ALLIANCE FORMATION AND TREATMENT OUTCOME AMONG MALTREATED ADOLESCENTS

MICHAEL J. ELTZ AND STEPHEN R. SHIRK
Department of Psychology, University of Denver, Denver, CO, USA

NEIL SARLIN
National Jewish Center for Immunological and Respiratory Medicine, Denver, CO, USA

Abstract—This study examined relationships among maltreatment experience, therapeutic alliance formation, and treatment outcome in a sample of 38 psychiatrically hospitalized adolescents. It was hypothesized that the experience of maltreatment would interfere with alliance formation, thereby compromising the effectiveness of therapy. Results indicated that maltreatment, multiplicity of maltreatment, and type of perpetrator of maltreatment were all associated with initial alliance difficulties. None of these variables predicted change in the alliance over time; instead, severity of interpersonal problems was the best predictor of alliance development. Maltreatment status was not directly related to treatment outcome; however, maltreated adolescents who failed to develop positive alliances with their therapists tended to show the poorest outcomes. Given the strong relationship between alliance formation and outcome, clinical recommendations for therapists who treat maltreated adolescents are presented.

Key Words—Psychotherapy, Alliance, Maltreatment, Adolescents.

INTRODUCTION

ALTHOUGH PSYCHOTHERAPY IS frequently prescribed for maltreated children and adolescents, very few studies have examined the process and outcome of such treatments (Graziano & Mills, 1992; O’Donohue & Elliott, 1992). One factor that has been identified by child clinicians as essential for the successful treatment of abused children and adolescents is the establishment of a positive therapeutic alliance (Friedrich, 1990; Long, 1986). The alliance refers to the “patient’s experiencing the therapist as supportive and helpful,” along with a sense of working together to solve problems (Horvath & Luborsky, 1993, p. 523). This clinical perspective is consistent with research that shows the therapeutic alliance to be one of the most consistent predictors of treatment outcome among adults (Horvath & Luborsky, 1993). However, the experience of maltreatment, particularly in the context of a caregiving relationship, could make alliance formation problematic for maltreated children and adolescents.

Clinical experience suggests that many abused children evince heightened vigilance and diminished trust in new interpersonal situations, and empirical research shows that maltreated children are at risk for a variety of emotional, social, and behavioral problems, including problems in interpersonal relationships (Aber, Allen, Carlson, & Cicchetti, 1989; Cicchetti, 1987; Shirk, 1988). In a review of the interpersonal sequelae of physical abuse, Shirk (1988) reported lower levels of social competence and increased levels of relationship conflicts among

Received for publication February 24, 1994; final revision received June 3, 1994; accepted June 13, 1994.

Requests for reprints should be addressed to Stephen R. Shirk, Ph.D., Department of Psychology, University of Denver, 2155 South Race Street, Denver, CO 80208.
maltreated children. Other investigators (e.g., Carlson, Cicchetti, Barnett, & Braunwald, 1989; Lynch & Cicchetti, 1991) have demonstrated maladaptive patterns of relationship expectations among maltreated children. It is likely, then, that many maltreated children and adolescents will enter therapy with significant interpersonal problems, including problems with forming relationships. Research has shown that interpersonal variables, such as the capacity for relationship, are among the best predictors of alliance formation among adults (Horvath & Luborsky, 1993), and children (Shirk, Saiz, & Sarlin, 1993). Thus, the experience of maltreatment could have both direct and indirect effects on child outcome. Not only does maltreatment produce problems that disrupt development and lead to referral, it also may undermine one of the most important conditions for effectively treating such problems, namely the capacity to form an alliance with a therapist.

The major aim of this study was to examine the relationship between maltreatment history and therapeutic alliance formation among a sample of adolescents in intensive psychotherapy. It was hypothesized that the experience of maltreatment would interfere with alliance formation, thereby compromising the effectiveness of treatment. The study also examined a set of possible mediators between maltreatment history and therapeutic alliance formation in order to address the question: How do past abusive experiences affect the formation of present treatment relationships? Based on a review of research on the interpersonal consequences of maltreatment, three mediators were considered: interpersonal expectations, social competence, and interpersonal problems. It was expected that the experience of maltreatment would result in increased interpersonal problems, relatively low social competence, and negative expectations about others’ supportiveness which, in turn, would diminish the maltreated adolescent’s capacity to form a positive therapeutic alliance.

**METHOD**

**Subjects**

Subjects were 38 adolescent inpatients attending an adolescent psychiatric unit at a regional pediatric hospital. An attempt was made to recruit all patients for participation. However, because of emergency admissions (often over weekends) not all patients were contacted. Of the contacted patients, the consent rate for participation was 75%. The participants in this study represent a subset of consenting patients for whom length of stay was sufficient to collect alliance data at two points in time (at least 14 days). The sample consisted of 25 female and 13 male subjects, with ages ranging between 12 and 18 years. Eighty-three percent of this sample was Caucasian. Structured diagnostic interviews were not conducted; however the most prominent clinical diagnoses were major depression, dysthymia, and conduct disorder.

**Treatment Context and Therapists**

All adolescents were seen a minimum of three times per week for 1 hour in individual psychotherapy sessions by one of 13 licensed clinical psychologists or board certified child psychiatrists. This therapy took place in the context of an inpatient treatment unit. Although the treatment was not manualized, as reflected by their licensure status, all therapists were experienced clinicians. Based on the report of the medical director, all therapists were psychodynamic in their theoretical orientation. Average length of stay in treatment for this sample was 57 days.

**Measures**

*Maltreatment assessment.* Maltreatment status was coded from Department of Social Service reports, interdisciplinary case conference notes, psychological evaluations, and the discharge
summary written by the attending clinician. The following variables, derived from Department of Social Service codes and the work of Wolfe (1987), were used:

(A) Maltreatment status—subjects were classified into one of three groups: “maltreated” when there was either DSS documentation of maltreatment or documentation by the attending clinician; “equivocal” when there was either DSS inquiries which were not substantiated, or if the staff or attending clinician reported suspicion that maltreatment may have occurred; and “nonmaltreated” when there were no DSS inquiries or suspicions mentioned in the discharge summary or interdisciplinary case conference notes. Records were reviewed and coded independently by two raters. Level of agreement as assessed by Cohen’s K was .89.

(B) These categories were used to further classify the “maltreated” group.

1. Maltreatment Type—This code referred to whether the patient suffered any of the following types of maltreatment: physical abuse, sexual abuse, or neglect. In order to account for co-occurrence of maltreatment, subjects were coded for all relevant types of maltreatment. In this sample, K for this classification was .88.

2. Multiplicity of maltreatment—This was a binary classification, in which maltreatment was classified “multiple” if there were multiple incidents or types, and “single” if there was only one incident and one type of maltreatment. In this sample, K for this classification was .83.

3. Child age at first maltreatment. There was complete concurrence for this rating.

4. Perpetrator of abuse. Categories included: biological mother, biological father, stepmother, stepfather, sibling, parental romantic interest, other relative, known nonrelative, and stranger. There was complete concurrence for this rating.

**Therapeutic Alliance Measures**

**Penn helping alliance questionnaire method.** This widely used measure was designed by Alexander and Luborsky (1986) to assess the patient’s perspective of their relationship with their therapist. Items on the scale assess the degree to which the patient experiences the therapist as supportive and helpful, and the relationship as a working collaboration. Previous research with adolescent patients revealed a high level of internal consistency with an alpha of .92 (Sarlin, 1992). Previous research has shown it to be one of the most consistent predictors of treatment outcome across types of patients and types of treatments (Horvath & Luborsky, 1993). The 11 items on this measure were rated on a 6-point scale ranging from one to six.

**Penn therapist facilitating behavior questionnaire method.** This measure, also designed by Alexander and Luborsky (1986), is a therapist report of the quality of the therapeutic alliance and parallels the Penn Helping Alliance Questionnaire. Therapist ratings of adolescent patients in prior research revealed a high level of internal consistency with an alpha of .92 (Sarlin, 1992). Consistent with the patient report form, previous research has revealed that this measure of process is highly predictive of treatment outcome (Horvath & Luborsky, 1993). The items on this 11-item measure were rated on a 7-point scale ranging from +3 to −3.

**Interpersonal Expectation Measure**

**Network orientation scale.** Developed by Vaux, Burda, and Stewart (1986) to measure people’s willingness to use their social support resources, this scale was adapted for use with adolescents (Sarlin, 1992). Tolsdorf (1976) described a positive network orientation as “a set of beliefs or expectations held by the subject that it is safe, advisable, and in some cases necessary to confide in the social network and draw on it for advice, support, and feedback in a stress
situation,” whereas a negative network orientation is described as “a set of expectations or beliefs that it is inadvisable, impossible, useless or potentially dangerous to draw on network resources” (p. 413). Vaux, Burda, and Stewart (1986) report internal consistencies ranging from .67 to .88, and stability in adult samples ranging from .85 to .87. In a study with adolescent inpatients, Sarlin (1992) reported a reasonable level of internal consistency, with an alpha of .75. Previous research has shown this scale to be significantly related in the expected direction with measures of social support, and modes of coping and self-disclosure among college students (Vaux, Burda, & Stewart, 1986).

**Relationship Problems Measure**

*Interpersonal problems scale.* This scale was derived from the Child Behavior Checklist (Achenbach & Edelbrock, 1983) to assess severity of interpersonal problems. Initially 12 child clinicians independently nominated items from the Child Behavior Checklist that indicated difficulties in interpersonal relationships. Items were then independently Q-sorted by the 12 clinicians and those items that were classified as most indicative of interpersonal problems were retained for the 12-item scale. The following items were included: Argues a lot; Clings to adults or too dependent; Cruelty, bullying, or meanness to others; Destroys things belonging to his/her family or other children; Doesn’t get along with other children; Feels or complains that no one loves him/her; Gets in many fights; Not liked by other children; Physically attacks people; Teases a lot; Threatens people; and Withdrawn, doesn’t get involved with others. With this sample, internal consistency for this scale as assessed by Chronbach’s alpha was .83.

**Severity of Psychopathology Measure**

*Child Behavior Checklist (CBCL).* The CBCL is a 118-item inventory completed by parents who evaluate the intensity or frequency of behavioral symptoms on a 3-point scale (Achenbach & Edelbrock, 1983). The scale provides a number of scores, including an overall index of severity of symptomatology (Sum T). Factor analysis has revealed two broad band dimensions, Internalizing and Externalizing behavior problems where the former refers to emotional or personality problems and the latter to disruptive behavior problems. This measure also provides an index of social competence. The internal consistency for the Sum T score as assessed by Chronbach’s alpha was .96 for both boys and girls aged 12–18, while the internal consistency for the social competence score as assessed by Chronbach’s alpha was .60 for 12–18-year-old boys and .61 for 12–18-year-old girls (Achenbach & Edelbrock, 1983).

**Therapy Outcome Ratings**

*Therapy outcome-adolescent rated.* This measure was adapted by Sarlin (1992) from similar scales used by O’Malley, Suh, and Strupp (1983) as a global measure of the adolescent’s perspective on their treatment progress. It is comprised of three items rated on 5-point anchored scales to assess the adolescent’s view on improvement during hospitalization. The items on this scale were: (a) How much has being in the hospital helped you with your problems; (b) Compared to when you came to the hospital, how are you feeling about your life now?; and (c) How much have your problems changed because you were in the hospital? Previous research with adolescent patients revealed good internal consistency with an alpha of .83 (Sarlin, 1992).

*Therapy outcome-therapist rated.* This is a parallel version to the adolescent outcome rating that assesses the therapist’s perspective on the adolescent’s treatment progress. Therapist ratings
of adolescent patients in prior research revealed a high level of internal consistency with an alpha of .92 (Sarlin, 1992).

Procedure

Informed consent to participate in this study was obtained at the time of admission. The Child Behavior Checklist was also given to the parents at this time. Within the first week of treatment, the Network Orientation Scale was administered to the adolescent by a research assistant. One week after admission, the alliance scales were administered to the therapist and the adolescent, independently. These measures were then given again as close to 1 week prior to discharge as possible. There was some variation in the timing of the second administration of the alliance scales because discharge dates were occasionally subject to last-minute changes. Therapists and adolescents also made outcome ratings during the final week of treatment. All other demographic information, including the patient’s full scale IQ, was obtained from the medical charts.

Chart reviews were conducted by the first author and a research assistant to obtain the data for the maltreatment measures. Raters were blind to the scores on all other measures. The data for the interpersonal problems measure was collected from the CBCL’s which were previously administered as a part of the clinical protocol.

RESULTS

Preliminary Analyses

Two sets of preliminary analyses were conducted in order to assess the representativeness and comparability of the subject groups. First, participating and nonparticipating (including noncontacted admissions) groups did not differ significantly on age, full scale IQ, or overall level of symptomatology. In fact, there were few significant differences between participating and nonparticipating adolescents. These included a higher percentages of females and adolescents with affective disorders in the inpatient population than in the study sample (62.5% vs. 55%; 62.5% vs. 52%, respectively), and a lower percentage of adolescents with disruptive behavior disorders in the inpatient population (16.5%) than in the study sample (22%).

Classification of subjects by maltreatment criteria resulted in 21 maltreated cases (55%), 2 equivocal cases (5%), and 15 nonmaltreated cases (40%). Given the low number of equivocal cases they were removed from the sample, thus resulting in a final sample of 36 cases. In order to assess the comparability of the maltreated and nonmaltreated groups, a series of T-tests were conducted comparing these groups on: age; full scale IQ; length of stay; and level of psychopathology (as measured by the SUM T on the CBCL). No significant differences were found. Additionally, there was not a significant gender difference between the groups, $\chi^2(1, N = 36) = .086, p = .77$.

Within the maltreated group, 24% of subjects ($n = 5$) were assessed as having experienced a single episode of maltreatment, while 76% of subjects ($n = 16$) were assessed as having experienced multiple maltreatment. Physical maltreatment was experienced by 57% of subjects ($n = 12$), sexual maltreatment by 52% of subjects ($n = 11$), and neglect by 43% of subjects ($n = 9$). Sixty-seven percent of the subjects ($n = 14$) experienced multiple types of maltreatment. The average age when the child was first maltreated was assessed as being 6 years, 10 months old, with a standard deviation of 4 years, 5 months. In 43% of the cases, a biological parent was involved in the perpetration of maltreatment, while in another 43% of cases the perpetrator involved was a stepparent, foster parent, or other romantic partner of the primary
Table 1. Maltreated and Non-Maltreated Means and Standard Deviations for the Initial Therapeutic Alliance

<table>
<thead>
<tr>
<th>Source</th>
<th>Maltreated</th>
<th>(SD)</th>
<th>Non-Maltreated</th>
<th>(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>3.9 (.90)</td>
<td>4.7</td>
<td>(.12)</td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td>3.5 (.90)</td>
<td>4.2</td>
<td>(.60)</td>
<td></td>
</tr>
</tbody>
</table>

caretaker. Overall, 38% of subjects (n = 8) experienced maltreatment by multiple perpetrators and 62% of subjects (n = 13) were maltreated by their primary caretaker.

Preliminary correlations between age and all alliance, mediational, and outcome variables revealed no significant effects. Although adolescence is by no means a homogeneous category, developmental effects may have been attenuated by the restriction of the age range (11 to 18). Due to the lack of significant effects though, age was not included in subsequent group comparisons as a between group factor. However, because gender has been shown to moderate the effects of maltreatment (Friedrich & Reams, 1987), it was included in subsequent analyses. It was also noteworthy that length of stay, though variable, was not related to any of the process or outcome measures.

Maltreatment Status and the Therapeutic Alliance

A status by gender (2 × 2) multivariate analysis of variance was conducted with the initial therapeutic alliance scores from therapist and adolescent perspectives as the dependent variables. There was a significant multivariate effect, using Wilk’s criterion, for maltreatment status, F(2,30) = 9.7, p < .001. Followup univariate tests showed significant effects for both the adolescent’s perspective, F(1,31) = 5.9, p < .05, and therapist’s perspective, F(1,31) = 6.8, p < .05. There were no other significant effects. As shown in Table 1, from both perspectives, maltreated adolescents established poorer initial alliances than nonmaltreated adolescents.

In order to rule out the possibility that group differences in initial alliance scores were attributable to differences in level of psychopathology, two Analyses of Covariance were computed with alliance scores as the dependent variable, first from the adolescent’s perspective, and then from the therapist’s perspective. Maltreatment status was the sole between group factor and level of psychopathology, as measured by the Sum T of the CBCL, was the covariate. In both cases, there was no covariate effect and a significant main effect for status: adolescent’s perspective, F(1,35) = 5.5, p < .05; and therapist’s perspective, F(1,34) = 6.7, p < .05. Thus, maltreatment status was related to quality of the initial therapeutic alliance, even after controlling for level of psychopathology.

Additional analyses were conducted within the maltreated group comparing multiply maltreated adolescents with nonmultiply maltreated adolescents. Limited sample size precluded the inclusion of gender in these analyses. A multivariate multiplicity effect was found, using Wilk’s criterion, for both perspectives of the therapeutic alliance, F(2,17) = 5.0, p < .05. Subsequent univariate tests revealed a significant effect for the therapist perspective, F(1,18) = 8.2, p = .01, but not for the adolescent’s perspective, F(1,18) = .1, p = .733. Comparisons of means indicated that, according to therapists, multiply maltreated adolescents had poorer initial alliances than nonmultiply maltreated adolescents (X’s = 3.23 vs. 4.45).

Comparisons of initial alliance scores of adolescents whose maltreatment involved sexual abuse and those whose maltreatment did not failed to reveal any significant group differences, F(2,17) = 2.47, p = .11. However, a comparison between adolescents whose maltreatment included parental abuse and those whose maltreatment was perpetrated by individuals other
Table 2. Maltreated and Non-Maltreated Means and Standard Deviations for Therapeutic Alliance Formation (Change)

<table>
<thead>
<tr>
<th>Source</th>
<th>Adolescent Rating</th>
<th>Therapist Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maltreated Mean</td>
<td>Non-Maltreated Mean</td>
</tr>
<tr>
<td>Male</td>
<td>-.02 (.82)</td>
<td>-1.1 (1.8)</td>
</tr>
<tr>
<td>Female</td>
<td>.27 (.80)</td>
<td>.02 (.73)</td>
</tr>
</tbody>
</table>

than parents revealed a significant multivariate effect, $F(2,14) = 4.2, p < .05$. Subsequent univariate tests produced a significant effect for the therapist perspective, $F(1,18) = 7.46, p < .05$, but no significant effect for the adolescent’s perspective. Adolescents who were maltreated by their parents showed poorer initial alliances, according to their therapists, than adolescents who were maltreated by others ($X^2 = 3.1$ vs. 4.3).

In addition to the initial alliance, change in the therapeutic alliance over the course of treatment (alliance formation) was assessed. Alliance formation was operationalized as the residualized change score between the initial and termination scores on the alliance measures. A Status by Gender ($2 \times 2$) multivariate analysis of variance was conducted with the residualized change scores from therapist and adolescent perspectives as the dependent variables. This analysis did not produce a significant multivariate effect for maltreatment status. Instead, there was a significant multivariate effect for gender, $F(2,23) = 3.8, p < .05$. Subsequent univariate tests showed that the therapist’s view was significant, $F(1,24) = 6.5, p < .05$, while adolescent’s view approached significance, $F(1,24) = 3.4, p < .10$. As indicated in Table 2 adolescent females tended to show more improvement in alliance quality than their male counterparts.

Multivariate tests of the effects of multiplicity, type, and perpetrator of maltreatment did not produce any significant results for change in the therapeutic alliance over time. Thus, while maltreatment status, multiplicity, and perpetrator role were all significantly related to initial alliance level, none was associated with change in the alliance over the course of treatment. It was noteworthy that correlations between all alliance variables and age of initial maltreatment and length of time since last maltreatment were all nonsignificant.

Associations Among Maltreatment, Mediation, and Therapeutic Alliance Variables

Correlations among maltreatment, mediation (e.g., interpersonal expectancies, relationship problems, and social competence), and alliance variables are displayed in Table 3. Consistent with previous analyses, maltreatment status was associated with initial alliance quality for both therapist and adolescent perspectives, but was not related to alliance formation variables. Instead, alliance formation was most consistently related to severity of interpersonal problems. These results indicated that adolescents who entered treatment with high levels of relationship problems showed poorer alliance development over the course of treatment than those with fewer relationship problems. It should be noted that while the relationship problem measure was significantly correlated with the total problems score from the CBCL, $r = .73, p < .001$, the total CBCL score was not significantly correlated with any of the alliance variables, either initial or formation. There was also a significant correlation between interpersonal expectancies and alliance formation from the adolescent’s perspective, indicating that adolescents who began treatment with more positive help-seeking expectancies viewed themselves as relating better with their therapist over time than adolescents who began treatment with negative expectations. This result, however, was not replicated from the therapist’s perspective.

Surprisingly, there were no significant correlations between maltreatment status and any of
Table 3. Correlations among Maltreatment, Mediational, and Alliance Variables

<table>
<thead>
<tr>
<th>Maltreatment Status</th>
<th>Interpersonal Status</th>
<th>IAA</th>
<th>IAT</th>
<th>AFA</th>
<th>AFT</th>
<th>Social Competence</th>
<th>Interpersonal Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltreatment Status</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Alliance Adolescent (IAA)</td>
<td>−.36*</td>
<td>−</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Alliance Therapist (IAT)</td>
<td>−.43**</td>
<td>−.12</td>
<td>−</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Formation Adolescent (AFA)</td>
<td>.30</td>
<td>.00</td>
<td>−.10</td>
<td>−</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Formation Therapist (AFT)</td>
<td>.06</td>
<td>.27</td>
<td>.00</td>
<td>.36</td>
<td>−</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Competence</td>
<td>−.07</td>
<td>−.27</td>
<td>.07</td>
<td>−.18</td>
<td>.07</td>
<td>−</td>
<td></td>
</tr>
<tr>
<td>Interpersonal Expectations</td>
<td>−.19</td>
<td>−.19</td>
<td>.13</td>
<td>.34*</td>
<td>−.21</td>
<td>.20</td>
<td>−</td>
</tr>
<tr>
<td>Interpersonal Problems</td>
<td>−.01</td>
<td>−.02</td>
<td>−.20</td>
<td>−.39*</td>
<td>−.46**</td>
<td>−.21</td>
<td>−.09</td>
</tr>
</tbody>
</table>

* p < .05.
** p < .01.
*** p < .001.

the mediational variables. Relationships among these variables were also tested through a series of Gender by Maltreatment Status (2 X 2) Analyses of Variance. These analyses revealed no significant main effects for maltreatment status. There was a significant gender effect, $F(1,36) = 11.6$, $p < .01$, and gender by maltreatment status interaction effect, $F(1,36) = 8.5$, $p < .01$, for the interpersonal problem measure. Overall, males evinced more interpersonal problems than females; however a Newman-Keuls post-hoc comparison indicated that male adolescents who were not maltreated showed significantly higher levels of relationship problems than all other groups. It is likely that this finding reflects the over representation of males with disruptive behavior disorders in the study sample.

Because of the lack of relationships between maltreatment status and the mediational variables, further tests of the mediational model were unwarranted. According to Baron and Kenny (1986), to establish mediation, the independent variable, in this case, maltreatment status, must first be shown to affect the mediational variables (relationship problems, interpersonal expectancies, and social competence). The pattern of results obtained from the correlational analyses indicated that maltreatment status was related to initial alliance quality but not to the proposed mediators. Thus, these results were not consistent with the hypothesized model that the relationship between maltreatment history and the therapeutic alliance is mediated through social competence, relationship problems, or interpersonal expectancies.

Maltreatment, the Alliance, and Treatment Outcome

It was hypothesized that the experience of maltreatment would interfere with alliance formation, and thereby would compromise treatment progress. Maltreated adolescents who developed relatively poor alliances were expected to show less progress than those who were able to establish a more positive working relationship with their therapist. In order to test this hypothesis high and low therapeutic alliance groups were formed using median splits on both the initial therapeutic alliance scores and alliance formation scores (residualized change scores) from the therapist’s perspective. These groupings were then used in separate multivariate analyses of variance as between group factors, along with maltreatment status. The adolescent’s and the therapist’s outcome ratings were the dependent variables in these analyses. The first set of analyses, based on the initial level of the therapeutic alliance, did not reveal significant main effects for maltreatment status or alliance level, nor a significant status by alliance group
Table 4. Means and Standard Deviations for Treatment Outcome Based on the Therapist’s Perspective of the Therapeutic Alliance and Maltreatment Status

<table>
<thead>
<tr>
<th></th>
<th>Adolescent’s Outcome Rating</th>
<th>Therapist’s Outcome Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maltreated</td>
<td>Non-Maltreated</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>(SD)</td>
</tr>
<tr>
<td>Low Alliance</td>
<td>3.5 (.96)</td>
<td>3.3 (.67)</td>
</tr>
<tr>
<td>High Alliance</td>
<td>4.2 (.65)</td>
<td>4.4 (.62)</td>
</tr>
</tbody>
</table>

interaction. However, for analyses based on change in the alliance, there was a significant multivariate effect for alliance group, using Wilk’s criterion, $F(2,20) = 4.7, p < .001$. Subsequent univariate tests showed significant effects for both the adolescent’s perspective of outcome, $F(1,20) = 8.4, p < .01$, and the therapist’s perspective of outcome, $F(1,20) = 20.1, p < .001$. As revealed in Table 4, for both ratings of treatment progress, adolescents who showed more positive change in the therapeutic alliance evinced greater treatment progress. There was a marginally significant multivariate interaction effect, $F(2,19) = 3.0, p = .076$. Subsequent univariate tests revealed a significant status by alliance group interaction effect for the therapist’s outcome rating, $F(1,20) = 5.7, p < .05$. The univariate test for the adolescent’s rating of outcome was nonsignificant. A post-hoc Newman-Keuls test revealed that maltreated adolescents who showed poorer alliance development posted the least treatment progress. Overall, then, these analyses indicated that positive change in the alliance was associated with greater improvement from both the adolescent’s and the therapist’s perspective. Maltreatment status was not directly associated with the magnitude of treatment progress, but there was some evidence indicating that maltreated adolescents who developed poorer alliances over time showed the least improvement.

DISCUSSION

Previous research has focused on the detrimental effects of child and adolescent maltreatment on adaptive functioning (Cicchetti, 1989). Few, if any, studies have addressed the potential impact of maltreatment on therapeutic processes that are intended to offset the negative consequences of abuse. It was hypothesized that the experience of maltreatment would interfere with the formation of a therapeutic alliance which, in turn, would undermine treatment progress. Results from this study provide substantial support for the first claim, and limited support for the second.

Maltreated adolescent patients, compared to their nonmaltreated counterparts, showed poorer initial treatment alliances. This result remained significant even after controlling for severity of symptomatology. Consistent with this finding were results indicating that multiply-abused adolescents formed poorer initial alliances than nonmultiply abused patients. Thus, the experience of maltreatment appears to have a corrosive effect on adolescents’ initial entry into therapy. The impact of maltreatment on initial alliance formation was not linked through any of the predicted mediators: negative interpersonal expectations, lower social competence, or heightened interpersonal problems. In fact, maltreated adolescents did not differ from other inpatients on these variables. The absence of expected group differences undoubtedly reflects the overall severity of disturbance of the study sample, including the non maltreated, psychiatric comparison group. Other studies have failed to find significant differences between maltreated
and nonmaltreated groups on cognitive and interpersonal variables when level of overall psychopathology or distress is comparable across groups (Wolfe & Mosk, 1983).

There are multiple possible explanations, though, for the relationship between maltreatment experience and initial alliance difficulties. Among the possibilities are: decreased feelings of safety in new situations, reluctance to trust others, and increased emotionality, which may negatively affect relationships. Similar suggestions have often been made in the clinical literature (Brassard, Germain, & Hart, 1987; Kempe & Kempe, 1984; Terr, 1990). For example, Brassard, Germain, and Hart (1987) have referred to an inability of maltreated children to build interpersonal relationships with new adults because of heightened mistrust. It was noteworthy, in this connection, that adolescents who had been maltreated by a parent showed poorer initial alliances compared to adolescents whose maltreatment did not involve parents. It is possible that similarities in the caregiving roles of parent and therapist increase the adolescent’s vigilance and mistrust when entering the therapeutic relationship. Other factors might mediate between maltreatment history and initial alliance difficulties. It is important to consider the fact that maltreatment affects other processes not examined in this study, including mood, problem-solving abilities, control beliefs, and impulse regulation, all of which could influence entry into a new relationship. These factors might represent important links between the experience of maltreatment and the process of therapy, and should be examined in future investigations.

It is important to consider, however, that there may be another explanation for the foregoing results. Some treating therapists could have had prior knowledge of their patients’ histories, including abuse histories, which could have lead to systematic differences in the way that maltreated children were rated or treated. However, there are several reasons to believe that prior case knowledge had a limited influence on ratings in this study. First, often therapists did not know about maltreatment at the time of admission and time of initial alliance rating. In many cases, the therapists did not find out until briefings with the social worker or until findings of the maltreatment emerged during the course of therapy. Thus, they would not have been affected by prior knowledge. Second, all the adolescents treated by these therapists presented with multiple risk factors and were highly symptomatic, thus making it unlikely that they would systematically treat or rate maltreated adolescents differently than other disturbed inpatients. And third, the adolescents themselves rated the initial alliance lower, thereby providing converging evidence with the therapist ratings. Therefore, it is unlikely that the clear relationship between the experience of maltreatment and initial alliance difficulties can be attributed to biased ratings by therapists.

In contrast to the clear finding of relationships between maltreatment and initial alliance difficulties, maltreatment was not related to change in the alliance over the course of therapy. Rather, adolescents with high levels of interpersonal problems and negative interpersonal expectations showed difficulties in alliance formation over time. That is, adolescents with less relationship problems and more positive expectations eventually formed more positive alliances, or, conversely, adolescents who entered therapy with more interpersonal problems and negative interpersonal expectations showed less improvement in alliance quality over time. This finding is consistent with previous research which showed that high degrees of patient defensiveness and interpersonal problems result in poorer alliances across the course of treatment (Gaston, Marmar, Thompson, & Gallagher, 1988). Interpersonal problems and negative expectations may directly interfere with the goals of therapy, in that they may disrupt or make more difficult the patient’s ability to collaborate around therapeutic tasks. Second, relationship problems may make it more difficult for the therapist to get a clear sense of the nature of the adolescent’s core difficulties; that is, if a patient is always arguing or fighting with their therapist, it may function as a defense against the emergence of more critical therapeutic issues. Third, interpersonal difficulties may have an indirect effect as well, in that if an
adolescent is having relational difficulties with peers, where mutuality is developed, it may make them less well equipped to engage in the type of mutual involvement that characterizes positive therapeutic relationships. Interestingly, even though the Interpersonal Problems Scale correlated highly with the CBCL’s total problems score, only the Interpersonal Problems Scale predicted alliance formation. In fact, the interpersonal problem scale was a better predictor of alliance formation than the measure of social competence from the CBCL. These results suggest that the interpersonal problem scale measures a unique factor from the overall symptom scale, and therefore may be a better predictor of interpersonal behavior in therapeutic and other social contexts.

Why would it be the case, though, that the initial alliance would be affected by maltreatment status while the formation of an alliance across treatment would be affected more by interpersonal problems? This may be due to factors associated with the initial alliance which differ from the formation of a relationship over time. It is likely that issues pertaining to safety and exploitation are highly salient to maltreated adolescents at the start of treatment with a new adult. However, as therapy progresses, issues of safety or fears about being exploited may be addressed and overcome, thus making relationships more positive. Also, it may be the case that relationship problems do not exert much of an effect on the initial relationship, that is, during the so-called “honeymoon” period in inpatient treatment. But, over time, this initial period of harmony may wane as the therapist attempts to address difficult issues. Interestingly, there was increased convergence between the adolescent and therapist views over the course of alliance formation (as compared to the initial alliance), which may in itself offer some evidence of an alliance in the form of a shared perspective.

Given the connection between interpersonal problems and therapeutic alliance formation, it was not surprising that males showed less positive change in the alliance than females. In this sample, males evinced higher levels of interpersonal problems than females at the start of treatment. However, it was also the case that type of maltreatment was not equally distributed across the two genders. In fact, females were more likely than males to experience maltreatment that included sexual abuse. It is unlikely that sexual victimization facilitates alliance formation; consequently, the most likely interpretation of the gender difference in alliance formation is that interpersonal difficulties, especially prominent among males, interfered with their ability to form a positive alliance relative to females.

One additional question was examined in this study: was maltreatment status related to therapeutic outcome? In this sample, adolescents with maltreatment histories did not show poorer outcomes than nonmaltreated adolescents. Instead, the best predictor of outcome, consistent with prior research (Horvath & Luborsky, 1993), was the formation of a positive therapeutic alliance. Given that maltreated adolescents did not differ from nonmaltreated adolescents in therapeutic alliance formation, comparable outcomes would be expected. However, there was some evidence to suggest that maltreated adolescents who do not ally well with their therapist over time appeared to have the poorest outcomes. Thus, the process of forming a relationship in therapy may be especially critical for maltreated adolescents, in that it may moderate the link between the experience of maltreatment and therapeutic outcome. Research into the importance of process variables has been overlooked in therapy research with maltreated children, in favor of comparisons of technique, an approach that has not proven especially fruitful (O’Donohue & Elliott, 1992).

This study had several important limitations. First, the retrospective nature of the maltreatment assessments did not allow for the consideration of additional information regarding early environments or other early relationship experiences of these adolescents, which may carry important risk and/or protective significance for maltreated youngsters (Cicchetti, 1989; Egeland, Jacobvitz, & Sroufe, 1988; Wolfe, 1987). Second, the maltreatment classifications were based on existing documentation. Although the classification of existing records was
highly reliable, the accuracy of the original reports could not be assessed. Third, therapists were not randomly assigned and patients were typically treated by multidisciplinary teams. Although such a procedure is common for studies of this type (cf. Colson, Cornsweet, Murphy, O’Malley, Hyland, McParland, & Coyne, 1991), it did not permit a systematic examination of the contribution of the therapist to the process of treatment.

Despite these limitations, the study does point to some important implications for clinicians who work with maltreated adolescents. The strongest impact of maltreatment on the therapeutic alliance was during the initial phase of therapy. Consequently, therapists should be prepared to address safety issues that are likely to be salient to maltreated youth early in treatment. It is our speculation that therapists who are able to address such issues facilitate alliance formation. Over time, maltreated adolescents showed a pattern of improving alliances, comparable to their nonmaltreated counterparts, and the development of a positive alliance was predictive of treatment outcome. Given the relationship between alliance formation and outcome, therapists should closely attend to the quality of the evolving relationship with maltreated adolescents, and they should actively address obstacles to the development of a positive working relationship. Future research should examine the focal concerns of maltreated youth as they enter therapy, and the actions of therapists that enable maltreated adolescents to overcome such concerns in order to establish a positive therapeutic alliance.

Acknowledgement—The authors would like to thank the staff at the Children’s Hospital of Denver for their collaboration and would particularly like to acknowledge Dr. David Raney who facilitated the conduct of this study.

REFERENCES


Résumé—Cette étude a porté sur la relation entre les expériences de maltraitance, la formation des relations d’aide thérapeutique et le résultat du traitement. L’échantillon comprenait huit adolescents hospitalisés dans un service de psychiatrie. L’hypothèse était que les mauvais traitements empêchent la formation de relations d’aide, et conséquemment compromettent l’efficacité du traitement. Les résultats indiquent que les mauvais traitements, leur fréquence et le type d’agresseur jouent un rôle dans la formation initiale des relations d’aide. Aucune de ces variables ne prédit des changements au niveau de la relation d’aide à la longue. Plutôt, c’est la sévérité des problèmes interpersonnels qui s’avère le meilleur outil pour prédire des difficultés dans le développement des relations thérapeutiques. La nature de la maltraitance ne semble pas affecter le traitement; cependant les adolescents maltraités qui n’ont pas réussi à développer des relations positives avec leur thérapeute sont ceux pour qui les résultats du traitement sont les plus faibles. Étant donné la forte relation entre la formation d’alliances et le résultat thérapeutique, on propose des recommandations pour les thérapeutes qui traitent les adolescents victimes de mauvais traitements.

Resumen—Este estudio analizó la relación entre la experiencia de maltrato, la formación de la alianza terapéutica, y el resultado del tratamiento, en una muestra de 38 adolescentes hospitalizados en un centro psiquiátrico. Se formuló la hipótesis de que la experiencia de maltrato interferiría con la formación de la alianza, comprometiendo por ello la eficacia de la terapia. Los resultados indicaron que el maltrato, la multiplicidad de malos tratos, y el tipo de persona que lo cometió, eran factores todos ellos asociados con dificultades iniciales en la alianza terapéutica. Ninguna de esas variables predijo cambios en la alianza a través del tiempo; en lugar de ello, la severidad de los problemas interpersonales fue el mejor predictor de la evolución de la alianza. El hecho de haber sufrido maltrato no estaba directamente relacionado con el resultado del tratamiento; sin embargo, los adolescentes maltratados que fracasaban en desarrollar una alianza positiva con sus terapeutas tendían a presentar los resultados más pobres. Dada la fuerte relación entre la formación de la alianza terapéutica y el resultado del tratamiento, se presentan recomendaciones clínicas para los terapeutas que tratan a adolescentes maltratados.