

Early Therapeutic Alliance as a Predictor of Treatment Outcome for Adolescent Cannabis Users in Outpatient Treatment

Guy S. Diamond, PhD,^{1,2} Howard A. Liddle, EdD,³ Matthew B. Wintersteen, PhD,¹ Michael L. Dennis, PhD,⁴ Susan H. Godley, RhD,⁴ Frank Tims, PhD⁵

¹Center for Family Intervention Science, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania

²Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania

³Center for Treatment Research on Adolescent Drug Abuse, University of Miami School of Medicine, Miami, Florida

⁴Chestnut Health Systems, Bloomington, Chicago, and Madison, Illinois

⁵Operation PAR, Inc., St. Petersburg, Florida

The association of early alliance to treatment attendance and longitudinal outcomes were examined in 356 adolescents participating in a randomized clinical trial targeting cannabis use. Both patient and therapist views of alliance were examined, and outcomes were evaluated over 12 months after numerous other sources of variance were controlled. Patient-rated alliance predicted a reduction in cannabis use at three and six months and a reduction in substance-related problem behaviors at six months. Therapist-rated alliance did not predict outcomes. Neither patient nor therapist alliance ratings were associated with attendance. The findings support the important and often overlooked role that alliance can play in treating substance abusing, often delinquent, adolescents. (Am J Addict 2006;15:26–33)

Therapeutic alliance has consistently been associated with treatment outcome.¹ Individual and meta-analytic studies on the therapeutic alliance with adults have demonstrated that: a) it is established by the third or fourth session; b) early alliance is a better predictor of outcome than later alliance; c) it predicts outcome equally well regardless of theoretical orientations; d) patient, therapist, and observer alliance ratings are all predictive of outcome, with patient's point of view being especially predictive; and e) the correlations between these different perspectives

are low.^{2,3} There is also evidence that alliance impacts treatment retention.⁴

Most alliance research has focused on adult individual psychotherapy, with very few studies focused on children and adolescents.⁵ This is surprising given that alliance formation and engagement are particularly important when working with adolescents. Many adolescents are coerced to attend treatment by parents, school personnel, probation officers, or other external sources.⁶ They deny needing treatment and lack motivation for change.⁷ In fact, 50–70% of adolescents terminate treatment early.⁸ This is particularly true for substance-abusing adolescents, where nearly 73% of teens in a national sample of outpatient treatment exited therapy before receiving a clinically recommended dose (i.e., 12 sessions over three to four months).⁹

Shirk and Karver⁵ recently completed a meta-analysis of 23 studies on alliance and other broad therapy relationship factors in child and adolescent treatment. Most of the studies were methodologically weak (e.g., single sample, non-standardized measures, poorly defined constructs of alliance), but still some interesting conclusions were drawn. Overall, they found a moderate effect size (.22), similar to those found in the adult literature, demonstrating that measures of alliance and the therapeutic relationship are predictive of outcome. The association was not moderated by age, behavioral versus non-behavioral treatment, therapy modality, or manualized versus non-manualized treatment. In contrast to adult studies, therapist report of alliance was a stronger predictor of outcome than patient report. Furthermore, they noted that child-reported alliance tended to cluster at the positive end of ratings,¹⁰ indicating a tendency for appraisals to be positively biased. Also in contrast

Received April 3, 2006; revised June 1, 2006; accepted August 17, 2006.

The opinions expressed herein are those of the authors and do not reflect official positions of the government.

Address correspondence to Dr. Diamond, Center for Family Intervention Science, Children's Hospital of Philadelphia, 34th St. and Civic Center Blvd, Philadelphia, PA 19104. E-mail: gdiamond@psych.upenn.edu.