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La alianza terapéutica en tensión: una aproximación a partir de la práctica clínica del trabajo social

The therapeutic alliance in tension: an approach from the clinical practice of social work

Ximena de-Toro Consuagra[1, 2*] **& Dariela Sharim Kovalskys**
[1] Pontificia Universidad Católica de Chile, Escuela de Psicología, Chile;
[2]Universidad Autónoma de Chile, Chile

Abstract:
Evidence has demonstrated that the therapeutic alliance and the repair of alliance ruptures are related to positive psychotherapeutic results. However, this has been less frequently studied in other helping relationships, in family interventions, and in mandatory interventions. This article aims to analyze the tensions within the therapeutic alliance between caregivers** and social workers from the Chilean child protection system. Ours is a longitudinal study that followed six social worker–caregiver dyads for 11 months. Techniques such as observation, in-depth interviews, and session-by-session interviews were carried out, followed by content analysis. The main results are: the therapeutic alliance is subject to tensions when there is a questioning of the parental abilities; asymmetry of power and the threat that the children may be taken from the house. These tensions affect the caregiver's trust in the social worker; thus managing and understanding the tensions make it possible to strengthen the relationship. Some strategies are reinforcing the clinical space as a safe space and developing a collaborative dynamic. This article discusses how tensions are associated with the family, social worker, methodology, and child protection system. Future lines of research to observe, analyze, and strengthen the therapeutic alliance are proposed.

* *Para Correspondencia: Ximena de Toro, Mail: xldetoro@uc.cl
Estudiante de Doctorado, Pontificia Universidad Católica de Chile (PUC), Escuela de Psicología, Santiago, Chile. Beca: Doctorado Nacional ANID 2019, Folio: 21190814

Resumen

La evidencia ha demostrado que la alianza terapéutica y la reparación de rupturas están relacionadas con resultados positivos en psicoterapia. Sin embargo, dichos procesos han sido menos estudiados en otras relaciones de ayuda, en intervenciones familiares y en aquellas de carácter obligatorio. Este artículo tiene como objetivo analizar las tensiones dentro de la alianza terapéutica entre cuidadores/familiares y trabajadores/as sociales del sistema de protección a la infancia en Chile. Se trata de un estudio longitudinal que siguió a seis diadas de trabajadores/as sociales y cuidadores/as durante 11 meses con técnicas como la observación, entrevistas en profundidad y entrevistas sesión a sesión, seguidas de un análisis de contenido. Los principales resultados son: la alianza terapéutica está sujeta a tensiones cuando hay un cuestionamiento de las capacidades parentales, una asimetría de poder y la amenaza de que los niños/as sean llevados a una residencia. Estas tensiones afectan la confianza del cuidador/a en el trabajador/a social, por lo que el manejo y comprensión de las tensiones es necesario para fortalecer la relación. Algunas estrategias incluyen reforzar el espacio clínico como un espacio seguro y desarrollar una dinámica colaborativa. Este artículo discute cómo las tensiones se asocian con factores vinculados a la familia, el trabajador social, la metodología y el sistema de protección. Se proponen futuras líneas de investigación para observar, analizar y fortalecer la alianza terapéutica.

Introduction

Although the clinical practice of social workers has been historically present, less research has been conducted on therapeutic processes that lead to transforming subjective experiences. For example, the therapeutic alliance and the repair of ruptures have been well-studied in psychotherapy, but they have received less attention in other helping relationships (Escudero & Friedlander, 2017; Flückiger, del Re, Wampold, & Horvath, 2018; Krause, Altimir, & Horvath, 2011; Safran, Muran, & Eubanks-Carter, 2011), such as social work practice, which has, in turn, led to less practical knowledge about how to facilitate change processes in individuals and families. Here, change is understood not as an end but in a relational way—as a process associated with resignifications of the patient's self and a change in the intersubjective space (Szmulewicz, 2013).

Therapeutic alliance and therapeutic ruptures

The therapeutic alliance is considered an indicator of the quality of an effective and collaborative bond between a therapist and a patient, as well as a way of working together productively in psychotherapy (A. Horvath, 2018; Krause et al., 2011). To Bordin (1979), it is a construct composed of three elements: First, it is a positive bond that includes aspects such as trust, concern, and commitment. Second, it is an agreement about objectives or the

extent to which a patient perceives a joint collaboration on problems for which they ask for support. The third element is an agreement in relation to tasks or to what extent a patient feels comfortable with tasks or that they meet their expectations.

Safran and Muran (2005) define an alliance as a negotiation instead of a collaboration since it is not a static variable but an emergent property that is in constant change and has yet to be solidified. For the authors, this process of continuous negotiation at conscious and unconscious levels is an important driver of change, as it helps to develop a greater capacity for intersubjective encounters through recognition of oneself and others. Following Bordin's construct, a therapeutic alliance is a negotiation of therapeutic tasks and goals between two different subjectivities, not only to reach a consensus but also in relation to more fundamental dilemmas of human existence.

Additionally, Safran and colleagues (Safran & Kraus, 2014; Safran & Muran, 2005; Safran et al., 2011) emphasize therapeutic ruptures, which they define as periods of tension or breakdown either in the collaboration or the communication between a therapist and a patient. Their resolution is associated with a strengthening of the alliance and the achievement of positive results in therapy. If those ruptures are not adequately resolved, however, they could result in the abandonment of therapy or unfavorable results, which would reflect patients' difficulties in developing an authentic relationship. In this context, patients' learning to negotiate their own needs versus the needs of others is a critical task. The authors distinguish two types of ruptures: a) confrontation ruptures, in which the patient explicitly and directly confronts the therapist with their concerns and complaints in relation to the therapist personally, their competencies, or the relationship itself; and b) withdrawal ruptures, in which there is no direct expression of dissatisfaction, but rather an implicit distancing from communication with the therapist by giving minimal responses, denying aspects of communication, or other means. The authors also distinguish ruptures in relation to the three elements indicated by Bordin. According to Aspland et al. (2008), for an adequate resolution of a rupture, the therapist should: a) recognize the rupture and seek the patient's feedback, b) explore and validate the patient's experience of the rupture, c) explore similarities with other scenarios outside of therapy, and d) co-create courses of action or define new tasks. By introducing the concepts of alliance and rupture, the focus is on the process through which change is obtained instead of on the question of whether an intervention model works (Steens et al., 2018).

Alliance and ruptures beyond psychotherapy

Scholars have highlighted that the association between a positive alliance and increased benefits of treatment not only makes sense in individual psychotherapy with adults but also in other treatment modalities (Escudero & Friedlander, 2017; A. Horvath, 2018). For Bordin (1979), the alliance is generic to all therapies, and the only difference lies in the tasks and goals. Research on alliances has been extended to use with children, groups, couples, and families, as well as in various contexts, such as doctor–patient relationships or with social workers, who may or may not have specific training in psychotherapy (Cheng & Lo, 2019; Steens et al., 2018). However, alliances and ruptures have not been widely researched among social workers or in family intervention or child protection services, although there is general agreement on their relevance to those contexts (Escudero & Friedlander, 2017; Killian, Forrester, Westlake, & Antonopoulou, 2017; Muntigl & Horvath, 2016; Rait, 2000). This is because professionals often encounter bonding difficulties or misinterpret some resistance to services as family animosity, which can lead to perceptions that communication with social workers is negative, weakening the alliance and satisfaction with the service.

Regarding the practice of social workers in the Chilean child protection system, it is worth distinguishing another concept: the parental therapeutic alliance. This concept describes a collaborative alliance with caregivers during treatment that seeks to strengthen children's psychosocial development (de Greef, Pijnenburg, van Hattum, McLeod, & Scholte, 2017). Scholars agree that parents and caregivers play an important role in children's treatment; however, the few existing studies on parental alliances have mainly focused on parental alliances with the child's therapist rather than with a different therapist in the same program or with an intervention team (Kazdin & Whitley, 2006). To Accurso et al. (2013), regardless of the modality (family therapy or child-focused therapy), the parental alliance warrants further study using instruments other than those used in individual therapy, which do not adequately measure the construct.

Considering just a single therapist when evaluating an alliance does not reflect the complexity of treatments in which there is a multidisciplinary team involved, as is the case in the Chilean protection setting, where social workers intervene with families. Hence, the literature suggests investigating what happens when the caregiver is seen by a therapist other than the child's therapist (Kazdin & Whitley, 2006; Lamers et al., 2015).

Steens et al. (2018) have emphasized that with the intervention of social workers in protection systems, there is a constant tension between meeting the expectations of the organization and connecting with the families, which hinders the alliance and the processes of change. An example is the requirement that social workers inform the courts about compliance with the intervention, which can affect the pillars of the therapeutic process, such as trust and confidentiality. This highlights the importance of reflecting on non-

voluntary interventions and institutional factors, seeking to clarify how these clients are identified or characterized by therapists (Relvas & Sotero, 2014), and understanding whether this interferes with the consolidation of a working alliance.

What is described here is consistent with the predictors of parental alliances investigated by de Greef et al. (2018) for interventions with home visits. In that study, parents who reported having previous experiences in similar family care services demonstrated lower levels of parental alliance. Favorable expectations related to the process and its results were associated with a better parental alliance throughout the intervention. However, contrary to predictions, the high expectations of caregivers were not related to the high expectations of professionals. Because this finding may be the result of unrealistic levels of parental expectations, qualitative studies may illuminate how expectations of care are related to alliances over the course of that care. Taking this into account, this article aims to identify and analyze the tensions that occur in the parental therapeutic alliance between social workers and caregivers in the protection system, as well as the related coping strategies.

Methodology

This investigation utilizes a qualitative and longitudinal multiple-case design, which involves a systematic and intensive examination of specific cases over time by collecting in-depth data from multiple sources of information, yielding a detailed description of the subject matter (Creswell, 2014). Each "case" is understood as the social worker–caregiver dyad (where the caregiver is typically a child's family member). The procedures used in this research are conceptually similar to constructivism, which suggests using qualitative research methods to describe and understand the phenomenon's complexity based on the participants' subjective perspectives.

Participants

The sample selection is based on criteria described by Flick (2007). First, it is a convenience sampling because the fieldwork was carried out in the institution with which the researcher could sign a collaboration agreement that met the requirement of an institution implementing programs of the Chilean protection system. In both programs, children and caregivers derived from the Family Court are cared for collaboratively—the social workers are tasked with working with the adults, and the psychologist works with the children.

The main researcher used complete sampling strategy to select the social workers (all the social workers from the institution with which the contact was made and who were willing to participate in the study). For selecting caregivers, the criterion of typical cases was used: cases in which success or failure are really characteristic for the average or the

majority of cases (Flick, 2007). Only the intervention time within each program was applied as a selection criterion (two dyads at the beginning of intervention, two dyads with four months of intervention, and two with eight months of intervention), applying a randomness criterion among those with the same intervention time. This method was chosen because the study seeks to analyze dyads that interact at different times, and this method allows the research to cover a greater amount of time to understand the trajectories of the alliance better. The exclusion criteria comprised a decreased capacity to consent due to mental disability or being under 18. From the above criteria, six female caregivers (three mothers, a maternal grandmother, an aunt-in-law, and an informal caregiver), five female social workers, and one male were selected.

Procedures

All participants were asked for their informed consent. Due to the restrictions of the pandemic, the procedures and data collection techniques were primarily conducted online or by telephone.

The study is part of the doctoral thesis in Psychology of the main author and has the ethical approval of the Pontificia Universidad Católica de Chile (ID: 210401002). All the implications of doing qualitative research during a pandemic were the focus of a study group with other doctoral students during the first semester of the pandemic. The results of said study group (including ethical implications in times of covid 19) were systematized and published and were a guide for the development of this remote research (Cornejo, Bustamante, Del Río, De Toro, & Latorre, 2023)

Techniques

A combination of different methods was carried out over 11 months, accompanied by a process of continuous reflexivity by the researcher from the beginning of the investigation. The techniques included a) A field notebook; b) Observation of a session of the dyad (6 observations in total); c) Two in-depth interviews for each participant separated by five months (12 interviews with caregivers and 12 interviews with social workers, 24 interviews in total); d) Weekly or fortnightly session-by-session telephone interviews after the meetings of the day (approximately 2 monthly contacts for each participant, 240 contacts in total); e) A closure space with each participant to assess to what extent the researcher's initial interpretations fit the experiences lived by the participants, which is consistent with Lincoln and Guba(1985), to whom the goal of constructivist research is to reach a consensus on the issues that define the object to be investigated (12 interviews in total); f) Review of court reports (six family files); g) Discussion group of initial results with three participating social workers. For each technique, there was a semi-structured guideline.

Data analysis

This research applied the thematic information analysis technique. This method aims to identify, analyze, and report patterns from the data, exploring the congruences and inconsistencies among the participants (Braun & Clarke, 2006).

Results

Next, the main tensions throughout the parental therapeutic alliance between social workers and caregivers are described, including an examination of tensions within the relationship dyad, tensions between family members, and tensions with other professionals. Different strategies are distinguished for resolving tensions, showing that a counterproductive effect is produced when the professional's position of power is reinforced.

Tensions at the beginning of the therapeutic relationship

A tense beginning

Although professional help is often expected and sometimes viewed as a positive opportunity, for most caregivers, it involves an intervention required by the family courts that generates fear, uncertainty, and anxiety about possibly losing the care of their children.

"At first, I felt uncomfortable. I didn't talk as much because I was still afraid that they were going to take the girl away from me forever." (Caregiver 1)

Several factors affect caregivers' sense of security and trust in the social worker. These include the traumatic experience leading to the origination of the legal case, negative experiences with other professionals in the system (especially those on the front line or those who initiated the case), and the stigma associated with the protection system.

"It was (…) traumatizing because I didn't know if they were going to give me my son (…) at the hospital. They treated me like [I was] crazy, like ignorant." (Caregiver 4)

In this way, the therapeutic space can be viewed as a nuisance or a battle to be won, with the social worker perceived as part of a system:

"The goals are to recover and be able to win the battle I'm going through, win the fight and fully recover custody of my children." (Caregiver 4)

The mandatory nature of the process also generates contradictions for professionals because they must insist on conducting the interventions even if the caregiver does not want to:

"I am convinced—and perhaps for this reason, suddenly I have these conflicts with this job—that no one can be forced to reflect on your parenting role (...) I feel super conflicted because it's like persecuting the [caregiver] because of the record that I have to make of the intervention." (Social Worker 5)

Loss of control

Tension expressed by professionals and family members is often related to the consequences of the loss of personal care for children or the loss of control over decisions at the family level due to the protection measure:

"At the beginning, it was very difficult for her to let me do my job; it was too difficult for her to understand that she had lost personal care, so the relationship that she established with me and with everyone, I would say, was rather trying to be a manager." (Social Worker 6)

Given that the caregiver cannot refuse to receive support without a judicial sanction and that they must request specific permissions from the protection program or the family courts, perceptions such as feeling threatened, invaded, or helpless can arise:

"That strange people come to the house, that they enter one's life is, like, strong. You have a person in front of your house, and you have to let them in because there is a paper from the court that says so; it is all strong and invasive." (Caregiver 2)

Tensions during the evaluation phase

Non-confidential nature

The requirement that the social workers periodically inform the family courts of the progress being made often causes concern in the caregivers, who point out that they do not know the content that will be reported in advance, which exacerbates their uncertainty, fear, and mistrust. This is evidenced by indicators such as hiding information, lying, not showing weaknesses, submission, or responding in socially desirable ways to appear competent:

"[Caregiver] told me a friend had told her that you should never tell the professionals everything, you had to lie to them, and that way everything would be fine." (Social Worker 3)

Additionally, the professional's mediating role in the judicial system can generate tension when the contempt of a judicial measure or a situation threatening a child's well-being must be reported.

Extension and predominance of the investigative role

In addition to their helping role, social workers must assume a necessary control and investigative role to prevent new violations. This additional role can create tension when it becomes predominant, and caregivers feel that they are constantly being evaluated or prosecuted:

"Imagine you were a person addicted to drugs, like me, who lost track of the minute I started doing it. I only realize when I'm already doing it. Let him come and tell me, 'Why did you do this?' (...) and I've been questioning something for 20 years that a person comes to rub it over and over again, over and over, over and over again, so how can I not [be] bother[ed]?" (Caregiver 3)

There is also tension when other relatives or third parties are used to triangulate information without the caregiver being aware:

"I felt overwhelmed, but we're going to see each other, and I'm going to make things clear (…) because I don't like playing cop and thief." (Caregiver 3)

Tensions during the intervention phase

Unmet expectations

Social workers assume various roles, including a social support management role, a socio-educational role, and a therapeutic role. In the management of social support, tension arises when the professional promises support that is not delivered or steps that are not carried out:

"She agreed to support me with a neurologist, with school supplies, something for the children, I don't know, uniforms, she just assumed commitments, and from then on, I didn't hear anything more from her." (Caregiver 6)

In the socio-educational or concierge role, tension is generated when suggestions are given that caregivers do not feel they are in a position to carry out. Meanwhile, in the therapeutic role, tensions arise when the support does not arrive with the expected frequency, there is no clarity of the frequency, no shared goals, or the role does not match the user's expectation of professional support.

Certain initial reactions are also evident, such as non-problematization, lack of commitment, denial, or resistance, and these are maintained over time when the bond has not been strengthened or when there are no shared objectives. These responses interfere with the likelihood that caregivers will discuss relevant issues and seek alternatives for change.

Other tensions indicators that caregivers demonstrate are repeated absences, passive participation, and a submissive attitude. This lack of tension warns professionals about the effectiveness of professional support for the user. For their part, professionals may experience feelings of frustration, discomfort, or exhaustion due to not observing progress or feeling interfered with.

Intimidation of the professional

Another form of tension can arise when violent situations threaten the physical integrity of a family member or professional; this primarily occurs in interventions carried out at home. Drug use, a risk factor for these reactions, generates an additional conflict when the professional has to report the situation. The professional also might feel intimidated when family members file complaints about their actions with the head office or other judicial entities. Additionally, the social worker may feel questioned in their work in the face of a family problem that is becoming more acute or when there is a caregiver who might give up personal care of a child. Indicators of this tension include an aggressive or defiant attitude of the caregivers and professionals' feelings of discomfort, lack of enthusiasm, and physical and emotional distress.

Tensions between members of the family group

Since it is possible to simultaneously work with more than one caregiver within a family group, tensions in the alliance can occur in many situations. Conflicts can arise when family group members have internal disagreements (e.g., couples' conflicts); when members have different assessments of the therapeutic relationship; when a family member reveals information that another caregiver did not want to have revealed; or when a caregiver wants the professional to assume a role of mediator in an internal conflict.

"In this session, she pressured me or tried, through words, to pressure me so that we as a program—of course, specifically me—could do something to further promote the father's mobility, responding to her tiredness." (Social Worker 2)

Other tensions arise when contradictory information is given to family members, or there are expectations that the professional will help them in a relationship that is not the program's focus. The conflicts are often complicated by gender violence in couples, which challenges the relevance of an intervention model focused on the parenting role as opposed to therapeutic intervention focused on the family as a whole. Tensions also arise from caregiver conflicts with third parties who are not in the therapeutic space or do not participate because they are incarcerated or a restraining order is in place.

Tensions during closure

In the closure phase, tensions can arise from the user's weariness with the consequences of the judicial process or their lack of knowledge of the deadlines for future hearings. There are also tensions due to the exacerbation of certain risk factors or changes within the family group that may dictate an extension of the protection measure for continued monitoring or a referral of the family group to another program, which extend the user's participation in the system. The user may display some of the following indicators due to these tensions: tired tone during the sessions, loss of contact, boredom, or the presence of an emotional distance despite working together. The relationship can also end due to the dismissal or resignation of the professional.

Strategies for coping with tensions

Counterproductive strategies

Professionals employ a set of strategies in the presence of stress indicators, but some can increase the distance of the social worker–caregiver. Among some counterproductive strategies are those that highlight the professional's position of power in the relationship. Counterproductive strategies include constantly reminding the user of the rules instead of agreeing on objectives that make sense to the user and the threat of informing the courts in the case of repeated absences.

"So I feel that the most tense thing was that at the end of last year, I had to tell her, 'You know what, [caregiver's name], if you don't come, that is, I understand you, but if you don't come, I have to report to court.' So, falling with that half-police yoke of a protection system on top was the greatest tension with her." (Social Worker 4)

Beneficial strategies

Professionals often utilize preventive strategies associated with strengthening the alliance when there is a tense beginning to the relationship. These strategies include using active listening, offering empathy, providing credibility to families and not confronting confusing information, sharing the results of a report, and visualizing the person beyond the problem.

"This is an instance that permanently reminds her that at some point she was judged in her role as a mother, so I have tried to resignify that from revealing more to the [name of caregiver] now and not to the [caretaker name] of the court file." (Social Worker 4)

Once the relationship has been stressed, repair strategies can be used, such as resignifying the process around common objectives so that the user can find value in it and, thus (in

the words of one of the professionals), move "from compulsory to voluntary." Other positive strategies highlighted by caregivers and professionals in the event of family conflict include family mediation or meeting with each adult separately. Positive strategies also include receiving criticism, clarifying the expectations and possibilities of the program, and reinforcing the idea that the dyad's members are allies—that it is not the professional allied with the family courts against the caregiver.

"In some cases, it works well; it's creating alliances like 'us and them,' like 'the two of us are going, now, we're going to do this intervention together, and we're going to help you,' 'and, what family courts are external, and we both are the program'" (Social Worker 2)

Given that there is no space here for the caregiver to withdraw if the disagreement worsens without a legal sanction, some strategies that have been implemented are to go to the caregiver's home or involve the coordinator to frame the situation, taking care that the professional is not the one who mentions the judicial consequences of a withdrawal. External supervision and group case discussion are other valuable support strategies.

Professionals generally regard tension as an opportunity to improve—a moment when implicit needs emerge or as a way of relating. To a lesser extent, their responsibilities in the tensions are recognized, such as not attending the confirmed home visits.

Discussion

The results of this study revealed a set of implicit and explicit tensions that occur in the trajectories of the parental therapeutic alliance between social workers and caregivers involved in the protection system. The tensions are present from the beginning of the relationship. They are identified mainly by the obligatory nature of the relationship, the predominance of the investigative work, the fear that their children will be taken away from their homes, and the feeling of being excluded from the decision-making process about their rights.

Faced with tensions, professionals utilize various strategies, some of which have positive effects and others exacerbate the tensions. Becoming aware of how to address those tensions and the attendant sensations of fear, distrust, and feeling excluded facilitates the change process. Otherwise, as evidenced in the results, tensions may worsen, triggering absences, defiant attitudes, or a feigned collaboration designed to prevent legal consequences (Schreiber et al., 2013).

Tensions that transcend the national reality

It is concerning that these tensions and caregivers' negative experiences about how tensions are managed are not new phenomena in the literature and that similar tensions have been observed in different countries (Holt & Kelly, 2018; Hughes et al., 2016; Killian et al., 2017; Smithson & Gibson, 2017). Protection services are frequently perceived as not supportive, impersonal, annoying, overly demanding of information, demeaning, and unprofessional in their treatment. Parents or caregivers often feel excluded from decision-making, judged, ignored, treated like children, and subject to demands or interventions imposed on them but not considered useful. Dissatisfied caregivers actively confronted the social worker aggressively or denyingly or would feign cooperation for fear of having their children taken away. The literature highlights that satisfied participants are those who feel that their perspectives are considered in decision-making and the construction of objectives, that they are recognized as experts regarding their children, that their needs (and not only their children's) are taken into account, and that strengths and resources are prioritized over deficits.

Can a therapeutic alliance be developed in compulsory contexts?

When addressing these tensions and querying whether it is possible to build a therapeutic alliance in compulsory intervention contexts, conflicting approaches appear in the literature. Cheng and Lo (2018) have asserted that complying with reporting requirements and the intrusive and authoritarian nature of family investigation tasks (which are sometimes essential to avoid harm) restrict the possibilities for a positive alliance. As this study has shown, having to report suspected abuse can trigger ruptures in the alliance. Indeed, Tufford (2014) has remarked that professionals often feel trapped between preserving the alliance in pursuit of treatment and complying with their legal reporting obligations.

A contradiction also exists at a general level because, although parents want to be empowered, they lose power over decisions regarding their children. Balancing this role of control, investigation, and help is one of the professional challenges, the face of which Escudero (2009) has proposed managing the obligations of the control system as an obligation that affects everyone rather than something that is imposed, which offers some guidance in negotiating the contradictions inherent in the professional obligation and the costs to the alliance of making threats of a legal report. Similarly, Relvas and Sotero (2014) and Steens et al. (2018) have reported that consolidating the therapeutic alliance is more difficult when accompanied by pressure from an authority figure—but it is not impossible. The security on the therapeutic space considered by Escudero and Friedlander (2017) in their alliance model with families becomes important. This model also considers the influence of more members of the family group in the alliance, which makes sense for

the current intervention system in Chile, where more than one caregiver may be involved in the treatment.

The results of this study show that although there are trajectories where tension is the predominant state, in others the establishment and strengthening of a collaborative and positive relationship are achieved. In line with the literature, it is observed that the tensions are associated with factors related to the caregiver, the professional, the methodology, and the protection system.

Factors related to the caregiver

The caregiver's motivation, fears, life history, and experiences with other professionals in the protection system all influence the alliance. Tensions are heightened when the caregiver is the mother whose quality as a parent is being questioned. At the same time, the relationship might flow better when the caregiver is a grandfather or uncle who has assumed care voluntarily. Similarly, when the caregiver expects therapeutic support even though an authority has referred them, it is a good indicator that the intervention will be helpful. For other caregivers, the social worker is simply one more actor in the system who imposes unsolicited help on them, and it is expected that they will not be very cooperative or that there will be more ruptures, especially if there is a family member who is an aggressor (Relvas & Sotero, 2014).

Factors related to the professional

The results of this study show that the professional skills that facilitate the strengthening of the alliance and the management of tensions are crucial to developing a positive alliance. According to the literature (Hughes et al., 2016; Studsrød et al., 2018; Toros et al., 2018), professionals must be prepared to share power, minimize the fear generated by being in the protection system, and establish collaborative relationships that consider the needs of the parents A trusting relationship can mitigate the stress that being in the protection system implies, as can being helpful, respectful, warm, and asking for and implementing feedback.

Other factors increase the likelihood that tension will arise and rupture the alliance. These include weak communicative or empathic skills when insufficient information is provided or when it predominates an intrusive position or a narrow focus on children's needs and wishes rather than family needs. (Gallagher et al., 2012). These factors challenge social workers to strengthen their clinical and relational skills training, alliances, and strategies to face tensions from a more collaborative perspective.

Factors related to the model

This research revealed the limitations of socio-educational models and counseling in facilitating change, because of which the literature suggests moving toward a relational and collaborative family intervention model that considers the relevance of relationship quality for change and the participation of families in the intervention process (Holt & Kelly, 2018). Additionally, the results showed the significance of a model where the relationship is conceived as the therapeutic engine that allows repairing past experiences with other professionals in the system. Following López-Davalillo (2021), the relationship is the true instrument of aid through which a space free of external and internal threats is created where they can understand their situation and live different experiences that allow them to advance in their purposes. In this way, the alliance is expected to provide a relational context that sets a new precedent against family members' current ways of relating (Rait, 2000). Likewise, focusing on strengths allows us to see opportunities for change even in the most complex family situations and utilize repair strategies after stress. In the words of Madsen (2007), to have an appreciative ally as a relational stance with families, that is, to position ourselves in alliance with caregivers so they experience us as on their side.

These results and the literature review have revealed that the participation of families is an ongoing challenge that implies developing techniques that allow the involvement of families in decisions, in the development of specific objectives, in tasks, and evaluations (Iachini, Hock, Thomas, & Clone, 2015; Karam, Sprenkle, & Davis, 2015). As Smithson and Gibson (2017) have noted, "not having access or time to read the report prior to the conference and not having a central part in writing the resulting plans can be considered symptomatic of this."

Factors related to the protection system

The results of this study challenge public policy operators to facilitate the conditions so that more collaborative practices can take place, considering the influence of contextual and institutional factors in the therapeutic alliance and considering that misuse of power occurs when there are many cases, little supervision, and less space for reflexivity (Hughes et al., 2016). The literature highlights a tension between paradigms within the protection system, such as a forensics model focused on risk reduction and a justice-based paradigm that seeks to promote child welfare (McLaughlin, Gray, & Wilson, 2015). To Toros et al. (2018), a forceful child protection discourse decreases engagement, as parents feel disempowered. Among the criticisms of child-focused policies and protection systems is that services are provided when children are at risk, and there is an excessive prioritization of the protection of children, leaving out issues such as drug use or relationship problems. Hence, it is recommended to change the paradigm from a focus on child protection to one on child welfare that recognizes the rights of children and families and the importance

of their participation; this model would take a more preventive than remedial stance and would focus on strengths and reinforce relational interactions (Smithson & Gibson, 2017; Toros et al., 2018).

The critical role of tensions

The importance of not underestimating the task of identifying and repairing ruptures is evident. (Escudero, Boogmans, Loots, & Friedlander, 2012; Relvas & Sotero, 2014). Bordin (1994) has emphasized the centrality of managing fluctuations in the therapeutic process and noted that their resolution allows learning and developing a different response, extending this change to other aspects of life or relationships. Consequences of not repairing the tensions include greater judicialization and children's exposure.

In this study, repair strategies other than those typical of family interventions were evidenced (e.g., the separation of subsystems in the therapeutic context to increase safety and a focus on the experiences shared by the family group) (Escudero et al., 2012; Escudero & Friedlander, 2017). Tufford (2014) has also recommended periodically reviewing the limits of confidentiality, reinforcing the alliance prior to a report of abuse, and discussing the duty to inform and involve the family in the process. This would allow for developing a sense of collaboration and managing emotional and relational stress after a report.

How tensions are interpreted is also relevant and should focus on avoiding blame and reflecting on how the professional contributes to the tension (Escudero, 2009). A critical skill is a deep understanding of how to address the initial adverse reactions in a context of forced intervention, such as by not problematizing or denying the conflict, while also understanding how families perceive control and the institutional context.

Research limitations

Some limits of the study have to do with the fact that the follow-up was done on the work of professionals from the same institution, which may constitute a bias in the study. The limited sample that did not allow for identifying differences according to the intervention program or the type of agency. Nor does the reduced sample enable generalizations to be established, although this was not the objective of the study. Third, the data collection was done in a pandemic, and the therapeutic relationship was marked by a highly stressful context and a leap to virtuality, which differs from a traditional face-to-face context. Although in the field of psychotherapy there have been important advances in remote interventions, virtual family interventions by social workers are considered to be a field that requires further investigation due to the difficulties inherent in socio-family intervention contexts.

Future lines of research

The follow-up of six caregiver–professional dyads for almost a year opened up future lines of research that will contribute to clinical social work with families in the protection system. One of the challenges involves generating greater awareness and knowledge of the alliance, the tensions, and the strategies for addressing them, which will encourage a more favorable relationship and more positive results in working with families. Another prospective avenue is the investigation of instruments that inform professionals in evaluating the alliance not only at the beginning of the relationship but also throughout the therapeutic process because, as evidenced in this study, tensions arise throughout the process, and this can culminate in a breakdown at any point in the intervention. Additionally, it would be useful to have tools that can evaluate the tensions, the handling of the ruptures, and the relational competencies of the professional that are validated for the national context.

It is also interesting to observe the divergent opinions of the alliance, specifically how the professionals tended to rate the alliance more negatively than the caregivers. This finding is like another study (Greef et al. (2018) that refers to divergent appreciation using psychometrics instruments, an issue to explore more extensively.

Future research could also observe each session to investigate—as has been done in psychotherapy—how therapeutic communication can create a rupture or facilitate change processes and analyze how this is related to the results of the intervention. Another study could examine what common factors are linked to positive results in the clinical practice of social workers, together with what characteristics of the professionals, the methodology, and the context facilitate or hinder the relationship. It is important to move toward a welfare system, more collaborative relationships in family intervention, and effective participation mechanisms. Finally, these processes should be viewed from a gender perspective, considering that the majority of caregivers and social workers are women, and from a critical or anti-oppressive social work perspective, since the majority of families that come into the system live in conditions of poverty or vulnerability.

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