ORIGINAL ARTICLE

FAMILY PROCESS

Toward a broader understanding of split alliances in family therapy: Adding the therapist to the mix

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Abstract

To broaden our understanding of a split alliance in family therapy, we investigated the frequencies and correlates of sessions in which therapists, youth, and caregivers reported markedly different perceptions of the alliance. The sample consisted of 156 Spanish families who received Alliance Empowerment Family Therapy (Escudero, *Adolescentes y familias en conflicto*, 2013) for child maltreatment. Family members and therapists rated the alliance on the SOFTA-s (Friedlander et al., *Journal of Counseling Psychology*, 2006, 53, 214) after sessions 3, 6, and 9; family members rated their perceptions of treatment progress before sessions 4, 7, and 10. A cluster analysis differentiated sessions with a *split adult-youth alliance* (27.7%) from a *split family-therapist alliance* (44.1%), and a *balanced alliance* (similar ratings across the three perspectives; 28.2%). Client-rated treatment progress was differentially associated with the type of alliance split and the average alliance rating, whereas better posttreatment outcomes (child functioning and family goal attainment) were associated with fewer sessions having either type of split alliance.

KEYWORDS
Therapeutic Alliance, Split Alliance, SOFTA, Child Maltreatment, Family Therapy Process

Since the working alliance in couple and family therapy was first described by Pinsof and Catherall (1986), one of its unique aspects has been amply investigated, the *split alliance*, which occurs when family members' alliances with the therapist are unbalanced, rated more strongly by one client than by another. Several studies have shown that split alliances are common occurrences (e.g., Heatherington & Friedlander, 1990), can be observed behaviorally (Friedlander et al., 2008, 2021; Muñiz de la Peña et al., 2012; Sotero et al., 2016), vary in timing and severity (Muñiz de la Peña et al., 2009), and tend to predict worse couple and family therapy outcomes (meta-analytic $r = .316$, $d = 0.666$; Friedlander et al., 2018).

These general findings explain little about the complexity of the phenomenon, however. The variability of split alliances was apparent in a study with two family therapy samples, one in the United States and one in Spain (Muñiz de la Peña et al., 2009). In both samples, adolescents' alliances with the therapist were stronger than those of their parents just as often as the parents' alliances exceeded those of their children. Moreover, split alliances worsened over time in some cases but improved in other cases, underscoring the need to understand their occurrence in more depth.

To advance knowledge on this topic, we investigated (a) how common it is for therapists' perspectives on the alliance to differ from those of family members, and (b) how split alliance sessions, assessed at three points in time, are associated with perceived therapeutic progress and posttreatment outcomes. We reasoned that without assessing the therapist's perspective on the alliance in relation to the perspectives of family members, a systemic understanding of this complex phenomenon is incomplete. Just as family members form an impression of their personal alliance with the therapist while comparing the therapist's responses to them with the therapist's responses to everyone else, therapists form an impression of their alliance with the family system by monitoring how each person is responding, how safe each person seems to feel in the therapeutic context, and how well family members are collaborating with one another on setting goals and carrying out the tasks of therapy. To the extent that perceptions of the alliance are consistent with in-session behavior, such as when an adolescent who feels alienated from the process refuses to participate in the discussion, each person's alliance can both influence and be influenced by the alliances of others—therapist and family members.

One way that therapists try to maintain a balanced alliance is by not elevating the importance of one family member's concerns over the concerns of other family members. This balancing act can falter, however, when the dynamics within a session shift, such as when one client starts blaming another client and the therapist challenges the blaming individual to protect the more vulnerable individual (cf. Escudero et al., 2012). Even in the absence of hostile conflict, a balanced alliance can become unbalanced when the therapist's empathic remark to one family member is seen as impartial by other family members (cf. Friedlander et al., 2021). If the therapist is unaware that everyone is experiencing the process as not helpful, the therapist's rating of the alliance might greatly exceed the ratings of all members of the family.

Despite the importance of comparing the therapist's view of the alliance to those of youth and caregivers, we located one family therapy study that did so (Welmers-van de Poll et al., 2020). Results showed that therapists' perceptions of the alliance were less congruent with the perceptions of adolescents than with those of their parents, particularly the mothers. The authors did not consider the congruence of alliance perceptions across perspectives (parent, child, therapist), however, or the association between alliance congruence and treatment outcomes.

With respect to outcome, several previous studies found that family sessions with more unbalanced alliances (operationalized as parent-rated alliance minus adolescent-rated alliance) predicted treatment noncompletion (e.g., Robbins et al., 2003). With respect to perceptions of therapeutic progress during conjoint treatment, we located two relevant studies: (a) in a study of family therapy, adolescents' and parents' alliance perceptions were positively associated with their ratings of improvement so far (Friedlander et al., 2012); and (b) in a study of couple therapy, alliance perceptions measured over time covaried with clients' perceptions of their

personal well-being (Kuhlman et al., 2013). Although split alliances were not the subject of either study, their results suggest that clients' perceptions of therapeutic progress can predict and be predicted by their perceptions of the working alliance.

To conduct the present study, we used an archival database of measures administered over the course of Alliance Empowerment Family Therapy (AEFT; Escudero, 2013, 2020), a manualized, team-based treatment developed specifically for child welfare-involved families. As the name implies, in AEFT building, balancing, and sustaining strong working alliances is of prime importance for leveraging change. The assumption is that for clients to take the behavioral and emotional risks necessary for systemic change, each family member needs to develop a strong personal bond with the therapist and feel safe in the therapeutic context.

In developing this approach, Escudero (2013) recognized that when an abused or neglected child comes to the attention of Child Protective Services (CPS) and the family is mandated to engage in therapy, it is common for parents to mistrust a therapist who represents governmental interference in their lives. Since the circumstances surrounding a CPS referral tend to be a source of shame, it is essential—albeit highly challenging—to foster a sense of collaboration.

Reflecting the challenge of treating child welfare referred families, a recent meta-analysis found that associations between alliance and outcome were weaker among involuntary families than among families seeking professional help on their own (Friedlander et al., 2018). When child neglect or abuse is present, therapist and parent might agree on the ultimate treatment goal (e.g., family reunification) but disagree about the nature of the problem (child maltreatment versus government interference) and/or the need for professional intervention. Although these kinds of polarized differences are common, some maltreating families readily accept therapeutic help when it is offered. As the therapy evolves, however, some members of the family may come to mistrust the process. In a case study of a single mother and child, for example, a previously strong and balanced alliance became split when the therapist confronted the mother about her harsh, unrelenting blame of her daughter (Escudero et al., 2012).

On the other hand, initially negative perceptions of the working alliance can improve over time in therapy. In a study of involuntary families (Sotero et al., 2016), for example, the weak alliances observed in the first session were largely attenuated by the fourth session, and in two studies with maltreating families, successful outcomes were achieved when the working alliance was strong (Bachler et al., 2016; Johnson & Ketring, 2006). In other words, when family members who enter therapy with reluctance begin to recognize its benefits, they are likely to feel more engaged, more connected with the therapist, and more collaborative with one another.

For this reason, a systemic understanding of the family therapy process requires an assessment of clients' and therapists' alliance perceptions at multiple time points in relation to family characteristics, intermediate and final treatment outcomes. In the present study, we hypothesized (a) a negative association between the occurrence of a split alliance session and clients' perceptions of the status of the problem and their improvement to date rated before the next session begins and (b) a negative association between more frequent split alliance sessions and posttreatment outcomes (youth functioning and attainment of family-specific goals).

Additionally, we explored associations between the frequency of split alliance sessions and three pre-therapy family characteristics: (a) the family's initial attitude toward the referral for therapy as judged by the CPS caseworker, (b) the length of time the family had been involved in the child welfare system (an index of chronicity), and (c) whether the family was in crisis. A negative attitude toward family therapy has previously been studied as *low treatment expectations* (Bachler et al., 2006) and *low readiness for change* (e.g., Skoranski et al., 2021). Although we located no studies on the initiation of family therapy while in crisis, AEFT therapists consider this risk factor to be negatively prognostic of alliance development with the vulnerable families in their care.

METHOD

Setting and participants

A sample of 156 Spanish families with complete CPS referral, process, and outcome data was randomly selected from an archival database maintained by six clinical teams affiliated with a government-funded university research center whose mission is to treat child welfare-involved families. On average, the 87 boys and 69 girls in the sample were $M = 14.03$ years of age ($SD = 2.71$, range 6–17). At the time of referral, 16% of these youth were temporarily in residential care with supervised family visits; the other youth were living with nonoffending family members (29.5%) or foster parents (27.6%). In all families, the caregiver who attended the family sessions was the mother, sister, aunt, or grandmother. (Since male parent figures either did not participate in the therapy or attended sessions infrequently, we did not use their data in the analyses).

In terms of pretreatment characteristics, at the point of referral the families had been monitored by CPS for $M = 30.79$ months ($SD = 42.85$; range 0–168), and 41% of families were identified by the CPS caseworker as being in crisis (defined as a child experiencing severe conflict or emotional dysregulation for 2 or more days). Across cases, the CPS caseworkers rated the families' initial attitude toward the referral as somewhat positive, $M = 1.61$ ($SD = 0.078$), where 1 = *positive or voluntary*, 2 = *accepting of the referral*, and 3 = *negative or involuntary*.

The 20 therapists in the sample (70% women; mean age = 39.40 years; $SD = 9.08$) worked in teams in six regional offices, one team per location. The majority (85%) were master's-level psychologists with an average of 12.8 years of experience ($SD = 7.22$). The therapists worked with an average of 7.88 families ($SD = 4.92$), range from 4 to 17.

The families attended $M = 11.04$ AEFT sessions ($SD = 3.29$; range 5–25), which began weekly and then were intentionally spaced out over an average of 8.31 months ($SD = 3.79$). Therapy ended when the individual and family goals were judged to have been achieved (71.8% of families), the family dropped out of treatment (10.9%), and the child was transferred to a residential facility at another location (5.8%) or referred elsewhere for special needs treatment (8.3%). In a recent evaluation of the effectiveness of AEFT with this sample (Escudero et al., 2021), results showed significant changes in youth functioning and family-specific goal attainment, as summarized below.

Alliance empowerment family therapy

The assumption underlying AEFT is that by fostering a trusting and caring relationship with each family member and the family as a unit, the therapeutic context can empower individual change and within-family attachments (Escudero, 2013). AEFT processes involves five inter-related tasks: (a) development of a strong working alliance with individuals, subsystems, and the family system as a whole; (b) assessment of family members' relationship problems, their individual perspectives on the problem, and their histories of attachment; (c) development of shared goals, arrived at by co-constructing a non-blaming perspective on the family's difficulties; (d) relationship change resulting from an integration of systemic family therapy techniques; and (e) a focus on the healthy individuation of family members. As the name of this approach implies, all five tasks require continuous monitoring of the strength of alliances with each client and the family system as a unit.

AEFT was developed and evaluated (Escudero et al., 2021) as a team intervention. While the primary therapist interacts with the family, up to five members of an observing team view the session on closed-circuit TV or one-way mirror. After roughly 50 min, the therapist takes a break to meet with the team members to develop a concluding intervention, such as

a suggestion for further reflection at home, a synopsis of the session, or a specific homework assignment. The therapist then returns to the family to deliver the team's recommendation.

This manualized approach (Escudero, 2013, 2020) requires at least 100 h of training. Adherence is enhanced by periodic meetings of all therapists at which time each team presents cases and receives supervision from the developers of the model.

Treatment outcomes

As reported in the previous AEFT effectiveness study (Escudero et al., 2021), we used two measures of outcome: (a) the 100-point Children's Global Assessment Scale (CGAS; Shaffer et al., 1983), which was adapted for youth from the adult Global Assessment Scale (Axis 5 in the *DSM III-R*; American Psychiatric Association, 1987); and (b) a 4-point modification of the Global Attainment Scale (GAS; Kiresuk & Sherman, 1968). Significant posttreatment improvement in youth functioning was found on the CGAS, $p = .000$, $d = 1.12$, with a Reliable Change Index (Jacobson et al., 1984) = 2.81 ($p < .05$) and mean scores (66.06; $SD = 16.63$), that approached the cutoff (70) for healthy child functioning (Dyrborg et al., 2000). Posttreatment GAS scores revealed moderately high attainment of the families' specific team-identified goals, $M = 3.05$, $SD = 0.99$, where 1 = *no improvement*, 2 = *partial but insufficient improvement*, 3 = *partial but clinically relevant improvement*, and 4 = *full attainment of goals*.

Process measures

System for observing family therapy alliances self-report

The SOFTA-s (Friedlander et al., 2006) is a self-report alliance measure developed specifically for couple and family therapy rather than adapted from individual therapy. Its 16 items reflect the classic view of alliance as a strong emotional bond and client/therapist agreement on therapy goals and tasks, along with items reflecting two unique aspects of conjoint therapy: a sense of safety in conjoint therapy with family members, and within-family collaboration.

In line with the SOFTA's multidimensional model, the measure has four subscales: Engagement in the Therapeutic Process (e.g., *What happens in therapy can solve our [this family's] problems*), Emotional Connection with the Therapist (e.g., *The therapist is [I am] doing everything possible to help me [this family]*), Safety within the Therapeutic System (e.g., *There are some topics that I am [the family members are] afraid to discuss in therapy*), and Shared Sense of Purpose within the Family (e.g., *Each of us [person in the family] helps the others get what they want out of therapy*). Clients are asked to rate each item on a 1 = *not at all* to 5 = *very much* scale in terms of their own experience of the alliance and how they view other family members experiencing the alliance. On parallel items, therapists report their experience of the alliance in relation to the family as a unit. After the negatively worded items are reverse scored, the raw scores are summed to arrive at a total score, range = 16 (low) to 80 (high).

The SOFTA-s was simultaneously developed in English and Spanish (Friedlander et al., 2006). In earlier studies, its scores were congruent with observational ratings of the alliance (e.g., Friedlander et al., 2008; Muñiz de la Peña et al., 2009), supporting the assumption that clients' in-session behavior reflects their experience of the alliance. In session 3 of the current study, internal consistency reliabilities (.85 youth, .83 caregivers, .91 therapists) were comparable to or exceeded those in previous reports (Alvarez et al., 2020; Friedlander et al., 2006).

Identification of split alliances

One methodological feature of the present analyses is notable. First, rather than either comparing participants' alliance scores to those of an entire sample or subtracting one participant's score from that of another participant, we used a clustering method (Hair et al., 2006) to identify unbalanced alliances. As critiqued by Edwards (2002), difference scores are problematic because this method omits information about the strength of the alliance. For example, a difference of 1 point when the child rates the alliance as "1" and the parent rates the alliance as "2" is equivalent to a difference of 1 when the respective ratings are 4 and 5. In other words, a 1-point difference when both participants see the alliance as weak is not the same as a 1-point difference when both participants see the alliance as strong. For this reason, we identified sessions with split alliances by accounting for both the level and pattern of the alliance ratings across perspectives (caregiver, youth and therapist), as did Kivlighan and Shaughnessy (2000) and Li et al. (2020) in studies of individual and group therapy respectively. This analysis is described in further detail in Results.

Measures of therapeutic progress

Before each session, youth and caregivers completed one-item measures of their perspective on the problem "today" on a scale from 1 = *worst possible* to 10 = *perfectly resolved*, and their "improvement from the start of therapy until today" on a scale from 1 = *not at all* to 5 = *a lot*. The improvement item is from Luborsky et al.'s (1996) Helping Alliance Questionnaire, and both measures were used in previous family therapy studies (Escudero et al., 2008; Friedlander et al., 2008, 2012). Although internal consistency reliability cannot be tested with a single item, the validity of these brief measures of problem status and improvement, which we chose for ease of administration in a practice setting, was supported by significant associations with observations of alliance-related behavior (Escudero et al., 2008; Friedlander et al., 2006, 2008) in previous family therapy research.

Procedure

Routine data collection was approved by the university's Ethics Commission. Upon referral to the regional team by CPS, the treatment team obtained the family's informed consent for participation in both the therapy and the research.

The SOFTA-s was completed by family members and the therapist following sessions 3, 6, and 9. Youth (aged 10+) and their primary caregivers provided responses to the one-item progress measures prior to each session. In terms of outcome, the youth's early CGAS score (before the third session) was determined consensually by the primary therapist, the other members of the treatment team, and the referring caseworker. Specifically, the therapist and other team members independently provided a CGAS score, after which any differences were negotiated to consensus. The score was then forwarded to the CPS caseworker, who either concurred with the rating or requested a meeting for further negotiation with the therapy team.

Also before the third session, the team and caseworker identified three family-specific treatment goals, such as "improve the consistency of parental discipline." Attainment of the family-specific goals was consensually rated by the team and the referring CPS caseworker when therapy ended.

RESULTS

Descriptive statistics, intercorrelations, and identification of sessions with split alliances

Table 1 shows the means, standard deviations, and intercorrelations of all session-level variables, which indicated moderate correlations among the three perspectives on the alliance, with higher average ratings by caregivers than by youth and therapists. As shown in the table, family members' average problem status and improvement ratings were also moderately high.

As described earlier, in contrast to previous methods of identifying split alliances, we accounted for both the level and pattern of alliance ratings (cf. Kivlighan & Shaughnessy, 2000; Li et al., 2020) by averaging the SOFTA-s ratings of youth, caregivers, and therapists for each session and then subtracting each person's score from the session average. The result of this centering was three deviation scores that effectively removed differences in alliance strength at the case level. Although we considered using a latent class analysis, that method requires the sessions to be independent of one another. Instead, we used the Ward clustering method, which uses ANOVA to maximize between-group variances and minimize within-group variances in the clusters (Hair et al., 2006) in the absence of assumptions about distributional properties.

Specifically, we followed the steps outlined by Hair et al. (2006) to determine the number of clusters in the final solution, that is, the number of different types of alliance sessions. To do so, we examined the agglomeration schedule (coefficients indicating how much information is lost when two clusters are combined), the size of each cluster, and the conceptual interpretability of and distinctiveness of each cluster.

After examining a range of solutions from 2 to 5 clusters, we accepted the 3-cluster solution as the most parsimonious and interpretable result because it (a) showed one of the largest "jumps" (i.e., difference between two adjacent coefficients) in the agglomeration coefficients; (b) had no small clusters that might indicate outliers; and (c) showed distinguishable and interpretable alliance ratings for each cluster. Figure 1 depicts the average deviation scores across participants for each of the three clusters; values on the vertical axis indicate scores above and below the average of the three (youth, caregiver, therapist) alliance ratings, where 0 = the average alliance rating.

Cluster 1, which we called *split family-therapist alliances*, included 86 sessions (44.1% of the sample) with above average alliance ratings by youth and caregivers and below average ratings

TABLE 1 Descriptive statistics and intercorrelations of the session-level variables averaged across sessions 3, 6, and 9

Variable	1	2	3	4	5	6	7
1. Youth alliance	—						
2. Caregiver alliance	0.38	—					
3. Therapist alliance	0.38	0.37	—				
4. Youth problem status	0.40	0.28	0.15	—			
5. Caregiver problem status	0.22	0.26	0.28	0.30	—		
6. Youth improvement so far	0.57	0.28	0.22	0.63	0.30	—	
7. Caregiver improvement so far	0.27	0.28	0.32	0.29	0.68	0.37	—
M	66.35	71.75	65.03	5.88	5.16	3.12	3.22
SD	9.43	6.41	8.71	1.77	1.65	1.14	1.04

Note: N = 156 families. Alliance = total score on the 16-item System for Observing Family Alliances self-report (SOFTA-s; Friedlander et al., 2006), possible range 16 (low)–80 (high). Problem status "today" was rated on a 10-point scale, from 1 (*worst possible*) to 10 (*perfectly resolved*); improvement so far was rated on a 5-point scale, from 1 (*not at all*) to 5 (*very much*).

by therapists. Cluster 2, which we called *balanced alliances*, had 55 sessions (28.2% of the total) with similar average ratings by youth, caregivers, and therapists. Cluster 3, called *split adult-youth alliances*, had 54 sessions (27.7% of the total) with below average youth ratings, above average caregiver ratings, and average therapist ratings.

We calculated the proportions of the three alliance types by session, which showed significant differences ($p < .005$; see Table 2). In session 3, split family-therapist alliances were more frequent (34% of the sample) than split adult-youth alliances (20%). By session 9, the percentages of both types of splits were substantially reduced (to 22% and 8%, respectively), with increases in the percentage of balanced alliances (from 46% to 70%).

Split alliances predicting client-rated therapeutic progress

Next, we assessed session-level outcomes (rated by youth and caregivers) at the dyadic level using the Common Fate Model (CFM; Lederman & Kenny, 2012), a sophisticated method for analyzing outcomes when the unit of interest is a dyad (Woody & Sadler, 2005). To our knowledge, this novel approach for understanding systemic dynamics (Lederman & Kenny, 2012) has only been used in two previous family therapy studies (Donarelli et al., 2019; Mitchell et al., 2015). The CFM is considered particularly apt for examining family treatments because the statistical model is closely aligned with the theoretical assumptions that (a) the family and therapeutic systems are more than the sum of their parts, and (b) when the therapist joins the family system, it is fundamentally changed to become a *therapeutic system*.

In our application of the CFM, alliance and session outcomes were latent variables representing the systemic alliance and systemic evaluation of session outcome, with the individual perceptions of family members and therapists as indicators of these two system constructs. In other words, the CFM treated the individual perceptions of youth, caregivers, and therapists as arising from an overarching system alliance and system evaluation of session outcomes.
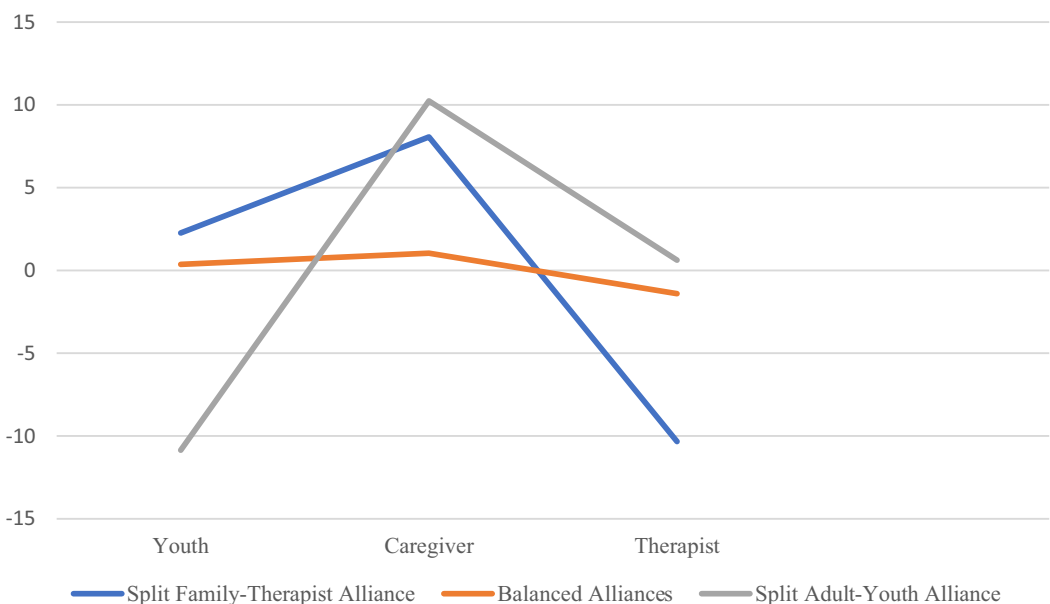
FIGURE 1 Alliance types. *Note.* Depicted are the average deviation scores for youth, caregivers, and therapists resulting from the cluster analysis [Colorfigure can be viewed at wileyonlinelibrary.com]

TABLE 2 Proportions of split and balanced alliances across sessions

Alliance cluster	Session 3	Session 6	Session 9
Split adult-youth alliance	.20	.15	.08
Split family-therapist alliance	.34	.20	.22
Balanced alliance	.46	.65	.70

Note: $\chi^2(2) = 14.911$, $p > .005$.

To conduct the CFM analysis of session-level (intermediate) outcomes, we averaged the youth and caregiver Problem Status and Improvement ratings to create Youth ($\alpha = .70$) and Caregiver ($\alpha = .72$) Progress variables. These two variables were used as indicators of a latent Family Progress variable.

In this analysis, we tested associations between two dummy variables, Split Adult-Youth Alliances and Split Family-Therapist Alliances (with Balanced Alliances as the reference group), Average Alliance (the mean of youth, caregiver, and therapist ratings within each session), and the latent Family Progress variable. We also examined interactions between each dummy variable and Average Alliance. To address the nesting of sessions within families and families within therapists, we followed the suggestion of McNeish et al. (2017) and used the COMPLEX option in MPLUS to estimate cluster robust-standard errors.

Three fit indices were used to evaluate the fit of the model: the comparative fit index (CFI), root mean square error of approximation (RMSEA), and standardized root mean square residual (SRMR). According to recommendations by Hu and Bentler (1995), criteria for acceptable fit have range from CFI ≥.90 and RMSEA and SRMR ≤.10 to more conservative criteria of CFI ≥.95, SRMR ≤.08, and RMSEA ≤.06.

The model had an adequate fit ($\chi^2 = 29.49$, $df = 10$, $p = .001$, CFI = .93, RMSEA [90% CI] = .058 [.041, .089], SRMR = .048. The two types of split alliance sessions and the average alliance accounted for 59% of the variance in therapeutic progress ($p < .001$).

As seen in Table 3, youth ratings of therapeutic progress (.72, $t = 9.97$, $p < .001$) and caregiver ratings of therapeutic progress (.48, $t = 4.47$, $p < .001$) loaded significantly on the Family Progress latent variable.

In terms of uniquely significant results, the Split Adult-Youth Alliance dummy variable was negatively related to the latent Family Progress variable ($-.31$, $t = -2.10$, $p = .036$), whereas Average Alliance was positively related (.47, $t = 3.14$, $p = .002$) to Family Progress. The interaction was not significant. These results mean that when there was a split alliance between youth and caregiver in a session, both the youth and caregiver rated their progress lower at the beginning of the following session.

In contrast, the Split Family-Therapist Alliance dummy variable was not associated with Family Progress (.02, $t = 0.14$, $p = .890$). However, there was a significant interaction effect (.36, $t = 3.74$, $p < .001$), the form of which is displayed in Figure 2. A simple slopes analysis showed that when the Average Alliance was low (1 *SD* below the mean), sessions with a Split Family-Therapist Alliance were followed by *lower* Family Progress scores in the following session (simple slope = $-.69$, $t = -2.31$, $p = .022$). However, when the Average Alliance was high (1 *SD* above the mean), sessions with Split Family-Therapist Alliances were followed by *higher* Family Progress scores (simple slope = .74, $t = 2.37$, $p = .019$). In other words, Split Family-Therapist Alliances were associated with *more* therapeutic progress at the session level when the average alliance for the session was high but *less* progress when the average alliance was low.
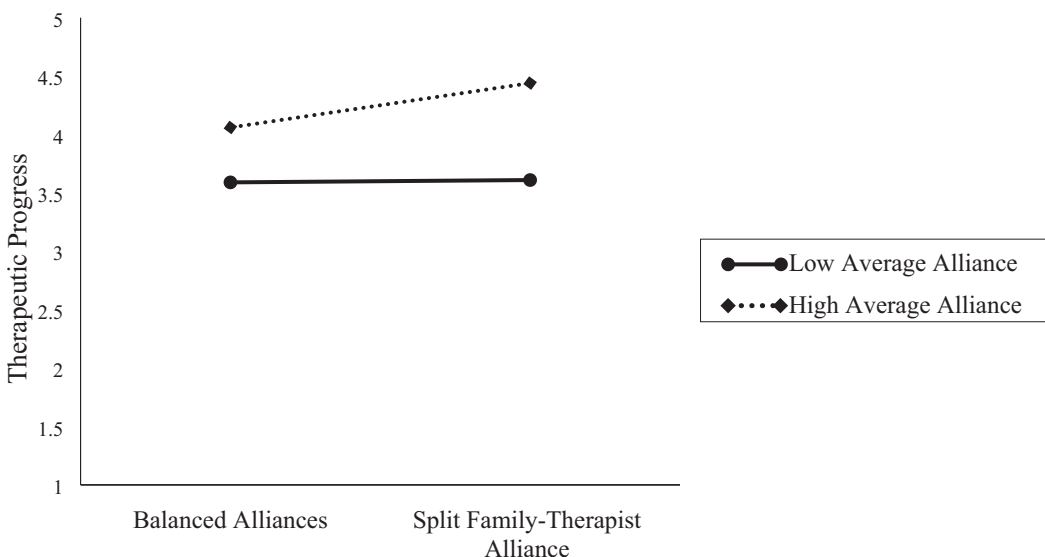
Alliances predicting posttreatment outcome

In the first step of this analysis, the latent Posttreatment Outcome variable (composed of Goal Attainment and posttest CGAS scores) was predicted by the Overall Alliance score (Average Alliance aggregated across sessions 3, 6, and 9) and the percentages of sessions with Split Adult-Youth Alliances and Split Family-Therapist, controlling for Treatment Length and early CGAS scores. In a second step, we examined interactions between Overall Alliance and the percentages of each type of split alliance. The nesting of families within therapists was addressed using the COMPLEX option in MPLUS (cf. McNeish et al., 2017).

The model had an adequate fit ($\chi^2 = 9.48$, $df = 4$, $p = .050$, CFI = .937, RMSEA [90% CI] = .126 [.00, .232], SRMR = .049. The standardized coefficients indicated that posttreatment CGAS (.93, $t = 25.41$, $p < .001$) and Goal Attainment scores (.69, $t = 9.64$, $p < .001$) loaded significantly on Posttreatment Outcome. The two control variables, early CGAS (.49, $t = 4.82$, $p < .001$) and

TABLE 3 Split alliance type, average alliance, and their interactions predicting latent therapeutic progress

Model	Estimate	SE	t	p
Therapeutic progress by				
Youth-rated progress	.72	.07	9.97	<.001
Caregiver-rated progress	.48	.11	4.47	<.001
Therapeutic progress on				
Split adult-youth alliance	−.31	.15	−2.10	.036
Split family-therapist alliance	.02	.11	0.14	.890
Average alliance	.47	.15	3.14	.002
Split adult-youth alliance × average alliance	−.14	.17	−0.84	.403
Split family-therapist alliance × average alliance	.36	.10	3.74	<.001

Note: Progress = clients' ratings of problem status and improvement so far. Average Alliance = mean alliance rating of the youth, caregiver, and therapist within each session.

FIGURE 2 Interaction of split alliance type and average alliance predicting therapeutic progress

Treatment Length (.24, t = 2.21, p = .027), were also related to Posttreatment Outcome, indicating better outcomes for families staying in therapy longer and for those whose youth were rated as having better functioning at the start of therapy (see Table 4). The full set of predictor variables accounted for 51% of the variance in Posttreatment Outcome (p < .001).

As shown in Table 4, Overall Alliance (.15, t = 2.91, p = .004) was uniquely related to the latent Posttreatment Outcome variable, indicating that families with a stronger alliance (averaged across perspectives and sessions) had more positive outcomes. The percentages of Split Adult-Youth Alliance sessions (−.20, t = −2.45, p = .014) and Split Family-Therapist Alliance sessions (−.17, t = −3.14, p = .002) were also significant, supporting our hypothesis that families with better posttreatment outcomes had significantly fewer of both types of split alliance sessions. Inclusion of the interactions between each of the split alliance variables and the overall alliance score did not improve model fit and therefore did not predict outcome.

Exploratory analyses with family characteristics

The percent of sessions with Split Adult-Youth Alliances, and percent of sessions with Split Family-Therapist Alliances and the Overall Alliance (averaged across perspectives and sessions) were predicted by the following pre-therapy characteristics: Family Attitude toward treatment at referral, months of involvement with CPS, and Family Crisis (yes or no). Similar to the above analyses, we used the COMPLEX option in MPLUS to estimate cluster robuststandard errors. Fit indices are not reported because the model is saturated.

As shown in Table 5, the three family characteristic factors accounted for 18% of the variance in the percent of sessions with Split Adult-Youth Alliances (t = 1.42, p = .157), 13% of the variance in the percent of sessions with Split Family-Therapist Alliances (t = 2.46, p = .011), and 9% of the variance in Overall Alliances (t = 2.20, p = .028). As seen in the table, Family Attitude was uniquely related to (a) the percent of sessions with Split Adult-Youth Alliances (.42, t = 2.68, p = .007) and (b) overall Alliance (−.29, t = −4.08, p < .001). Since higher Family Attitude scores indicated a worse attitude, these results mean that families rated as having worse pretreatment attitudes had more sessions with Split Adult-Youth Alliances and reported weaker alliances overall. Additionally, Family Crisis was uniquely related to the percent of sessions with Split Family-Therapist Alliances (.33, t = 3.14, p = .002), meaning that families entering therapy in crisis had more sessions with split family-therapist alliances.

TABLE 4 Percentages of split alliance sessions and overall alliance predicting latent posttreatment outcome

Model	Estimate	SE	t	p
Step 1: Posttreatment outcome by				
Posttest CGAS	.98	.04	25.41	<.001
Goal attainment	.69	.07	9.64	<.001
Step 2: Posttreatment outcome by				
Early CGAS	.49	.10	4.82	<.001
Treatment length	.24	.11	2.21	.027
Overall alliance	.15	.05	2.91	.004
% Of split adult-youth alliance sessions	−.20	.08	−2.45	.014
% Of split family-therapist alliance sessions	−.17	.06	−3.14	.002

Note: CGAS = Child Global Assessment Scale (Dyrborg et al., 2000). Overall alliance = Alliance ratings of youth, caregivers, and therapists averaged across sessions 3, 6, and 9.

TABLE 5 Family characteristics predicting percentages of split alliance sessions and overall alliance

Model	Estimate	SE	t	p
% Of sessions with split adult-youth alliances on				
Family attitude	.42	.16	2.68	.007
Months of CPS involvement	.08	.11	0.68	.499
Family in crisis	−.07	.05	−1.37	.172
% Of sessions with split family-therapist alliances on				
Family attitude	−.03	.14	−0.25	.805
Months of CPS involvement	−.16	.10	−1.61	.107
Family in crisis	.33	.11	3.14	.002
Overall alliance on				
Family attitude	−.29	.07	−4.08	<.001
Months of CPS involvement	−.06	.13	−0.43	.667
Family in crisis	−.07	.09	−0.70	.485

Note: Family attitude (toward therapy at the time of referral): 1 = *positive/voluntary*, 2 = *accepting of the referral*, 3 = *negative/involuntary*.

Abbreviation: CPS, Child Protective Services.

DISCUSSION

The objective of the present study was to investigate associations between AEFT outcomes and the occurrence and frequency of sessions with notably discrepant perceptions of the alliance. In terms of posttreatment outcomes (improved youth functioning and family-specific goal attainment), results were consistent with our hypothesis in that families with better outcomes had fewer sessions with a split alliance; the full model accounted for 51% of the variance. These results echo the meta-analytic finding that unbalanced alliances were associated with less treatment effectiveness (Friedlander et al., 2018).

Conceptually and methodologically, the study's design broadened our knowledge of the incidence and correlates of split alliances in family therapy. First, by "adding the therapist to the mix," we were able to consider split and balanced alliances across three perspectives: therapist, youth, and caregiver. Since therapists work with multiple families, their perspective on the alliance with any one family provides an understanding of split and balanced alliances not considered in other investigations.

Second, our method for identifying split alliances was unique in the couple and family literature. Rather than subtracting one alliance score from another (e.g., Robbins et al., 2003) or comparing clients' alliance scores to those of other clients in the sample (e.g., Friedlander et al., 2021; Heatherington & Friedlander, 1990), we used a clustering method that was not sample dependent. With sessions nested within families and families within therapists, we found three clusters of alliance scores that distinguished sessions with a balanced alliance (similar alliance ratings across the three perspectives) from two types of split alliances: (a) *adult-youth* splits, in which the ratings of caregivers were notably lower than those of youth, and (b) *family-therapist* splits, in which the above average alliance ratings of caregivers and youth exceeded those of therapists.

Third, rather than using a measure developed for individual psychotherapy, we used the SOFTA-s (Friedlander et al., 2006) to identify alliance splits. This measure, which reflects the systemic aspects of alliances in family therapy, asks clients to report on their personal experience of the alliance and their perceptions of working collaboratively with other family members; on parallel items, therapists are asked to report on their alliance with the family as

a system. Results showed that the therapists' alliance ratings were aligned with those of family members in 28.2% of sessions, indicating that in these sessions, the therapists' perceptions were similar in strength to those of both clients. In the 27.7% of sessions in which the therapist's ratings were midway between those of the youth and caregiver, it seems that the therapists accurately perceived the marked imbalance in family members' alliance perceptions. It seems possible that the decrease over time in split alliance sessions (Table 2) might be due to the therapists' efforts to re-balance the alliance, a strategy inherent in the AEFT treatment model.

Fourth, we investigated alliance perceptions rated at the conclusion of sessions 3, 6, and 9 in relation to how family members perceived their therapeutic progress at the start of the next session (i.e., sessions 4, 7, and 10). Notably, although most session 3 alliances were split (54% of the sample), by session 9 this percentage was reduced to 30%, suggesting a successful re-balancing over time. The session-level results showed that the two types of alliance splits and the level of alliance averaged across perspectives predicted 59% of the variance in client-rated therapeutic progress. The specific findings were nuanced: Whereas more perceived progress was associated with higher average alliance ratings, less progress was associated with sessions having a split adult-youth alliance (compared to a balanced alliance). With respect to split alliances between the two family members and the therapist, a significant interaction was found: When clients reported more progress, the average alliance for the session was high, but when the average alliance was low, less progress was reported in the following session.

A fifth feature of the present study was our investigation of some pre-therapy family characteristics in relation to percentages of split alliance sessions. As hypothesized, the three characteristics accounted for substantial proportions of variance (9%–13%) in the occurrence of split alliance sessions. Specifically, proportionately more family-therapist splits (which were more frequent than adult-youth splits in session 3) occurred when the family entered treatment in crisis, and more adult-youth alliance splits occurred when the family had a worse attitude toward therapy upon referral by CPS. Notably, months of CPS involvement, an index of chronic child maltreatment, contributed to the overall model but was not uniquely associated with either type of alliance split.

The latter findings have several practical implications. First, since more negative attitudes toward therapy were associated with more alliance splits in which caregiver ratings exceeded those of children, therapists may need to work especially hard with maltreated youth to achieve a balanced within-family alliance. Second, since we found that when in crisis, family members' perceptions of the alliance notably exceeded those of their therapists, therapists should recognize that an urgent need for help may dampen their own view of the alliance more so than the views of the family members and that families remaining in AEFT longer had better overall outcomes.

Our results also point to the importance of the alliance repair process, which is likely to differ depending not only on the nature of the issues at hand but also on whether the rupture is located in (a) the therapist's alliance with one member of the family, (b) the therapist's differing alliances with two (or more) family members, (c) the therapist's alliance with the family as a unit, or (d) within the family system itself apart from the therapist.

Behavioral indicators of split alliances include a low level of engagement on the part of one or more family members (cf. Higham et al., 2012) or intense cross-complaining, defensiveness, and blame between partners or family members (cf. Friedlander et al., 2008; Lambert et al., 2012). Although the repair of an alliance rupture differs depending on the type and timing of a rupture and on the unique characteristics of the clients and their family dynamics, several case studies (e.g., Benítez et al., 2019; Blow et al., 2009; Escudero et al., 2012; Heatherington et al., 2018; Muntigl & Horvath, 2016) suggest that a successful repair process requires the therapist to enhance the emotional bond with each client, attend to everyone's safety, and intentionally foster family members' attachments with one another.

To do so, the therapist can create specific client-focused interventions, even dividing a session to speak privately with a client whose alliance seems weak. In our view, it is important to avoid giving clients the impression "choosing sides," which likely could strain or rupture the alliance with one or all members of the family. We recommend that therapists forestall the risk of a split alliance at the beginning of therapy or any time the risk arises, by describing the therapeutic process in a way that promotes family collaboration and minimizes divisiveness.

In terms of the present study's limitations, although the client-rated progress measures provided important information about intermediate outcomes, we did not collect outcome data from the perspective of family members. Additionally, we lacked sufficient alliance and progress data from male parent figures to reliably include their perspective in the analysis. In this treatment protocol, whose mission is to treat child abuse and neglect, men rarely participate in the therapy due either to being incarcerated, having left the family, or not being permitted to see their children. In future research, it would be important to sample families with two consistently involved parent figures to further our understanding of balanced versus split alliances in relation to outcome.

As additional suggestions for future study with a larger sample, we suggest testing (a) whether pre-therapy family characteristics moderate the relation between percentage of split alliance sessions and therapeutic effectiveness and (b) whether the re-balancing or repair of severely split alliances might be predictive of posttreatment outcomes. Additionally, it would be of interest to investigate the assumption in AEFT that balanced alliances promote stronger within-family attachments.

Finally, we consider some of our findings to be particularly informative: Despite the critical importance of closely monitoring the working alliance when working with maltreating families, we found that in most sessions with an alliance split, particularly the early ones, the therapists rated the alliance more negatively than did the family members, especially the caregiver. Moreover, a large discrepancy between the perceptions of therapist and family members was only related to client-rated therapeutic progress when the alliance was weak, and the percentage of this type of alliance split in session 3 (34%) was substantially reduced by session 9 (to 22%). In practical terms, a discrepancy in the alliance perceptions of therapist and family members may not ultimately be damaging when the alliance is viewed favorably, or at least not unfavorably, and when the family remains in treatment for five or six more sessions.

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