en el éxito de las intervenciones ha sido ampliamente estudiada en la literatura (Flückiger et al., 2018; Friedlander et al., 2018; Karver et al., 2018; Welmers-Van de Poll et al., 2018), aunque todavía no están claros los mecanismos concretos por los que la alianza terapéutica influye en la eficacia de las intervenciones. La presente tesis doctoral ha supuesto una contribución en esta dirección.

En los resultados obtenidos en esta tesis doctoral, la regulación emocional ha emergido como un elemento clave para el establecimiento de la alianza terapéutica y como mediador entre la alianza terapéutica y el éxito de la intervención grupal post-divorcio. Por lo tanto, a nivel clínico, resulta esencial introducir el trabajo en regulación emocional en programas de intervención post-divorcio, respaldando resultados obtenidos con otras modalidades terapéuticas y en otras problemáticas (Amato & Hohmann-Marriott, 2007; Braver et al., 2016; Sandler et al., 2020).

Es también importante destacar la contribución de la presente tesis doctoral a la comprensión de la alianza terapéutica en un contexto de intervención grupal. Hasta el momento, la mayoría de la literatura se ha centrado en estudiar la alianza terapéutica en otras modalidades de intervención, identificando su papel en el éxito terapéutico (Baldwin

et al., 2007; Del Re et al., 2012; Nissen-Lie et al., 2015). En la presente tesis doctoral también se ha identificado el papel de la alianza terapéutica en el éxito de intervenciones grupales.

Por último, la presente tesis doctoral ha proporcionado validez estructural a un instrumento de evaluación de la alianza terapéutica que puede ser empleado en tres contextos terapéuticos, individual, familiar y grupal, y que permite recoger tanto la perspectiva del cliente como del terapeuta.

En resumen, una adecuada alianza terapéutica y regulación emocional de los clientes es esencial para el éxito terapéutico, siendo de especial relevancia la alianza terapéutica en las primeras sesiones y el mantenimiento de la misma durante el proceso terapéutico.

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ANEXOS

*Carta informativa para los progenitores***Introducción**

El divorcio o la separación de la pareja es un suceso cada vez más frecuente en las familias de nuestro entorno. La ruptura de la pareja conyugal conlleva cambios importantes para toda la familia.

Los padres y madres quieren proteger a sus hijos/as de los efectos negativos que el conflicto pueda tener sobre ellos/as, pero ésta no es siempre una tarea fácil. Para facilitárselo, les ofrecemos participar en un programa educativo para padres y madres separados-divorciados o que se encuentran inmersos en un proceso de separación o divorcio.

Objetivo

Se trata de un programa grupal psicoeducativo, de aprendizaje de habilidades y estrategias concretas. Es una intervención breve que, además de permitirles reflexionar, ofrece pautas concretas de actuación que faciliten la transición hacia un nuevo funcionamiento familiar más satisfactorio para todos/as.

Método

El programa consta de once sesiones. Las once sesiones se realizan en diez semanas consecutivas, de hora y media de duración.

La participación está abierta tanto a madres como a padres, tengan o no la custodia de los hijos/as. Sin embargo, no es conveniente que ambos progenitores acudan juntos, de forma que cada uno deberá participar en un grupo diferente.

Los padres y madres, antes, durante y después de su participación deberán contestar a unos cuestionarios, a modo de evaluación. Eso nos ayudará a comprobar la situación individual de cada uno y ajustar las intervenciones en función de las necesidades concretas.

Los datos obtenidos de estos cuestionarios, así como la información que se recoja a lo largo de las sesiones, son totalmente confidenciales. La evaluación de los datos nos permitirá ajustarnos a las necesidades de las diferentes familias que atraviesan un proceso de divorcio.

En el caso de que desee participar en el grupo, es fundamental que se comprometa a acudir a todas las sesiones y a cumplimentar todos los cuestionarios antes, durante y después de participar en el programa. Es muy importante que asumamos estos compromisos para que la experiencia sea provechosa para todos/as.

Estamos a vuestra disposición para cualquier aclaración.

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*Carta informativa para los centros participantes***Introducción**

El divorcio o la separación de la pareja es un suceso cada vez más frecuente en las familias de nuestro entorno. La ruptura de la pareja conyugal conlleva cambios importantes para toda la familia.

Los padres y madres quieren proteger a sus hijos/as de los efectos negativos que el conflicto pueda tener sobre ellos/as, pero ésta no es siempre una tarea fácil. Para facilitárselo, les ofrecemos participar en un programa educativo para padres y madres separados-divorciados o que se encuentran inmersos en un proceso de separación o divorcio.

Objetivo

Se trata de un programa grupal psicoeducativo, de aprendizaje de habilidades y estrategias concretas. Es una intervención breve que, además de permitirles reflexionar, ofrece pautas concretas de actuación que faciliten la transición hacia un nuevo funcionamiento familiar más satisfactorio para todos/as.

Método

El programa consta de once sesiones. Las once sesiones se realizan en diez semanas consecutivas, de hora y media de duración.

La participación está abierta tanto a madres como a padres, tengan o no la custodia de los hijos/as. Sin embargo, no es conveniente que ambos progenitores acudan juntos, de forma que cada uno deberá participar en un grupo diferente.

Los padres y madres, antes, durante y después de su participación deberán contestar a unos cuestionarios, a modo de evaluación. Eso nos ayudará a comprobar la situación individual de cada uno y ajustar las intervenciones en función de las necesidades concretas.

Los datos obtenidos de estos cuestionarios, así como la información que se recoja a lo largo de las sesiones, son totalmente confidenciales. La evaluación de los datos nos permitirá ajustarnos a las necesidades de las diferentes familias que atraviesan un proceso de divorcio.

En el caso de que los participantes estén de acuerdo con todo lo indicado, y deseen participar en el grupo, es fundamental que se comprometan a acudir a todas las sesiones y a cumplimentar todos los cuestionarios antes, durante y después de participar en el programa. Es muy importante que asuman estos compromisos para que la experiencia sea provechosa para todos/as. Además, hay que indicar a los participantes de que los datos se mandarán de forma anónima al grupo investigador para su análisis.

Estamos a vuestra disposición para cualquier aclaración.

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Consentimiento informado para los progenitores

Este programa tiene un carácter preventivo, ya que intenta ayudar a padres y madres a desarrollar conocimientos y habilidades apropiadas para minimizar el estrés de los hijos e hijas, derivado del divorcio y todo lo que este proceso conlleva.

El programa consta de doce sesiones más una sesión adicional de inicio y presentación (12 +1). La sesión de presentación y las diez primeras sesiones se realizan en diez semanas consecutivas, de hora y media de duración. Se realiza una sesión de seguimiento a los seis meses de finalizado el programa y una segunda sesión de seguimiento al año del programa.

La participación en el programa implica que usted y uno de sus hijos/as rellene unos cuestionarios, los cuales serán procesados por los responsables del proyecto.

Recordamos que se necesita el consentimiento informado de ambos progenitores para que el hijo/a pueda participar contestando a las evaluaciones en el caso de que éste tenga entre 12 y 16 años. En este caso, se solicitará la firma de este documento por parte de ambos progenitores.

Por favor, marque con un X si está conforme con lo siguiente:

He sido informado/a del objetivo del programa	
Se me ha dado la oportunidad de hacer preguntas sobre el programa y del estudio de evaluación asociado	
Se me ha informado del número de sesiones y de su frecuencia	
Me comprometo a completar la entrevista y los cuestionarios asociados al programa	
Acepto participar el programa	
Acepto informar al otro progenitor de la participación de nuestro hijo/a en la evaluación	
Observaciones al consentimiento	

Nombre del participante

Firma del participante

Nombre del progenitor no participante

Firma

Fecha

Tfno.: 944139000/ Ext. 2756
E-mail: iratialvarez@deusto.es

Consentimiento informado para los profesionales

Este programa de intervención ha sido desarrollado por el equipo de investigación Deusto FamilyPsych. Es necesario llevar a cabo el procedimiento que proponemos de manera rigurosa para tratar que la investigación se vea afectada en la menor medida posible.

El programa tiene un carácter preventivo, ya que intenta ayudar a padres y madres a desarrollar conocimientos y habilidades apropiadas para minimizar el estrés de los hijos e hijas, derivado del divorcio y todo lo que este proceso conlleva.

Como persona responsable de la implementación del mismo debe cumplir con una serie de exigencias éticas y legales.

Por favor, marque con un X si se compromete a lo siguiente:

Respetar la privacidad y confidencialidad de las personas participantes	
Respetar la libertad de abandonar el programa de las personas participantes	
Tener siempre presente las necesidades y perspectivas de las personas participantes en el proyecto	
Garantizar que la acción no genere daño o perjuicio a las personas participantes	
Hacer una supervisión de los datos recogidos	
Desarrollar medidas para minimizar el malestar, la tensión, el estrés, el riesgo físico o emocional, en el caso de que se produzca	
Asegurar la protección de los datos recabados	
Recoger el consentimiento informado de los participantes por duplicado y enviar una copia al equipo investigador	
Enviar al equipo investigador los datos recabados, de forma anónima, para su análisis	

Nombre del Responsable

Firma del Responsable

Fecha

Tfno.: 944139000/ Ext. 2756
E-mail: iratialvarez@deusto.es

Instrumentos de evaluación utilizados en los estudios

Nº: _____



PROTOCOLO DE EVALUACIÓN PARA PROGENITORES

A continuación, se presentan una serie de cuestionarios. Es importante que contestes de la forma más sincera posible a todas las preguntas que se te presentan en estas hojas.

Te aseguramos la total confidencialidad respecto de los datos recogidos. Antes de responder a cada pregunta, lee bien todas las posibilidades de respuesta.

Muchas gracias por tu colaboración

iratialvarez@deusto.es

1) ¿Cuál es su fecha de Nacimiento? (año): _____	2) Número de hijos: _____ 3) Edades: _____ Sexo: _____
4) Usted es el/la: 1. Padre 2. Madre	5) Usted es el padre/madre: 1. Custodio 2. No custodio
6) Estado civil: 1. Soltero/a 2. Separado/a 3. Divorciado/a 4. Casado/a, no primer matrimonio 5. Pareja de hecho Otros (especificar): _____	7) Estado civil del otro excónyuge: 1. Soltero/a 2. Separado/a 3. Divorciado/a 4. Casado/a, no primer matrimonio 5. Pareja de hecho Otros (especificar): _____
8) ¿Quiénes vivís en la misma casa? _____ _____	9) Su familia está formada por: 1. Hijos biológicos 2. Hijos adoptivos 3. Hijos biológicos y adoptivos
10) Indique los estudios cursados: 1. Menos de estudios primarios 2. Estudios primarios 3. Bachillerato 4. Carrera media 5. Carrera superior 6. Máster, doctorado	11) Indique los estudios cursados por su excónyuge 1. Menos de estudios primarios 2. Estudios primarios 3. Bachillerato 4. Carrera media 5. Carrera superior 6. Máster, doctorado
12) ¿Cuál es su situación laboral / profesional? _____	13) ¿Cuál es la situación laboral / profesional de su excónyuge?
14) ¿Cuántas horas dura su jornada de trabajo? _____ 15) ¿Y la de su excónyuge? _____	16) ¿A qué hora termina su jornada diaria? _____ 17) ¿Y la de su excónyuge? _____
18) ¿En el último trimestre cuantas veces ha acudido al servicio de Atención Primaria por su propia salud? _____ Describa los motivos: _____ _____	19) ¿En el último trimestre cuantas veces ha acudido al servicio de Atención Primaria por la salud de su hijo? _____ Describa los motivos: _____ _____
20) ¿En el último trimestre cuantas veces ha acudido al servicio de Atención Especializada por su propia salud? _____ Describa los motivos: _____ _____	21) ¿En el último trimestre cuantas veces ha acudido al servicio de Atención Especializada por la salud de su hijo? _____ Describa los motivos: _____ _____

22) ¿En el último trimestre cuantas veces ha acudido al servicio de Urgencias por su propia salud? _____ Describa los motivos: _____ _____	23) ¿En el último trimestre cuantas veces ha acudido al servicio de Urgencias por la salud de su hijo? _____ Describa los motivos: _____ _____		
24) ¿En el último trimestre cuantas veces ha acudido al psicólogo por su propia salud? _____ Describa los motivos: _____ _____	25) ¿En el último trimestre cuantas veces ha acudido al psicólogo por la salud de su hijo? _____ Describa los motivos: _____ _____		
26) ¿Cuánto tiempo ha transcurrido desde la separación? 1. Menos de dos meses 2. De dos a seis meses 3. De seis meses a un año 4. De uno a dos años 5. De dos a tres años 6. Más de tres años	27) ¿Tras cuantos años de unión se separaron? _____ 28) El proceso fue: 1. Contencioso 2. Mutuo acuerdo 29) El proceso fue: 1. Amistoso 2. No amistoso		
30) ¿Empleó el procedimiento de mediación? 1. Si 2. No	31) El tipo de custodia es: 1. Compartida 2. Exclusiva de la madre 3. Exclusiva del padre Otro. Describalo: _____		
32) ¿Con qué frecuencia ve usted a su hijo(s)? 1. Todos los días 2. Varios días a la semana 3. Una vez a la semana 4. Cada dos semanas 5. Cada mes 6. Con menos frecuencia	33) ¿Y su excónyuge? 1. Todos los días 2. Varios días a la semana 3. Una vez a la semana 4. Cada dos semanas 5. Cada mes 6. Con menos frecuencia		
34) Tras la separación ¿cómo son las relaciones entre usted y su excónyuge? 1. Inexistentes, no cruzan palabra ni por teléfono 2. Muy escasas, y casi siempre hostiles, con insultos y reproches 3. Restringidas, intercambian la información mínima sobre los niños (problemas escolares, enfermedades...) 4. Fluidas en relación con los niños y corteses en cuanto a ustedes 5. Variables y/o ambiguas	35) Especificar si ha habido etapas diferentes en dichas relaciones: _____ _____ _____		
36) ¿A través de qué servicio ha conocido este programa? <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top;"> 1. Centro de Apoyo a la Familia 2. Punto de Encuentro Familiar 3. Servicio Jurídico </td> <td style="vertical-align: top;"> 4. Centro de Salud Mental 5. Servicios Sociales Otro. Describalo: _____ </td> </tr> </table>		1. Centro de Apoyo a la Familia 2. Punto de Encuentro Familiar 3. Servicio Jurídico	4. Centro de Salud Mental 5. Servicios Sociales Otro. Describalo: _____
1. Centro de Apoyo a la Familia 2. Punto de Encuentro Familiar 3. Servicio Jurídico	4. Centro de Salud Mental 5. Servicios Sociales Otro. Describalo: _____		

	0	1	2	3	4
	Nada o en absoluto	Un poco	Moderadamente	Bastante	Mucho o extremadamente
1) Dolores de cabeza	0	1	2	3	4
2) Nerviosismo o agitación interior	0	1	2	3	4
3) Sensaciones de desmayo o mareo	0	1	2	3	4
4) Pérdida de deseo o placer sexual	0	1	2	3	4
5) Ver a la gente de manera negativa, encontrar siempre faltas	0	1	2	3	4
6) Dolores en el corazón o en el pecho	0	1	2	3	4
7) Sentirse bajo de energías o decaído	0	1	2	3	4
8) Pensamientos suicidas, o ideas de acabar con su vida	0	1	2	3	4
9) Temblores	0	1	2	3	4
10) Llorar fácilmente	0	1	2	3	4
11) Timidez o incomodidad ante el sexo opuesto	0	1	2	3	4
12) La sensación de estar atrapado o como encerrado	0	1	2	3	4
13) Tener miedo de repente y sin razón	0	1	2	3	4
14) Culparse a sí mismo de todo lo que pasa	0	1	2	3	4
15) Dolores en la parte baja de la espalda	0	1	2	3	4
16) Sentirse solo	0	1	2	3	4
17) Sentirse triste	0	1	2	3	4
18) Preocuparse demasiado por todo	0	1	2	3	4
19) No sentir interés por nada	0	1	2	3	4
20) Sentirse temeroso	0	1	2	3	4
21) Ser demasiado sensible o sentirse herido con facilidad	0	1	2	3	4
22) La sensación de que los demás no le comprenden o no le hacen caso	0	1	2	3	4
23) La impresión de que otras personas son poco amistosas o que usted no les gusta	0	1	2	3	4
24) Que su corazón palpita o vaya muy deprisa	0	1	2	3	4
25) Náuseas o malestar en el estómago	0	1	2	3	4
26) Sentirse inferior a los demás	0	1	2	3	4
27) Dolores musculares	0	1	2	3	4
28) Ahogos o dificultad para respirar	0	1	2	3	4
29) Escalofríos, sentir calor o frío de repente	0	1	2	3	4

30)	Entumecimiento u hormigueo en alguna parte del cuerpo	0	1	2	3	4
31)	Sentir un nudo en la garganta	0	1	2	3	4
32)	Sentirse desesperanzado con respecto al futuro	0	1	2	3	4
33)	Sentirse débil en alguna parte del cuerpo	0	1	2	3	4
34)	Sentirse tenso o con los nervios de punta	0	1	2	3	4
35)	Pesadez en los brazos o en las piernas	0	1	2	3	4
36)	Sentirse incomodo cuando la gente le mira o habla acerca de usted	0	1	2	3	4
37)	Sentirse muy cohibida o vergonzosa entre otras personas	0	1	2	3	4
38)	Sentir que todo requiere un gran esfuerzo	0	1	2	3	4
39)	Ataques de terror o pánico	0	1	2	3	4
40)	Sentirse incomoda comiendo o bebiendo en publico	0	1	2	3	4
41)	Sentirse tan inquieta que no puede ni estar sentada tranquila	0	1	2	3	4
42)	La sensación de ser inútil y no valer nada	0	1	2	3	4
43)	Presentimientos de que va a pasar algo malo	0	1	2	3	4
44)	Pensamientos o imágenes estremecedoras o que le dan miedo	0	1	2	3	4

	1	2	3	4	5
	Casi nunca	A veces	Alrededor de la mitad del tiempo	La mayoría del tiempo	Casi siempre
¿Con qué frecuencia cada una de las siguientes afirmaciones te describe?					
1) Mis emociones me sobrepasan y están fuera de control	1	2	3	4	5
2) No tengo ni idea de cómo me siento	1	2	3	4	5
3) Me cuesta trabajo entender por qué me siento como me siento	1	2	3	4	5
4) Me importan mis sentimientos	1	2	3	4	5
5) Estoy confundido(a) sobre cómo me siento	1	2	3	4	5
CUANDO ME SIENTO ENFADADO/ ME SIENTO MAL:					
6) Me enoja (<i>enfado</i>) conmigo mismo(a) por sentirme de esa manera	1	2	3	4	5
7) Me siento incómodo por sentirme así	1	2	3	4	5
8) Me cuesta trabajo hacer mis deberes.	1	2	3	4	5
9) No soy capaz de controlarme	1	2	3	4	5
10) Creo que así me sentiré mucho tiempo	1	2	3	4	5
11) Creo que después me sentiré muy deprimido(a)	1	2	3	4	5
12) Me resulta difícil concentrarme en otras cosas	1	2	3	4	5
13) Siento que pierdo el control	1	2	3	4	5
14) Me siento avergonzado(a) conmigo mismo(a) por sentirme de esa manera	1	2	3	4	5
15) Me siento culpable por sentirme de esa manera	1	2	3	4	5
16) Me cuesta trabajo concentrarme	1	2	3	4	5
17) Me cuesta controlar lo que hago	1	2	3	4	5
18) Creo que no hay nada que pueda hacer para sentirme mejor	1	2	3	4	5
19) Me molesto/a conmigo mismo/a por sentirme de esa manera	1	2	3	4	5
20) Me empiezo a sentir muy mal conmigo mismo/a	1	2	3	4	5
21) Creo que no puedo hacer otra cosa más que dejarme llevar por cómo me siento	1	2	3	4	5
22) Pierdo el control sobre mi manera de comportarme	1	2	3	4	5
23) Me resulta difícil pensar en otra cosa	1	2	3	4	5
24) Me toma mucho tiempo sentirme mejor	1	2	3	4	5
25) Siento que no puedo controlar mis emociones/mi estado emocional	1	2	3	4	5

	1	2	3	4	5
	Totalmente en desacuerdo	En desacuerdo	Ni desacuerdo, ni de acuerdo	De acuerdo	Totalmente de acuerdo
1) Desde el divorcio mi ex esposa-o y yo nos hemos peleado o criticado mutuamente cuando los niños estaban alrededor.	1	2	3	4	5
2) Desde el divorcio mis hijos han tenido problemas en la escuela (notas más bajas, problemas de conducta, o se niegan a ir a la escuela).	1	2	3	4	5
3) Pienso que a veces los niños creen que nos hemos divorciado por su culpa.	1	2	3	4	5
4) Desde el divorcio mi exesposo-a y yo nos hemos gritado el uno al otro.	1	2	3	4	5
5) Desde el divorcio mi exesposa-o y yo hemos discutido sobre cómo educar a los niños.	1	2	3	4	5
6) A veces me pregunto qué estará haciendo mi ex – pareja en este momento.	1	2	3	4	5
7) Estoy enfadada-o hacia mi ex pareja.	1	2	3	4	5
8) Desde el divorcio me siento deprimido-a con frecuencia (insomnio, llanto, dificultades de levantarme por la mañana).	1	2	3	4	5
9) Paso mucho tiempo pensando sobre mi ex pareja.	1	2	3	4	5
10) Desde el divorcio no puedo mantener económicamente a mis hijos como lo hacía antes.	1	2	3	4	5
11) Cuando yo he necesitado hacer un cambio en los acuerdos de visita, mi ex pareja ha cedido para que pudiera adaptarme mejor.	1	2	3	4	5
12) A veces me cuesta creer que estemos separados.	1	2	3	4	5
13) Nuestra situación financiera después del divorcio nos ha obligado a cambiar de casa.	1	2	3	4	5
14) Desde el divorcio mi ex esposo-a ha cumplido con su parte en cuanto a la crianza y el mantenimiento económico de los niños.	1	2	3	4	5
15) Desde la separación, mi ex pareja y yo estamos de acuerdo sobre la mayoría de las decisiones domésticas.	1	2	3	4	5
16) Mi ex pareja es una ayuda para mí en la crianza de nuestros hijos.	1	2	3	4	5
17) Creo que nunca voy a superar la separación.	1	2	3	4	5
18) Pienso que, en general, el divorcio ha causado un montón de problemas emocionales a mi hijo /a.	1	2	3	4	5
19) Cuando necesito ayuda con respecto a mis hijos, se la pido a su padre madre.	1	2	3	4	5
20) En general, me gustaría que mis hijos pudieran ver más a su padre/madre.	1	2	3	4	5

SOFTA (GRUPO)

Código del participante: _____

Fecha: ____/____/____

	Nada	Poco	Algo	Bastante	Mucho
1. Lo que hacemos en el grupo puede solucionar nuestros problemas.	1	2	3	4	5
2. El conductor/a me comprende	1	2	3	4	5
3. Las sesiones me sirven para abrirme (por ejemplo: expresar sentimientos o probar cosas nuevas).	1	2	3	4	5
4. Los/as participantes queremos conseguir lo mejor para que todos los miembros del grupo resuelvan sus problemas.	1	2	3	4	5
5. Resulta difícil comentar con el conductor/a lo que hay que hacer en el grupo.	1	2	3	4	5
6. El conductor/a está haciendo todo lo posible por ayudarme.	1	2	3	4	5
7. Me siento cómodo/a y relajado/a en las sesiones.	1	2	3	4	5
8. Todos los que venimos al grupo valoramos el esfuerzo y el tiempo invertido por los demás aquí.	1	2	3	4	5
9. Siento que estoy trabajando en equipo con el conductor/a.	1	2	3	4	5
10. Considero que el conductor/a se ha convertido en una persona importante para mí.	1	2	3	4	5
11. Hay algún tema del que no me atrevo a hablar en el grupo.	1	2	3	4	5
12. Algunos miembros del grupo consideran que sus objetivos son incompatibles con los de los demás.	1	2	3	4	5
13. Entiendo el sentido de lo que se hace en el grupo.	1	2	3	4	5
14. Al conductor/a le faltan conocimientos y capacidad para ayudarme.	1	2	3	4	5
15. A veces estoy a la defensiva en las sesiones.	1	2	3	4	5
16. Todos los participantes intentamos ayudar a que los demás consigan en el grupo lo que necesitan.	1	2	3	4	5

SOFTA (GRUPO-TERAPEUTA)

Terapeuta: _____

Fecha: ____/____/____

	Nada	Poco	Algo	Bastante	Mucho
1. Lo que hacemos en el grupo puede solucionar los problemas de los/las participantes.	1	2	3	4	5
2. Comprendo a este grupo.	1	2	3	4	5
3. Las sesiones les sirven a los/las participantes para abrirse (por ejemplo: expresar sentimientos o probar cosas nuevas).	1	2	3	4	5
4. Los/las participantes quieren conseguir lo mejor para que todos los miembros del grupo resuelvan sus problemas.	1	2	3	4	5
5. Resulta difícil que los participantes y yo comentemos lo que hay que hacer en el grupo.	1	2	3	4	5
6. Estoy haciendo todo lo posible por ayudar a este grupo.	1	2	3	4	5
7. Creo que los/las participantes se sienten cómodos y relajados en las sesiones.	1	2	3	4	5
8. Todos los que vienen al grupo valoran el esfuerzo y el tiempo invertido por los demás aquí.	1	2	3	4	5
9. Siento que estoy trabajando en equipo con los/las participantes	1	2	3	4	5
10. Creo que me he convertido en una persona importante para los/las participantes.	1	2	3	4	5
11. Hay algunos temas de los que los/las participantes no se atreven a hablar en el grupo.	1	2	3	4	5
12. Algunos miembros del grupo consideran que sus objetivos son incompatibles con los de los demás.	1	2	3	4	5
13. Los/las participantes entienden el sentido de lo que se hace aquí.	1	2	3	4	5
14. Me faltan conocimientos y capacidad para ayudar a este grupo.	1	2	3	4	5
15. A veces los participantes se muestran a la defensiva en las sesiones.	1	2	3	4	5
16. Todos en el grupo se ayudan entre sí para conseguir en el grupo lo que necesitan.	1	2	3	4	5

Autorización del Comité de Ética en Investigación de la Universidad de Deusto**DICTAMEN DEL COMITÉ DE ÉTICA EN LA INVESTIGACIÓN DE LA UNIVERSIDAD DE DEUSTO**

Ref: ETK-7/16-17

Tras la evaluación del proyecto “Estudio de la efectividad y eficiencia de un programa de intervención dirigido a padres y madres divorciados/as o separados/as en el bienestar psicológico de hijos e hijas [BIENESTAR]” que presenta Dña. Ana Martínez Pampliega, en calidad de coordinadora del proyecto, el Comité de Ética en Investigación de la Universidad de Deusto, tal y como se hace constar en el acta de la reunión del 18 de Noviembre de 2016 en la que se tomó el acuerdo, no encuentra objeción alguna, y califica el proyecto de **APTO**.

El proyecto propone evaluar un programa dirigido a familias en las que los progenitores han iniciado un proceso de divorcio. Cuenta con una fase previa de evaluación piloto. El proyecto aleatoriza la incorporación de los participantes al grupo experimental y control, incluye la aplicación de la intervención a los participantes del grupo control posteriormente, incluye procedimientos de consentimiento informado e implica potenciales beneficios para los participantes del estudio. Los datos van a protegerse de acuerdo con la normativa vigente.

Por todo ello, el Comité de Ética (CEI) considera que desde el punto de vista ético el proyecto es adecuado en todo lo referente a la protección y evitación de riesgos a los participantes y el respeto a la autonomía. Asimismo, se ajusta a los principios metodológicos, éticos y jurídicos que debe tener este tipo de investigación. No se observan riesgos de ningún tipo para los participantes.

Y para que así conste,

Dña. Cristina de la Cruz Ayuso
Coordinadora de la Comisión de Ética en Investigación
Universidad de Deusto

En Bilbao a 21 de Noviembre de 2016

