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SUMARIO / SUMMARY / RESUMO

Editorial

We continue with the fifth edition of the journal Psychology Research, consolidating the publication in the hope that previous issues have been of interest to researchers in the area. I would like to thank the team that makes up this magazine for their involvement and effort, as well as the authors who have sent their work, so that this fifth issue has gone ahead.

We begin the current issue with an investigation in which a review of the concept of resilience and its implications in practice is carried out. For this, an analysis of different intervention programs aimed at families with adolescent sons and daughters and who show behavioral problems is carried out. Next, a positive parenting program is presented for the prevention and promotion of parenting skills to support positive parenting and promote an improvement in the level of resilience and emotional well-being in fathers and mothers.

The following contribution deals with bullying, either in the form of bullying or mobbing as violent and intentional conduct aimed at causing damage. The article also provides data on the prevalence of this problem, both in other countries and in Colombia. The purpose of the research was to study the effects of a social acceptance program based on resilience in a group of students. The results indicate the positive reduction of aggressive behavior among peers and rejection behaviors that maintained bullying and mobbing after the intervention carried out.

The purpose of the third article is to guide good practice and avoid ethical sanctions in the professional practice of the forensic psychologist. To do this, it delves into the fundamental requirements that should be taken into account in the preparation of forensic psychological reports in the family sphere in cases of custody and parental authority. The article is based on data derived from scientific and legal research, which allows identifying the psychoemotional consequences in families that have suffered a marital breakup. In addition, it explores the limitations, the scope of practice, the evaluation tools, as well as the legal characteristics of family law and introduces an expert report model derived from good practices in this context.

From another point of view, the following article analyzes the strategies of cognitive behavioral therapy in bariatric surgery patients as the most effective treatment for morbid obesity. Since the psychology professional is a fundamental part of the multidisciplinary team involved, and cognitive behavioral therapy has been the branch most used by these professionals, the objective of this work is to clarify the effectiveness of the different resources and identify patterns focused on these patients. For this, individual, group and distance intervention strategies were comparatively evaluated, as well as the success and non-success factors in the different modalities and analysis of the effects of psychological comorbidities associated with obesity on the prognosis of surgery.

In fifth place, a study is proposed whose objective was to describe the experience of families with a member living with type 2 diabetes mellitus. To do this, both the meanings that are constructed in the face of the disease experience and the changes in life are explored. family that involve a new lifestyle as a result of diabetes. The feelings and mood characteristics derived from the disease in the participating families and the impact of perceived family support for a person living with type 2 diabetes mellitus are shown.

Finally, and from another radically different point of view, the issue of restorative methods of conflict resolution as tools for use in justice and in the different spheres of action of society is addressed from a review. This article addresses its specific use for the management of intrafamily conflicts in cases of parental alienation, bringing to light the parental alienation syndrome. It is observed that restorative conflict resolution methods provide new options for effective and efficient support for intrafamily conflicts in these cases.

Dr. Juan Luís Martín Ayala
Editor Jefe / Editor in chief / Editor Chefe

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LA PROMOCIÓN DE LA RESILIENCIA PARENTAL EN FAMILIAS CON HIJOS CON PROBLEMAS DE CONDUCTA

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Resumen. En este artículo realizamos una revisión a cerca del concepto de resiliencia y sus principales implicaciones para la práctica. Con el objetivo de profundizar en las implicaciones prácticas de este concepto, se realiza un análisis de los distintos programas de intervención destinados a padres y madres que tienen hijos *preadolescentes y adolescentes* con problemas de conducta. Dada la ausencia de intervenciones basadas en promover la resiliencia parental, se presenta un programa destinado a la prevención y la promoción de competencias parentales para apoyar la parentalidad positiva y promover en los padres una mejora en su nivel de resiliencia y bienestar emocional. Entre sus objetivos están: desarrollar estrategias de afrontamiento para gestionar las situaciones adversas que se plantean en el día a día de cara a la tarea de educar a sus hijos/as; promover habilidades parentales que permitan a las familias actuar con eficacia ante los problemas de conducta de los hijos/as, facilitar una buena gestión emocional de los problemas de conducta y ser capaz de recuperarse del impacto que causan los mismos. El programa sigue una metodología experiencial, las familias son agentes activos en el proceso de cambio, y se acompaña de una implementación y una evaluación rigurosa para analizar los cambios que se van produciendo a medida que se avanza en la intervención.

Palabras clave*:* resiliencia; problemas de conducta; parentalidad positiva; educación parental; metodología experiencial

THE PROMOTION OF PARENTAL RESILIENCE IN FAMILIES WITH CHILDREN WITH BEHAVIORAL PROBLEMS

Abstract. In this article we make a review of the concept of resilience and its main implications for practice. We carried out an analysis of different intervention programs for parents with preadolescent and adolescent

children to broaden our understanding about the practical implications of this concept. Given the absence of interventions based on promoting parental resilience, we present a program for the prevention and promotion of parental competencies to support positive parenting and promote in parents an improvement in their level of resilience and emotional well-being. The main objectives of this program are: the development of strategies to manage the adverse situations that arise in the daily life related to the task of educating children; to promote parental skills that enable families to effectively respond to children's behavioral problems, to facilitate good emotional management of behavior problems, and to be able to recover from the impact caused. The program follows an experiential methodology, families are active agents in the process of change, and is accompanied by a rigorous implementation and evaluation to analyze the changes that occur as the intervention progresses.

Keywords: resilience; behavior problems; positive parenting; parental education; experiential methodology

Introduction

The task of educating a child is a difficult task, even more so when we find children with behavioral problems (aggressiveness, rebelliousness, social and emotional problems, disobedience). These problems are a concern in the family environment (Montiel-Nava, Montiel-Barbero & Peña, 2005; Robles & Romero Triñanes, 2011) to the point that, according to an epidemiological study conducted with a sample of 1,220 parents, 59.6% believe that their child has behavioral problems and 52% believe they need psychological help to solve these problems (Cantero-García & Alonso-Tapia, 2018). The way in which parents deal with such problems affects not only the behavior of their children but also the parents' own psychological well-being (Luengo Martín, 2014; Pérez, Menéndez & Hidalgo, 2014). The management of these behaviors can sometimes become a stressful life situation, an adverse situation, so sometimes parents may demand help to cope with this type of situations. Such situations can come from sudden events or major crises that the family is going through but also from more normative and expected situations, such as the vital transition that represents the arrival of children to pre-adolescence and adolescence (Rodríguez, Martín and Rodrigo, 2010).

In these situations, parents usually ask themselves questions such as: - what am I doing wrong? what is going wrong? why me? why my child? what can I do? who can help me? - To answer these questions it is considered necessary, on the one hand, to work with parents on basic aspects of positive psychology, such as: their level of resilience and emotional well-being, aspects that will contribute to the improvement of the psychological well-being of parents, as well as to the improvement of the family climate, and on the other hand, to work on the promotion of effective educational guidelines, based on the exercise of positive parenting, that will help them to exercise their parental role in an adequate way; in addition, it is considered that these guidelines can also contribute significantly to the improvement of the emotional well-being of parents and to the improvement of the behavioral problems of their children.

The aim of this study is, on the one hand, to review the concept of resilience, as well as the multiple definitions that have been given of this concept in recent times and its application to the family environment. And, on the other hand, to know the different interventions oriented to work on the resilience of parents who have children with behavioral problems. Due to the lack of this type of programs, the decision was made to describe the design of an intervention proposal to work on these aspects.

The origin of the concept of resilience goes back to research such as that of Rutter (1987) in which he argues that when faced with a difficult situation it is important to

reduce the perception of threat, as this can lead to maladaptive coping. In addition, this author emphasizes that it is important to give meaning to experiences and neutralize negative ones. However, improving the environment or eliminating adversities does not necessarily make people more resilient since the mere elimination of stressful situations does not help to cope adequately. Despite the numerous investigations that have been carried out in recent times, there is still a problem of conceptualization in relation to this term, which has given rise to the multitude of existing definitions (Windle, 2011). Among them we highlight the definition of Luthar (2006) in which he emphasizes positive adaptation or recovery in the face of adverse situations or experiences, and this involves the two elements: 1) significant threat and 2) positive adaptation. Other authors consider resilience to be the stable balance in behavior in the face of a traumatic event without affecting performance and daily life (Skinner and Zimmer- Gembeck, 2007). More recently, Windle (2011) defines resilience as the process of negotiation, management and adaptation to significant sources of stress or trauma, a process in which the resources of individuals, their lives and their environment facilitate this capacity to adapt and recover in the face of adversity. Furthermore, this author points out that resilience is not a static trait; on the contrary, resilience is a dynamic process that varies throughout the life cycle, depending on the environments and situations. Along the same lines, Alonso-Tapia, Nieto and Ruiz (2013) define resilience as positive adaptation or recovery in the face of potentially aversive situations that have a high risk of generating a maladjustment of the person. As can be seen, the differences between the various authors cited are more in form than in substance, as they all point to the two elements cited by Luthar. However, given that our intervention is going to focus on the parents - the family - it is necessary to approach the concept of family resilience.

Family resilience can be understood considering family members in their individuality (Cowan et al., 1996; Hetherington and Blachman, 1996; Kim, 1998; Woodgate 1999 a,b) or considering the family as a unit, from a systemic perspective (Patterson, 1995; Walsh, 1996). This last meaning means that the concept of family resilience brings a new perspective to the concept of resilience. As opposed to individual resilience, family resilience occurs when the dynamics of family interactions contribute to the family as a whole - not only each of its members - not sinking in the face of adversity (Lee et al., 2004). This is also taken up by authors such as Cicchetti (2010), who points out that the main indicators of family resilience are: a) mental flexibility, b) ability to reflect on emotions (one's own and others'), c) having a positive self-image, d) creation of a safe and protective environment (stable, sensitive and secure). Along the same lines, we highlight Olson's (1997) circumplex model, which highlights key aspects such as: a) family cohesion, b) family adaptability and c) family communication.

More recently, authors such as Rodrigo, Máiquez, Martín and Byrne (2008) go further and differentiate between family resilience and parental resilience. The former refers to the dynamic process that allows the family as an open system to react positively to threats. The most characteristic features of the resilient family are family cohesion, affection in the couple, family appreciation and commitment, ethical attitude towards life, positive stress management, optimism and positive outlook, sense of control over life events, flexibility and perseverance. On the other hand, for Rodrigo et al. (2008) parental resilience is understood as the dynamic process that allows parents to develop a protective and sensitive relationship with their children's needs despite living in an environment that fosters suboptimal behaviors. The traits that characterize parental resilience are recognition of their role as parents, motivation for change, optimism and possibilism instead of victimhood and fatalism, and greater reciprocity in relationships. This idea is

in line with what authors such as Barudy and Dantagnan (2005) propose to speak of resilient parenting. This differentiation and clarification of concepts is not sufficient if we do not have reliable instruments to measure these concepts. For this reason, recent research (Almeida,2015 ; Martín, Cabrera, León, & Rodrigo, 2013) have developed instruments to assess parental competence and resilience, although these authors go a step further, there is still much work to be done and to facilitate this type of resilience it will be necessary, therefore, not only to focus attention on the coping processes that underlie the resilience of each individual but also on the interaction processes - of exchanging perceptions of the situation, of attributions of the observed phenomena, of possible ways of coping with problems, of ways of assuming and regulating emotions, etc.- that shape the functioning of the family in the face of adversity over time.

All the aspects gathered here lead us to carry out a search on different interventions that have been made to promote parental resilience in parents with a specific adverse situation such as behavioral problems. So far, we have not been able to find any intervention to evaluate the effectiveness of a program aimed at promoting resilience in this group, so due to the lack of scientific evidence of interventions aimed at this purpose, we propose the design of a parental education program that covers the theoretical aspects mentioned here.

The program, Get over yourself, don't throw in the towel!

In recent times, the incorporation of parental education programs has been booming (Martínez-González, 2009; Rodrigo, Máiquez, Martín, & Byrne, 2008; Triana & Rodrigo, 2010; Rodrigo, Byrne, & Álvarez, 2016). Thus, we can verify that there are many psychoeducational support programs both national and international: Strengthening Families Program (Kumpfer and Molgaard, 1990), Parent Training Program (Barkley, 1997), Triple-P (Margaret and Sanders, 2001), Incredible Year (Webster Stratom et al, 2003), Adolescent Mothers and Fathers Support Program (Oliva et al, 2007), Coping Power (Lochman and Wells, 2002; Lochman et al., 2007), EmPeCemos (Romero, Villar, Luengo, Gómez-Fraguela and Robles, 2009), Living Adolescence in the Family: A program of parental support in adolescence (Rodríguez, Martín and Rodrigo, 2015). All of them promote the use of appropriate parental competencies to deal with children's behavioral problems in childhood as well as in pre-adolescence and adolescence. These programs are focused on the different evolutionary stages, teach effective techniques for the good management of behavioral problems and are carried out with an active and participatory methodology. In addition, through the training programs, parents learn how a change in their own behavior can promote a change in their children's behavior, which implies an improvement in the daily interactions between them (Kazdin, 1995).

However, it is notorious the scarcity of programs that work on resilience and emotional well-being of parents living with this problem. For this reason, it was decided to design the intervention program, Get over yourself, don't throw in the towel!, in which special importance is given to the resilience and emotional well-being of parents as an influential variable for the improvement of children's behavioral problems. This idea is in line with what is proposed by authors such as Amorós, Fuentes-Peláez, Molina, and Pastor (2010) who point out that the educational practices established in the family dynamics are a fundamental part of parental resilience and the capacity to exercise positive parenting. The program is offered as a versatile resource that can be applied in different areas, such as, educational, clinical, or as a prevention and promotion program from the Social Services area. This program is in line with the Recommendation Rec

(2006) 19 of the Committee of Ministers to Member States on policies to support positive parenting on the use of parenting education programs to support positive parenting.

Target population

The program is aimed at families who have children between the ages of nine and thirteen, who have high levels of stress due to their children's behavioral problems. It is also aimed at those families who consider that they need to improve their way of dealing with their children's behavioral problems or those other families who believe in the opportunity offered to them to reflect on their way of educating, the consequences it entails for their children and to enrich themselves with other models. In this way they improve their emotional well-being and optimally cope with the adversities that arise in connection with their children's behavioral problems.

Parental objectives and competencies

General objectives

- Promoting resilience and improving the emotional well-being of parents.
- Improve children's behavioral problems.

Specific objectives

- Deepen on the behavioral changes of the children in each evolutionary stage.
- Work on the importance of assertiveness and empathy in family communication to improve the relationship with children.
- Approach parental stress situations and learn strategies for their management.
- Recognizing one's own emotions and dealing with negative emotions (aggression, anger, rage, anger, sadness) caused by children's misbehavior.
- Promote adaptive coping styles and reduce the use of emotion-focused coping strategies (self-blame, rumination, isolation).
- Promote humor as a tool to face difficult circumstances.
- Introduce alternative educational practices to physical punishment to respond to misbehaviors.
- Work on conflict resolution in the family nucleus.

During the development of the program, it is intended that parents acquire new cognitive, social, and emotional competencies that contribute to design the new roles involved in the performance of the parental task. It is about parents designing their own parental role, in their own scenario and family context, which is unique. For this purpose, it is not intended to administer prescribed prescriptions, but rather that families can think about their role as parents, taking into account not only the evolutionary characteristics of their children, but also their own emotional characteristics and those of the context in which they develop. Therefore, this program not only aims to work on parental competencies to improve behavioral problems, but also to promote the emotional competencies of parents to improve their well-being, thus contributing to improve the competencies of their sons and daughters.

Thus, at the emotional level, resilient skills related to assertiveness, self-esteem, self-control, active coping strategies in stressful situations, conflict resolution, and a

positive view of problems and crises are promoted in parents. In addition, the program seeks to promote other educational skills, among which we can highlight: a) the application of strategies to regulate children's behavior, and b) the use of strategies to improve family communication. Finally, the program promotes competencies aimed at improving parental self-efficacy, the internal locus of control, the perception of the parental role, and the overcoming of adversities that may arise in the family environment.

Program contents

In order to meet the objectives and achieve the competencies described above, the program is structured in 12 sessions of 90 minutes, which will be carried out on a weekly basis. In addition, a session zero or initial session will be developed whose main objective is to promote the familiarization of the facilitator with the group of parents and vice versa, in addition to establishing the first rules of the group (confidentiality, respect, etc.). In addition, the families are introduced to the objectives-contents of the program and briefly reflect on the importance of working on behavioral problems. The following is a brief description of each of the sessions.

Session 1. -How do our children behave? The objective is to reflect on the importance of knowing the behavior of children, as well as the characteristics of the evolutionary stage in which they are at. In addition, the importance of addressing the behavior in specific terms is emphasized, avoiding labeling the child with negative attributes. Parents are encouraged to identify the spiral of negative interactions that may be affecting their relationship with their child and the need to pay attention to positive behaviors, which may go unnoticed, is emphasized. Throughout the session, appropriate forms of praise are discussed, modeled, and practiced.

Session 2. -We put ourselves in our children's shoes. Educating in and from assertiveness and empathy is one of the fundamental processes involved in the development of family relationships and specifically in the development of positive interactions between parents and children. Working on all this in one session would be too extensive, so it has been decided to divide this session in two: in the first part, we will work on assertiveness and empathy; in the second part, which will take place next week, we will work on active listening skills and positive communication skills. Throughout this session, we will reflect on the characteristics that differentiate an assertive person from an aggressive or passive one. In addition, we will reflect on the importance of putting ourselves in the other person's place to better understand his or her way of acting.

Session 3. - We learn to communicate in the family. This session is dedicated to enhance communication skills that are necessary for a good family functioning, which will be the basis and support of other parental strategies that we will see in other sessions. Good listening and adequate communication will allow the family to develop the ability to value themselves positively, to cooperate, to understand, to manage their emotions, and to relate adequately with others. The fact that parents can work on their assertiveness will contribute to the improvement of the family climate, as well as their own wellbeing.

Session 4. - Without stress we are better off. Approaching stress situations and their consequences for the family dynamics, as well as working on techniques for its management are some of the aspects that will be worked on in this session. Parents of children with behavioral problems are subjected to various sources of chronic stress, so

throughout this session they will learn different techniques to deal in a healthier way with the stress caused by the behavioral problems of their children.

Session 5. - We know ourselves. In this session we will work on the importance of self-control and self-regulation. Promoting these skills together with the reduction of parental stress, assertiveness and empathy will contribute to the improvement of the family climate. We start from the idea that parents are role models with an unquestionable impact on children, therefore, it is considered necessary to deepen on these skills that allow a better understanding of their own emotions and contribute significantly to the improvement of conflict resolution.

Session 6. - We regulate behavior I. Effective commanding, setting reasonable and predictable limits, and ignoring some behaviors are three of the strengths that need to be reinforced in families with children with behavior problems. After having practiced praise in the first few weeks, this session introduces parents to the topic of limits and family discipline. Parents will learn to formulate their orders and requests appropriately, avoiding excessive unnecessary instructions in a chain or formulated in the form of a question. The "ignore" technique will be introduced as a technique for responding to misbehavior.

Session 7. - We regulate behavior II. This session is dedicated to the use of punishment as a consequence of misbehavior. In this session parents will learn to recognize the characteristics that define an effective punishment (immediacy, consistency, proportionality) and will learn, mainly, to establish and put into practice a particular type of punishment: logical and natural consequences. In addition, they will learn to establish a system of reasonable, predictable consequences, appropriate to the child's age and ability (withdrawal of privileges, extra work). The "time-out technique" is one of the most useful disciplinary options and is presented as an alternative to physical punishment. However, it will be emphasized that the use of negative consequences should be minimized in favor of behavior-reinforcing forms of interaction.

Session 8. - We value our children's good behaviors. In this session we reflect on the importance of reinforcement, although praise is a powerful reinforcer, it is often necessary to resort to other types of reinforcement combined with praise to get children to acquire behaviors or achieve goals that are particularly difficult for them. This session addresses parents' expectations of the behaviors to promote in their children and delves into the appropriate use of tangible reinforcement as a complement to praise. Parents will be able to design a system for those behaviors they wish to establish or consolidate in their children.

Session 9.- Positive thoughts and feelings. Throughout this session we will work on the importance of changing negative thoughts for more optimistic ones, the importance of changing irrational ideas, self-instructions. This session also deals with coping with negative emotions. The importance of the emotional well-being of parents for the improvement of their children's behavioral problems will be emphasized again.

Session 10. - Overcoming difficulties without throwing in the towel. Throughout the session we will reflect with the participants on the concept of resilience and the importance of keeping in mind the aspects discussed in the different sessions, as well as the different strategies and coping styles for the improvement of their parental self-efficacy, emotional and family well-being, as well as for the improvement of their children's behavioral problems. More specifically, throughout this session we will work on acceptance, non-rumination, the search for solutions, and learning potentials, thinking

about how to grow and how to overcome adversities, analyzing things from the point of view of responsibility, strengthening self-concept, positive thinking, problem solving, facing fears.

Session 11.- With H for Humor and L for Love. In this penultimate session, we will work on "humor" as a tool to reduce anger and worry. The aim is to make parents aware of the importance of taking things with a sense of humor, as well as of the benefits it produces: it reduces stress, acts as an analgesic, improves people's mental health, helps to reduce depression and anxiety.

Session 12.- Final session. The final session is dedicated to recapitulate the techniques learned, both for the management of the children's behaviors and for the improvement of the parents' emotional well-being. Once again, we emphasize the importance of parental well-being in order to act effectively. Finally, parents are prepared for coping with behavioral problems that may arise once the program ends, different strategies to prevent relapses will be presented, and self-efficacy will be enhanced to face the challenges of raising their children.

Experiential methodology

The program uses the experiential methodology that has already been validated in parental education programs (Martín, Máiquez, Rodrigo, Correa and Rodríguez, 2004; Rodrigo, Martín, Máiquez and Rodríguez, 2005). The true meaning of the experiential model implies following a process of reflection and analysis of educational practices and their consequences in family life or in the development of the children in order to finally encourage the verbalization of personal objectives for change. Thus, we find the need to elaborate activities that encourage participation and the exchange of experiences among the participants. Throughout the different sessions, group techniques typical of the experiential methodology will be used, such as the case technique, video-feedback, work in small groups, guided discussion, guided fantasy, role-playing, tasks to work on at home and/or commitments. In addition, other types of dynamics will be developed for specific activities. All these techniques will be adapted to the objectives of each session.

With this methodology, the facilitator's role is to help build knowledge in a shared way in the group and, for this purpose, a series of principles must be taken into account, such as regulating the emotional climate of the group, building knowledge as a member of the group, working on the basis of the needs and concerns of the families, encouraging negotiation and the search for consensus among group members, supporting personal initiative and reinforcing feelings of belonging to the group.

Program implementation

The implementation of the program is one of the most relevant aspects that can facilitate or, on the contrary, complicate the effectiveness of the work with families (Rodrigo, 2016). Therefore, we must ensure fidelity to the principles and methodology of the program, in addition to adapting the program to the characteristics of the context and thinking about the conditions that allow improving the results.

To carry out the program, the research team will meet and present it to the different educational centers. Once the program has been presented, it will be disseminated by means of posters, leaflets, web resources, etc., in order to subsequently select the families

that have a suitable profile for this type of program or those that voluntarily wish to form part of the group.

Once the groups have been formed, an inauguration ceremony will be held with University personnel, school personnel, and the families who will attend. The program will then be implemented through weekly meetings of approximately one and a half hours. At the end of the intervention, a closing ceremony will be held with the presentation of diplomas to the families, thanking them for their participation and collaboration. Finally, a final report will be made evaluating the implementation of the program and its results.

Program evaluation

In order to carry out a rigorous evaluation of the program, it will be carried out in three different moments throughout its implementation: 1) initial-final evaluation, 2) process evaluation, 3) final evaluation and 4) follow-up. Table 1 [Insert] describes the instruments to be used in the different phases of the evaluation. The closure of the program does not mean that the researchers will terminate the intervention but rather that 6 months after the end of the program a new follow-up measure will be taken to determine whether the effects evaluated are maintained in the long term.

Final comment

The aim of this study was to review the concept of resilience, as well as to deepen in concepts related to this term such as family resilience and parental resilience. After the review we can conclude that, although much progress has been made in this field in recent times, it is necessary to continue working to unify definitions and prevent this term from overlapping with others. In addition, it is necessary to continue in the line of research initiated by authors such as Alonso-Tapia, Nieto, and Ruiz (2013); Martín et al., (2013) and to construct valid and reliable elements that allow us to measure resilience and parental resilience, as well as to know the coping strategies behind resilient families. The present study is in line with what authors such as Gónzalez (2009) propose. In addition, it covers some of the lines of research that have been raised in other recent studies (Bravo and López, 2015) in which it is recognized that one of the main challenges is to increase family resilience intervention programs. Accordingly, this article provides a practical and useful tool to work from Social Services, clinical or educational settings.

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MOMENTOS	INSTRUMENTOS	DIMENSIONES EVALUADAS	INFORMANTES
Contexto	Características sociodemográficas.	Perfil sociodemográfico.	Padre/Madre
Inicial/final con post-test inmediato y aplazado	Cuestionario de Clima Familiar, perspectiva de los hijos (CFPC-H, 2016)	Evalúa la percepción de los hijos sobre la forma de actuar de los padres ante los problemas de conducta.	Hijo/Hija
	Cuestionario de Afrontamiento de los Problemas de Conducta de los hijos (CRPC, 2016).	Evalúa cinco formas de afrontamiento, tres de ellas de tipo positivo - pensamiento positivo; apoyo y cooperación y dos de tipo negativo - pérdida de motivación/desánimo y pérdida de control del propio comportamiento.	Padre/Madre
	Cuestionario Afrontamiento Adultos + Escala Resiliencia (CRAF-PC, 2017).	Evalúa distintas estrategias de Afrontamiento en situaciones específicas como son los problemas de comportamiento de los hijos. Además, evalúa la Resiliencia tanto general como específica.	Padre/Madre
	Adaptación Española Bienestar psicológico de Ryff.(2006).	Evalúa el bienestar psicológico de los padres.	Padre/Madre
	Escala de satisfacción con la vida (SWLS).(1985)	Evalúa el juicio global que hacen las personas sobre la satisfacción con su vida.	Padre/Madre
	Inventario parentalidad Adulto-adolescente. versión A. (Bavolek y Keene, 2001)	Evalúa expectativas inapropiadas, empatía, creencia uso de castigos, inversión de roles y autonomía/ control.	Padre/Madre
	Strengths and Difficulties Questionnaire (SDQ), versión autoinforme. (2016)	Evalúa problemas emocionales y comportamentales en la adolescencia.	Hijo/Hija
	Cuestionario de Estrés parental. (Abidin, 1995)	Evalúa el estrés del padre /madre o cuidador.	Padre/Madre
Proceso	Fichas de seguimiento de las sesiones.	Valoración e implementación del programa	Padre/Madre
Final	Cuestionario Final.	Valoración y satisfacción con el programa.	Padre/Madre

Tabla 1. Instrumentos para la evaluación del programa.

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BULLYING Y MOBBING EN LA ESCUELA: EFECTOS DE UN PROGRAMA DE INTERVENCIÓN

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Resumen. El Acoso escolar ya sea que se manifieste como bullying o mobbing, constituye una conducta violenta e intencional, dirigida a ocasionar daños, de tipo verbal y físico a otra persona que se percibe como víctima, sobre la cual se ejerce un sometimiento que perpetua su evolución violenta y su incidencia. La problemática se presenta en diversos países y culturas y en Colombia ya han sido registrados en el presente año 8.981 casos a nivel de todo el territorio. En el distrito de Barranquilla el fenómeno presenta una prevalencia de 1.330, lo cual dio lugar al planteamiento de la investigación, que tuvo como objetivo, estudiar los efectos de un programa de aceptación social basado en la resiliencia en un grupo de estudiantes. La metodología se planteó con un enfoque cuantitativo y con un diseño cuasiexperimental longitudinal, con observación antes (pre test) y observación después (postest) de la intervención del programa. Se llevó a cabo un muestreo intencional con una participación de 26 estudiantes, 13 conformaron grupo control y 13 el grupo experimental, del grado 8 de básica secundaria con problemas de convivencia registrados por la dirección escolar. Se les aplico la escala CIE-Abreviada. Los resultados revelaron que la intervención llevada a cabo redujo significativamente el comportamiento agresivo entre pares y las conductas de rechazo que mantenían el bullying y el mobbing, Se intensifico la inclusión social, la participación positiva dentro del grupo y la convivencia. El análisis estadístico se realizó con la aplicación de la prueba T de student.

Palabras clave: Mobbing; intervención psicopedagógica

BULLYING AND MOBBING AT SCHOOL: EFFECTS OF AN INTERVENTION PROGRAM.

Abstract. School bullying, whether it manifests as bullying or mobbing, constitutes a violent and intentional behavior, aimed at causing damage, of a verbal and physical nature to another person who is perceived as a victim, on which a submission is exercised that perpetuates its evolution violent and its incidence. The problem occurs in various countries and cultures and in Colombia 8,981 cases have already been registered this year throughout the country.

In the district of Barranquilla, the phenomenon has a prevalence of 1,330, which led to the research approach, which aimed to study the effects of a social acceptance program based on resilience in a group of students. The methodology was proposed with a quantitative approach and with a longitudinal quasi-experimental design, with observation before (pre-test) and observation after (post-test) the intervention of the program. An intentional sampling was carried out with the participation of 26 students, 13 made up the control group and 13 the experimental group, from grade 8 of elementary school with coexistence problems registered by the school administration. The ICD-Abbreviated scale was applied to them. The results revealed that the intervention carried out significantly reduced aggressive behavior among peers and rejection behaviors that maintained bullying and mobbing. Social inclusion, positive participation within the group and coexistence were intensified. Statistical analysis was carried out with the application of the Student's T test.

Keywords: Mobbing; psychopedagogical intervention

Literature Review

The prevalence of bullying in Colombian schools manifests an increasing progression, taking into account that during the period from 2017 to 2020, 8,981 cases have been registered, which places Colombia as one of the countries with the highest prevalence of bullying. (Miglino, 2021). The problem in turn presents an important dynamic in social networks such as Facebook, Tik Tok, Instagram, Twitter, and Zoom, which are used to harass and abuse. The phenomenon presents nuances that characterize the harassers, such as paid Trolls and Trolls who attack for pleasure, different population groups, generating highly complex consequences in their victims, such as suicide. The phenomenon evolves as aberrant problematic within which the humanity of the victim is unknown of their rights to be respected and protected in their physical, psychological, sexual, and moral integrality. (Celis and Rodríguez, 2019). It is necessary to recognize in this regard that the nature of the educational scenario is fundamentally socio-anthropological and within it converges the symbolic interactionism of educational agents, who form a social discourse, as a result of the amalgamation of minds, which is provided with beliefs, anti-values, and exclusionary judgments with respect to what is plausible, acceptable, and permissible in the interactive dynamics of fellow human beings in school, which leads to rejecting what is different.

In this sense, bullying is a phenomenon that comes from the social constructionism of students, from the transactional forms determined, from the processes of primary socialization, which are transferred to the field of educational interaction, generating chaos in school coexistence (Ortega & del Rey, 2016) that manifests itself as an aggression of verbal, physical, and psychological type that triggers aggressive symbolic acts towards subjects that represent the victim, who may possess some psychological, social, physical, and/or economic disadvantage, within which may be mentioned mental handicap, physical disability, religious and ethnic differences, low economic profile, leading to collective social rejection, which is unjustifiably maintained by the followers and the victimizers (Hymel, 2014).

Systematic studies on bullying stem from the publications of Dan Olweus who in his book "Aggression in the schools: bullies and whipping boys" (Rodriguez, 2020) allows determining that the phenomenon becomes important due to the consequences related to adolescent suicide due to its recurrent and repetitive manifestation, due to the violation of the rights of equality and reciprocity, gender violence and mistreatment since the victim's self-esteem and capacity of expression to defend himself is violated, a process that in turn increases the violent behavior of the victimizer.

The research is developed in the city of Barranquilla, capital district of the Atlantic region of Colombia, where the starting point is a negative coexistence problem growing in a district school, which has been experiencing the phenomenon for several years without achieving an effective solution to it. Since the problem has various manifestations characterized by precarious interpersonal relationships, poor academic performance, conflict between peers, verbal and physical aggression, violent rejection and intimidation, which have led the school to be forced to take measures to keep students with highly aggressive practices out of the school as a measure to maintain the school's coexistence balance.

The serious problem lies in its massiveness as a problem that evolves by degrees of intensity from one type of aggression to another, from one type of bullying to another, and the marked influence it triggers among peer groups to support or reject its manifestation. In the school under study, the massiveness of the problem motivated the research design and the objectives set for the achievement of an effective solution based on empirical evidence.

The deterioration of the school's coexistence process was identified based on the behaviors of rejection, social intimidation, recurrent teasing, and manifestations of physical and verbal violence. These have affected the academic performance of aggressors and victims. Therefore, the empirical process of the research involved the previous diagnostic evaluation of the students' state of coexistence, with the application of the Cie-Abreviated questionnaire for the evaluation of school bullying, before and after the psycho-pedagogical program applied in order to verify its effects on the systematic reduction of violent behavior and the intensification of inclusive behavior, the reduction of teasing, the opening to social acceptance, to otherness, and the recognition of the other as an equal. The psycho-pedagogical intervention program was applied in order to demonstrate and verify the reflection of the phenomenon and the rethinking of erroneous thoughts, which did not allow an acceptable coexistence among peers. Research in psycho-pedagogy has led to the scientific advancement of the discipline, which has allowed its interdisciplinary deployment for the development of various strategies, for competent intervention in topics related to normalization, social integration, human development, aggression of disability and special educational needs, learning disabilities, and special education. Process that in turn allow the integration of various models of preventive, projective, and educational application that are integrated with the fundamental pedagogical principles of schooling, which promotes the development and social adaptation of human beings who interact in it, as an institution and as a process. (Arroyo, 2015).

In this sense, psycho-pedagogical intervention in the school constitutes a tool that favors the opening and critical reflection of the phenomenon of bullying and mobbing in order to close the gaps of inequality, so that communicational bridges can be built for the reciprocal acceptance of individual differences, as a fundamental axis of intervention, for the advancement of an inclusive coexistence among students. Diversity is a daily phenomenon in schools, therefore, the plans and programs applied from psychopedagogy propose the achievement of psychological and social welfare of students, the self-formation of personality, so that they feel good about themselves and achieve empowerment of their abilities and skills since human development involves structural changes, mediated socio-cognitively (Almonte & Montt, 2013).

In the case of the research referred to in this article, the Psychopedagogical Intervention was aimed at achieving cohesion and acceptance by articulating the reduction of aggressive behavior and social rejection. The program was based on the theory of resilience and as a pedagogical principle integrated socio-constructivism in order to restructure the cognitive content, reducing in turn affective tones related to fear, anguish, insecurity, feeling annulled and defeated, so that victimized students could self-affirm their personality and manage to express themselves with freedom before their peers (Rohner & Carrasco, 2014). Likewise, to promote assertive communication, reflecting critically on good and bad contacts.

The psycho-pedagogical intervention stimulated the exposure of the problem and the emotions linked to it in order to enhance insight and self-determination. Likewise, an analysis of aggressive and exclusionary behaviors and of the predisposing and triggering factors linked to the phenomenon so that victims and perpetrators could take on the task of modifying them, giving rise to empathy, listening, attention, healthy interpersonal relationships, human development, and concerted and shared coexistence. The research proved the importance of communicative interaction, mediation, coping, discussion of meanings as dialogical bridges that favor critical reflection of the phenomena that alter coexistence, as well as the importance of resilience for all social actors since the problems that prevent the acceptable course of coexistence is also related to factors as an agent of change in schools (Pacheco, 2018).

Bullying and mobbing are manifested in the school environment in children of different ages and both include nuances of both verbal and physical violence. The review of research on both phenomena has made it possible to clarify that there is no difference between them. Historically, bullying was associated exclusively with the school environment, while mobbing was related to the workplace. However, it has now been clarified that both problems are expressed in the school environment maintaining the same aggressive interactional forms between victims and perpetrators, which leads to establish the non-differentiation between the two processes (García and Ascencio, 2015; Pereiro, 2016).

It is necessary to take into account that the evolutionary process of bullying is determined by the interactive dynamics of risk factors associated with both the victim and the victimizer. In the aggressors or victimizers, there may be situations related to age, gender, the characterization of an aggressive personality, which needs to be expressed as a form of compensation for a personal sense of inferiority. In turn, the aggressor presents low academic level, little empathy, which is related to precarious intrafamily relationships where the hard parenting pattern prevails, which in fact is defined by the statistical manual of mental disorders as a predisposing factor in the development of behavioral problems (Oliveira, 2015). Within the family-type risk factors of the aggressors, conflictive intrafamily dynamics, the use of abuse as a legitimate disciplinary strategy at home, incoherence and inconsistencies in the communicative content between parents and children, and the persistence of affective spectrum disorders in the mother, who in her psychological condition cannot constitute a support for the resolution of bullying or mobbing can be mentioned. The perpetrators may present flat affect, maladjustment, false courage, anger, depression and impulsivity, extreme distrust, insensitivity to the pain of others, lack of empathy, feelings of inferiority.

Abused or victimized individuals may have family, social and economic disadvantages, mental handicap problems, physical defects, problems related to sexual status, depression, low self-esteem, ethnic group, and specific religion.

The consequences of boys and girls abused by a school coexistence where the aforementioned phenomena prevail implies for the affected behavioral situations related to maladaptation, false courage, persistent fear, school absence, low academic performance, obvious aspects in personal presentation, such as coming home with torn clothes, broken school materials, nutritional decompensation because their food or money to buy it can be stolen, can manifest withdrawal, stuttering, explosions of violence, psychosomatic disorders, such as stomach aches, affective problems, such as crying for no apparent reason, sleep problems, enuresis, hiding the truth, coming home with physical trauma, which are not justified in a convincing way (Oliveira, 2015).

School bullying appears in the school dynamics as a particular phenomenon in which an individual is accused, assaulted, intimidated, and victimized by a group of individuals in an unjustified manner, who turn him/her into a scapegoat, depository of harassment, which keeps him/her in a position of social exclusion. The victimizer generates a gregarious structure of companions who participate in the bullying with differences in degree. The objective of mobbing is to maintain the dominance-submission structure, which in turn is accompanied by the vulnerability of the victims, the absence of a parental commitment for its dissolution, of a precarious recognition and compliance with the norm, and a disregard for the teaching authority (Camodeca, Caravita, & Coppola, 2015).

Its evolutionary dynamics is manifested as a type of verbal, physical, and psychological violence with complex and evolutionary multifactorial etiology that precedes reiterative behaviors of harassment, intimidation, ridicule, aggression, and rejection towards an individual who does not deploy mechanisms of self-defense and self-affirmation, (Hymel, 2014) The deterioration of mental health constitutes a consequence of this process as it is frequent in the educational scenario where the aforementioned problematic prevails.

The response to this problem requires an interdisciplinary intervention that integrates the psycho-pedagogical, psychological, prophylactic, and resolutive aspects since the family, teachers, students, and the counselor need to work as a team in its conduction. It is necessary to analyze the origins related to the social construction of the primary reality that is configured in the parental nucleus, which may be tinged by prejudices and anti-values, which are symbolically represented in the theory of mind of children and adolescents, forming the discourse of aggression that will be reproduced internationally in the educational environment, to trigger aggressive behaviors that deteriorate the school climate, isolating those affected in a systematic and repetitive manner since its objective is the suffering, sadness, isolation, contempt ,and submission of the victim. (Diaz, 2015).

Resilience and Social Adaptation

Resilience comes as a capacity that individuals and human groups can express in the face of adversity to remain resistant and adapted in the face of drastic situations; therefore, it allows them to maintain their mental health to tolerate stressful situations, emerging strengthened from them (Gómez & Rivas, 2017).

Resilience can be trained, as individuals have the ability to modify their mental habits in the face of critical circumstances, integrating positive attitudes towards risks,

strengthening their confidence, personal security, and values with cognitive flexibility, firmly supported by their personal beliefs and capabilities.

At the family level, resilience leads to maintaining affective relationships characterized by secure attachments and mutual support, which allows inferring that healthy family relationships are characterized by integral and positive affective tonalities that produce psychological well-being and the harmonious perception of the family nucleus characterized by constant and affectionate parents who represent a healthy support for their children, a process that will generate the deployment of resilient, self-affirmed personalities. This family base leads to the adaptive overcoming of risks, conformed in such nucleus a functional unit due to the management of essential transactions that allow families to withstand and overcome psychosocial burdens, (Jaramillo & Moreno, 2017).

Families lay the foundations of an interactional process for the representation of the affective bond loaded with symbols, meanings, and signifiers that constitute the socio-cognitive basis of social relations of adaptation and affectivity in later ages. Family resilience leads to positive social adaptation characterized by rational processes, trust, security, absence of fear, hope, and affectivity.

Resilient families maintain socio-affective integration, emotional self-control, and emotional differentiation; they lay the axiological foundations for honesty, truthfulness, respect, and gender identity. The development of resilience in the family lays the foundations for positive self-control of emotions, the development of skills for social cohesion, coexistence with peers, through prosocial behaviors that express respect for others, personal self-image, and the deployment of one's own convictions.

However, families that present problems of cohesion and affective bonds are characterized by great imbalances that hinder the development of resilience and with it the exposure to the difficulties of social adaptation. The representation of the world of students characterized by conflictualized homes configures a form of social interaction, within which the behavioral patterns that were considered legitimate are transferred. Problems of social adaptation to the educational norm, the acceptance of differences, and problems of coexistence may arise since the representation of the world is transferred to the school order.

In the case of the school investigated, the victimizing students presented a history of follow-up for non-compliance and alteration of the educational norm, there were behaviors of intolerance, aggression, mistreatment, rejection, and reiterative harassment. The families of the perpetrator students present educational inconsistencies that prevent the coherent representation of principles and values. The children show an inability to live in peace with their peers, there is social rejection, denial of the person of those affected. The school and teachers, with the support of psycho-pedagogical intervention, focused their efforts to alleviate the problem of school mobbing.

Resilience in the family context potentiates human strengths for the overcoming of defects, as people can surface their potentialities as human beings who can positively face social changes by remaining resilient and emerging strengthened from them (Terazona & González, 2018).

Hypothesis

Taking into account the quasi-experimental methodology of the research, the following hypotheses are put forward:

Null Hypothesis

There are no differences in the scores obtained in the collection of the CIE-A social bullying scale, before and after the application of a program on social acceptance and resilience in students of a school in Barranquilla, Atlántico-Colombia.

Alternative Hypothesis

There is a difference between the scores obtained in the social intimidation scale before and after the application of a resilience program in students of a school in Barranquilla, Atlántico-Colombia.

Objectives

The general objective of the research is to study the effects of a social acceptance program based on the foundations of resilience on the social intimidation-social acceptance relationship in a group of students. This in order to determine the effects at the level of reduction of bullying, harassment, and social rejection, which would indicate an increase in the social relationship among peers. Likewise, the following specific objectives were set as specific objectives:

Objective 1: Identify the characteristics of social bullying that hinder social acceptance among peers in students of a school in Barranquilla, Atlántico, Colombia.

Objective 2: Compare the effects of the program on social acceptance and resilience on social bullying behavior in students of a school in Barranquilla, Atlántico, Colombia.

Objective 3: Analyze the effects of the program on social acceptance behavior in the experimental group.

Methodology

A quasi-experimental longitudinal design was applied in the research with observation before (oa, pretest) and observation after (od posttest) the application of the psycho-pedagogical intervention program based on the theory of resilience and social constructionism, as a methodological reference for the development of the workshops. The impact of the program was determined based on the measurement of the effects in terms of greater acceptance and cohesion with peers, reduction of aggressive behavior and expression of inclusive prosocial behaviors, reduction of fear, and of perceiving oneself as socially excluded.

Participants

For reasons of the academic calendar, the sample consisted of 26 students, 13 belonging to the experimental group and 132 belonging to the control group. This purposive sample was defined with the support of the school counselor since students

without academic and social problems were selected before students with social and academic problems.

This participating sample of 26 students belonging to the control and experimental group is typical. It is composed of students with low self-esteem, social rejection, weak axiological support, behavior aimed at exclusion and aggression. This school belongs to calendar a, which starts classes in February and ends in November with intermediate vacations in June and July.

Purposive sampling is defined as a deliberate effort by the researcher to obtain representative samples, which share supposedly typical characteristics. (Cuesta & Herrera, 2015). In the case of the present research the purposive sample is constituted by 8th grade students with the long trajectory in the intervened school. The sample is distributed by gender as follows:

Control Group

Girls. 8

Boys. 5

Experimental Group

Girls. 9

Boys. 4

The characteristics described not only obey the reports of the school counselor but are also corroborated by the dimensions of the CIE-Abbreviated. The experimental and control group subjects are part of the 8th grade of the District Educational Institution located in the Modelo neighborhood of the city of Barranquilla, and their ages range between 12 and 17 years old. The research was carried out with the informed consent of the school principal and the parents of the participating subjects.

The distribution of students by experimental group (13) and control group (13) was made based on the report of coexistence 8°A and 8°B provided by the directors in which they define that grade 8°A is characterized by better interpersonal relationships, with fewer manifestations of intrapersonal aggression. While group B is characterized by greater manifestations of aggression towards specific individuals within the group, this means that not all individuals are excluded, only some experience intimidation, rejection, and harassment, which indicates that they are victims of Mobbing.

Instruments

The CIE-Abbreviated scale of mediation of bullying and social rejection validated for the Colombian context and the psychopedagogical intervention program based on resilience are used in this research to test its effects.

The ICD-A was designed by Cuevas, Hoyos & Ortiz (009). These researches designed the ICD-A questionnaire, which was submitted to a validation process by nine expert judges in children's clinics according to Bejarano, Diaz, Valencia & Cuevas (2008). This led to a first level of validation. This process allowed its design in 2 forms CIE-A and CIE-B, which initially had 203 questions that were applied to students aged between 8 and 18 years. This questionnaire yields results in three domains: roles of social

bullying, victims, or bullies; prevalence; forms of bullying and effects on victims and bullies.

The construction and validation of the instrument went through several stages, i.e. instrument solution, evaluation of the psychometric properties of the ICD-A for the elaboration of a reduced questionnaire. An exploratory factor analysis was carried out with a field study to determine the internal consistency of the scale. (Moratto, Cárdenas & Berbesí, 2012).

A total of 512 students between 11 and 8 years of age participated in the validation of the questionnaire. This exercise yielded the following structure for the first component with 64 items, a Cronbach's alpha of 0.958 was obtained; for the second component about anxiety symptomatology, a Cronbach's alpha of 0.875 was reached; and for the third component about aggressors, 64 items, a Cronbach's alpha of 0.964 was obtained. For the validation of the abbreviated version applied in the present research, the application was carried out in 788 students, resulting in a Cronbach's alpha of 0.87 for the bullying victimization category 0.95; for the second anxiety symptomatology category 0.817; for the third category bullying by correspondents, a Cronbach's alpha of 0.96.

Table 2

ICD-Abbreviated Scale

ategories	**riginal cale Item o.**	**ronbach's lpha**	**Abbreviated scale Item No.**	**ronbach's lpha**
ictimization section r intimidation hysical, verbal, ɔcial, and ɒercion)	4	0.95	12	0.87
ymptomatology of nxiety, depression, ɔst-traumatic stress isorder and effects n self-esteem.	4	0.87	12	0.89

timidation by the spondents.	4	0.96	12	0.83

Psychopedagogical Intervention Program Based on Resilience and Coping.

The program was designed in order to mediate in the students, victims and perpetrators, a space for critical reflection on the problems of coexistence experienced by the school. The program therefore executes a training for the management of affective tonalities, for the promotion of changes in the perspective of thinking and attitudes.

The participating students belong to stratum one, characterized by multiple psychosocial problems arising from the same home. Therefore, the process of workshops and exercises was oriented to change adverse behavioral patterns, so that the students would abandon persistent erroneous thoughts that conflict the relationship with their peers, also attending to the strengthening of self-esteem very affected in the participating group. Fundamentally, the program carries out activities that prepare the student to assume a positive self-concept, for the management of positive attention and listening, for social acceptance with their peers, making the communication of thoughts and feelings more flexible, with openness to what is different.

The program has three main phases: A Coping phase characterized by relaxation and mindfulness exercises, a phase of gradual exposure of thinking, characterized by conflict resolution, flexibilization of thinking, change of negative thoughts, reduction of the external locus of control to strengthen the internal locus of control, and acceptance of difference. In the phase of psychoeducation oriented with an educational and preventive character in order to strengthen the achievements reached by the students. It is necessary to clarify that at the beginning of the research the students of the school had not received any intervention to solve the problem.

During the intervention, the students experienced in themselves fundamental changes in the way they perceive the relationship with others, especially in the management of affective tones and in the reduction of aggressive behavior, teasing, harassment, and a gradual overcoming of the inability to live in peace. The social construction of the participating students expresses the discourse of aggression represented, experienced and reproduced from the basic family and socioeconomic environment, a process that becomes dynamic in the daily life of the school environment.

During the first phase, mindfulness exercises, relaxation, and mandalas are oriented towards the regulatory management of emotions, as a basis for dealing positively with suffering and overcoming the pain of harmful experiences. At the same time, the assertive response is increased, the negative affective tone is reduced and the participants' capacity for openness to change is strengthened.

In the second phase of the program, critical reflection on the content of thought, allows the establishment of assertiveness cores to reduce social rejection, overcome sadness, reduce fears, question the aggressive behaviors that maintain bullying and mobbing, questioning their prevalence in the interactional process of students, so that participants issue relevant and sufficient conclusions for their solution. The self-esteem of the aggressors is confronted, training in the management of effective communication,

the acceptance of difference, the development of autonomy and social understanding, for the rethinking of the interrelationship with fellow human beings. (Pacheco, 2018)

The third phase, corresponding to psychoeducation, constitutes a phase of strengthening and feedback of the learning and skills acquired in the previous phases, in such a way that assertive behaviors, integrative communication, self-reflection and acceptance of difference, tolerance, and non-aggression are emphasized. It is achieved with the reinforcement of psychoeducation the modification of misconceptions that were represented in the theory of mind, to the reduction of automatic negative emotions, without any justification in reality and to the establishment of a more reflective and coherent posture with reality (Pacheco, 2018).

The didactic intervention of the program was based on constructionism, so that the mediation of the psycho-pedagogist would lead to the deployment of new skills, abilities, and integrative behaviors. The mediation was proposed in terms of questioning, critical reflection workshops, case studies, socio-dramas, and relaxation exercises, aimed at the student's self-questioning and dynamizing the changes in the content of thought and affective tonalities for the construction of a new approach to interrelation with peers. The teachers of the institution received the guidelines to give continuity to the program in order to strengthen its effects over time for a more lasting solution to the problems of coexistence.

The following table presents the organization of the psycho-pedagogical intervention program.

Table 1

Coping and Resilience Program Planning Matrix

Phases.	**Number of sessions.**	**Number of Hours.**	**umber of eeks.**	**Type of intervention.**
Coping.	3	6	1	elaxation and indfulness, Color erapy, Social cceptance. Problem cceptance, Social ejection, Resolution nd Overcoming arriers. ntagonistic.
			3	

xposition of ought.	3	6	3	elf-esteem, self-etermination, ssertiveness, mpowerment,

Procedure

For the development of the research, initially a protocol approach process is carried out in the intervened school, to explain to the rector and the faculty the scope of the research. Informed consents are signed to grant permissions for the execution of the research. With the intentional sample, a sample of 26 students is organized, 13 belonging to the control group, and 13 belonging to the experimental group. Once the sample was identified, the CIE-Abbreviated instrument was applied to the control group and the experimental group to carry out the observation before or A of the study.

After the evaluation carried out in the observation exercise before, the psycho-pedagogical intervention program is applied in the experimental group. It is executed during 16 weeks with the students, who go through the relaxation exercises, then in the process of gradual exposure of thought, the students carry out critical reflection workshops, from which they expose the conflictualization they experience carrying out a reflective process with the mediation of the researcher and the support of the teachers.

The psycho-pedagogical intervention program was implemented with a scientific approach, articulating theoretical and methodological principles, with the aim of reducing social bullying, rejection, and potential changes in the theory of mind, to provide a solution to school coexistence. The realization of coping skills is carried out with the exercise of mindfulness, the elaboration of mandalas, free drawings, and relaxation for the regulation of emotions, in the face of painful events, to significantly reduce the perception of the intimidation, flexing anger, deploying self-control, and representational change.

Self-acceptance, self-discipline, and positive discipline. The second phase of gradual exposure of thought and representational change involves critical reflection on social rejection, bad contacts, and self-questioning, analyzing the reasons for negative behavior. The third phase, referring to psychoeducation, constitutes the implementation of assertive behaviors, eliminating unjustified rejection behaviors and the reduction of negative thoughts about oneself and others. After the completion of the program, the observation is carried out afterwards, applying again the CIE-Abbreviated in experimental and control groups, in order to verify the difference in means between both groups, in order to determine the acceptance and/or rejection of the hypothesis.

The participant sample was chosen by purposive sampling since the participating students have homogeneous characteristics, which have configured and represented during several years of schooling their educational environment, and therefore exhibit typical characteristics. Purposive sampling is used in research when the researcher cannot control the values of the independent variable at will.

Data Analysis

The data collected by the instrument are analyzed using the EXCEL program as a tool in which a quantitative methodology is used with the application of the following techniques:

•Descriptive statistics technique: Student's t-test. To give answers to objectives one and three of the research presentation.

•Correlational analysis technique: Pearson correlation coefficient. To give an answer to objective two.

In the case of the first objective, i.e. to identify the characteristics of social bullying, this information is recorded with a CIE-Abbreviated test, whereby the scores obtained with the processing of descriptive statistics (Student's t-test), reveal the trends of the elements related to bullying, social rejection, and school mobbing. In the cases of correlational techniques (Pearson) are applied to determine the differences between the scores before and after the psycho-pedagogical intervention.

Results

The results were processed with the application of the Student's t-test to analyze the significance of the impact of the psycho-pedagogical intervention program on the perception of the students, in terms of a reduction of social aggression, rejection and bullying, articulated to an increase in acceptance and inclusion among peers. The Student's t-test allowed to establish the significance between the difference of means obtained before and after the program applied in the experimental and control groups.

The results of the Student's t-test are presented in the following table:

Table 3

Student's t-test applied to the results of the control group.

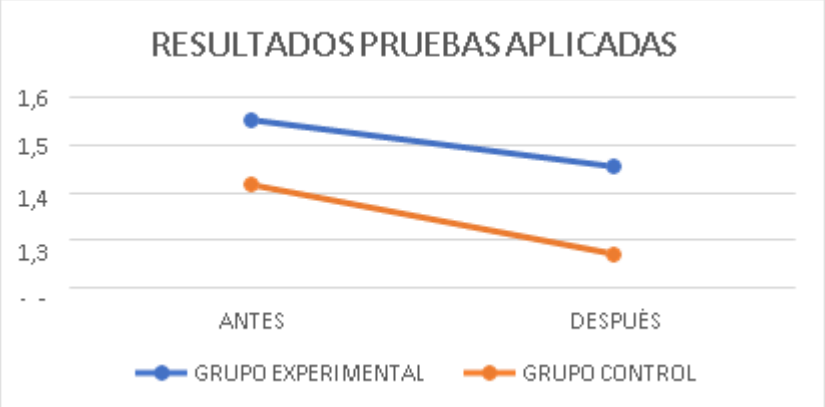
CONTROL GROUP	**BEFORE**	**AFTER**
Media	1.4167	1.2714
Variance	0.04372428	0.027797563
Remarks	13	13
Pearson correlation coefficient	**-0.296944262**	
Hypothetical difference of means	0	
Degrees of freedom	12	
T-statistic	1.725069894	
P(T<=t) one tail	0.055075054	
Critical value of t (one-tailed)	1.782287556	

When applying the Student's T test in the control group, the results show that the P value=0.11 is greater at the established significance level greater than 0.05. Consequently, the null hypothesis is not rejected, so it is assumed that, although there are

differences in the measures, these differences are not statistically significant between the results obtained before and after the application of the psycho-pedagogical intervention program for the control group.

As for the experimental group, made up of students who present a trajectory of negative coexistence within the school, characterized by social rejection, aggression, mockery towards peers, disqualification and social exclusion, problems that have been registered by the school counselor, their results after the psycho-pedagogical intervention show a difference in the means, in the student t-test before, and after. However, this is not considered statistically significant. Because the experimental group registers minimal differences at the level of observation before and observation after the psycho-pedagogical intervention. However, it is considered a positive effect because it complies with objective number three, which refers to the effects of the program on the behavior of social acceptance in the experimental group. In this sense, beyond the numerical effect, there are the effects on the socio-affective qualities of the students since the perception of bullying and social rejection was reduced, thus fulfilling the effect of the program.

The results presented analyze the before and after means recorded by experimental and control groups. There is a reduction in the perception of bullying, rejection, and Mobbing. A greater reduction is presented in the control group since in fact it is made up of students who do not present behaviors that affect coexistence at school, since they are not directly responsible for bullying. However, Pearson's correlation coefficient (see graph No. 1) shows that in the experimental group the higher the score in the test before, the greater the difference in the test score after applying the program with the consequence that it can be determined that the psycho-pedagogical intervention had a greater impact on the experimental group in terms of the reduction of the perception of bullying, which is inferred from the wider difference in means.



Graph 1

Means before and after experimental and control groups

The hypothesis is fulfilled, since the students present behavioral changes, from which intimidation, social rejection and aggression are reduced. It is necessary to note that the students of the experimental group come from a long process characterized by negative coexistence, present high levels of anxiety, and recurrent annotations to the institutionally registered norm.

The psycho-pedagogical intervention has allowed the recomposition of their affective tonalities and a rethinking of the content of the theory of mind, the problems of

the affective spectrum of the experimental group constitute a factor of resilience to change, which led to recommend a strengthening of the sessions of the psycho-pedagogical intervention process and the complementary individual intervention to enhance the integral human development of the students.

Discussion

The differences between the observation before and observation after are not significant from the parameters of the test, but they are significant in terms of the changes that the students show in the responses observed in the classrooms, a reduction in the perception of social rejection of peers is evidenced. More autonomy and less intimidation are observed.

It is necessary to clarify that the control group is the group with less rejection activity since it does not present recurrent manifestations of social bullying and is characterized, according to the coexistence reports, for being a more integrated group. For their responses in the dimensions of the CIE-Abbreviated are inclined towards no, which indicates a low performance in bullying behaviors, in the presence of affective spectrum disorder and bullying by respondents. This indicates that individuals in the control group have low screening for school bullying and school Mobbing.

In relation to the experimental group, the results obtained in the test during the observation before and after, express a minimal difference that is not significant. Analyzing the responses that the experimental group evidenced in the CIE-Abbreviated, most of them are located in the yes, which is a high screening, in terms of bullying behavior, presence of affective spectrum disorder and bullying by the respondents. Students in the experimental group come from an academic and disciplinary background characterized by the prevalence of aggression, bullying and rejection. In the first dimension of the CIE-Abbreviated, which is defined as victimization by bullying variation, students in the experimental group describe in their responses that their bullying victimization condition is severe.

Regarding the symptoms of stress, depression, and effects on self-esteem, the students of the experimental group manifest in their responses, a symptomatology related to problems of the affective spectrum. It should be remembered that the victims of Mobbing usually present an affective condition that predisposes them to find themselves in victim situations, which means that not all subjects are victims of Mobbing. Only those who, due to their psycho-affective and socio-cultural disadvantages, present themselves as candidates to be victimized, in this case, the students in the experimental group.

In fact, in the item "sometimes I feel like dying" and the item "sometimes I hate myself" the students of the experimental group present positive responses. In bullying by respondents, the students of the experimental group present more positive responses, especially in the items "I do not let participate, I exclude," "I make fun of him or her" are items that represent school Mobbing, which indicates in psychological terms that this is part of the content of the theory of mind of the students of the experimental group and constitutes a legitimate form of social interaction, which has remained for a long time in the students' communicational forms.

The program was executed during 8 sessions, within which the students of the control group and the experimental group confronted the coexistence difficulties they

have experienced during years of shared schooling, which has affected coexistence and the possibility of understanding between the parties. It is necessary to clarify that the results achieved in the observation afterwards do not show statistically significant differences from the parameters of the student's t-test. Since the participating subjects did experience changes in the reduction of aggressive behavior and in the expression of affective tonalities, a process that could reveal that an intensification of the hours of the applied program would have greater effects that would be statistically revealed. The participating school had never before implemented programs aimed at reducing bullying. The research provided the first controlled experience for the reduction and resolution of the problem.

In this sense, in psycho-pedagogical terms, there were reductions in bullying behavior and social rejection. This indicates that psycho-pedagogical intervention is key in the processes aimed at triggering significant changes that enhance healthy school coexistence and the human development of students.

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LA EVALUACIÓN PSICOLÓGICA FORENSE EN EL CONTEXTO DE FAMILIA EN COLOMBIA: CUSTODIA Y PATRIA POTESTAD

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Resumen. El presente artículo tiene como propósito orientar la buena praxis y evitar sanciones éticas en el ejercicio profesional del psicólogo forense, profundizando en los requisitos fundamentales que se deberían tener en cuenta en la elaboración de informes psicológicos forenses en el ámbito de la familia en casos de custodia y patria potestad. El artículo está basado en los datos derivados de la investigación científica y jurídica, lo que permitió identificar las consecuencias psicoemocionales en padres e hijos originarias de las rupturas conyugales. Al igual que las implicaciones éticas de la actuación del perito psicólogo, las limitaciones, el alcance de su práctica y las herramientas de evaluación, así como los lineamientos legales propios del derecho de familia e introduce un modelo de informe pericial derivado de las buenas prácticas en este contexto.

Palabras claves: Evaluación psicológica forense, custodia, patria potestad, separación y divorcio, modelo de informe psicológico forense.

FORENSIC PSYCHOLOGICAL EVALUATION IN THE CONTEXT OF THE FAMILY IN COLOMBIA: CUSTODY AND PARENTAL AUTHORITY

Abstract. The purpose of this article is to guide good practice and avoid ethical sanctions in the professional practice of the forensic psychologist, delving into the fundamental requirements that should be taken into account when preparing forensic psychological reports at the family level in custody cases and parental

authority. The article is based on data derived from scientific and legal research, which made it possible to identify the psycho-emotional consequences in parents and children derived from marital breakups. As well as the ethical implications of the performance of the psychologist expert, the limitations, the scope of their practice and the evaluation tools, as well as the legal guidelines of family law and introduces an expert model report derived from good practices in this context.

Keywords: Forensic psychological evaluation, custody, parental authority, separation and divorce, forensic psychological report model.

Introduction

The forensic psychological reports that are derived therefrom are intended to support the competent authority in making decisions in custody, parental authority, or visitation proceedings. Given the implications of this type of professional actions for the judicial system and the families involved in the process, the expertise and competence of the psychologist performing the psychological evaluations is of vital importance.

In Colombia, excluding the statistics of separations in which civil unions and contentious divorces do not take place, the official figures of the Superintendence of Notaries and Registry (2020) establish that in the last four years an average of twenty-two thousand and twenty-nine (22,029) cases of mutual agreement divorces have been dissolved annually. Although after the separation most of the ex-couples manage to mourn and reassign their roles, there are also cases where the conflict is perpetuated in arguments and disagreements, triggering endless litigation with a high cost for all members of the family nucleus that can even be extrapolated to the extended family. With the aim of providing support tools for the forensic psychologist who performs evaluations in the family context, this document provides a synthesis of the main aspects that the professional should know at the time of making an assessment in the family context. Key elements such as the causes of separation of couples, emotional consequences of marital breakup, legal parameters, ethical aspects, and guidelines for forensic psychological evaluation are knowledge that guide an adequate professional practice and tends to prevent ethical misconduct and places the psychologist to safeguard the best interests of children and adolescents, as well as to provide quality, reliable, and valid resources to the administration of justice.

Separation and divorce in the family

Family breakdown implies a change for its members; it is a loss that demands the restructuring of its functioning and involves restoring emotions, attitudes, behaviors, and feelings (Cantón et al., 2002). Research on general predictors of marital breakdown indicates that coming from a divorced family increases the risk of separation in a marriage (Amato & DeBoer, 2001), being unemployed (Tumin & Qian, 2017), marrying during adolescence, becoming a mother before marital union, cohabiting with the future spouse prior to marriage (Sweeney & Phillips, 2004), and having a low level of education (Bramlett & Mosher, 2002) are risk factors that can end in divorce. As well as interpersonal aspects, associated with patterns of negative interactions (Clements et al., 2004), infidelity as a cause of divorce and a consequence of the deterioration of the relationship (Previti & Amato, 2004; Teachman, 2004), the absence of positive affection (Gottman & Levenson, 2000), the physical and emotional impact of marital violence (DeMaris, 2000) and other types of violence, the use

of alcohol or drugs, personality problems, lack of communication, and physical or mental abuse (Amato & Previti, 2003). For many couples, unions represent emotional support, companionship, sexuality, security, economy, and healthier lifestyles, benefits that with the breakup often generate stress and loss of protective factors (Amato, 2014). Because of this, divorce is a process that unfolds over months or years, during which time the former spouses may experience a variety of stressful events associated with the division of economic resources, resulting in a decrease in the quality of life (Amato & Sobolewski, 2001).

Psychosocial consequences on parents

Studies have shown that most divorced adults experience more mental and health problems than those who are married (Amato, 2014). In the early years of separation there is a deterioration in parenting because grief centralizes parents in attending to their own emotional responses, coupled with the readjustment of single parenthood with work and social needs. Consequently, separated parents are more prone to emotional lability, are more at risk for depression, alcoholism, drug abuse, and psychosomatic complaints in contrast to those who are married (Kelly & Emery, 2003).

Empirical work indicates that it is generally the mother who assumes custody of the children, which implies an overload in parenting since the father is no longer present in the home to exercise his parental role. In addition, work activities inside or outside the home, added to the grief involved in the separation, increase the emotional consequences and can be extrapolated to the children. Parents experience distress, even when the separation is not conflictive because they often lose the permanent contact they had with their children. Specifically, to the non-custodial parent (usually the father), studies in the area of social work warn that little attention is paid to their feelings of loss and grief when they are away from the children (Baum, 2015).

In Colombia, in forensic practice it is common to find that in contentious separations visits are established between the non-custodial parent and the children, corresponding to a weekend every 15 days and vacation periods are alternated between both filial figures (Constitutional Court of Colombia, 2014, Sentence T115; Vallejo- Orellana et al., 2004). Although the non-custodial parent has the right to interact and continue developing affective relationships with his or her children to contribute to their special care and protection, the transition from permanent contact to reduced time represents a loss for the non-custodial parent that may affect his or her state of mind and have negative consequences for the children associated with interparental tension, deterioration, and the meaning of the filial bond.

Adjustment to divorce can be understood as a resolved grief (Yárnoz-Yaben, 2017); however, adaptation is going to depend according to access to educational resources, support networks of family, friends, and new partners, as well as individual differences of each parent, e.g., social skills, positive ways of coping, and the meaning attributed to the separation (a personal failure or an opportunity to start anew).

The analysis established by Yárnoz-Yaben (2017) on grief in separations establishes that:

- Unresolved grief is significantly associated with the length of time the relationship lasted.
- Oppositional attitudes toward divorce coincide with the level of unresolved grief.
- People with insecure attachment have a higher grief score than those with secure attachment.

- Bereavement intensity predicts person adjustment, conflict, forgiveness, and subjective well-being but does not have causality with co-parenting nor with the perception of help received by the ex-partner.

Psychosocial consequences on children

In the expert work it is observed that the separation of parents constitutes a challenge and changes for the children. The main objectives of forensic psychological evaluations involving children and adolescents in legal proceedings in the family context include the assessment of the areas of adjustment (personal, family, social, and school), which result in psychological adaptation or maladjustment, i.e., absence or presence of clinical symptoms or behavioral problems. Thus, the results of the assessments show that psychologically adjusted children respond adequately in their context, comply with the instructions and regulations established at home and school, and have the ability to relate positively with their peers; in contrast, maladjustment correlates with internalization problems (depression, anxiety, etc.) and externalization problems (aggression, indiscipline, vandalism, delinquency, among others) (Cummings & Davies, 2010).

Different experts agree that children of separated families are more likely to develop adjustment problems, which may even persist into adulthood (Amato, 2014; Lansford et al., 2006; Vandervalk et al., 2005). However, the psychological maladjustment of children of divorced parents is higher during the first two years of separation, then most manage to adapt positively (Amato & Cheadle, 2008). Children with separated parents compared to children of married parents boast more behavioral problems, have more emotional difficulties, have lower academic scores, and possess deficits in social relationships (Amato, 2014; Cummings & Davies, 2010). Hispanic studies conducted with divorced single-parent versus two-parent families showed that physical and verbal aggression was higher in children and adolescents with single-parent families in contrast to those who cohabit in two-parent structures (Rodriguez et al., 2013).

Similarly, Amato & Cheadle (2008) discuss the passive genetic model which suggests that when parents possess problematic traits such as neuroticism or a tendency to antisocial behavior, it may increase the likelihood in disagreement with other parents that they will experience marital discord or that their unions will end in divorce. Thus, if these traits are genetically transmitted from parents to children, the children will have an elevated risk of developing behavioral problems.

In studies conducted by Amato & Anthony (2014), to estimate the effects of divorce in elementary school children, with fixed effects models (reading, mathematics, positive approach to learning, interpersonal skills, self-control, internalizing and externalizing) revealed that divorce was significantly associated with those variables. They also confirmed in adolescents in eighth grade through senior high school that parental separation is associated with consistent decreases in achievement and adjustment. Specifically, regardless of the conflict that may occur before or after parental separation, divorce alone significantly changes children's lives, including domiciles, parental relationships, exposure to interparental conflict, and lifestyle (Amato & Anthony, 2014).

Among the effects of marital dissolution and single parenthood, Booth & Amato (2001), Amato & Anthony (2014), Amato & Cheadle (2008), and Kelly & Emery (2003) have documented different changes in children's lives that influence their psychological maladjustment:

- Decrease in the quality of life.

- Poor care as a result of stressed parents.
- Low parental supervision and decreased parenting time.
- Extrapolation of post-divorce parental conflict.
- Relocation to new neighborhoods and schools.
- Introduction of new parental partners in the households.

Even though adjustment to parental divorce, low conflict, the establishment of a co-parenting program, and parental competence facilitates the psychological adjustment of children to separation (Kelly & Emery, 2003; Yárnoz- Yaben, 2017), it has also been identified that the extrapolation of interparental conflict in children leads to a higher risk of developing gastrointestinal, genitourinary, dermatological, and neurological problems, making parental separation a public health problem (Martinón et al., 2017), as well as emotional consequences associated with guilt, anxiety, depression, and aggressive symptoms (Miedo et al., 2009).

Forensic practice allows us to identify that the difficulties that are most difficult for parents to resolve after separation are associated with child support and physical contact with the children. Disputes range from interruptions in child support payments to parental interference such as conflict of loyalties, i.e., when one parent denigrates the other parent or limits contact between the child and the other parent, which is another form of psychological abuse (Baker and Brassard, 2013). Even when the conflict reaches judicial instances, some parents are willing to lie and manipulate their children to harm the other parent (Clemente et al., 2020).

Previous research indicates that early exposure of children to parental relationship instability may predict a greater likelihood of sexual activity and major depression among adolescents (Donahue et al., 2010). Likewise, marital conflict is collinear with lower levels of parental involvement in parenting; parents are less likely to engage in play activities, reading, and time together, aspects that correlate with child and adolescent maladjustment (Buehler & Gerard, 2002). However, whatever the conflict between parents, the closeness and time spent with each parent after divorce is positive for children's adjustment, as poor parent-child relationships are a predictor of poor physical health (Fabricius & Luecken, 2007).

Thus, in Colombia, when there is conflict between the ex-couples that makes it impossible for them to have a healthy co-parenting relationship, a contentious process arises in which the judicial body will be in charge of adopting pertinent measures regarding custody, visitation, and food regulation to watch over the interests of the children because their welfare takes precedence over the particular interests of the parents or their legal representatives.

Legal aspects: custody and parental authority

The family is a dynamic and complex unit of analysis that guides its members in multiple processes of development, interaction, and learning protected by the Colombian state as the fundamental nucleus of society in which the rights of individuals are harmonized in relation to the demands of social life. Thus, it is constituted as the foundation of the evolution conformed by legal bonds through marriage, contained in the Civil Code or natural bonds determined by the will and responsibility to conform it (National Constituent Assembly, Political Constitution of Colombia, 1991, Article 5 and Article 42).

According to the Colombian Civil Code, the family ties of descendants are identified as those existing between persons who are united by consanguinity (procreated within a marriage, marital union or extramarital union) and the so-called civil relationship, which emerges between parents and adopted children. However, although the ties are identified in a differentiated manner, the Civil Code establishes that "legitimate, extramarital and adoptive children will receive the same protection, equal rights, opportunities and obligations" (Congress of the Republic of Colombia, 1873, Law 84, Article 250).

In relation to children and adolescents (NNA), it is possible to identify that the Political Constitution of Colombia elevates them as subjects of special protection not only by the primary nucleus to which they belong but also by the state and society (National Constituent Assembly, 1991). Likewise, Law 1098, by which the Code of Childhood and Adolescence is issued, ratifies that all persons under 18 years of age are subjects of rights (Congress of the Republic of Colombia, 2006, Article 3) to whom conditions must be preserved for an adequate development consistent with the prevention - protection from risks and unfavorable changes in the present conditions of the environment in which they are immersed (Constitutional Court of Colombia, 2007, Sentence T-090).

In this way, children and adolescents have the right to grow and be welcomed but especially not to be separated from their primary nucleus as a fundamental institution in the development at a socioemotional, intellectual, interpersonal, physical, and personal level (Constitutional Court of Colombia, 1994, Sentence T-278). Therefore, separation from the family constitutes a threat to the fundamental rights of each individual, such as health, physical integrity, balanced nutrition, education, culture, and the right to grow up in an environment of affection and solidarity, where the basis for the full exercise of other rights such as personal identity and freedom of conscience are structured.

As has been pointed out, the marital separation affects all the members of the family nucleus. However, even if the union ends voluntarily, with respect to the children, the obligations, duties, and rights remain intact. For this reason, for the supreme interest and welfare of the children and adolescents involved, Law 1098 of 2006 and Law 640 of 2001 promote the peaceful conciliation of conflicts related to the regulation of visitation, food, and custody, either in a judicial way immersed in a legal process or extrajudicially in conciliation centers "before ombudsmen and family commissioners, regional and sectional delegates of the Ombudsman's Office, agents of the public prosecutor's office, before judicial and administrative authorities in family matters and before notaries" (Congress of the Republic of Colombia, 2001, Law 640, Article 31).

Thus, parental authority is a paternal-filial regime of protection of the unemancipated child and their respective assets that the law attributes to both parents (Decree 2820, 1974, art. 24) to facilitate the exercise of the duties that their role imposes (Congress of the Republic of Colombia, 1968, Law 75, Article 19), which are framed in covering the legal, personal, and patrimonial needs of the minor, which involve aspects such as raising, educating, establishing, and forming morally and intellectually (García - Presas, 2013). The Colombian Civil Code (1873), establishes that the rights of the parents are reduced to the usufruct of the assets (art. 291), the administration of these (art. 295), and the judicial and extrajudicial representation of the children (Congress of the Republic of Colombia, Law 84, Article 306).

The parental authority of children and adolescents as a legal effect of the paternal or maternal filial relationship has a duty, which seen from an external perspective is considered a natural and subjective right to be parents that emanates a tutelary character in which the guardianship and custody of children are structured (Lledó-Yagüe, 2015). This issue calls for

parental responsibility of both parents, so that together they promote the guidance, care, accompaniment, and upbringing of children in their formation process with the aim of ensuring their emotional and material well-being (Constitutional Court, 2004, Sentence C-997), as well as the maximum satisfaction of the rights determined by their role (Congress of the Republic of Colombia, 2006, Law 1098, Article 14).

According to Lledó-Yagüe and Monje-Balmaseda (2017), parental authority is non-transferable and unavailable to the extent that it cannot be regulated, modified, or extinguished voluntarily, except in cases where the law allows it (Montoya, 2015). Therefore, it is the obligation of parents to protect and enhance the rights of minors in order to promote the free development of their personality and comprehensive welfare (López - Contreras, 2015).

When the fundamental rights of children established in the Political Constitution of Colombia are transgressed by the family, the state, or society, in general, the offenders must be sanctioned (National Constituent Assembly, 1991, Article 44). Thus, if the family does not guarantee the comprehensive development of minors and the exercise of their rights, it can lead to the temporary suspension or extinction of parental authority (Saumeth and Henry, 2018), depending on whether the grounds are presented indistinctly:

- *Suspension:* is the temporary loss of rights over unemancipated children in which the parents maintain the exercise of their duties (Congress of the Republic of Colombia, 1873, Law 84, Article 310). It occurs when either parent suffers from dementia or a mental disability that makes it difficult for him/her to understand the scope and consequences of his/her acts, has long absence, or is in interdiction to manage his/her own assets due to excessive exposure to risks regarding the management of his/her patrimony (Presidency of the Republic of Colombia, 1975, Decree 772, Article 7; Turriago, 2019).
- *Extinction:* It is the definitive loss of the rights over the children decreed by a judge, which does not exonerate from the fulfillment of the obligations when the parents incur in situations of abuse, abandonment, depravity related to the issuance of corrupt conduct or outside the law that negatively affects the education of the minor, absence due to deprivation of liberty sentence of the parent exceeding one year and commission of criminal offense by the minor as stated in law 1453 of 2011: "When the adolescent had been punished for the crimes of intentional homicide, kidnapping, extortion in all its forms, and aggravated crimes against freedom, integrity, and sexual formation, and it is proven that the parents favored these conducts" (Congress of the Republic of Colombia, Article 25).

Emancipation, then, is an event that terminates parental authority (Congress of the Republic of Colombia, 1873, Law 84, Article 312) either by voluntary public instrument that must be authorized by a judge with knowledge of the cause (Presidency of the Republic of Colombia, 1974, Decree 2820, Article 43), by events such as the real or presumed death of the parents, the child's marriage, the child having reached legal age (Presidency of the Republic of Colombia, 1974, Decree 2820, Article 44), or by decree of a judge as described above.

According to Law 29 of 1982, "legitimate, extramarital, and adoptive children have equal rights" (Congress of the Republic of Colombia, Article 1), which means that from the first instance the parents are holders of parental authority, based on the recognition provided by law to the family bond by consanguinity, different from what happens when the relationship is mediated by a civil act, where kinship between parents and children in cases

of adoption takes place (Castro-Gonzalez, 2017). However, without differentiating the underlying of the family bond, all children and adolescents have the right that "their parents in a permanent and solidary way assume direct and timely custody for their integral development" (Congress of the Republic of Colombia, 2006, Law 1098, Article 23), even more so when it is their obligation "in common or established by law to provide for the personal care, upbringing, and education of their children" (Congress of the Republic of Colombia, 1873, Law 84, Article 253).

Having said the above, the custody and personal care of children and adolescents, as a right derived from parental authority, is defined as "the duty of supervision, upbringing, education, maintenance, and guidance of the minor" that parents and those who live with minors fulfill to provide them with the necessary tools and support in the course of their development. In Colombia, sole or single-parent custody is that in which the care of the child, physical custody, and the distribution of resources to respond to all their needs corresponds to one of the parents or in exceptional cases to a third party (Ochoa et al., 2020), where the non-custodial parent is assigned a visitation regime and monthly economic contribution (Gallego, 2018).

In the case of joint custody, the participation and legal responsibility of both parents is joint to the extent that not only the economic contributions, but also the periodical or rotating time spent with the children are dosed. This provides the opportunity for both parents to participate actively and responsibly in the process of upbringing, care, and education of the children ensuring that they share the legal rights and responsibilities to make important decisions affecting their children (Fariña et al., 2017). Thus, among others, it constitutes a duty of both parental figures to provide their children with the food and means necessary for their integral development throughout their minority until they are older, only if they continue their period of academic training (Gallego, 2018).

Regarding the development of children and adolescents, the term "child support" refers to everything required by the minor to satisfy his/her needs and promote his/her adequate development, such as sustenance, clothing, medical assistance, recreation, housing, and education (Congress of the Republic of Colombia, 2006, Law 1098, Article 24). Although in Colombia there is no exact regulation of the amount of this obligation, different criteria are taken into account to determine it, such as the economic capacity of the parents, food obligations with other persons, the needs of the children and adolescents, labor situation, wage garnishment limit, and periodic adjustment according to the consumer price index (Congress of the Republic of Colombia, 2006, Law 1098, Article 24).

Granting custody of the minor children to one of the parents or third parties does not deprive the other parent of his or her right to visitation and its respective regulation to maintain communication and closeness. The Constitutional Court states that the regulation of visitation is a system that seeks legal homeostasis between separated parents in the exercise of parental rights (Constitutional Court, 1993, Sentence T-500). Thus, in order not to denaturalize the relationship between parents and children, the right to visitation is implemented with the purpose of preserving the emotional bond, family unity, care, and protection, but especially to maintain the necessary basis for the psychological and emotional development that the particular characteristics of each child demand (Ochoa et al., 2020).

The evaluation process

Evaluating family dynamics is not a simple task and it is even more complex when psychological evaluations are carried out in the forensic field. In the forensic work it is

observed that the family is a complex body of knowledge, where not only the individual characteristics of its members are involved but also the interactions between them, the patterns of upbringing that are established, the generational patterns, the role played by the extended family, and the degree of tension that they imprint on the system, as well as the members that make up the social support network with their paradigms and individualities. In addition to the above, the level of emotional maturity, mental health, and resilience of the parents, who in most cases are the main risk factor for the psychological health of the children, specifically in contentious separations.

From this perspective, forensic psychology in the field of the family is provided with scientific tools that allow establishing the capacity of a person to assume responsibilities, roles or functions, based on the evaluation of their mental and cognitive abilities (Hernández and Espinosa, 2011). Thus, the experience in professional practice allows us to account for the orientation of the work of the expert psychologist towards the determination of emotional interferences in any of the parents and their implications in the performance of parental functions or in the mental health of the children. Starting from the premise that it is the forensic experts who must provide the competent authority with strategies and/or recommendations aimed at reestablishing the balance of the family system, giving priority to the emotional state of the child, the psychologist is required to clarify the nature and directionality of the evaluation, as well as his loyalty to the truth, which is established through scientific evidence and professional responsibility. Therefore, after the reading and analysis of the judicial documents to the extent that it allows knowing the individual circumstances of each family and favors the construction of hypotheses, which will be confirmed or disapproved, it is vital to make a triangulation of all the variables of the case and make use of some evaluation tools among which stand out (Lobo et al., 2016):

1. *Conducting interviews with the evaluated subjects*, which serves to obtain. in a systematized and flexible manner, psychobiographical information on the subjects of interest and information of importance for the evaluation.
2. *Collateral interviews* widely recommended by the American Psychological Association, which are conducted with persons related to the examinees, as determined by the evaluator or documentary evidence, which are used to complement and contrast the information provided and thus confirm or reject the data obtained.
3. *The use of psychometric instruments* that contribute to the measurement of human behavior and cognitive processes, from reliable and valid measurement tools, based on scientific, objective, and demonstrable evidence. The results of the psychological instruments allow to pronounce on the psychopathology, the personality, the capacity of understanding, and volition of the evaluated persons to exercise the functions of protection and care in the children. They enrich the evaluation process based on validity and reliability, and they discourage the risk of simulation of clinical symptomatology, depending on the instrument applied.

That said, it is by obtaining information through different sources of information that the expert will be able to argue those hypotheses and respond to the evaluation objectives. Thus, with regard to the children, the aim is to determine the adaptation in the different spheres of functioning, forms of bonding, and socialization with the parents. Habits related to sleep, leisure, food, hygiene, and physical activity. The establishment of the moral development of the children (rules and behavioral norms) and the acquisition of values. While in the parental figures it is essential to assess the pre-existence or absence of mental illness and personality disorders, global adjustment, labor stability, support networks, and

history of the ex-partner (resolution of grief due to marital separation), their current situation (post-breakup interparental relationships, forms of communication, attitude towards the other parent, and motivations for obtaining custody of the children), the incidence of the existence of new parental partners (forms of interaction with the children), and parental styles (parenting patterns/educational style, time spent with the children, emotional bonding, assertive communication, and the level of moral development).

It is also essential to assess the presence or absence of emotional or parental interference. Research and experience in evaluations with parents involved in child custody disputes has shown that in some cases parental interference is present. Thus, the best interests of the children prevail perennially over the particular interests of the parents, coupled with how essential it is for their proper development to have both parental figures and their respective family contexts. It is essential that the evaluator, regardless of the party for which he/she has been hired, examines the existence or not of possible interferences and report it to the competent authority.

Ethical and deontological aspects

The relationship between the disciplines of law and psychology is close due to the concordance with their object of study, human behavior. However, with different approaches in terms of their understanding and methodologies for their approach, law does so from a perspective of the regulation of human behavior by establishing mechanisms to control social interactions, while psychology, from the comprehensive view, through the evaluation and analysis of the behaviors established within the framework of such relationships. In this sense, the specialty of psychology that maintains a closer link with law is forensic psychology.

When the specialist acts in the "forum" scenario, his professional work is framed in the context of justice, being the result of his intervention, an expert report that is part of the judicial decisions made by the judge, so that the implications and social impact generated by his actions leads to the expertise in the development of his work to be located at the highest levels of quality from the scientific, technical, and ethical perspective. Therefore, expert professionals are required to provide objective, reliable, and valid answers supported by scientific criteria at the service of justice and society.

All psychologists must be governed by ethical principles that guide their actions. In the case of Colombian psychologists, non-compliance with the guiding principles and duties of the Colombian Psychology Law 1090 of 2006, which regulates the professional practice of psychology in the country, leads to the commission of an alleged ethical misconduct and with it, probably, an investigation by the Courts of the Colombian College of Psychologists -COLPSIC, resulting in a sanction for the specialist, which depending on its severity could result in a blemish in his professional record with serious implications at the time of proving in court his ethical and moral suitability. For the forensic psychologist who works in family contexts, his expertise contains a high level of specialty and complexity, and at the same time the one that generates the most ethical controversy. For this reason, the forensic psychologist has the obligation to know in depth the current legislation on family law in his or her country, the characteristics, concepts, and functioning of the system, among other aspects (Urra, 2007). As well as having expertise in clinical evaluation of children, adolescents, and adults, they must have knowledge of family systems, parenting patterns, psychopathology, evaluation instruments in the family forensic field, as well as a high understanding of the ethical and legal implications of their actions. In other words, the

professional practice of psychologists, without exception, must be oriented to the ethical approaches established by Colombian law and the Code of Ethics (Congress of the Republic of Colombia, 2006, Law 1090). As well as ensuring compliance with universal ethical principles: beneficence, non-maleficence, autonomy, and responsibility should be the guiding notions of professional action. Beneficence indicates a moral obligation to act for the benefit of others, while non-maleficence reveals that the professional is obliged not to cause harm to the user and even to third parties who might be involved in the evaluation process. The deontological and bioethical handbook of psychology of the Colombian College of Psychologists presents these universal principles, which should be mandatory for all psychology professionals. Therefore, every specialist must carry out a thorough deliberative process in each of the decisions and conclusions reached in their approach processes.

The Colombian psychologist law (1090 of 2006) establishes that all psychologists are obliged to maintain high standards of competence, recognizing the limits of their knowledge and expertise, as well as the techniques available for the evaluation (Congress of the Republic of Colombia), bearing in mind that they only use the methodologies and methods in which they have been trained and are qualified in order to guarantee the well-being of their users. Thus, prior to the beginning of the evaluation, the limitations, if any, should be presented, as well as the scope and implications, clarifying to the users and their legal representatives, attorneys, and proxies that they are not co-authors of the report (Molina-Bartumeus, 2017), and also clarifying that the conclusions derived therefrom are the result of the evaluation and not of the particular interests of the interested parties, regardless of the costs incurred as part of the expert's fees. This aspect in particular requires special attention given that in Colombia there is no regulation of the rate of expert's fees.

Correspondingly, the American Psychological Association (APA, 2010), according to the ethical principles and code of conduct to be assumed by psychologists established by this association for family child custody evaluations, the primary purpose is to help determine the child's best psychological interests and well-being.

Because of the above, the APA (2010) states that professionals in psychology should strive to:

- Achieve and maintain specialized competence.
- Function as impartial evaluators.
- Engage in culturally informed and non-discriminatory valuation practices.
- Avoid conflicts of interest and multiple relationships when approaching.
- Establish the scope of the evaluation in a timely manner, in accordance with the objectives of the evaluation.
- Adequately obtain informed consent.
- Employ multiple methods of data collection.
- Interpret information in a manner consistent with the context of the evaluation.
- Complement the approach with the appropriate combination of tests.
- Base recommendations, if any, on the best psychological interests of the child.
- Create and maintain professional records in accordance with ethical and legal obligations.

Informed consent

Professional secrecy, informed consent and the handling of sensitive and confidential information are aspects of important relevance in forensic psychological evaluations, which

are known to the judge and the actors in the process. One of the frequent difficulties in family expert evaluations is the lack of information regarding the scope and explanations of the psychological evaluations that are carried out, which sometimes leads to misunderstandings generated by the lack of prudence and responsibility in some cases, which is associated with the diminished expertise of the professional. When evaluating minors, it is necessary to keep in mind that the Informed Consent (IC) is under the responsibility of both parents as legal representatives of the minor, according to Colombian legislation. Similarly, it is essential to recognize its dual function, i.e., a duty that the psychologist is obliged to comply with and a right for the user, which is in a position to demand. Thus, it becomes a priority for the expert to inform the interviewee and ensure that he/she understands the procedures, techniques, and strategies to be used in the evaluation or intervention.

Accordingly, doctrine No. 3 of the Colombian College of Psychologists, which refers to Informed Consent (IC) in the practice of psychology in Colombia, establishes that before a psychological evaluation all users must know in a clear and detailed manner what the evaluation process to be performed consists of, the procedures, techniques, and methodologies to be followed.

The process is legalized from the signature of the IC, which is of total knowledge for the evaluated and/or his legal representative, this must meet at least four requirements, being the most important perhaps the recognition that the IC is not provided with the simple signature of a document, the process goes far beyond, existing the central element, the autonomy of the appraisee in the decision making in front of the evaluation process. Likewise, the psychologist must be certain that the person being evaluated has understood the explanation, as well as guaranteeing that the assessment is carried out without any kind of flaw, on the contrary, it is carried out voluntarily and without pressure.

Another aspect of special relevance in the family forensic context is the handling of sensitive information because it belongs to the private life of the people who undergo the evaluation, so the professional must safeguard and guarantee the duty not to disclose the information obtained from its users as a result of their professional practice. In this regard, Doctrine No. 2 of the Colombian College of Psychologists (Hernández, 2018a) establishes the obligation of every psychologist to keep in reserve the information obtained, based on the work with the user and is not authorized to disclose without the prior authorization of its sole owner. In this sense, it should be clear that it is not the judge or the operators of justice who are the owners of the information but the user. This aspect is not easy to understand in the forensic field, taking into account that the result of the evaluation will be known to the judicial authorities and those who make up the forum. However, given the trust that the person being evaluated places in the expert psychologist who, in the use of his faculties as a psychology professional, has access to privileged and private information concerning his intimate life (habits, customs, way of life, difficulties in his relationship life, among others) that leaves him in a situation of vulnerability, the psychologist is obliged to keep the information in absolute reserve and to foresee the handling that will be given to it by the parties involved.

Thus, the role of the forensic psychologist takes place in a context of extreme care, with sometimes unclear boundaries. However, in any case, the forensic psychologist cannot forget that the well-being of the user must be his or her main interest, as they are human beings and their dignity is a fundamental value.

Finally, the minimum ethical requirement for a forensic psychologist, according to Urra (2007), recommends caution when making predictions about antisocial behavior, as

well as making reference to the mental state of any of the family members without having performed a previous psychological evaluation. The author recommends clearly documenting conclusions and recommendations, which should be based on scientific evidence, the current state of the theoretical body and research advances in the area. In this way, the psychologist must maintain his autonomy and professional judgment, not lend himself to confusing situations, inform the evaluated subject of his obligation to provide valid and reliable information, as well as the obligation to inform the competent authority of the commission of a crime of which he has become aware through the evaluation. Although the Colombian legislation on psychology and the National Constitution establishes that professional secrecy is inviolable and every psychologist is protected by the duty of confidentiality, the knowledge of a crime obliges him/her to report it.

Conclusion

The challenges for the specialty of forensic psychology in Colombia are enormous; divorce statistics and empirical work have shown the serious problems that arise within families after marital breakup. Therefore, it is vital that the interventions of the forensic psychologist in associated cases are carried out in a rigorous and exhaustive manner that tends to an exploration of all the variables of the case. The research shows the socioemotional alterations that parents and children may present upon separation and that may be exacerbated by difficulties that emerge around custody, visitation regulation, or parental authority. There are interruptions in the maintenance and physical contact with the children, as well as parental interferences, such as the conflict of loyalties due to the particular interests of each of the parents because of their high emotional charges in which negative feelings of anger, frustration, and revenge prevail, which seems to cloud the conscience of the parents and prevents them from objectively analyzing the situation, leaving the best interests of the children undermined and the welfare of the family system affected.

In this type of situation, an impartial third party, in this case the psychologist, must make use of the scientific foundations and his professional expertise to provide alternatives aimed at the welfare of the children and the preservation of family harmony. Then, the psychologist must remain in continuous training and experience that allows him to feedback his practice, so that his actions are subject to absolute impartiality, understanding that he owes psychology as a science to the extent that his arguments are based on scientific evidence, ethics, responding to high quality standards, and adjusting to the premises established by the Colombian legislation to adapt his work; prioritizing the psychological welfare and the best interests of the children over the individual interests of parents and/or parties involved in the process.

For this reason, it is transcendental to follow the guidelines subscribed in this article, unifying criteria for forensic psychological evaluation processes through the attached report model, which make the professional work a more standardized, reliable, and valid process. Likewise, the parameters that serve as a guide for forensic psychologists as well as for family law attorneys or users of forensic services on the implications of this type of evaluations, their limitations, their frame of reference, and their technical-scientific quality in the vicinity of judicial decision making in cases of separation and divorce are gathered.

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Annex

OFFICIAL MODEL
Approved by the List of Experts in Forensic Psychology
Colombian College of Psychologists
www.colpsic.org.co

MODEL REPORT, FORENSIC PSYCHOLOGICAL EVALUATION: CUSTODY AND PARENTAL OWNERSHIP

1. IDENTIFICATION	1.1. **Forensic psychology expert**'s data (brief summary of professional profile). 1.2. Data on the person **being evaluated** (name, identification number, age, date of birth, education, occupation, marital status, origin, number of children, religious affiliation, among others). 1.3. Details of the **requesting authority** (judge, commissioner, lawyer, or others).
2. REASON FOR THE EXPERTISE	2.1 Put in quotation marks and italics the **request made** by the requesting authority verbatim.
3. DOCUMENTS PROVIDED FOR THE STUDY	3.1. Describe all **court documents** (document title, issuing entity, number of pages, date of preparation, and name of the person signing the document). 3.2. Request the clinical history of the examinee. This document generates knowledge about the examinee's psychopathological background and minimizes the confabulation of information.

4. ALLEGED FACTS	4.1 Describe the possible **facts subscribed** in the judicial documents. It is essential to include the version of both parents or persons involved in the process, as well as of the subjects evaluated. 4.2 Refer to the **current status** of the case and the procedural stage of the case.
5. OBJECTIVE OF THE EXPERTISE	4.1 Delimit the scope of the **expert's objective** according to psychology and its areas of knowledge.
6. EVALUATION METHODOLOGY AND PROCEDURE	6.1. Explain the **assessment strategies** (document review, consultation with other professionals, home visits to the family nucleus, and observation of the interaction between parents and children). 6.2. Describe the **interviews conducted with the evaluated** (name, date and type of interview). 6.3. Include **interviews of third-party sources of information** or collateral interviews (name, date, and type of relationship). 6.4. List the **psychological tests** applied (name of the test, author, and brief description).
7. FINDINGS	7.1. **Results of the descriptive analysis by areas** (mental examination, physical and mental health history, family history; personal, academic, social, and occupational adaptation). 7.2. **Results of the history of the ex-couple** (bonding of the children with the new partners, parents' ability to differentiate the parental role from the marital role, forms of communication, among others). **7.3. Results of the collateral interviews.** 7.4. **Psychological test results** (describe the purpose of the test, its psychometric properties, and interpretation of the scores obtained).
8. DIAGNOSIS	8.1. According to the results of the evaluation, **relate diagnoses** based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5R) or the International Classification of Diseases Manual ICD-10.
9. CASE ANALYSIS	9.1 Make the analysis of the case relating the findings with the previous study of the documents of the judicial file.
10. FORENSIC DISCUSSION	10.1 Compare the results with the specialized scientific literature.
11. CONCLUSIONS	11.1 Provide conclusions that meet the objective of the report.

12. RECOMMENDATIONS	12.1 Provide recommendations according to the evaluator's criteria and the findings.
13. NAME OF EVALUATOR	13.1 Incorporate the evaluator's full name, professional card number, signature, and date of preparation of the report.
14. BIBLIOGRAPHIC REFERENCES	14.1 According to the latest version of the APA norms.
15. ANNEXES	15.1 Attach **accreditation of the expert**, in accordance with article 226 of the General Code of the Process (if required). 15.2 Attach elements of the **content of the report**, as considered by the expert (psychological tests, transcripts of interviews, or others).

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LAS ESTRATEGIAS DE LA TERAPIA COGNITIVO CONDUCTUAL (TCC) PARA PACIENTES DE CIRUGÍA BARIÁTRICA: REVISIÓN SISTEMÁTICA

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Resumen. Desde 1991, cuando los NIH reconocieron la cirugía bariátrica como el tratamiento más efectivo para la obesidad mórbida, el número de estos procedimientos no ha dejado de crecer. El psicólogo es una parte fundamental de este equipo multidisciplinar, y la terapia cognitivo conductual ha sido la rama más utilizada por estos profesionales. Sin embargo, se observa una gran variedad de tácticas y recursos de TCC aplicados a los pacientes de cirugía bariátrica, y el objetivo de este trabajo es clarificar la efectividad de los diferentes recursos e identificar patrones centrados en estos pacientes. El método empleado consiste en una revisión sistemática de estudios científicos de TCC para pacientes de cirugía bariátrica. Los resultados fueron el análisis comparativo de estrategias de atención individual, grupal y a distancia, factores de éxito y no éxito en las diferentes modalidades y análisis de los efectos de las comorbilidades psicológicas asociadas a la obesidad en el pronóstico de la cirugía. Las estrategias de TCC presentaron diferentes beneficios entre sí; para una correcta elección de estos recursos, se deben tener en cuenta de modo continuado e individual algunas variables, como la comorbilidad psicológica del paciente, su entorno social, autoestima y capacidad de adaptarse al postoperatorio. Igual de importante que la elección de la estrategia es respetar el tiempo y el período de terapia a lo largo del contexto quirúrgico.

Palabras clave: terapia cognitivo conductual, cirugía bariátrica, cirugía de la obesidad, bypass gástrico, comorbilidad psicológica.

THE STRATEGIES OF COGNITIVE BEHAVIORAL THERAPY (CBT) FOR BARIATRIC SURGERY PATIENTS. A SYSTEMATIC REVIEW

Summary. Since 1991, when bariatric surgery was recognized by the NIH as the most effective treatment for morbid obesity, the number of these procedures continues to grow. The psychologist is a fundamental part of this multidisciplinary team, and cognitive behavioral therapy has been the most used therapy. However, a wide variety of CBT tactics and resources applied to bariatric surgery patients is observed and

the objective of this work is to clarify the effectiveness of these different resources and identify patterns of resources focused on bariatric surgery patients. The method employed is a systematic review of scientific studies of CBT for patients of bariatric surgery. The results were the comparative analysis of individual, group and online therapy strategies, success and non-success factors in the different modalities and analysis of the effects of psychological comorbidities on the prognosis of surgery. The CBT strategies presented unlike benefits to bariatric surgery patients. For a correct choice of CBT resources to be applied to these patients, some variables must be considered individually, such as the psychological comorbidity of the patient, their social environment, self-esteem and ability to adapt to the postoperative period. Equally important to the choice of strategy, is to respect the time and period of therapy throughout this context.

Keywords: cognitive behavioral therapy, cognitive behavioural therapy, bariatric surgery, gastric bypass, psychological comorbidity.

Introduction

In 1991, the expert committee of the U.S. National Institutes of Health (NIH) concluded that bariatric surgery was the most effective treatment for morbid obesity, so more and more people have resorted to this procedure to control excess weight. In 2013, the Worldwide Obesity Surgery conducted a study that noted "468,609 bariatric surgeries performed in this same year; United States and Canada, 154,276; Brazil with 86,840; France with 37,300; and Argentina with 30,378" (Angrisani et al., 2013, p.1). In 2000, the Spanish Society for the Study of Obesity (SEEDO) showed that the demand for bariatric surgeries per year in Spain is around 16,000 (Arteaga et al., 2018).

The World Health Organization (WHO) (1997) considered that "morbid obesity is *[sic]* when body mass index, *[sic]* BMI is $\geq$ 40 kg/m^2 or 35 kg/m^2 with severe clinical comorbidities" (p. 1). Likewise, that same year the WHO exposes an important concern about obesity being a multifactorial chronic disease of numerous substantial comorbidities, including a number of psychological disorders (WHO, 1997). Thus, beyond absolute weight loss, the definition of surgical success must consider the improvement of associated physical and psychological comorbidities and the patient's quality of life. Consequently, in 2009, NICE established multidisciplinary work, with the participation of the psychologist, in bariatric surgery. In 2012, it was also considered by the American Association of Clinical Endocrinologists (AACE), the American Society for Metabolic and Bariatric Surgery (ASMBS), and the American Obesity Society (TOS). In 2017, it is similarly stated by SECO (Martin, 2017; Mechanick et al., 2013; NICE, 2009).

Currently, it is observed that experimental studies, systematic reviews, and psychological care guidelines established by authorities show that cognitive behavioral therapy (CBT) presents greater empirical evidence and higher prevalence in anti-obesity treatments. In 2016, NICE considered it the Class A treatment and it occupied 60% prevalence in studies, while behavioral therapy accounted for 30%. The latter was losing its space over time in favor of CBT, specifically since 2001, when Cooper identifies that by adding cognitive techniques to behavioral therapy these seem to improve the success of surgery, reduce weight regain, and improve the psychological well-being of the patient (APA, 1998; Baile, 2019; Bunner, 2014; Cooper, 2001; NICE, 2016; Shaw et al., 2010; Wilson, 1999).

Although CBT is currently the therapy that presents the most empirical evidence for obesity, in clinical practice and scientific studies there is a great variety of strategies and resources applied to bariatric surgery patients. There is no rigorous protocol of care for this population, which is demonstrated in different tactics where interventions divided

into three large groups are observed: distance psychotherapy, group therapy, and individual therapy (Ogden et al., 2011; Shaw et al., 2010). Similarly, it is necessary to systematically and comprehensively analyze data from scientific experimental studies applying CBT to these patients in order to clarify the effectiveness of these resources and identify patterns of success and non-success.

Likewise, this study has the following objectives: to compare the different strategies employed in experimental clinical scientific studies; to identify successful and unsuccessful practices in these strategies applied to bariatric surgery patients; to understand the management of psychological comorbidities associated with obesity; and to identify assessment tools, collaborating in the treatment decision so that the psychologist's contribution is more effective and patients have better surgical outcomes and better quality of life.

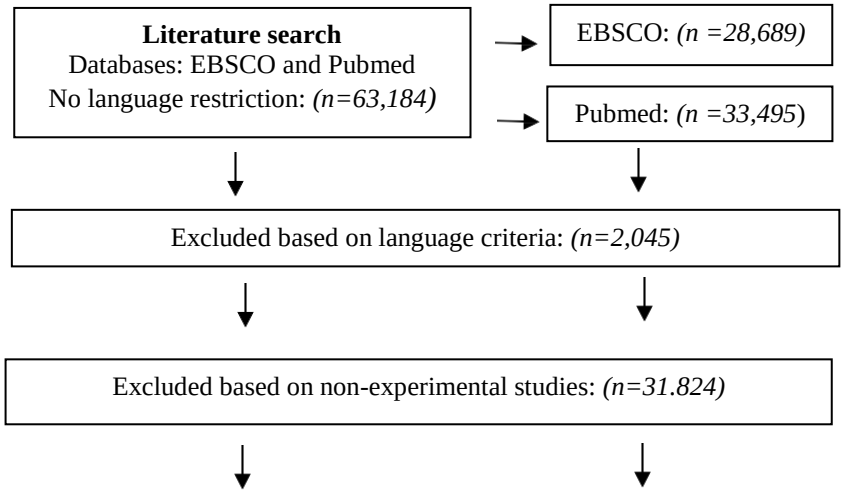
Method

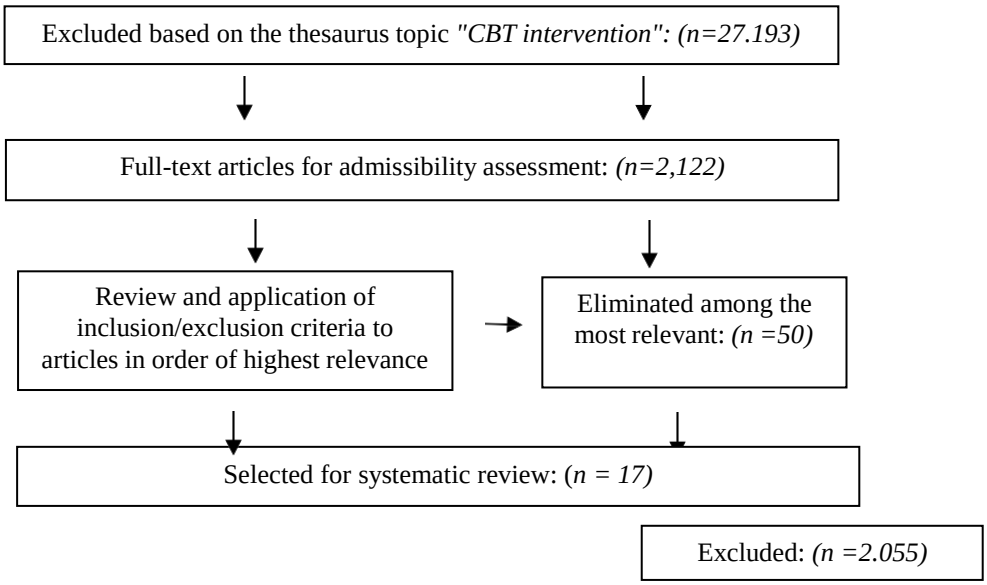
For this study we have chosen the method of systematic review of scientific articles published in the last 12 years. These articles include qualitative and/or quantitative experimental studies of clinical trials with patients of bariatric surgeries performed with the implementation of cognitive behavioral therapy (CBT) in the pre and/or postoperative period.

As documentary sources, this work has searched for scientific studies published in the Pubmed and EBSCO databases. Based on the objective of this research, a search protocol has been defined with the combination of keywords and Boolean operators as follows: (*("cognitive behavioral therapy" OR "cognitive behavioral therapy") AND ("bariatric surgery" OR "gastric bypass surgery" OR "weight loss surgery")).*

The inclusion criteria used were: (1) that the papers dealt with experimental studies in adult patients aged 18 years and older who met the established criteria of recommendations for bariatric surgery; (2) that these experiments applied a CBT intervention in the pre and/or postoperative period; and (3) that they were experimental studies conducted with scientific methodology.

On the other hand, the exclusion criteria adopted were: (1) that they were not about clinical trial studies; (2) that they were single case studies; (3) that they were duplicate articles in the two databases; (4) that they were duplicate articles due to information updating; (5) that they were about topics unrelated to psychology; (6) that the languages were neither Spanish nor English; and (7) that they were not about CBT techniques. The following is an outline of the results of the search for articles:





Following the retrieval of these 17 articles, the second phase of this review focused on the comprehensive review of the documentary source, which was largely in English. In addition to these experimental data, this study also obtained references from other authors about the theoretical underpinnings of bariatric psychology.

The following section reports the results of this review: the demographic data found in the articles, the variables and the assessment instruments studied by the authors are shown, followed by a systematic comparative analysis of the group, individual and distance care interventions. Finally, final considerations are established with the synthesis of the main effects of CBT in its different models and of the management of psychological comorbidities in bariatric surgery.

Results

After analyzing the sociodemographic characteristics of the articles in this review, a sample of 3,688 persons was obtained, 61% of whom were female. The mean age was 43 years, with a mean BMI of 48 kg/m^2. Ninety-three percent were white and 80% were married or in a stable union. The majority were subjects with a high school or professional education. The countries present in these experiments were the United Kingdom, Spain, Germany, Italy, Norway, Canada, the United States, Mexico, Colombia, and Chile.

Some 35.29% of the studies applied CBT in the preoperative phase; another 35.29%, in the postoperative phase to assess therapeutic gains. Some 29.41% credited factors of success or non-success of the CBT intervention in the context of surgery, the efficacy of the assessment instruments and the endorsement of differentiated methods to increase the therapeutic reach in these patients. Psychological comorbidity has been the key point in all experiments. It was identified that 52.94% of the items assessed depressive symptomatology; 47.05%, EDs; 41.17%, anxiety and BMI; 35.29%, quality of life; 17.64%, stress, self-esteem, family relationships, and adherence to treatment; and 11.76%, personality traits. Table 1 shows what each article individually included and the intervention modality applied, which the authors defined basically according to the resources available and/or the objective of the study.

Table 1

Table of the psychological variables evaluated in the articles of this review, with the main objective of the author's intervention and the CBT intervention model used.

Item data			***Intervention factors***											
Author	***Type of intervention***	***Participants***	***Objectives***	***Stress***	***Anxiety***	***Depression***	***Self-esteem***	***Quality of life***	***TCA***	***Family relationships***	***Personality***	***BMI/Contour***	***Adhesion***
Abilés et al. (2010)	A	*(n=50)*	1	x	x	X	x	x	x	x	x		
Abilés et al. (2013)	A	*(n=110)*	2	x	x	x	x	x	x	x		x	
Abilés et al. (2013)	A	*(n=110)*	3	x	x	x	x	x	x	x	x		
Conceição et al. (2016).	C	*(n=180)*	1										x
Delgado et al. (2015)	A	*(n=14)*	2		x	x						x	
Garcia et al. (2012)	A	*(n=27)*	1						x			x	
Hege et al. (2014)	A	*(n=98)*	2		x	x			x				x
Kalarchian et al. (2016).	A	*(n=199)*	3								x		
Martinez et al. (2013)	A	*(n=50)*	2		x	x							
Marzocchi et al. (2008).	A	*(n=135)*	3			x		x	x				
Ogden et al. (2011)	A	*(n=10)*	1									x	
Ogden et al. (2015)	A	*(n=206)*	3									x	
Román et al. (2012)	A	*(n=50)*	2		x	x							
Rudolph and Hilbert (2020)	A	*(n=7)*	3			x		x	x				
Sierra et al. (2014)	B	*(n=15)*	2					ς				x	
Sockalingam et al. (2017).	C	*(n=19)*	3						ς			x	
Zhang et al. (2015)	C	*(n=2408)*	1										x

(A) Individual Face-to-Face Intervention
(B) Face-to-Face Group Intervention
(C) Online / Remote Intervention

(1) Therapeutic Outreach Expansion
(2) Comorbidity Reduction in Preoperative Intervention
(3) Comorbidity Reduction in Postoperative Intervention

Note: Own elaboration based on the cited authors.

Preoperative diagnosis is a substantial success factor, since psychological disorders have been found that, in order to avoid causing a poor prognosis for surgery, need at least one year of treatment and stability of their symptoms before the surgical procedure is performed (Clark et al., 2003). In sum, the patient must be declared able to meet the necessary dietary requirements to be able to perform the surgical procedure (Martinez et al., 2013; Marzocchi et al., 2008).

For the diagnosis of psychological comorbidities, in addition to structured, semi-structured and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition) based interviews, a variety of 28 types of metrics have been found to assess a minimum of nine psychological comorbidities associated with obesity. The list of these instruments, which largely relate to EDs, is in Table 2. Because of this diversity found in the articles, below, we also reference the assessment instruments mentioned by Martín et al. (2017) in the report of the Spanish Association of Surgeons (AEC), the Spanish Multimodal Rehabilitation Group (GERM), the Foundation of the Spanish Society for the Surgery of Obesity (FUNSECO), and SECO. These are:

- **General psychopathology:** Symptom Checklist-90-Revised (SCL-90-R) and Difficulties in Emotion Regulation Scale (DERS): measures that will include anxious-depressive symptomatology, general psychopathology index, and difficulties in emotion regulation, frequently present in these patients and associated with a worse prognosis (p. 18).
- **Eating psychopathology:** Eating Disorder Inventory-2 (EDI-2); Semi-Structured Clinical Interview for the Detection of an Eating Disorder (SCID-I); Alcohol Use Disorders Identification Test (AUDIT); and Yale Food Addiction Scale-2 (YFAS-2): measures that will include eating psychopathology and diagnostic criteria for both a possible co-occurring eating disorder and a possible substance use disorder or food addiction, generally associated with a higher relapse rate and worse prognosis (p. 18).
- **Personality Traits:** Temperament and Character Inventory-Revised (TCI-R) and UPPS-P (Impulsive Behavior Scale): measures that will include personality traits of temperament and character, as well as impulsive personality traits, generally associated with worse prognosis and poorer adherence (p. 18).

Table 2

Psychological assessment instruments for bariatric surgery patients found in the articles reviewed.

Psychological assessment instruments used in bariatric surgery patients

Anxiety and Depression	Abbreviated Anxiety and Depression Scale (Montón et al.); General Health Questionnaire (GHQ)
	Beck Depression Inventory I and II (BDI-I and BDI-II)
	Patient Health Questionnaire-9 for depression (PHQ-9)
	Hospital Anxiety and Depression Scale (HADS) (HADS- D) (HADS-A) State-Trait Anxiety Inventory by Spielberger, Gorsuch and Lushene (1970). STAI-E/STAI-R/(BDI-SF)
Self-esteem	Self-esteem: Rosenberg Self-Esteem Scale (RSE) (Vázquez et al.)
Quality of life	Quality of life (PGWBI). Quality of life. Obesity-specific - Impact of weight on quality of life-lite. Inventory of quality of life and health (INCAVISA) (Sánchez-Sosaet al., 2009).
	Quality of Life Index (QLI-SP) (Mezzich)
Stress	(CEDD44-B) (Sanz-Carrillo et al.)
Family	Individual and family function. (Family APGAR) (Bellón et al.)
Body Measurements	CC: Waist circumference / BMI: Body Mass Index
Others	Obesity-related well-being 97 (Orwell-97)
	DSM-IV structured and semi-structured interview
	Specific psychological variable instruments developed for Apollo - Bari.
Personality	Personality (Eysenck Personality Questionnaire-Revised)
	Mini International Neuropsychiatric Interview (MINI) (Sheehan et al., 1992)
Eating disorder	Symptomatology (Eating Disorder Examination-Questionnaire, version 4) Food Craving Questionnaire-Trait (FCQ-T) (Cepeda-Benito et al.) Binge Eating Scale (BES) Eating disorder 7-item (GAD7) Three Factor Eating Questionnaire (TFEQ R-21)
	Eating Disorder Examination Interview (EDE) German version of the Eating Disorder Examination-Questionnaire (EDE-Q, version 4) (Katrine et al.) CB (EDE-BSV) QEWP-R: Questionnaire on eating and weight patterns

Source: Own elaboration based on Abilés et al. (2010), Abilés et al. (2013), Abilés et al. (2013), Conceição et al. (2016), Delgado et al. (2015), García et al. (2012), Hege et al. (2014), Kalarchian et al. (2016), Martinez et al. (2013), Marzocchi et al. (2008), Ogden et al. (2011), Ogden et al. (2015), Román et al. (2012), Rudolph and Hilbert (2020), Sierra et al. (2014), Sockalingam et al. (2017), and Zhang et al. (2015).

All studies have used cognitive restructuring as the main CBT technique for the promotion and maintenance of healthy behaviors, as well as for the reduction or elimination of undesirable behaviors and, thus, weight loss (Van Dorsten and Lindley, 2008). As main cognitive restructuring exercises, activities such as self-reporting and self-monitoring were found to be effective techniques for developing self-control. Stimulus controls and problem-solving therapy were also used to prevent relapses and

maintain social support, mainly from the family. On the other hand, in the study by Román et al. (2012), the use of progressive muscle relaxation by Jacobson et al. (2000) was evidenced; this is used following a recording with indications for relaxation exercises and psychoeducation about the change of habits and the different phases of the surgical process, contemplating from the pre to the postoperative period.

Finally, a description of the main results of the interventions studied is presented below. Table 3 shows a comparison of the main effects and results of each of the intervention modalities found in the experimental articles and in the support materials used in this review.

Table 3

Comparison of cognitive behavioral therapy intervention strategies for bariatric surgery patients.

Authors	***Type of intervention***	***Main effects / results***
Abilés et al. (2010); Delgado et al. (2015); García et al. (2012); Hege et al. (2014); Kalarchian et al. (2016); Martínez et al. (2013); Marzocchi et al. (2008); Ogden et al. (2011); Román et al. (2012); Rudolph and Hilbert (2020).	Individual Face-to-Face Intervention	a) It allows the diagnosis and effective treatment of moderate to severe psychological comorbidities that affect the prognosis of surgery. (1) High resolution, up to 88%, in preoperative studies and 94% in postoperative experiments of psychopathology of mild symptomatology. (2) b) Some patients show significant difficulty or resistance to attend sessions, especially those with mild symptomatology. c) High experimental death rate, 71%. d) High cost compared to the others.
Sierra et al. (2014); Megan (2012).	Face-to-Face Group Intervention	a) Effective in reducing mild symptomatology psychopathology. (2) However, it needs more individual support for those of moderate-severe level (1). b) Higher efficacy in weight loss and improvement of BMI compared to the other types of intervention, very important to comply with the technical conditions prior to surgery and the patient's commitment to change. c) High patient satisfaction and acceptance. d) A 40% experimental death.
Conceição et al. (2016); Sanjeev et al. (2017); Zhang et al. (2015).	Online / remote intervention	a) High rate of resolution of mild symptomatology; in some cases, for this population it was shown to be more effective in the long term than individual face-to-face intervention. No data have been observed for this intervention for moderate-severe comorbidities. b) Increased accessibility, reach and adherence to treatment, with a lower number of experimental deaths

compared to the other models, this being 20%.
c) Improved BMI, even in the long term.
d) High patient satisfaction and acceptance.
e) Lower cost.

(1) - Moderate-severe symptomatology: (DSM-5) personality disorders, bulimia, anorexia, schizophrenia, abuse, and major depression.

(2) - Moderate-mild symptomatology: anxiety, depression, quality of life, stress, ED, self-esteem, motivation.

Note: Own elaboration based on the cited authors.

These data have allowed us to observe different levels of efficacy for the different intervention models, weighted together with the individual patient profile and the comorbidity involved. Thus, Table 4 represents the main effects of psychological comorbidities and other important psychological factors in the context of bariatric surgery and CBT intervention management, according to all the literature found for this work.

Table 4

The management of psychological comorbidities associated with obesity in the context of bariatric surgery and CBT intervention.

Authors	**Psychological comorbidity**	**Association with surgical success/non-success**	**CBT intervention**
Black et al. (2003); Clark et al. (2003); Kalarchian et al. (2016); NICE (2016); SEEDO (2000).	Bulimia, suicide rate, schizophrenia, substance addictions, bipolar and anorexia.	These patients have been shown to be unable to comply with postoperative restrictions because of unsatisfactory weight reduction (less than 50% reduction in excess weight was seen). In addition, the absorption of psychiatric medication may not be sufficient after surgery, impairing postoperative treatment.	Need for preoperative intervention until symptoms are controlled and stabilized. Treatment recommended one year before surgery and up to two or three years after surgery.
Clark et al. (2003); Goldman (2014); NICE (2016); SEEDO (2000).	Major depression	It is related to a lower long-term weight loss and to other comorbidities, such as ED, and a lower quality of life. It is more prevalent in obese people with BMI over 40 than in moderately obese people.	Need for preoperative intervention until symptoms are controlled and stabilized one year before surgery is recommended. Individual face-to-face intervention is the most recommended until symptoms are stabilized.
Abilés et al. (2010); Abilés et al. (2013); García et al. (2012); Hege et al. (2014); Marzocchi et	Binge eating disorder	This is the highest psychological comorbidity among the morbidly obese and can reach 50%. It is usually accompanied by depression, anxiety, major depression, lower self-esteem, and low quality of life in up to 16% of cases. Some studies show a great	Need for preoperative intervention for the period necessary to reduce severe symptoms before recommending surgery. Need for continuous long-term

al. (2008); Rudolph and Hilbert (2020); Sockalingam et al. (2017).		difficulty in postoperative adaptation, with less weight loss. Other studies do not confirm a difference regarding weight loss with those without ED, both with CBT intervention. They also showed greater concern about food and weight and revealed feeling more hunger, fear, guilt, and worries about shape and food intake after surgery.	monitoring and follow-up after surgery.
Abilés et al. (2010); Abilés et al. (2013); Delgado et al. (2015); Hege et al. (2014); Martínez et al. (2013); Marzocchi et al. (2008); Román et al. (2012); Rudolph and Hilbert (2020).	Anxiety and depression	They can make postoperative adaptation difficult and have poorer surgical outcomes. Social support is very important for these patients. There is a 48% prevalence of surgical patients suffering from anxiety, and 50% of female surgical candidates have been previously medicated with antidepressants. Sixteen percent of these patients may progress to ED.	Need for preoperative intervention for approximately five months or until symptoms stabilize. Need for constant follow-up and diagnosis of other associated psychological comorbidities, such as ED.
Black et al. (2003); Clark et al. (2003); Guisado and Vaz (2002); Kalarchian et al. (2016); Tsushima et al. (2004).	Personality disorder	May present results of less than 50% of excess weight (paranoid hysteria and health-related scales).	Need for preoperative intervention until symptoms are controlled and stabilized for an average of one year.
Fernández (2008)	Intrinsic motivation	If motivation is high, it promotes improved adherence to treatment; if it is low, there is difficulty in decision making regarding surgery and in implementing BC restrictions.	Need for preoperative intervention, without having to wait for results for surgery. Need for constant follow-up and diagnosis of other psychological comorbidities, such as ED.

Ray et al. (2003); Marzocchi et al. (2008); NICE (2016).	Social support	Very important to collaborate when mild symptomatology occurs, which contributes to treatment. If not high, it can lead to weight gain two years after surgery and contribute to future bad habits.	Need for preoperative intervention, without having to wait for results for surgery. Need for constant follow-up and diagnosis of other psychological comorbidities, such as ED.
Ogden (2011); SEEDO (2007);	Patient's own capacity	This component includes patients who report difficulties in adapting to postoperative restrictions unrelated to psychological disorders.	Need for intervention to work on strengths and adaptation needs from the preoperative period without the need to postpone surgery.
Marzocchi et al. (2008).	History of trauma or abuse	It has been identified that abuse, mainly sexual, may have an impact on obesity and binge eating behaviors or difficulty in postoperative adjustment.	Good efficacy, with the need for preoperative intervention until symptoms are controlled and stabilized for one year.
Clark et al. (2003); Martinez et al. (2013); Marzocchi et al. (2008).	Intellectual disability	It is necessary that the patient has the conditions to assume the change of habits demanded by the surgery. In case he/she is not able to become aware of it, it is recommended to guide the family and that they sign the responsibility.	Need for parental consent and preoperative CBT intervention, without the need to postpone surgery.
Abilés (2010); Goldman (2014).	Degree of obesity	Higher anxiety and prevalence of major depression in obesity grade IV.	Regardless of the degree of obesity (grade III and IV were compared, with no differences observed), CBT intervention has the same result in mild symptomatology.
Fernandez (2008); Grilo and Masheb (2005); Mitchell et al, (2001)	Self-esteem	Low self-esteem is associated with a high level of binge eating and body dissatisfaction before and after surgery: before, due to excess weight, and after, due to excess skin. High prevalence in the female sex.	Effectiveness of CBT for the improvement of self-esteem and self-image. Surgery does not change self-esteem; this factor should be worked on together with the patient when he/she presents low indices.
Fernández (2008); Mitchell et al. (2001);	Body image	Relation with a high rate of binge eating. Very frequent in women, hence the high percentage of female sex. Body image is associated with a high depression score, low self-esteem, or perfectionism. Expectations of reconstructive surgery.	CBT intervention for self-image improvement without restricting surgical recommendation.

Source: Own elaboration based on the cited authors.

These analyses allow us to conclude that the different modalities of CBT used

with bariatric surgery patients, divided into individual face-to-face, group and online treatment, could be used in a combined or preferential way according to the patient's diagnosed symptomatology. First, it is necessary to rule out the presence of serious comorbidity that would prevent requesting surgery for the patient, in addition to always monitoring the evolution of the symptomatology in all of them, regardless of their level, since its severity may vary. The individual intervention strategy was shown to be the most appropriate for treating patients with more severe comorbidities, as it showed positive effects during a year of treatment before surgery and managed to avoid poor postoperative results.

On the other hand, this same individual strategy revealed very low adherence in patients who do not present severe symptomatology and would not be the most appropriate for this population. Patients who do not present symptomatology severe enough to discourage the surgical procedure, but who also present comorbidities that hinder adaptation to surgery, should be offered support for a better prognosis of the surgery. Group CBT intervention strategies provide efficacy to this population, mainly with respect to the following elements: technical improvement of physical preparation for bariatric surgery, so important in these cases of morbid obesity; better adaptation to postoperative restrictions; and reduction of psychological comorbidity symptomatology. Likewise, online or distance strategies can also be used with these latter patients by providing greater scope and adherence to long-term continuous treatment so important for the bariatric patient.

The group and online therapy resources showed great efficacy for mild to moderate symptomatology present and offered even better results than the individual care strategy, both in the effects of comorbidities and in greater weight loss and maintenance in the long term. After observing a constant variability in the degree and symptomatology affecting these patients throughout the different phases of bariatric surgery, it is suggested that the efficacy of these two methods is always conditioned by the psychologist's periodic consideration of the patient's individual circumstances in relation to the associated comorbidities and his or her personal capacity to adapt to the surgical postoperative period. It can be concluded that a combined model of strategies for continued monitoring over time would be most efficient.

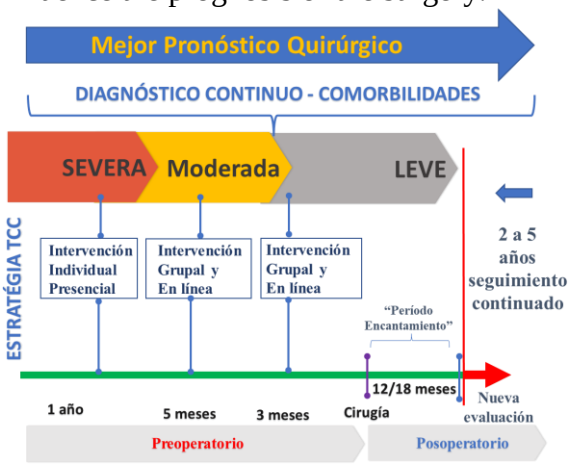
Following the analysis of this instability related to the psychological comorbidities associated with the different phases of the CB procedure and the effects that psychoaffective comorbidities exert on the results of surgery, treatments for mild and moderate comorbidities should be initiated at least three to five months before surgery and up to two years after surgery has been performed. Thus, it can be concluded that online care offers great benefits by presenting better long-term adherence and should be considered as part of this set of strategies for greater continuity of psychotherapeutic follow-up by avoiding poorer long-term surgical outcomes.

An important effect observed is that weight loss after CB can also improve the psychological comorbidity of patients. After undergoing surgery, they go through a period of great physical and psychological improvement that lasts between 12 and 18 months approximately; after this period, a decrease in well-being conditions may be reflected and there may even be weight regain. This represents an increase in symptomatology and psychological support is needed so that it does not affect the results of CB.

In addition, as a final factor, patients often view surgery as the only remedy for overcoming obesity and often experience the postoperative period as an illusion that surgery has solved all their problems, followed by frustration and the need for support.

The sum of all these components underscores the importance of choosing multiple strategies for effective ongoing follow-up.

Finally, it has been observed that the psychological factors of the patient with the best prognosis for surgical outcomes are the following: no moderate or severe psychological comorbidity; coping skills and emotional regulation, especially of their self-image and self-esteem, which were the origin of much of the symptomatology of these patients; they must always be focused, with social support and motivation; they have a good understanding of the surgical process; and they have the ability to adapt to the restrictions that surgery entails. Thus, a proposal of how a structured strategic care plan for bariatric surgery patients could be realized is shown in Figure 1. It considers the prevalent comorbidities, the different CBT modalities found in the studies and the observed concepts that offer greater efficacy, by reducing symptomatology to allow surgery and performing a continuous assessment well before surgery up to a long term afterwards, which may influence the prognosis of the surgery.



(1) - Moderate-severe symptomatology: (DSM-5) personality disorders, bulimia, anorexia, schizophrenia, abuse, and major depression.
(2) - Moderate to mild symptomatology: anxiety, depression, quality of life, stress, ED, self-esteem, motivation.

Figure 1. *Strategic plan for the choice of modality and periods of CBT for bariatric surgery patients. Proposal for combined and continued care.*

Note: Own elaboration based on the authors cited in Table 3.

Discussion and conclusions

After the study of the different CBT strategies applied in bariatric patients, it could be concluded that the selection of resources according to the psychological comorbidity of the patient in each phase of the surgery context could increase the efficacy of the treatment. Thus, it would justify the need for future clinical trials to comply with this intervention approach from preoperative (up to one year before surgery) to long-term follow-up (for a minimum of two years after this procedure has been performed). Thus, it would be possible to design a series of strategies for the moments in which a greater need for support in this process was observed; this could avoid a poor prognosis of the

surgery since it has been seen that 20 to 50% of patients have inadequate weight loss or weight regain after 2 to 3 years of having performed bariatric surgery (Magro et al., 2008; Ogden et al., 2015; Van Hout et al., 2008). Furthermore, the Magro et al. (2008) study found that "approximately 30% of individuals need repeat surgery to achieve sufficient weight loss of at least 50% of excess weight" (p. 648). This value would be the minimum adequate value considered by NICE (2009) (Van Hout et al., 2008).

Likewise, to avoid control bias, it is recommended that future studies offer the control group the nutritional education received by the experimental group; the objective is that the effects of the nutrition team do not intervene in the evaluation of CBT results, once it has been concluded that this information received also generates changes in the patient. Similarly, it is necessary to consider the effect of complex comorbidities that existed before surgery, as well as the way in which the individual adjusts to the CBT process, in order to provide a real assessment of the therapeutic gains, of the effects of CBT, and of the general and specialized care models that could be considered.

Finally, it has been noted that the empirical evidence barely includes multidisciplinary responses, and far less is known about the use of preoperative psychological profiles to predict surgical outcome. This would also contribute to a better intervention proposal and, perhaps, suggest future studies for a bolder proposal of a continued, individualized, and standardized program. Finally, a complete program with different projects could be proposed according to the patient's ongoing diagnosis and choice of strategic resources. Assessment instruments with global standards would be used with the aim of collaborating to achieve more effective psychological care and a better prognosis of surgery.

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VIVIENDO CON DIABETES TIPO 2: DESCUBRIENDO LOS SIGNIFICADOS QUE LA FAMILIA CONSTRUYE EN TORNO A LA ENFERMEDAD CRÓNICA

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Resumen. El presente estudio busca descubrir y describir los significados que la familia construye en torno a la experiencia de la diabetes mellitus tipo 2. Para ello, a través del enfoque familiar sistémico y la utilización de preguntas circulares, se entrevistó a tres familias que tienen un integrante que vive con diabetes mellitus tipo 2. Las familias hacen alusión tanto a los significados construidos, y a los en los cambios en la vida familiar que suponen un nuevo estilo de vida impuesto por la llegada de la enfermedad.
En la metodología, se utilizó el diseño de Análisis Fenomenológico Interpretativo y mediante entrevistas en profundidad, se espera haber captado e interpretado la experiencia de las familias participantes. La muestra consideró a la persona que vive con diabetes y a los miembros de la familia que viven con él/ella, que tienen un vínculo cercano y/o que tengan algún nivel de responsabilidad en el tratamiento de la enfermedad. La persona que posee la diabetes presenta adherencia al tratamiento actualmente y se encuentran en un ciclo vital de adultez o adultez mayor, con presencia o ausencia de complicaciones médicas asociadas.
Dentro de los resultados, afloran sentimientos de tristeza, y ambivalencia frente al diagnóstico: hay negación, resignación y a su vez, aceptación con respecto al presente y futuro con la compañía de la enfermedad. El apoyo familiar percibido para la persona que vive con diabetes mellitus tipo 2, es primordial para cumplir con los cuidados que la enfermedad requiere, siendo ellas quienes cumplen la función de cuidadora.

Palabras claves: experiencia familiar, diabetes tipo 2, significados, enfoque familiar-sistémico, vínculos

LIVING WITH TYPE 2 DIABETES: DISCOVERING THE MEANINGS THAT THE FAMILY BUILD AROUND CHRONIC DISEASE

Abstract. The present study seeks to discover and describe the meanings that the family builds around the experience of type 2 diabetes mellitus. To do this, through the systemic family approach and the use of circular questions, three families who have a family member were interviewed who lives with type 2 diabetes mellitus. The families allude both to the constructed meanings and to the changes in family life that suppose a new lifestyle imposed by the arrival of the disease.

In the methodology, the Interpretive Phenomenological Analysis design was obtained and through in-depth interviews, it is expected to have captured and interpreted the experience of the participating families. The necessary sample to the person living with diabetes and the family members who live with him/her, who have a close bond and/or who will have some level of responsibility in the treatment of the disease. The person with diabetes currently adheres to treatment and is in a life cycle of adulthood or older adulthood, with the presence or absence of associated medical complications.

Among the results, feelings of sadness emerge, and ambivalence towards the diagnosis: there is denial, resignation and, in turn, acceptance regarding the present and future with the company of the disease. The perceived family support for the person living with type 2 diabetes mellitus is essential to comply with the care that the disease requires, being those who fulfill the role of caregiver.

Keywords: family experience, diabetes type 2, meanings, systematic family approach, relations

Introduction

The systemic family approach considers chronic illness as a problem that affects the other members of the family, those who dynamically influence the illness experience (Cifuentes, Chauriye, Erazo, Ferreira, & Jara, 2010); that is, the theoretical principle of social systems is based on the cooperation of all those involved to seek the best resolution (López, Pérez, Oropeza, & Roca, 2016; 2020).

In the presence of a chronic disease, the members of the family system fulfill and sustain different roles in which they deploy the necessary resources so that compliance with the treatment is not altered; however, the disease interrupts daily functioning in a variable way. In the first place, it depends on the severity attributed to the disease, and on the place the affected person occupies in the family; simultaneously, the way in which the symptomatology is inserted in the family's system of beliefs and values, interfering in the state in which the organization finds itself. The same disease can have an impact in different ways, evidencing particularities in one family or another, also influencing the moment of life and the life cycle in which the disease may emerge (López, Moncada, Suarez and Suarez, 2020; Figueredo, 2014; Pérez, Mercado and Espinosa, 2011; Armengol and Fuhrmann, 1998).

According to the aforementioned, families are building meanings in relation to the treatment of their condition, and these are influenced by the socio-cultural context and the historical moment in which they live, that is, both the person who cares and the one who receives care can create new and different meanings regarding their life, their own experience, and from their own context, being themselves the protagonist (Aristizábal, Flores and Guillen, 2016; Díaz, Galvis and Velásquez, 2014).

The caregiving experience in people with type 2 diabetes mellitus in the family context determines patterns of care that impact culturally and are reflected in the home (Giraudo and Vietto, 2018; Carreón, Martínez, and Zenteno, 2018; Briñez and Muñoz, 2016; Leventhal and Phillips, 2016). Likewise, it is put in relevance how gender roles influence chronic disease care since men are the ones who achieve higher levels of therapeutic compliance than women. It is they who are more likely to assume the care of other family members, postponing themselves (Galvez and Gallardo, 2013; Cerrutti and Binstock, 2009). Consequently, emotional reactions and feelings of fear hinder the search for help mainly in male adults, who delay initiating treatments associated with the diagnostic surprise, which added to not feeling physical discomfort, do not usually consider medical advice (Domínguez, 2017).

With regard to statistics, in Chile, only 36% of diabetic patients in the primary health care system have good metabolic control. The percentage of compensation is deficient in both the public and private systems and the situation becomes alarming when the affected person is the breadwinner of the family since with his deterioration and/or disability, he considerably reduces the family income (MINSAL, 2010).

Diabetes mellitus type 2 in our country is considered within the Explicit Health Guarantees, ranking sixth among the most frequent in the population. As of 2010, the direct cost of diabetes mellitus for FONASA (National Health Fund) reached 27 billion pesos, and for ISAPREs, in the same year, it almost reached 4 billion pesos; a diabetic patient costs 2.5 times the expense of someone who does not have the disease (FONASA, 2016).

For this reason, type 2 diabetes mellitus goes beyond institutional and health frameworks, encompassing the daily life of the person and his or her family system since once diagnosed, it generates changes at the psychic and corporal level, modifying significant areas of life for the human being (Cárdenas and Molina, 2020; Ledón, 2011).

Therefore, research should be directed towards the family setting since the interactions that occur within play an important role accounting for emotional tension in the family that influences the control of those affected with chronic diseases (Epul, 2012; Rivas et al, 2011).

The above means a permanent stay in the health system and, at the same time, the deterioration that generates in the person that others take over and so vice versa (Urzúa et al, 2015).

Daily life and family adjustment to the disease

Interpretive sociology has emphasized that the subjective experience of health and disease processes cannot be fully understood unless they are analyzed in the context in which they appear, making it essential to understand everyday life, i.e., those things that are done countless times a day without the need to think about them, such as routines and interactions, the people involved, and the people who model what they do (Arenas, Hernández and Valde, 2001).

Living with type 2 diabetes mellitus in the adult's daily life means acquiring an understanding from common sense, that is, the person constructs his or her social representations and meanings without having an exact knowledge of the disease, often accompanied by negative emotions upon receiving the disease diagnosis and influenced by past experiences (scares, food, courage) associated with stressful situations, allowing him or her to function in the social context and transform his or her daily life to live with the disease (Alfaro, Moreno, Ramos, Rodríguez, and Sadimno, 2020; Amagua and Pazmiño, 2019; Franco and Marmolejo, 2016).

Chronic disease worries both individual family members and the family as a whole. The chronicity of the condition, its routines, the economic burden, the frustration in the face of

treatments with little progress, gradually begin to undermine family life, disrupting several areas of it (Cifuentes, Chauriye, Erazo, Ferreira and Jara, 2010).

Mainly, diabetes causes depression by itself, whose restrictive regimen and physical and sexual limitations predispose the affected person to other comorbidities associated with the mental health field (Cienfuegos, et al., 2018; Heredia and Pinto, 2008).

It is observed how the members of the nuclear family may experience social and emotional isolation but also with the extended family and friends. The complex interactions that are generated between the pre-existing family dynamics and the already chronic disease affect the family's identity, amplifying conflicts and dysfunctional patterns that already existed, thus impoverishing family competencies (Cifuentes, Chauriye, Erazo, Ferreira and Jara, 2010).

The quality of life of people with diabetes constitute a daily challenge that divides everyday life into a before and after diagnosis, inciting changes in lifestyle habits, which are not always negotiable by other family members (Cardoso, Da Silva, Fagundes, & Noguiera, 2018).

In some cases, what Pauline Boss in 2001 described as "ambiguous loss" tends to occur in which opposing feelings and emotions appear, generating intense anger and sometimes guilt. The response to the diagnosis of a chronic disease has complex psychological and social implications as family members are mobilized in the face of this, showing anguish when the issue of death, limitation, and disability is imposed. This process that the person and his family go through sometimes fails to be elaborated in the best way, being able to develop several conflicts that invade the integral health of the person and often the family system (Angle, 2015; Baldovino, Gomez, Madrid, Ordoñez and Villareal, 2013).

The entire family group undergoes a transformation facing life with the disease, the person, and his family seek their balance and coexistence; that is, in these circumstances they have the possibility of adapting to old age with the disease (Ofman, Taverna and Stefani, 2019). All of the above makes the family experience non-normative events and situations and uncertainty about this member that require an adaptive effort that complexifies the family dynamics (Barbosa, Vanegas and Zamora, 2020; Adfalla and Novis, 2014).

From the narrative perspective, people have different ways of constructing their experiences around diabetes, for example, "living without pleasures" or "living as if they did not have diabetes" that reflect shared ways of meaning and consequently, living with the disease, as well as who assumes the care (Aguilar, Camacho, Orozco, & Vieyra, 2021; González, Machado, & Valderrama, 2020; Heitmann, 2018).

Therefore, and by virtue of the theoretical and empirical background raised with respect to families living with a diabetic member, the following research question is formulated: What are the meanings that families construct around the experience of living with a member who has type 2 diabetes mellitus? From this, the general objective is to describe the experience of families with a member with type 2 diabetes mellitus. And to respond to the general objective, we intend to describe the meanings that the families construct around the experience of the disease and also to reveal the changes that occur in the family organization in the face of diabetes.

Method

Design

Interpretative Phenomenological Analysis (IPA) was considered as the most appropriate research design, which seeks to answer the way in which people give meaning to their lived experience in a particular context. Its purpose is to describe the meaning of that experience in

relation to the phenomena of interest, to make visible the features of that experience and its common characteristics, based on the understanding and the way in which meaning is constructed through perceptual content (Smith and Osborn, 2007).

Interest in phenomenological design in health sciences has arisen from the need to understand the lived experience, in particular the process of health and illness (Canto, Celis, Negrón, & Sosa, 2018; Mendieta, Fuerte, & Ramírez, 2015). In addition, IPA offers researchers the opportunity to explore how families construct an intersubjective perspective of lived phenomena (Allan & Eatough, 2016).

Participants

The participating families are enrolled in a family health center in the city of Osorno. The families were selected through convenience sampling, that is, by the access and administrative facilities provided by the head of the center. Participants were selected based on the following characteristics, choosing one family per age range in the adult life cycle (see Table 1). The inclusion and exclusion criteria were made explicit (see Table 2).

Table 1.
Characteristics of participating families

Participants	**Family 1**	**Family 2**	**Family 3**
	Family with a diabetic member (20 to 43 years old)	**Family with a diabetic member (44 to 64 years old)**	**Family with a diabetic member over 65 years old**
The person presenting the diagnosis, plus the primary caregiver and/or person with whom he/she maintains a close relationship.	**Family 1:** Composed by Alexis and his wife Lorena, both 34 years old. They live with their three children aged 18 years old, 11 years old, and 1 year 4 months old.	**Family 2:** Juan, 58 years old, and his sister Maria, 68 years old, live together.	**Family 3:** Lety, 70 years old, and her daughter Iris, 50 years old, who visits her approximately 5 times a year due to the physical distance. They communicate by telephone constantly.
Therapeutic compliance (adherence to treatment)	Alexis has had DM2 for 5 years, with therapeutic compliance.	Juan has had DM2 for 8 years and has been compliant with treatment for two months.	Lety presents diabetes diagnosed 11 months ago, with therapeutic compliance.

Complications associated with type 2 diabetes	There are no complications associated with the disease.	He presents renal disease, a consequence of complications of DM2.	He has no complications associated with DM2 but has comorbidity with hypertension, osteoarthritis, and arthritis.

Source: Own elaboration based on data collected in Ministry of Health (2010).

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria that account for the choice of participating families are presented below:

Table 2.
Inclusion and Exclusion Criteria.

	Inclusion	**Exclusion**
Criteria	1) Families that present a member with type 2 diabetes with at least 6 months of treatment since its diagnosis.	1) Families that have a member who is bedridden, either the person living with diabetes or another member.
	2) Family members are recognized by the same person with diabetes, living under the same household, and/or there is a close bond and/or they carry some level of responsibility for the care of the disease.	2) Families that have a member living with type 2 diabetes and coexist with problematic alcohol and/or drug use or other severe mental health problems, such as schizophrenia, mental retardation, or developmental disorders in that member or any other member of the family.

Source: Own elaboration based on data collected in Ministry of Health (2010).

Data collection techniques

As a data collection technique, the in-depth interview was used, which from the systemic approach was composed of circular questions, which allow the participants to construct meanings from their experiences, and in turn, the researchers can interpret the meanings, understanding that the results of this research are the product of a dialogue in a unique and particular moment with the families interviewed. That is why the result is a unique process of self-discovery and understanding for the family, and role of the psychologists, who carried out this technique, is to be a facilitator and ally in the dialogue (Heitmann, 2018).

Family interviews were conducted with the participation of the person presenting the diagnosis of type 2 diabetes, together with the selected family members, which made it possible to capture the circularity of the study phenomena.

It should be noted that the researchers are psychologists by profession, with at least four years of clinical experience in the primary health care system in Chile.

Procedure

Access to the exhibition

The first contact of the researchers to gain access to the sample and the study site was with the Director of the Municipal Health Department of the commune of Osorno. As a regular channel and by means of a formal request, a letter was presented to her, with a copy to the director of the specific family health center of investigation, followed by the research project to allow her authorization.

The key informants were the health professionals, who make up the direct care in the treatment, who could be nurses, physicians, or other related professionals. Their role was to inform which families could participate in this study, considering the inclusion and exclusion criteria. Subsequently, direct contact was made with the families who freely opted to participate through informed consent.

Principle of informed consent

For this purpose, as mentioned above, an informed consent form was used to ensure confidentiality of the data provided by the participants and the right to have subsequent knowledge of the results and permanent contact with the researchers during and after the study, in case further information and/or any reason related to the research was required.

Privacy and Confidentiality

In order to protect confidentiality, the names of the participants were replaced by a pseudonym and the place they occupy in the family system, declaring the commitment of the researchers to keep their identities confidential.

Analysis plan

To carry out the analysis, all the interviews were transcribed. Subsequently, a global reading of the interviews was carried out, that is, reading the text several times, in order to have multiple readings and annotations. This initial phase involved close reading of the transcription and, likewise, the audio recordings were listened to several times. This made it easier for the researchers to delve into the data and recall the environment in which the interviews were conducted. Notes were taken about observations and/or reflections on the interview experience and/or comments of importance. Distinctive phrases and emotional responses were made (Pietkiewicz and Smith, 2012).

In a second stage, the researchers worked with their notes (exhaustive details) rather than with the transcript itself, with the aim of transforming them into emergent themes, trying to formulate a concise sentence presenting a slightly higher level of abstraction, i.e., referring to a more psychological conceptualization (Pietkiewicz and Smith, 2012).

Subsequently, the third stage sought connections between the emerging themes, grouping them into interrelationships, conceptual analogies, and providing each group with a descriptive label. Finally, it leads to writing a narrative account of the study, which generally involves taking the themes identified in a list. The final paper contains the interpretive reflection of the researchers, as well as the narrative of the participant and their experience in their own words (Pietkiewicz and Smith, 2012).

Computer resources for data analysis

A tape recorder was used to transcribe the most important elements. For this transcription, the OFFICE program, Microsoft Word, was used. Then, using the same program, tables were generated to systematize the information obtained and, thus, the analysis by theme and sub-theme was carried out.

Results

Three central themes were found that provide insight into how families give meaning to their experience when there is a family member with type 2 diabetes mellitus. The first topic is *"The pain of life with diabetes," the* second topic is "*Shared food brings us together and separates us,"* and the last topic is "*My role as a caregiver*."

Topic 1: "The pain of life with diabetes"

This topic encompasses those feelings, emotions, and beliefs that appear in the face of the diagnosis and the condition of chronicity that the disease entails. It highlights the feelings of guilt, sadness, and hopelessness that appear and the consequences that would generate in personal and family life. The above is broken down into the following sub-themes:

1.1 "The world fell apart." This sub-theme shows that at the moment of receiving the diagnosis, an impact is generated in the person with diabetes, as well as in his/her significant links, threatening the life expectations of the person who suffers from diabetes. There are feelings of sadness and low spirits, accompanied by concern and fear when visualizing a possible future linked to physical and emotional limitation and, consequently, dependence on other family members.

"I got down, everything fell apart, I had the support of her and my family... yes, at the beginning I got down... I thought that if I controlled it, I could be fine. I was afraid... (Interview 1, page 1-2, lines 21-24, 34-year-old adult with the diagnosis)." We try to deduce that the person presents feelings of sadness, associated with a low mood due to the diagnostic surprise generated by receiving the news and the fear that accompanies it. Here it can be seen how the diagnosis influences the vital proposition and also the implications that diabetes will have on daily life are visualized. There is uncertainty as to how this disease will influence his life and whether or not he will be able to follow the guidelines to be healthy. Although he recognizes the family support, there is a fear associated with not being able to control himself and the consequences of this on his health.

"(...) Sometimes I did not feel like living...for a long time. I was listless. I felt like sleeping... Diabetes makes you sleepy, it is like a cancer. It hurts you..." (Interview 2, page 7, lines 19-21, 58-year-old adult with the diagnosis). The interviewee reports a sense of sadness and hopelessness associated with both psychic and bodily pain. Here the circularity and influence between both ailments can be appreciated. The metaphor of cancer could be associated with the fact that it is a disease, from his perspective, that ends his life. A death that can be real or a symbolic death of what her life implies.

1.2 "Getting used to what will follow us all our lives." This sub-theme reports that during the treatment process, family members are involved in negative emotions, initiating a process of

accommodation and ambivalence. A process between mourning and acceptance of the condition is set in motion. This situation may induce adaptive responses such as denial of the disease or resignation to lifelong diabetes.

(...) *"Sometimes he forgets that he is diabetic. He feels bad and goes to the emergency room (alluding to the emergency department) and I ask him, and you said you were diabetic? and there he says, I am diabetic." (Interview 1, page 4, lines 23-24, 34-year-old adult and wife of a person with the diagnosis).* The feelings of denial and the difficulty to assimilate the diagnosis are evident, translating into the affected person's narrative even in critical situations, such as a decompensation. Although the person forgot it, his wife has it incorporated, which could be associated with the identity of her husband due to the impact of the disease that is constituted around diabetes.

(...) "Get used to it, nothing can be done. I think that if Juan takes care of himself, he can lead a good life" (Interview 2, page 7, lines 9-10, 68-year-old sister). Feelings of resignation are perceived, which could be adaptive to face the disease and the changes it implies in the life of a person and his family. In addition, there is also an attribution to the member of the family who has the disease of its prognosis, ignoring that in some way the harmful eating habits are not necessarily related only to him but to the whole family system. The latter could lead to difficulties in family relationships.

1.3 "Worry that something will happen to him/her." This subtheme refers to the feelings of fear and anxiety that the caregiver feels for the person with diabetes. Families report constantly feeling feelings of uneasiness and fear about the future with the disease and its consequences, which can influence the perception of the diabetes caregiver by intensifying feelings of fear.

"We all know that it ends in catastrophic things... I don't know... the bad pancreas, the bad liver, the bad heart, because it is deteriorating inside or a poorly cared for wound... it is worrying... I feel concern because it is her health and since one is in charge of her it is also one's responsibility" (Interview 3, page 3 line 15-18, 50-year-old daughter). The family realizes that the concern for the care of others is driving the practices associated with caring. It also shows the commitment that is acquired, fearing that something will happen to her, with a catastrophic vision of the disease despite the fact that the affected person is currently following her treatment. The meaning of diabetes as a disease is tinged as a fatal disease.

(...) I know that sugar spikes are suddenly very strong. It scares me because I am the one who tells her what to do in case her blood sugar rises. I worry that something will happen to her" (Interview 1, page 3, lines 27-30, wife, 34 years old). Likewise, the wife is adopting a new role, loaded with responsibility that goes hand in hand with the fear and concern that complications may occur, feelings that indicate a not very encouraging future. She sees herself involved in the care, perceiving that she has the necessary skills to help the diabetic in case of emergency.

Topic 2: "Shared food brings us together and separates us"

Families report that, in order to face the treatment of diabetes, they must implement different changes, including relational dynamics, being able to talk about food and habits among all members of the family. To this end, the following sub-themes emerge:

2.1 "Nutrition that requires supervision." This sub-theme alludes to the fact that during the process of coming to terms with the changes associated with the food element, the caregiver tends to set limits with respect to food. The person with diabetes feels that he or she is losing power in making decisions about food, as it was an element that was not questioned before the diagnosis. These decisions are influenced by the determinations of the caregiver. Food is evidenced as the means for making one's own decisions.

" I challenge her about food, but as she is driven by her ideas... She had a sweet tooth, she ate whatever came and if there was a drink, sweets, everything, nobody was careful..." (Interview 3, Page 10, lines 17-18, 50-year-old adult, daughter of the person presenting the diagnosis). It is suggested that it would be difficult to change habits that were ingrained in daily life. It can be seen that it is difficult for the adult person living with diabetes to assume that others are involved and acquire power in decisions that were previously of an individual nature, showing certain resistance. It is also observed that there may be a feeling of exhaustion and constant worry on the part of the caregiver, which may generate difficulties in the relationship.

"When he doesn't listen to me about meals or remedies, I get angry. We don't get into more conflict" (Interview 1, page 5, lines 5-6, 34-year-old adult and wife of a person presenting with the diagnosis). It is inferred that the caregiver also makes an emotional effort to meet the objectives and carry out the necessary strategies to accommodate the diagnosis. Inflexible attitudes are perceived from the member with diabetes, who must adapt to changes that are imposed. However, he or she may receive it as a manifestation of love by collaborating to effect such changes.

2.2 "Giving each other affection through food." This sub-theme refers to the meanings behind the element of food, which are associated with the expression of union and affection towards the significant other who visits or lives in the home. Consequently, the family must incorporate new foods to the family diet and others that usually starred in family gatherings are eliminated, for example: soft drinks, barbecues, roasts, pastries, among others. There would be a change in the affective relationship with food, which continues to be an element of affection, maintaining its function but with other elements that ensure the patient's quality of life.

"We can no longer eat anything tasty…Before, everything was shared, now we are careful, because one cannot eat salt, another cannot eat sugar" (Interview 3, page 12, lines 39-41, 70-year-old woman). It is interesting to interpret that it is possible to assume the change in spite of the fact that for the family it is usually a pleasure to share certain flavors associated with the experience of being all together. There is a before and an after in family gatherings, where members report that they have knowledge about each other's food and a mutual interest in respecting it, showing a sacrifice in pursuit of caring for the health of others.

"She makes demands on me at meals. Sometimes I ask her for noodles with sauce and meat, and she doesn't make them for me. If she wasn't there, I would have already cut myself (alluding to death)" (Interview 2, page 4, lines 11-13, 58-year-old adult presenting the diagnosis). It is possible to perceive that family support is usually essential when it comes to accepting the changes, that is, in this section the person recognizes that in order to maintain an adequate diet it is essential that the other person is present accompanying him/her in his/her care. The affected person appreciates, values, and recognizes their work.

Topic 3: "My role as a caregiver"

This theme alludes to the place adopted by the caregiver, who, through the link with the diabetic, directs his or her efforts to become the main support network for this person. It is also evident that female figures are the ones who take charge of the care: the wife, the sister, and the daughter. Sometimes, changes in hierarchies and family roles are visualized.

To this end, the following sub-themes are derived:

3.1 "Getting involved in their care." This sub-theme allows us to interpret that the caregiver is getting involved in the care of the other person, showing commitment and adopting this role with responsibility, allowing to face certain difficulties related to the disease from daily knowledge in order to overcome the complications that emerge.

"I cured him. I cured him with natural medicine" (Interview 2, page 4, lines 27-28, 68-year-old adult and sister of a person presenting with the diagnosis). A positive perception of personal competencies and sense of self-efficacy emerges along with the ability to use everyday resources and knowledge to provide optimal care. This knowledge subscribes to a context outside of traditional medicine, which is meaningful to the caregiver and the one being cared for.

"Sometimes he forgets the pills, but I take care of fetching them and reminding him" (Interview 1, page 3, line 21, 34-year-old adult and wife of a person presenting with the diagnosis). Here it is perceived how the caregiver adopts a responsibility in the care of her husband, allowing the interpretation that involvement in caregiving mobilizes and transforms the family system, managing to find a balance in the experience of illness. However, this may influence the way in which the affected person acquires commitment in the treatment.

3.2 "We in care". This subtheme points to women as caregiving figures, who welcome and accept this role and are also recognized by the person presenting the diagnosis.

"She is my sister, if she were not there, I don't know how I would have been..." (Interview 2, page 4, line 11, 58-year-old adult presenting the diagnosis). Here he points to the recognition of the figure of the sister as the main caregiver, alluding to an unfavorable future if he were to be detached from her support, which is why he values her care. There is a questioning of life in the case of not perceiving anyone in the care.

"I have her support more than anything else... because she takes care of me as she does of her children... she has put in a great deal..." (Interview 3, page 6, line 11, older adult, 70 years old, presenting the diagnosis). In the same way, it is perceived that female support is the only support for this person, which implies that if she were not there, there would be no other figure safeguarding his care, perceiving feelings of fear. This would translate as a limiting factor both at the individual and family level since it increases the fears of the affected person and the caregiver, who would feel as the only one responsible for this process, which could become an overload in the future.

Discussion and conclusions

From the interviews conducted with the three families and their subsequent analysis, it is revealed the emotion of surprise and shock at the news of the diagnosis since it is unexpected, initiating a process of adaptation which is accompanied by feelings of fear of limitation due to possible sequelae of the disease and, therefore, with hopelessness about the future. During this adjustment, it is possible to perceive that the family members with whom the person with the diagnosis has a close relationship are becoming involved in the care required by the disease, providing support and assuming decisions that allow an adequate adjustment. They also express various emotions tinged with concern, mainly about the possible consequences associated with diabetes, which leads to a change in the affective bond, emerging an invisible system in the family: "the caregiver and the affected" highlighting the role of the caregiver who protects and is committed to the care of the other.

Consequently, in order to respond to the specific objectives of the research, three major themes are presented in order to describe the meanings that families construct around the experience of illness and also to highlight the changes that occur in the family organization:

1. "The pain of life with diabetes"
2. "Shared food brings us together and separates us"
3. "My role as a caregiver"

The participating families mentioned that the close relationships among them are those that allow them to adequately cope with life with this condition, which is consistent with studies conducted in Mexico (López, Pérez, Oropeza and Roca, 2016; Riquelme, 2015), which report that the family is the main affective and practical support to provide the care that the disease requires. Families that have built a reciprocal support among its members are those that manage to maintain a good quality of life, despite emergency situations and/or consequences of diabetes.

Likewise, it is revealed that the participants are moving towards a process of mourning between denial and acceptance of the changes. Those affected report that they are losing power in decisions that were not previously questioned by the family. Such a loss is not only exposed by the person suffering from diabetes but also by the other members of the family. A study conducted in Bolivia (Angle, 2015) describes this process in diabetes and compares it with ambiguous loss (concept coined by Pauline Boss in 2001), indicating that the affected person and his family go through such loss presenting confusing feelings that sometimes fail to be adequately elaborated, reaching to generate various conflicts disrupting the integral health of the entire family system. It is reflected in the literature (Heredia and Pinto, 2008) that the condition of diabetes can generate other comorbidities in the affected person and his family in the experience of the disease.

The second theme, which points to "Shared food brings us together and separates us," that the person with the diagnosis is difficult for others to get involved and take control of decisions that were previously of an individual nature and that now become part of the family sphere. Our results coincide with studies mentioned in previous paragraphs (Angle, 2015; Riquelme, 2015) in which the family is coupling to the change entering into conflicts and solutions to find a new adjustment. Within the findings, it is possible to evidence that food is usually a central element in family life; when interpreting the meanings, it is revealed that food generates spaces for meeting

and fun. Through food, family identity and a sense of belonging are conceived; therefore, affection is shown when buying, cooking, and sharing food.

And as for the third theme that, alludes to "My role as a caregiver" in which the participating families reflect the birth of a new family structure facing the diagnosis of diabetes, such organization is finding new ways to adapt and that the whole system continues to function invisibly to its members (Adfalla and Novis, 2014), experiencing a transformation.

On the other hand, the empirical and daily life knowledge that the families possess regarding the care of the disease is revealed since the experience of care is influenced by social and cultural patterns. It is evident that the female gender is the one that assumes the predominant role when it comes to assuming care, which is associated with what has been culturally attributed to women; they are the ones who manage certain responsibilities, such as cooking and/or administering medication, optimizing their time between caring for the home, children, grandchildren, and diabetes (Gálvez and Gallardo, 2013).

As relevant background, it is possible to point out that a factor that can have an impact on the experience of diabetes is the moment of life in which it appears and the life cycle in which the family is (Figueredo, 2014; Armengol and Fuhrmann, 1998). However, in the present research, no elements were recognized during the dialogue with the participating families that would account for this. A study conducted in Chile (Alcaíno, Bastías, Benavides, Figueroa and Luengo, 2014) supports that people who cope better with the disease are those who have significant family ties regardless of the stage of the life cycle in which diabetes appears.

In conclusion, the relevance of this research is to provide knowledge in an area that is less deepened in our country, regarding the family in the affectation of diabetes mellitus type 2, contributing to the understanding of the experience of diabetes since this is not lived individually but rather in a relational way with those links that are significant and that manage to get emotionally involved in the care.

According to the above, the need arises to conduct a first conversation with families about the experience of diabetes, urging family therapists to perceive the narratives and stories, with the aim of rescuing the resources, skills, and values that could be used to cope with the disease. From this perspective, it is considered that diabetes is diabetes and the person with diabetes is not the problem, leaving behind stigmatizing meanings to the person with the disease, which often intensify the emotions of sadness and hopelessness. In this process, family therapists and health professionals can accompany families to deconstruct their meanings and co-construct new ones in relation to the diagnosis, the treatment, the relationship they have with food, and the new relational structure that emerges. With respect to family psychotherapy, the practice of understanding the meanings that each family member constructs of the process, nurtures, and allows the generation of common stories and alternative stories, establishing understanding among members and strengthening bonds.

It is also possible to consider that these meanings are constructed within a social, cultural, and gender context, allowing to understand the relational experience of the disease, which will

provide elements for health agents to empathize with those family members who take longer to establish changes or have poor adherence to treatments.

Finally, the following questions arise regarding what happens when roles are rigidified in other family systems around type 2 diabetes and, on the other hand, what are the challenges faced by families when there are already problems in the bonding relationship, i.e., it would be interesting to discover how type 2 diabetes impacts on these cases.

On the other hand, it is possible to mention the importance of the development and strengthening of skills of family therapists working in this area around building a circular dialogue that nurtures meanings and facilitates interpretations, that is, to deploy practices that allow the therapeutic conversation to generate experience and how these would impact on the treatment process. It is for this reason that we urge the generation of new national and local studies that investigate the experience of family members in living with type 2 diabetes mellitus.

It should be noted that the methodology used allows us to achieve the objectives initially set out, making it possible to understand and capture the experience of families who have a member with type 2 diabetes mellitus.

Although the sample has been heterogeneous in terms of individual and family life cycle, it is important to mention that this has made it possible to show the core of the experience of a group of families of different ages. As for the limitations of this study, it is possible to mention that no gender distinctions were made, which was not possible due to the scarce male participation in the study, which could have resulted in gender bias.

The bias of the researchers is also recognized since they both work in primary health care, and their resonance may influence the interpretative capacity of the results.

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A REFLECTION ON THE APPLICATION OF RESTORATIVE CONFLICT RESOLUTION METHODS IN PARENTAL ALIENATION

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Summary. Restorative methods of conflict resolution are tools in full use in Justice and in the various fields of activities in the society we live in. In this article, its specific use for managing intra-family conflicts in cases involving Parental Alienation is addressed, bringing to light the Parental Alienation Syndrome. The theoretical line adopted meets the current that assumes the existence of both Alienation and the Syndrome, while respecting contrary opinions. The following methods have been selected: Arbitration, Restorative Circles, Conciliation, Restorative Conferences, Systemic Constellation, Mediation, Negotiation, and Transaction. A systematic bibliographic review was carried out, in scientific works in the electronic bases of scientific research on the *internet* through *Google* Scholar. Sixty-one (61) academic works from the last 3 (three) years were selected, whose reading elucidated the recommendations of the Author(s) as to the specific recommendation of the methods in cases of Parental Alienation in Brazil. It was found that more than 60% of the papers recommend Mediation as the way forward, which suggests a conditioning of the professionals in the area of Parental Alienation, by pointing, in a majority, to Mediation. Most probably, influenced by existing legislation, leaving aside the other methods, which can be configured as excellent options, depending on the stage of the Disposal. These possibilities of application of Restorative Methods of Conflict Resolution according to these stages are presented, with the help of typology identified in Literature, to provide new options of an effective and efficient support to intra-family conflicts in cases of Parental Alienation.

Keywords: Restorative Methods, Conflicts, Parental Alienation

UMA REFLEXÃO SOBRE A APLICAÇÃO DOS MÉTODOS RESTAURATIVOS DE RESOLUÇÃO DE CONFLITOS NA ALIENAÇÃO PARENTAL

Resumo. Os métodos restaurativos de resolução de conflitos são ferramentas de pleno uso na Justiça e nos diversos campos de atividades da sociedade em que vivemos. Neste artigo, aborda-se o seu uso específico para gestão de conflitos intrafamiliares em casos que envolvam Alienação Parental, trazendo à luz a Síndrome de Alienação Parental. A linha teórica adotada vai ao encontro da corrente que assume a existência tanto da Alienação, bem como da Síndrome, contudo respeitando opiniões contrárias, sendo selecionados os seguintes métodos: a Arbitragem, Círculos Restaurativos, Conciliação, Conferências Restaurativas, Constelação Sistêmica, Mediação, Negociação e Transação. Realizada a revisão bibliográfica sistemática, em trabalhos científicos nas bases eletrônicas de pesquisas científicas na *internet* por meio do *Google* Acadêmico. Foram selecionados 61 (sessenta e uma) obras acadêmicas nos últimos 3 (três) anos, cuja leitura elucidaram as recomendações do(s) Autor(es) quanto à recomendação específica dos métodos em casos a Alienação Parental no Brasil. Verificou-se que mais de 60% dos trabalhos recomendam a Mediação como caminho a seguir, o que sugere um condicionamento dos profissionais na área de Alienação Parental, ao apontarem, de modo majoritário, a Mediação. Muito provavelmente, influenciados por legislações existentes, deixando de lado os demais métodos, que podem se configurar como excelentes opções, dependendo do estágio da Alienação. Estas possibilidades de aplicação dos Métodos Restaurativos de Resolução de Conflitos em função destes estágios são apresentadas, com o auxílio de tipologia identificada na Literatura, para prover novas opções de um apoio efetivo e eficaz aos conflitos intrafamiliares em casos de Alienação Parental.

Palavras-chave: Métodos Restaurativos, Conflitos, Alienação Parental

Introduction

A problematic situation experienced in a marital relationship, in Brazilian society, can be found in the moments of its dissolution, because it is not abnormal that, in this moment of relational disarray, the spouses fight among themselves and for the custody of the children, besides the probable disputes in the sharing of assets and rights. In this turbulent environment of marital dissolution, there are situations in which one of the spouses, tends to use them as a kind of weapon or means of punishment against the other, which brings strong conflicts of parenting involving these minors and brings, to the stage of the article, Parental Alienation. These intra-family conflicts traditionally end up in court regardless of their stage, that is, they are resolved with the imposition of a solution that comes from heterocompositive methods, which embed the sense of a victory or a defeat without the resolution of the conflict. Conflicts are not resolved because, there is a "dichotomous perspective, where there can only be one winner and therefore the other is reserved the place of defeat" (Maciel, 2019, p. 141). Notwithstanding the fact that the Brazilian Civil Code, in its article 1,583, clearly establishes the application of shared custody in the search for conciliatory practices in situations when there is no agreement with custody of the minors (Araújo, 2019), the issue of the relationship between spouses, family members and the minors is far from being resolved for the conflicts that lead to Parental Alienation. Thus, there is the need for these conflicts to be faced in a different way and, in this scenario, there is a great opportunity for Restorative Methods of Conflict Resolution to be used by professionals of several areas involved in the treatment in cases where there are indications of stages of evolution of Parental Alienation.

From this point of view, this scientific article aims to present an evaluation of the application of Restorative Methods of Conflict Resolution in face of the three stages of Parental Alienation pointed out in Gardner's typology (1985), supported by the Literature selected in the last 03 years (2019 to 2021). The choice of the theme is justified, initially, by a motivation of its own, since one of the authors experienced this process of compulsory removal of her children, as a result of several conflicts generated by the devaluation and

deconfiguration of the maternal image by the other spouse. The relevance of writing this scientific article is the deepening of the theme, by proposing an increase in the range of options of intra-family conflict management tools to help professionals deal with cases of Parental Alienation, because the author has been following these types of cases since she was a student, in a practical way. Now, as a Clinical Psychologist working in her Private Practice, her eyes shine as a stimulus to continue on this path, for she understands that there are great opportunities with the wide application of Restorative Methods of conflict resolution to pacify the intra-familiar environment. Additionally, there is the merit of advancing the line of democratic discussion that the Brazilian Federal Council of Psychology (CFP), establishes through the document "Psychology Practice Facing Parental Alienation Demands" (2019). Hence, comes the challenging research question that is intended to be answered: "How are Restorative Conflict Resolution Methods Recommended in the Literature for Parental Alienation Situations?"

Regarding Restorative Methods of Conflict Resolution, the Academic Literature presents several options of self-compositive methods, the most applied being Arbitration, Restorative Circles, Conciliation, Restorative Conferences, Systemic Constellation, Mediation, Negotiation, and Transaction. Thus, powerful tools are made available, with their peculiarities for application and, with their practical results, as auxiliary work techniques, in the fulcrum of a minimal restructuring of this family tie broken by Parental Alienation or even to obtain harmony of the actors involved in the external scope of Justice. In other words, Fermentão & Fernandes (2020, p. 75) advocate that "the parties can participate as protagonists of the resolution assuring to all the solution of the conflicts by adequate means, attending to their nature and peculiarity". The expectation of a wider range of applicability options of these methods for a Clinical Psychologist, in the case of one of the authors, could greatly stimulate a reduction in the number of cases that come to court, which is highly desirable. In this sense, Calçada (2019, p. 76) points out that the courts themselves are already "seeking alternative conflict resolution measures, such as mediation, or projects that seek to pacify conflicts and raise parents' awareness of their children."

Parental Alienation is regulated in Brazil by Law 12.318/2010, called Parental Alienation Law (LAP), which could, at first, be treated as an innovation of Brazilian Law in order to try to protect the child in this turbulent moment of marital dissolution, which Jorge (2020, p. 6) defines as "dissolutions of unresolved marital unions". This, in theory, would be commendable, but, in practice, it generates a great deal of controversy on several points of its execution and, moreover, gets mixed up with the discussed Parental Alienation Syndrome (SAP), which is still not accepted by the medical and academic fields, as identified, for example, in Lima (2019), Ciarallo (2019), Rabachini (2019), Oliveira (2019), and Veiga et al. (2020). The line of thought adopted in this article is based on the extensive clinical practice experienced by one of the Authors, corroborated by works of, for example, Borges (2019), Jesus and Amparo (2019), Bastos and Forneck (2020), Bolzani and Herculini (2020), Godoy, Silva & Santos (2020), Oliveira & Barros^{Fo} (2020), Oliveira (2020b), Silva (2020a), Sobrino (2020), Zaganelli, Maziero & Furriela (2020) and Ladvocat (2021) who understand that the Syndrome occurs as a consequence of Parental Alienation, that is, it could be expressed as a result of the consequences caused in the child who is exposed to acts of alienation from not only "necessarily one of his parents, it could be any person who has custody, surveillance or authority of the child" (Schwengber, Santos & Nolasco, 2020, p. 7). Furthermore, the syndrome is considered to exist, even though it is not yet a recognized psychological illness and not yet registered with an International Disease Code (ICD) by the World Health Organization (WHO). On this dilemma, Araújo (2019, p. 12) establishes that this discussion tends tobe settled, as "the term has been officially introduced in the ICD-11 version that will go into effect on January 1, 2022."

The Parental Alienation Syndrome was contextualized by the American psychiatrist Richard Gardner, in the 1980s (Mendes, 2019), as a disorder that would affect children and adolescents involved in situations of custody dispute between parents, upon dissolution of marital society. At this time, strong emotional tensions are established "and may generate expressions of anger, resentment, raids, and conflicts that involve, to some extent, the entire family system" (Mendes, 2019, p. 25). In this view, Santos (2020a, p. 18) translates the situation as "the existing conflict between adults overflows as a way to reach their children", which is configured by Figueredo (2018, p. 7), a scenario of conditions that "are sufficient for the indication of psychological monitoring by a Professional". This dynamic is embedded within the process that Landvocat (2021) categorizes as family therapy, under a focus identified by Sequeira (2020, p. 31) who emphasizes that "regardless of the situation in which it intervenes, its main objective is to identify the best way to resolve conflicts." Thus, Psychology must treat this framework, to "re-inaugurate the exercise of parenting, dissociated from conjugality" (Jorge, 2020, p. 6). In a specific look at the consequences to the children, it can be seen that Parental Alienation follows a trajectory of evolution in the way they behave in relation to the alienated parent, after having suffered interference in relation to how they should see him or her. Thus, Mendes (2019), Alvarenga & Alamy (2019) and Sequeira (2020) present the typology found in Gardenerian theory, which divides and scales Parental Alienation into three stages of evolution categories, which are found in Table 1:

Table 1.

Evolving Stages of Parental Alienation

Internship	***Features***
Light	It is still superficial and with the cooperation and visitation permission of the alienating spouse, when it begins to be demonstrated when there are problems at the time of return visits, where the victim does not show her emotions so strongly at times when the image of her alienated parent is denigrated and does not generalize the feelings of contempt towards him, still maintaining a balance in the face of the situation.
Medium or Moderate	There is already a sophistication, as the child already begins to refuse to go with the alienated parent, because sometimes in this process, the alienating parent is already more structured in terms of demoralization tactics, and the child already shows signs of repulsion towards the alienated parent's family and friends, refusing to live with this other family member or acting aggressively.
Grave	The most worrisome, in which the victim starts having intemperate and violent reactions towards the alienated parent, making visitation impossible, avoiding the conviviality between them and, in this way, expressing her repudiation or even being violent towards the alienator.

Grade. Adapted from Mendes (2019, p. 14), Alvarenga & Alamy (2019, p.11) and Sequeira (2020, p. 26)

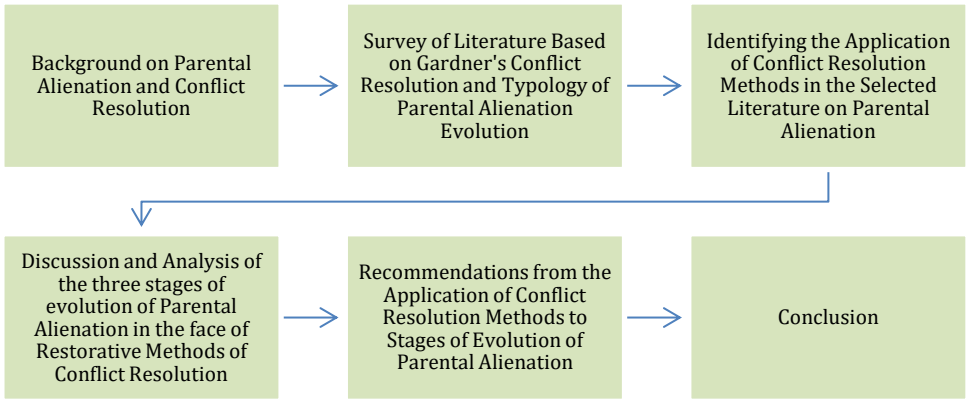
Methodology

This scientific article has a qualitative basis, presenting a discussion within a reflective and interpretive environment about the application of restorative methods of managing intra-family conflicts related to Parental Alienation. Thus, the research was developed through inductive and exploratory methods, with the aid of grounded observations and identified in

the Literature. The literature search used the syntax-driven selection technique in scientific and academic research bases through the electronic platform *Google* Scholarwith a direct search for specific terms: "Parental Alienation" + "Conflict Resolution" in the sample universe from 2019 to 2021. As a result of the search, 135 (one hundred and thirty-five) academic works were identified, including Books, Theses, Dissertations, and Articles. In a next step, those that did not explicitly describe in their abstracts a relationship between conflict resolution methods and Parental Alienation were discarded, leaving a final number of 61 (sixty-one) papers, which were read, cited in the course of this article and presented in the Results, as well as making up the Bibliographical References. The trajectory of the article's construction is presented in Figure 1.

Figure 1

Methodological Trajectory



Results

From the reading of the 61 (sixty-one) academic works, the recommendations and practices of the Author(s) were observed regarding the application of Restorative Methods of Conflict Resolution to Parental Alienation. Thus, we try to translate this result by putting the numeral "0" (zero) for the non-mention of the use of the Restorative Method specified, despite the academic work being about Parental Alienation. Furthermore, there were also Authors who did not cite any Restorative Method specifically throughout their research, so there is the numeral 0 "zero" also released. On the other hand, identifying the number "1" (one), translated as that the Author(s) pointedly cited the Restorative Method as a recommendation to be applied in cases of Parental Alienation. These results are condensed in Table 2:

Table 2.
Authors and Recommendations for Applying Restorative Methods

Number	***Authors***	***Publication Year***	***Arbitration***	***Peacebuilding Circles***	***Conciliation***	***Systemic Constellation***	***Restorative Circles***	***Mediation***	***Negotiation***	***Transaction***
1	Alencar	2020	0	0	0	0	0	0	0	0
2	Alvarenga & Alamy	2020	0	0	0	0	0	1	0	0
3	Barrio	2020	0	0	0	0	1	0	0	0
4	Clay	2019	0	0	0	0	0	1	0	0
5	Bastos, & Forneck	2020	0	0	0	0	0	1	0	0
6	Bolzani & Herculino	2020	0	0	0	0	0	1	0	0
7	Borges	2019	0	0	0	0	0	1	0	0
8	Brandão	2019	0	0	0	0	0	0	0	0
9	Sidewalk	2019	0	0	0	0	0	1	0	0
10	Ciarallo	2019	0	0	0	0	0	0	0	0
11	Dambros	2019	0	0	1	0	0	1	0	0
12	Drumond & Soares	2019	0	0	0	0	0	1	0	0
13	Favin	2020	0	0	0	1	0	1	0	0
Number	***Authors***	***Publication Year***	***Arbitration***	***Peacebuilding Circles***	***Conciliation***	***Systemic Constellation***	***Restorative Circles***	***Mediation***	***Negotiation***	***Transaction***
14	Fermentão & Fernandes	2020	0	0	0	1	0	1	0	0
15	Ferreira, Silva & Lasmar	2021	0	0	0	0	0	0	0	0
16	Gama, Andrade & Dipietro	2020	0	0	0	0	1	0	0	0
17	Godoy, Silva & Santos	2020	0	0	0	0	1	0	0	0
18	Ingrid	2020	0	0	0	0	1	0	0	0
19	Jesus & Amparo	2019	0	0	0	1	0	0	0	0
20	Jorge	2020	0	0	0	0	0	0	0	0
21	Ladvocat	2020	0	0	0	0	0	1	0	0
22	Lake	2019	0	0	0	0	0	0	0	0
23	Lima	2019	0	0	0	0	0	1	0	0
24	Lucca	2020	0	0	1	0	0	1	0	0
25	Maciel	2019	0	0	0	0	0	0	0	0
26	Mendes	2019	0	0	0	0	0	0	0	0
27	Monteiro & Carvalho	2020	0	0	0	0	0	1	0	0
28	Moreira Neto, Rocha & Pinheiro	2020	0	0	0	0	0	1	0	0
29	Oliveira & Barros[Fo]	2020	0	0	0	0	0	1	0	0
30	Oliveira	2019	0	0	1	0	0	1	0	0
31	Oliveira	2020a	0	0	1	0	0	1	0	0
32	Oliveira	2020b	0	0	0	0	0	0	0	0
33	Paiva & Pauseiro	2020	0	0	0	0	0	0	0	0
34	Piovezana, Silva & Leite	2020	0	0	0	0	0	1	0	0
35	Prazak, Soares & Souza	2020	0	0	0	0	0	0	0	0

36	Pretel, Vasconcellos & Oliveira	2020	0	0	0	0	0	0	0	0
37	Robachini	2019	0	0	0	1	0	1	0	0
38	Salles	2020	0	0	0	0	0	1	0	0
39	Santos	2020a	0	0	1	0	0	1	0	0
40	Santos	2020b	0	0	1	0	0	1	0	0
41	Santos & Cardoso	2019	0	0	1	1	0	0	0	0
42	Sales	2020	0	0	0	0	0	0	0	0
43	Santana & Santos	2021	0	0	0	1	0	0	0	0
44	Santos & Cardoso	2021	0	0	0	1	0	0	0	0
45	Schluga & Silva	2020	0	0	0	0	0	1	0	0
46	Schwengber, Santos & Nolasco	2020	0	0	0	0	0	1	0	0
47	Sequeira	2020	0	0	0	0	0	1	0	0
48	Silva	2020a	0	0	0	0	0	1	0	0
49	Silva	2020b	0	0	0	0	0	1	0	0
50	Silva & Canezin	2020	0	0	0	0	0	1	0	0
51	Silva & Paiva	2021	0	0	0	1	0	1	0	0
52	Silva, Carvalho & Melo	2019	0	1	0	0	1	0	0	0
53	Silva & Lima	2020	0	0	0	0	0	0	0	0
54	Silva & Costa	2020	0	0	0	0	1	0	0	0
Number	***Authors***	***Publication Year***	***Arbitration***	***Peacebuilding Circles***	***Conciliation***	***Systemic Constellation***	***Restorative Circles***	***Mediation***	***Negotiation***	***Transaction***
55	Silva, Chapadeiro & Assunção	2020	0	0	0	0	0	0	0	0
56	Sobrino	2020	0	0	1	0	0	1	0	0
57	Sousa	2019	0	0	0	0	0	1	0	0
58	Valderlon	2021	0	0	0	0	0	0	0	0
59	Veiga, Soares, Cardoso & Simplício	2019	0	0	1	0	0	1	0	0
60	Vieira & Moraes	2020	0	0	0	0	0	0	0	0
61	Zaganeli, Maziero & Furriela	2020	0	0	0	0	0	1	0	0

Source: Authors (2021)

In order to robust the discussion about the the answer to the authors' concern, it is necessary that the information be transformed into basic statistical data. Thus, the number of specific mentions of the Restorative Conflict Resolution Method are totaled, referred to as the "Individual Number of Referrals". As a second action, the percentage values of this "Individual Number of Citations" are calculated as a function of the total number of citations, that is, N=57 (fifty-seven) considering that there were articles that cited more than one method for Parental Alienation. The results are presented in Table 3.

Table 3.
Translation of the Information in Table 2 into basic statistical data

Description	***Arbitration***	***Peacebuilding Circles***	***Conciliation***	***Systemic Constellation***	***Restorative Circles***	***Mediation***	***Negotiation***	***Transaction***	***TOTAL***
Number of Indications	0	1	9	8	5	34	0	0	57

Total Percentage by Indications of Methods (N=57)	0	2%	16%	14%	9%	59%	0	0	100%

Source: Authors (2021)

Discussion and Conclusions

Mediation is the most mentioned Restorative Conflict Resolution Method, with 34 (thirty-four) times, out of the 57 (fifty-seven) mentions identified. In other words, it has its application determined in 59% of the opportunities of Parental Alienation cases, followed by Conciliation, Systemic Constellation, Restorative Circles and Peacebuilding Circles. On the other hand, there is no citation for Arbitration, Negotiation and Transaction in the selected works.

The histogram (Figure 2) is presented for greater clarity of this scenario, which corroborates the first place of indications of the application of Mediation in Parental Alienation cases. This may indicate that there is an intellectual convenience due to the tendency of the legislation itself to already prescribe it, which Brandão (2019, p. 176) calls a "*prêt-à-porter*solution" (in our free translation: "*ready to wear*").

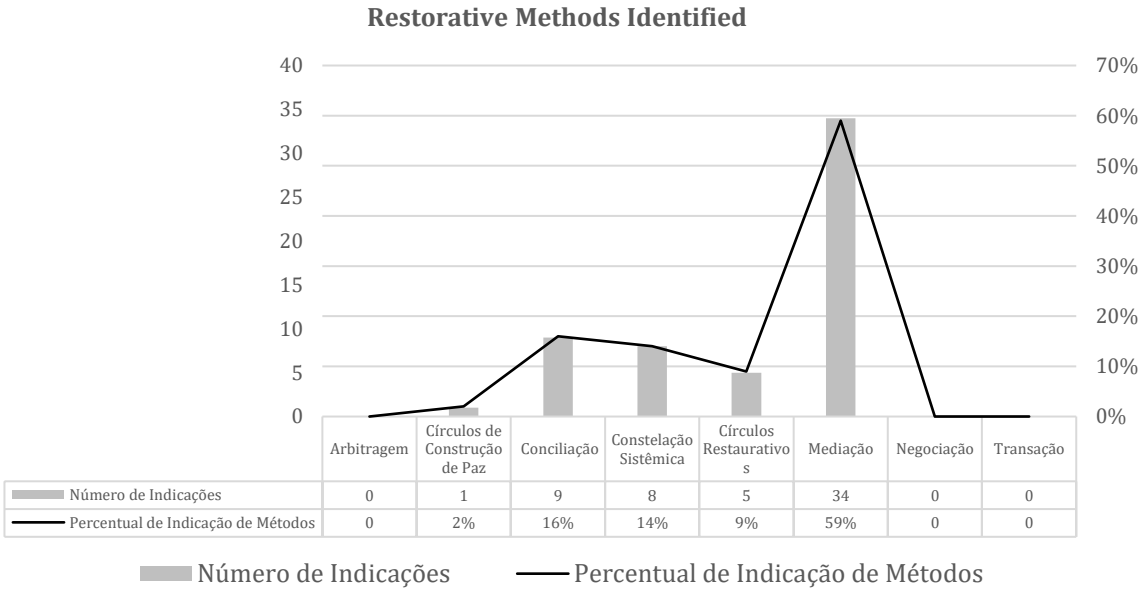


Figure 2: Identification Chart of Restorative Conflict Resolution Methods
Source: Authors (2021)

In other words, when Law 12.318/2010 was passed, the figure of Mediation was vetoed, which ended up, in an indirect way, popularizing it. In addition to this fact, Zaganelli, Maganela & Furriela (2020, p. 73) observed that after the enactment of the New Civil Procedure Code in 2015, "conciliation and mediation gained prominence", which can be translated into promoting a "forgetfulness" of the other Restorative Dispute Resolution Methods. Brandão (2019, p. 176) raises another important situation with the prescriptive use of Mediation, because for its application, there must be the premise that it "presupposes isonomy between the parties in the composition of resolutions," which in his opinion does not occur in the more complex Parental Alienation cases, i.e., in Serious Alienation. Existing a situation of a possible power imbalance, Drumond & Soares (2019, p. 127) advocate that "agreement cannot be encouraged at all costs." Moreover, Oliveira (2020b, p. 53) noticed that,

with the proposed use of Mediation, a "significant number of cases in which the possibility of settlement was proposed to the parties" emerged. In summary, Vieira & Moraes (2021, p. 99), understand Mediation is used as "a deal-making factory", which is done regardless of the stage of Parental Alienation. To increase the possible ineffectiveness of Mediation, it seems, the due understanding of the degree of evolution of Parental Alienation is not taken into consideration, much less for what Rodrigues Jr & Reis (2020, p. 24) warn, because, for the correct selection of the Restorative Method, the professional "must take into account the specificities of the litigation presented". In summary, Vieira and Moraes (2021, p. 99) advocate that Mediation is applied in an imprecise and indiscriminate way, concluding "by the latent need for a reconfiguration of this mechanism, especially in the judicial scenario, protecting and tutoring the dignity of the human person, both of the mediated and their children". From this point of view, Mediation must be very well analyzed. Not that, in its core, Mediation does not present qualities for conflict resolution when dialogue no longer exists between the couple, as, are highlighted in Bolzani & Herculini (2020) Santos (2020a), Piovezana, Silva & Leite (2020), Bastos & Forneck (2020) or Silva & Paiva (2021), but a discriminated use leaves few opportunities for the application of other methods in serious situations of Parental Alienation, such as, for example, Negotiation, which can bring this balanced solution to both sides.

The presence of the Negotiator has its importance by promoting that "the parties themselves, without any intervention from a third party, either facilitator or helper, discuss their problems developing their own solutions, as a direct conversation between those involved" (Sales, 2020, p. 52), having the quality of providing flexibility in the discussion of cases of Moderate and Severe Alienation for being "a less formal self-composition technique" (Alencar, 2020, p. 102). The application of Transaction, on the other hand, has the power to be a good option in cases of Severe Disposal, where dialogue is absent, because it consists of an agreement "the subjects of the dispute make reciprocal concessions to remove the controversy established between them" (Sales, 2020, p. 54).

In the application of Conciliation, there is the advantage of the participation of a neutral third party (Lucca, 2020) who appears as a facilitator for the solution of the conflict, which, in turn, cannot bring embarrassment or cause intimidation to any of the parties so that the risks of new conflicts can be managed in the search for a conciliated solution, "limiting itself only to intermediate the dialogue between the interested parties, without presenting, in fact, a concrete proposal for the resolution of the dispute" (Santana & Santos, 2021, p. 1345). Silva & Paiva (2021, p. 10) "emphasizes that there is effective participation of the conciliator, in which he or she points out suggestions, value judgment about the object in question.

The application of Arbitration, also, has its advantages, since it is a restorative method that deals with the proposal of bringing peace to those involved in conflicts through "the decision of one or more people freely chosen and called arbitrators without the intervention of the Judiciary and with the same enforceability that a judicial decision would have" (Silva & Lima, 2020, p. 318). 318), being "based on the autonomy of will of the parties, who define the rules of procedure, the arbitrator, the seat of arbitration, among other aspects" (Paiva & Pauseiro, 2020, p. 7). By the prescriptive approach, it seems, it could be applied in the Mild or Moderate stages of Parental Alienation, where there would be an environment for the agreement of the choice of arbitrator. However, for the most severe stage of Parental Alienation, the method does not seem recommendable, since there would still be no possibility of dialogue between the parties involved for the choice of this arbitrator.

In the use of Peacebuilding Circles, according to Silva & Costa (2020, p. 2) "they offer relevant resources that make it possible to work on both prevention and resolution of conflict situations" to reach consensual norms of coexistence for all involved. Furthermore, it establishes a territory for those involved to feel safe to externalize their mistakes and seek

possible solutions, which can be a recommended Method for any stage of Parental Alienation. However, it is understood that it would have better application in Moderate and Severe situations. In a practical example, Gama, Tavares and Depietro (2019) point out the Parent-Child Workshops, as a practice already recommended by the National Council of Justice, currently called Parenting Workshops, which present a specific focus on the prevention of Parental Alienation

In the use of Restorative Circles "the scope of a circle varies according to the need that people have" (Silva & Costa, 2020, p. 7), through "effective tools for motivation and change of posture among those involved;" (Silva, Carvalho & Melo, 2021, p. 1), start from the premise that there is a balance of powers between spouses, from sessions focused on supporting conflict resolution with a focus on bringing unique experiences of the parties to reach an agreement of material or relational repair through measures that generate a great restorative dynamics of the multiple members (Barrios, 2020).

The practices of Systemic Constellation are characterized as a conflict resolution method still little used in cases of Parental Alienation, but its potential application is considerable for serious cases, since it involves the robustness of Systemic Law. Ferreira, Silva and Lasmar (2021, p. 51) bring that the Constellation "converged to the analysis the application of Systemic Law, as a possible solution to these cases", completing the idea of Rodrigues and Reis (2020, p. 3) that its application "guarantees the development of integrated solutions, increasing their effectiveness in the long term".

Within the above, it is concluded that the application of Restorative Methods is freely recommended for the light stage of Parental Alienation, where intrafamily conflicts are in formation, because Dambros (2019, p. 8) highlights that it is healthy "the possibility of anticipating the conflict, performing preventive actions." However, for cases of Moderate or Severe Alienation, bringing the topic to the Clinical Psychology Professional, the area of one of the Authors, the Author should keep in mind Lago's (2019, p. 156) recommendation of "careful assessment is key." Thus, defining the stage of Parental Alienation to technically opt for the application of the Restorative Conflict Resolution Method that best suits the case, breaking the paradigmatic model of the immediate application of Mediation, for the sake of promoting the best interest of the minors and the relationship between spouses and relatives. As a limitation of this article, and considering an opportunity for future research, we suggest expanding the research bases by means of selection in other scientific search engines, such as *Dialnet, Redalyc, SciELO, PsycNET, Pubmed, and Medline*, for a deeper perspective on the validity of this serious trend, even if in embryonic form, beyond the Brazilian environment.

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