


DRUG & ALCOHOL FINDINGS *Review*

analysis

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► [Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy.](#)

Karver M.S., De Nadai A.S., Monahan M. et al.

Psychotherapy: 2018, 55(4), p. 341–355.

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Amalgamation of research findings for the American Psychological Association finds that the relationship between therapists and young clients and their parents matters nearly as much as for adults. Practice recommendations will aid counsellors, therapists and mental health teams in their work with young substance users.

SUMMARY [Though not specific to clients with drug and alcohol problems, the principles derived from this review of psychotherapy studies are likely to be applicable, partly because severe substance use problems generally form part of a complex of broader psychosocial problems. This review updates an [earlier version](#) by some of the same authors.]

The featured review is one of several in a [special issue](#) of the journal *Psychotherapy* devoted to features of the therapist-client relationship related to effectiveness, based on the work of a task force established by the American Psychological Association. This particular review analysed findings on the links between outcomes of individual psychotherapy focused on the treatment of children under 18 (though parent figures may also/instead be the target of therapy) and the alliance between therapist and client or parent figure. It complements reviews on the alliance in therapy for [adults](#) and [couples and families](#).

In child therapy the 'alliance' was first seen by psychoanalysts as the child's experience of a positive emotional connection with the therapist which enables the child to collaborate purposefully on the tasks of therapy. Later a pan-theoretical conceptualisation saw the alliance as a contractual bond composed of three interrelated dimensions: warm emotional bond between client and therapist; agreement on the goals of therapy; and agreement on the means ('tasks') for reaching these goals.

The focus on agreement captures the social contractual nature of the alliance, critical for working with older children and adolescents who

are frequently reluctant participants. Adult clients typically choose to attend psychotherapy, whereas youth clients come to therapy because adults believe they need it, confronting therapists with 'clients' who may not believe they have a problem (or blame others for them)

Key points

From summary and commentary

For the American Psychological Association this reviewed amalgamated findings relating psychotherapy outcomes to the strength of the collaborative working relationship and emotional bond ('alliance') between therapists and clients aged under 18.

The overall link between alliance and outcomes was moderate but statistically significant, and in individual studies consistently in the direction of stronger alliances being associated with better outcomes. However, the few studies of youngsters being treated for substance use found a much weaker link.

Though causality cannot be established by the types of studies included in the analysis, it is probable, and the safest stance is to presume that how the therapist is and behaves affects how well young clients do, and does so partly via the alliance generated with the client.



and who did not choose to engage in therapy. In these circumstances, establishing agreement may prove both more difficult and more critical in forging a working alliance.

A second developmental difference involves the multiple alliances involved even in individual youth therapy. Because children and adolescents are often referred by parents/carers, therapists are faced with establishing and maintaining a strong alliance also with these adults. Failure to do so can lead to early dropout, yet forging this relationship is complicated by the fact that youth, carers, and therapists often disagree about the primary goals of therapy.

To explore the links between alliance and outcomes, the reviewers sought studies of therapy focused on children aged under 18 rather than on their families. These had to have related the alliance (as assessed before the last third of treatment) between the therapist and the child or their parents/carers to later outcomes for the child in a way which made it possible to amalgamate the findings with those of other studies. Only studies published in English with at least 10 participants were included. In all 28 such studies were found involving 2,419 participants. These yielded 165 estimates of the strength of the relationship between alliance and outcomes, of which 129 were involved the youth–clinician alliance and 35 the parent–clinician alliance; 137 derived from non-residential treatment.

The review incorporated a **meta-analysis** which amalgamated the results of the individual studies to provide estimates of the **overall strength** of the link between alliance and outcomes, and probed for influences on the strength of the link. The strength of the alliance–outcomes link was calculated as a correlation coefficient, an expression of the degree to which outcomes co-varied with the solidity of the alliance. The chosen metric ranges from -1 (perfect negative co-variation, meaning that as one side of the link gets larger the other diminishes) to +1 (perfect positive co-variation, meaning that as one side of the link gets larger so does the other). Correlation coefficients were also converted to **effect sizes**. Effectively these metrics indicate how influential the alliance had been if causally linked to outcomes.

Main findings

The central estimate of the overall strength of the link between alliance and outcomes was a correlation of 0.19, equating to an effect size of 0.39 – a statistically significant link representing a moderate relationship which accounts for about 4% of the variance in outcomes. In other words, the more solid the working relationship between therapist and clients, the better the outcomes tended to be, but this link was far from perfect. Despite many more studies being included, this estimate was close to the correlation of 0.22 found by the **earlier version** of this review, and did not appear to be biased either up or down by studies possibly missed from the analysis.

Measuring the alliance in child therapy

Consistent with the original conceptualisation (**above**) of the alliance in child therapy, the **Therapeutic Alliance Scale for Children** checklist includes items targeting two dimensions: emotional bond, and collaboration. Task collaboration items vary to be consistent with the tasks entailed in **cognitive-behavioural** or psychodynamic approaches. The therapist version of the checklist asks them to rate the child's bond and task collaboration rather than the therapist's.

The later conceptualisation of the alliance as contractual bond has been assessed with variants of the **Working Alliance Inventory** completed by patient and/or therapist, which has been modified for use with adolescents. It includes statements indicative of the three dimensions of the alliance mentioned **above**. Sample statements below are taken from a **short version** intended to be completed by clients, who respond by choosing options ranging from "seldom" to "always".

"[My therapist] and I have established a good understanding of the kind of changes that would be good for me."

"I feel that the things I do in therapy will help me to accomplish the changes that I want."

"I feel that [my therapist] appreciates me."

Though different dimensions are measured by these scales, in practice youth reports of the alliance appear only to reflect a positive versus negative emotional orientation to the therapist/therapy – how much they like or dislike them.



However, the strength of the link varied substantially across the studies. Possible reasons for this variation were explored by dividing the studies into categories based on problem area, type of client, type of therapy, and type of alliance assessed. At just 0.01, the alliance–outcome correlation was near zero across studies of clients treated for substance use and significantly lower than it was for those treated for internalising problems, the most common focus for treatment. At a correlation of just 0.05, the same was true of clients treated for eating disorders. Larger correlations were seen for outpatient versus inpatient treatment, and for studies of behavioural therapies which see problems as learnt behaviour, versus those which also had non-behavioural components (though for the latter there were only two estimates). The relation between outcomes and the parent–therapist alliance (correlation 0.30) was stronger than with the child–therapist alliance (0.18), but this difference was not statistically significant, so chance variation could not be ruled out.

The studies found by the reviewers did not permit a conclusion about whether variations in the strength of the alliance actually contributed to, or were just associated with, variations in the outcomes seen. Direct evidence of causal links would require studies which randomly allocated patients to therapeutic programmes which deliberately generated strong versus weak alliances.

Practice recommendations

- Create multiple alliances, not only the alliance with the youth. The alliance between parent/carer and therapist is as closely related to outcomes as that between child and therapist.
- Monitor alliance formation and maintenance (consider using a formal measure, particularly those highlighted in the [panel above](#)) with both the child and the parent figures over the course of treatment, not just at the beginning. The alliance is related to outcome early in treatment and throughout.
- Avoid: being overly formal, attempts to find common ground which come off as inauthentic; ‘pushing’ the child to talk about or overly focusing on emotionally sensitive topics; raising issues before the client is ready or too frequently; and criticising young clients. These behaviours undermine the alliance.
- Promote the alliance by being friendly (even having fun or being humorous when appropriate), praising, and showing impartiality (not automatically taking the parental point of view) and genuine respect for the child while calmly and attentively eliciting information in an interactive manner about their experience. Address current practical concerns and only then gradually move on to deeper issues.
- Do not take initial mistrust personally; young people and especially adolescents, are not likely to come to therapy ready to trust a therapist who they often see as another adult authority figure.
- Earn trust and form an alliance by establishing confidentiality, carefully attending (using active/reflective listening methods) to the youth’s perspective, showing [empathy](#) so they feel understood, accepting/validating and seeing value in the child’s statements, and advocating for them and presenting yourself as an ally. Also critical is expressing support, especially when emotionally painful material is discussed.
- Expect and respect divergent views about treatment goals and how to accomplish them. Formation of a therapeutic alliance with the child and parent figures requires the therapist to be open to suggestions/ideas and to collaboratively formulate goals and treatment plans responsive to both.
- Acknowledge the parent/carers’ strengths and collaborate and set mutual expectations with them in a relaxed manner. If not adequately engaged in treatment, they will not bring the client, even if the child has a good relationship with the therapist.
- Socialise the child to treatment by providing an explicit, consistent, and [credible framework](#) for how it will work, orienting them to therapist and client roles, and establishing [hopefulness/expectancy](#) that it will be useful in the client’s life.
- Create a psychotherapy environment in which the young client feels like a partner and flexibly respond to their needs, even in manualised treatment. Youth, especially adolescents, are unlikely to remain engaged if they see the therapist as another adult authority figure who tells them what to do.



- Match or adapt alliance-enhancing behaviours and overall approach to the client based on developmental level, gender, cultural background, how they tend to explain their successes and failures ('attributional style'), readiness to change, treatment preferences, interpersonal skills, and how they typically relate to and connect with others ('attachment style').
- Adjust alliance-formation to parental characteristics (interpersonal skills, stress, expectations of involvement in treatment, and cultural values) and to any match/mismatch between parent and youth perspectives.

FINDINGS COMMENTARY Though research findings are far from definitive, the safest stance for trainers, supervisors, therapists, counsellors, parent figures and young clients, is to presume that a good working relationship is not just associated with but an important determinant of treatment success, and that nurturing, maintaining, and as needed, re-establishing such a relationship, are core tasks. The recommendations in the featured review aim to aid therapists and counsellors in those tasks. Though some are based on research findings, the reviewers admit that research is lacking on how therapists and counsellors can firm up alliances, leaving the more fallible pillars of common sense and experience to support much of what is suggested.

The reviewers' practice recommendations are based on the likelihood of a causal link between alliance and clients' progress, a link which can be leveraged by the therapist to augment progress. In other words, that how the therapist is and behaves affects how well clients do, and does so partly via the collaborative working bond they help form between themselves and their clients. This bond can be seen as the emergent result of the components also addressed by reviews (listed at the end of this analysis) commissioned by the same American Psychological Association task force, including [empathy](#), repairing [ruptures](#) in the client–therapist relationship, demonstrating [positive regard](#) for the client, conveying the [credibility](#) of the therapy, [instilling hope](#), and perhaps particularly for young clients, the [person-to-person relationship](#) they have with the therapist in the everyday sense of the term 'relationship'. For young clients, the 'liking–non-liking' dimension dominates ratings of the therapeutic relationship.

Causality likely but unproven

The main weakness in drawing practice implications from the reviewed studies is that they were not designed to establish whether a firmer alliance actually does contribute to better outcomes. Studies which observe the natural course of alliance development are generally unable to eliminate the possibility that (for example) clients who were going to do well in any event were more likely to cooperate with and feel positive about their therapists, or that therapists more capable of generating these feelings were also more competent in other ways. In these scenarios, alliance would remain *associated* with better outcomes, but not because it helped *cause* them. Without effectively random allocation of patients to high- and low-alliance therapies or therapists, alternative explanations of an alliance–outcomes link cannot be eliminated. However, ethical considerations would seem to rule out deliberately allocating troubled youngsters and parents to a cold, non-collaborative therapist to see whether this really does make their lives worse.

Despite the lack of research confirmation, for at least two reasons a causal link between alliance and outcomes seems likely. First is the consistency of the association between the strength of the alliance and outcomes. Though sometimes very small and non-significant, in only two of the 28 studies amalgamated by the review was this relationship negative. Second is the plausibility of the proposition that establishing a good working relationship will help keep youngsters and their parent figures in therapy and actively working with the therapist towards agreed therapeutic goals, and that this greater opportunity for therapy to work will often translate into it actually working better.



Additionally, there seems little or nothing to lose and possibly much to gain from establishing a good working relationship with clients, nothing to gain and possibly much to lose from failing to do so, and ethical considerations demand a positive attitude to troubled individuals who you have a responsibility to help.

The strength of the alliance–outcomes link was virtually identical to that found in the [earlier version](#) of this analysis, suggesting that further studies are unlikely to fundamentally alter the picture, an implication reinforced by the fact that there was no evidence that studies missed by the analysis would appreciably affect its results. If given current evidence we accept – or doubt – an effect of alliance on outcomes, future research is unlikely to change our minds.

Is the alliance less of an influence on substance use clients?

In England and probably in the UK as a whole, psychosocial interventions conducted in non-residential settings [dominate](#) substance use treatment for young people, making the findings of the featured review of considerable relevance. On the basis of just two studies ([1](#) [2](#)) of the treatment of youth substance use, it found the amalgamated relationship between alliance and outcomes virtually zero and significantly less than for the most common diagnostic category, internalising problems such as depression and anxiety. With one more study to hand, the [earlier version](#) of the review produced a similar finding, as did a [companion review](#) of the alliance–outcome relationship among adult psychotherapy clients.

Among adults, possible explanations for the finding focused on the disproportionately poor and black substance use treatment populations and their alienation and exclusion from mainstream society. Those characteristics seem less likely to distinguish young substance users from other youth therapy clients, though alienation may play a role because a high proportion are involved with the justice system at the time of their treatment. In the two studies included in the featured review, 76% and 63% of the adolescent samples were on probation. Cannabis use and under-age drinking were likely reasons for probation and their being forced into treatment, reasons which may not seem a problem to these youngsters, but rather a solution to other problems. Where youth substance use really is a severe problem, it may be more likely to be able to be seen as such by the child, making treatment more acceptable and giving working alliances (including agreement on treatment aims) a chance to form and exert their influence. Without this the child may like the therapist, but see no reason for and no point in the treatment. In line with this speculation, a [review](#) of family therapy for adolescents found that the treatments performed especially well when the sample included a relatively high proportion of children with severe substance use problems (before treatment using substances on more than 64 out of the past 90 days), or whose behaviour led to them being assessed as pathologically at odds with family and society. However, only deeper research can confirm why alliance seems less influential among young people treated for substance use.

As they are added to the Effectiveness Bank, listed below will be analyses of the remaining reviews commissioned by the American Psychological Association task force.

[Cohesion in group therapy](#)

[Treatment outcome expectations](#)

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[Therapist empathy](#)

[Therapist–client alliance](#)

[Alliance in couple and family therapy](#)

[Repairing ruptured alliances between therapists and clients](#)



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