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The Alliance Negotiation Scale: Psychometric construction and preliminary reliability and validity analysis

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Abstract

Current measures of the working alliance tend to emphasize the degree of agreement or collaboration between patient and therapist about therapeutic tasks and goals. There are, however, both theoretical and empirical grounds to suggest that the degree to which patient and therapist are able to constructively negotiate disagreements about tasks and goals is another important dimension of the alliance. The present study outlines the preliminary development and evaluation of a measure to operationalize this dimension. This measure, the Alliance Negotiation Scale (ANS), is a 12-item patient self-report instrument. Exploratory factor analysis and expert ratings informed the development of the scale, which consists of two distinct factors that demonstrate good internal consistency. Correlations between these factors and the working alliance offer preliminary support for its construct validity. A working version of the ANS is presented and the need for further validation is discussed.

Keywords: working alliance; negotiation; Alliance Negotiation Scale

The concept of the working (or therapeutic) alliance is one of the most researched subjects in the psychotherapy research literature (Horvath, Del Re, Fluckiger, & Symonds, 2011). Numerous studies have shown that the quality of the alliance is a significant predictor of change across treatment conditions (Horvath & Bedi, 2002; Lambert & Barley, 2002), demonstrating a modest but consistent impact on psychotherapy outcome with effect sizes ranging from .22 to .26 (Horvath et al., 2011; Martin, Garske, & Davis, 2000; Zuroff & Blatt, 2006). Researchers have concluded that the working alliance is an essential ingredient in therapeutic change (Bordin, 1979; Horvath & Greenberg, 1986; Lambert & Simon, 2008), resulting in recommendations that clinicians focus on establishing a strong and positive working relationship with their patients from the beginning of psychotherapy (Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996; Horvath & Bedi, 2002).

While the concept of the alliance originated in the psychoanalytic literature, seminal contributions by Luborsky (1976) and Bordin (1979) played key roles in galvanizing an interest in examining the role that

the alliance plays across diverse theoretical traditions. Bordin's pan-theoretical conceptualization of the alliance has been particularly influential. He argued that the alliance consists of the achievement of a collaborative stance between patient and therapist, and that its development is fostered by three processes: agreement about therapeutic goals, agreement about therapeutic tasks, and the quality of the bond between patient and therapist. Bordin also hypothesized that different therapies would emphasize different aspects of the alliance, since different therapies emphasize different tasks and goals.

Over the years, numerous measures of the alliance have been developed. Horvath et al.'s (2011) meta-analysis of 201 studies examining the relationship between the alliance and outcome included over 30 different alliance measures. They noted that the most commonly used measures are the California Psychotherapy Alliance Scale (CALPAS; Marmar & Gaston, 1988), the Helping Alliance Questionnaire (Alexander & Luborsky, 1986), the Vanderbilt Psychotherapy Process Scale (VPPS; Gomes-Schwartz, 1978) and the Working Alliance Inventory (WAI; Horvath, 1994; Horvath & Greenberg, 1986, 1989).

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Research on the factor structure of the WAI, CALPAS and HAQ suggests that the shared variance in these measures can be conceptualized as a “confident collaborative relationship” (Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfreund, 1995). Consistent with this finding, Horvath et al. (2011) suggest that “the most distinguishing feature of the modern pan-theoretical alliance construct is its emphasis on collaboration and consensus” (p. 10).

At the same time, there is literature suggesting that an exclusive emphasis on collaboration and consensus may be limiting. Bordin (1983), for example, argued for the importance of conceptualizing the alliance, not just in terms of the degree of collaboration between patient and therapist, but also in terms of their ability to repair strained alliances. In his words: “I have emphasized that the building of a strong working alliance is a major feature of the change process and that the amount of change which results will, perhaps, be more a function of the strength than the form of that collaboration... but this would be settling on an oversimplification. I believe that the amount of change is based on the building *and repair* of strong alliances” (p. 36). He goes on to argue that “the building of a working alliance and its repair is not viewed as establishing a relationship in order to facilitate the person’s acceptance of treatment. This building and repair process *is* the treatment” (Bordin, 1983, p. 36).

Safran, Crocker, McMain, and Murray (1990) argued for the value of augmenting research on the predictive validity of the alliance with research investigating the process through which ruptures in the alliance are repaired. They also provided preliminary guidelines for identifying ruptures in the alliance and conducted the first stage of a task analysis developing a preliminary model outlining the processes involved in repairing alliance ruptures. Bordin (1994), in his final article on the alliance, emphasized that the theme of dealing with ruptures or strains in the alliance was central to his conceptualization. In his words:

Almost from the beginning of my research I have given central importance to the events surrounding strain in the therapeutic alliance and to the understanding of how and why change occurs. I may not (however) have been clear and explicit about it. In my view three key elements in therapeutic working alliance that bear on change are: a) strength of alliance, b) the power of therapeutic tasks, and c) the dynamics of strains in the alliance. (Bordin, 1994, p. 18).

In this same article, he reiterates his position that the process of repairing strains or ruptures in the alliance

can be an important mechanism of change in and of itself. Finally, he argues that research on the alliance and on the investigation of rupture and repair needs to proceed in tandem.

In the last two decades there has been a growing empirical literature suggesting that fluctuations in the quality of the alliance over the course of treatment is common, and that the process of repairing strains or ruptures in the therapeutic alliance may be related to positive therapeutic outcome (Horvath & Luborsky, 1993; Muran, 2002; Norcross & Wampold, 2011; Safran, 1993; Safran et al., 1990; Safran & Muran, 2000b; Safran, Muran, & Eubanks-Carter, 2011; Stiles et al., 2004; Strauss et al., 2006). Along similar lines, research has begun to demonstrate the role of negotiation in the psychotherapy process. It has been shown that carefully negotiating the goals and tasks of therapy is a useful strategy that can help minimize early termination (Ogrodniczuk, Joyce, & Piper, 2005; Reiner & Campbell, 2001; Reis & Brown, 1999). Czogalik and Russell (1995) identified major factors that characterize the therapeutic process, naming one factor as therapeutic negotiation and noting that levels of this factor tended to increase throughout the course of therapy.

Influenced by relational psychoanalytic thinking (Benjamin, 1997; Mitchell, 1988, 1991; Pizer, 1992), Safran and Muran (2000a, 2000b, 2006) have argued for the value of conceptualizing both the work of building the alliance and of repairing strains in it, as involving a process of ongoing negotiation between therapist and patient. They argue that the traditional psychoanalytic conceptualizations of the alliance (e.g., Greenson, 1967; Sterba, 1934; Zetzel, 1956) from which Bordin’s (1979) thinking initially derived, tend to emphasize the importance of the therapist acting in a supportive and flexible manner, in order help the patient to ultimately identify with or adapt to the therapist’s conceptualization of the tasks and goals of treatment. Safran and Muran (2000a) suggest that, in contrast, Bordin’s trans-theoretical model lends itself to a more mutual and dynamic view of the alliance that assumes an ongoing process of negotiation between the therapist and patient regarding the tasks and goals of therapy. From their perspective this process both establishes the necessary conditions for change to occur and is a central component of the change process. Along similar lines, Falender and Shafranske (2004) argue that “the therapeutic alliance is an ongoing creation of the client and clinician and concerns three interrelated features: *change goals* and *tasks*, *bonding* and *strain*” (p. 96). They also state that “strains in the alliance are seen as normative in the therapeutic process and provide opportunities for change. The

work of the alliance becomes the rebuilding of the damaged alliance and thus the acquisition of new ideas about self and relationships” (Falender & Shafranske, 2004, p. 96).

While research on alliance ruptures and repairs (see Safran et al., 2011 for a review) provides one avenue for investigating the negotiation dimension of the alliance, it may also be useful to develop an empirically sound measure to operationalize this construct. Such a measure would allow investigators to test various hypotheses about negotiation, such as: Are high perceived levels of negotiation predictive of outcome? Is the negotiation of the alliance more relevant to some forms of therapy than others? How highly correlated are perceived negotiation and perceived collaboration? Does the process of negotiation facilitate collaboration in the therapeutic alliance?

Our objective in the present study was to develop a preliminary version of a short (and easy to administer) patient self-report measure to tap into the negotiation dimension of the alliance discussed above. Although it is common for existing measures of the alliance such as the WAI to augment positively worded items with negatively worded items (e.g., “I feel uncomfortable with [my therapist],” “I am frustrated by the things I am doing in therapy,” “I disagree with [my therapist] about what I ought to get out of therapy”; Horvath & Greenberg, 1986, 1989), there are a dearth of items that directly assess the degree to which the patient and therapist are able to constructively negotiate disagreements about therapeutic tasks and goals, or address strains in the relational bond. The patient may endorse disagreement or frustration with their therapist but it is unclear whether this disagreement is ever expressed and worked through in session. Of note, the short version of the WAI (WAI-S; Tracey & Kokotovic, 1989) is a brief and popular alliance measure that includes very few of the negative items included in the longer version of the scale. The current article outlines the development of the Alliance Negotiation Scale (ANS), a 12-item patient self-report measure with a range of positive and negatively valenced items designed to capture the degree of negotiation present in the psychotherapy process.

Before proceeding further we wish to emphasize that from our perspective conceptualizing the alliance in terms of negotiation or collaboration need not be seen as mutually exclusive alternatives. Instead we see them as different dimensions of the alliance or different lenses through which one can view the alliance. The collaboration dimension of the alliance highlights the state of the alliance at any given point in time. In other words, it focuses on the

degree to which the therapist and patient agree on the therapeutic tasks and goals, and the extent to which the patient trusts in and feels cared for by the therapist at a certain stage of therapy (or at a particular point in the session). In contrast, the negotiation dimension highlights the mutual and emergent nature of the alliance, as well as the extent to which the patient experiences the therapist as willing and able to adjust or modify in response to his or her needs, and to be appropriately responsive to the tensions in the bond between them. Similarly, the ANS was not developed as a replacement for existing measures of the alliance, but rather as an instrument for operationalizing and measuring a dimension of the alliance that is not typically assessed.

Method

Constructing the Alliance Negotiation Scale.

In accordance with the principles of psychometric theory (Gregory, 2004), the first step in scale construction is operationalizing the construct. The authors created a working definition of the *negotiation dimension* of the alliance on the basis of the underlying theory (Safran & Muran, 2000a) and existing literature on the topic (Benjamin, 1990; Bordin, 1994; Mitchell & Aron, 1999). A core work group, consisting of faculty and advanced graduate students who work at the Brief Psychotherapy Research Program, was created to examine the validity of the definition and evaluate subsequent items for the scale. The work group was composed of three doctoral-level psychologists, and eight advanced graduate students in clinical psychology. The definition was then subjected to critical review among the core work group, and was revised through collaborative discussion among its members until a final operational definition of negotiation was agreed upon (see Appendix A). The work group then engaged in an intense iterative process to construct an initial item pool, with each item ranked on a 7-point Likert-type scale. This process involved comprehensive review of the literature, drawing from existing items on measures of the alliance¹ and rupture/rupture resolution,² and generating items designed to capture critical components of the construct’s theory (Safran & Muran, 2000a). An initial item pool of 91 items was constructed, on the basis of Clark and Watson’s (1995) recommendation to err on the side of breadth and over-inclusiveness in item writing. A starting point for item construction was to write items that reflected the major dimensions of the alliance construct. Once written, items were sent to three senior members of our research team who were asked to read and categorize

the items as reflecting the Task, Goal, or Bond dimension of the alliance. This was done to check our own understanding and to make sure items were accurately reflecting the parts of the alliance they were originally designed to capture. These items and ratings were then reviewed in weekly research meetings with our core work group over the course of several months. Based on the feedback received, items were refined, eliminated, or rewritten to adhere to both psychometric guidelines and theoretical integrity. After this arduous, iterative refinement process a final 50-item pool was agreed upon to be used in our psychometric investigation.

Participants and procedure. Following informed consent, data were collected from 258 participants, who were all currently in psychotherapy and had a minimum of five sessions. Participants came from 26 states, with the majority (137; 53.1%) from New York. Five participants were from outside the United States, coming from Canada, England, and Turkey (2%). Participants ranged in age from 17 to 59 years, with a mean age of 28.5 ($SD = 8.7$). The majority of participants were Caucasian (182; 70.5%), females (203; 78.7%), current university students (201; 77.9%), and a little more than half of the sample was currently employed (137; 53.1%). Respondents reported that their therapists were primarily Caucasian (212; 82.2%) females (179; 69.4%), who were older than themselves (235; 91.1%). About one-third of participants reported being in psychodynamic or psychoanalytic treatment (88; 34.1%), with 42 in eclectic treatment (16.3%), 33 in cognitive-behavioral treatment (12.8%), and the remainder in humanistic, integrative, or creative arts therapies. Sixty-one participants (23.6%) reported that they did not know their therapist's approach. At the time of the survey, 79 participants had been in therapy for 6 months or less (30.6%), 32 had been in therapy for 6 months to 1 year (12.4%), and 123 had been in therapy for 1 to 5 years (47.7%). Only 20 participants had been seeing their current therapist for more than 5 years (7.8%).

Participants were recruited through university email listserves, social networking sites, and a few online discussion forums geared towards people interested in psychology. Participants were sent an initial request via email or discussion post and told that the study aimed to learn about what occurs in therapy and how patients feel about their therapists. Students at participating universities were given half of a research credit for completing the survey. Participants who chose to take the survey were directed to a data collection website, where they answered some demographic questions about themselves and their therapists and then responded to

each of the 50 potential ANS items, indicating their agreement on the 7-point Likert scale. Participants also filled out the short form of the Working Alliance Inventory (WAI-S; Tracey & Kokotovic, 1989), in order to provide the basis for a preliminary assessment of the convergent and discriminant validity of the ANS. Since the constructs of *alliance as agreement* and *alliance as negotiation* bear some conceptual relationship to one another (i.e., one would expect agreement to emerge out of constructive negotiation), the ANS and WAI should ideally be moderately but not completely correlated with one another. WAI items were randomly interspersed between ANS items in order to reduce the possibility of underestimating the degree of overlap between the two measures as a byproduct of administering them as separate instruments. Negatively worded items on the ANS were reverse-scored prior to conducting any statistical tests.

Panel of experts. An email participation request was sent to a panel of eight experts. Experts were senior psychotherapy researchers who investigate various aspect of the therapeutic relationship, including the alliance. These experts were selected on the basis of their having recently participated in a small conference on the working alliance. Six researchers responded to the email request and completed the survey, for a response rate of 75%. The six participants who agreed to complete the study were directed to a data collection website, where they first read several paragraphs on the background of the alliance construct, followed by the operational definition of the negotiation construct (see Appendix A). They were then asked to read each of the 50 ANS items and rate the quality of the item on a 5-point Likert scale ("poor item" to "good item"). They were also provided with open-ended space after each item to provide any qualitative feedback or to explain why they chose a particular rating. At the end of this survey, they were asked to indicate how valid they thought the negotiation construct and the scale were, and whether they had any suggestions for improvement either at the item level or pertaining to the overall definition or scale.

Results

Principal Component Analysis

An exploratory principal component analysis (PCA) was conducted on the patient self-report data in order to identify the underlying dimensions of the scale. Prior to conducting the analysis, the distribution of responses for the 50 preliminary ANS items was examined. No items were excluded from further

analysis as they did not violate statistical assumptions for conducting parametric tests (Kendall & Stuart, 1958). The final solution was obtained through the use of a PCA with a forced two-factor solution and a varimax rotation. While a three-factor solution was initially tested (as we expected the items to conform to the task, bond, and goal dimensions) the items did not cluster together in this manner, and an orthogonal two-factor solution was confirmed by graphical representations on both the scree plot and the component plot in rotated space (not shown). Correlations between the WAI subscales and the two ANS factors demonstrate that there are elements of task, bond, and goal across both factors (see Table I). Other methods of factor analysis were also considered, including principal axis factoring (PFA). Using PCA or principal axis factoring (PFA) yielded the same two-factor structure and highly similar factor loadings, and the items retained in the final version of the scale would not have changed using either method. Ultimately, the solution that was retained was done so on the grounds that it made the most theoretical and statistical sense.

In order to consider the various data points for each potential item, a large matrix was created. In this matrix, each item listed its factor loadings, its statistical viability for inclusion in the current version of the ANS scale, the mean of all six expert ratings, and all qualitative expert feedback. Each item was then carefully reviewed by members of a small workgroup (including the authors), who decided which items to include and exclude. In order for an item to be retained, it had to meet theoretical, statistical, and expert-rated criteria. Theoretically, items were included if they were deemed to adequately represent the construct. Both patient and therapist items, positive and negative items, and items from each of the alliance categories (task, bond, goal) were retained. Items were also included that spanned critical components of the theory, such as willingness and ability to negotiate, comfort with negative expression and disagreement, and compliance. Eigenvalues and the factor loadings derived from the exploratory factor analysis were used to determine which items were statistically viable for inclusion in the ANS. Based on established criteria

for item retention (Bryant & Yarnold, 1995; Clark & Watson, 1995; Tabachnick & Fidell, 2001), we retained items where eigenvalues were above 1, factor loadings were above .4, and there was a minimum difference of .4 between an item's factor loadings when it double-loaded on both factors. The first decision point was that any item that failed to meet statistical criterion was deleted from the scale. Items were then evaluated on the basis of expert ratings, and the threshold for keeping an item was a mean rating of 4 or above (the item had to have an average rating of "good" or "very good" on the 5-point Likert scale). Following this, qualitative feedback from our six experts was then considered for all items. Items that were retained based on their factor loadings and meeting the expert threshold for inclusion, but where experts did not think the item was well-worded or understandable to a lay population, were eliminated next. The final criterion for selecting items was solid theoretical justification, determined by the authors and in consultation with the core work group. As the current study aimed to closely adhere to the recommendations of psychometric theory (Gregory, 2004), several versions of the scale were constructed and presented for feedback and revision. This evaluation and decision process eventually resulted in the final, 12-item version of the Alliance Negotiation Scale. Table II lists the individual items in each subscale, their factor loadings, and associated expert ratings.

For the current study, the Kaiser-Meyer-Olkin test of sampling adequacy yielded a score of .86, exceeding the recommended threshold (Kline, 1994). Bartlett's test of sphericity (1954) was also significant, $\chi^2(66, N=258) = 1106.615, p < .001$. Factor 1 consisted of six items and had an initial eigenvalue of 4.67, with factor loadings ranging from .65 to .84. Factor 2 consisted of six items with an initial eigenvalue of 2.31, and factor loadings ranging from .59 to .83. Factor 1 and Factor 2 together accounted for 58.03% of the variance in scores. Items that load on Factor 1 appear to reflect therapist and patient comfort with the patient disagreeing or expressing negative feelings about the therapist or the treatment. We thus labeled Factor 1 "Comfort with negative feelings." Items loading on Factor 2 appear to reflect the patient's perception of the therapist's lack of flexibility or unwillingness/inability to negotiate tasks and goal. We thus labeled Factor 2 "Flexible and negotiable stance." A final working version of the ANS scale appears in Table III.

The positive and negative valences of the respective factors make it possible to argue that, rather than being conceptually distinct, they represent one factor that contains both positive and negative items. This

Table I. Correlations between WAI subscales and ANS factors

WAI subscales	ANS factors	
	1	2
Task	.622	-.531
Goal	.518	-.645
Bond	.671	-.544

Note. All correlations are significant at the .05 level.

Table II. ANS subscales, factor loadings, and expert ratings

	Factor loadings		Expert ratings
	1	2	Mean
I am comfortable expressing disappointment in my therapist when it arises.	.843	.063	4.33
My therapist encourages me to express any anger I feel towards him/her in the course of treatment.	.809	.020	5
I am comfortable expressing frustration with my therapist when it arises.	.796	-.145	4.83
My therapist encourages me to express any concerns I have with our progress.	.738	-.091	5
I feel that I can disagree with my therapist without harming our relationship.	.665	-.357	4.83
My therapist is able to admit when he/she is wrong about something we disagree on.	.654	-.330	5
I feel that my therapist tells me what to do, without much regard for my wants or needs.	-.122	.830	4.17
My therapist is inflexible and does not take my wants or needs into consideration.	-.197	.815	4.17
My therapist is rigid in his/her ideas regarding what we do in therapy.	-.138	.703	4.33
I feel like I do not have a say regarding what we do in therapy.	-.074	.693	4.17
I pretend to agree with therapist's goals for our therapy so the session runs smoothly.	-.393	.600	4.17
My therapist and I are not good at finding a solution if we disagree about what we should be working on in therapy.	.086	.595	4

singularity hypothesis was considered and subjected to statistical testing in the course of the factor analysis, with both forced one- and two-factor solutions employed. The psychometric properties (e.g., internal consistency for each factor, factor loading coefficients for each item) were strongest with the two-factor solution presented herein, and also offered the most logical interpretation of the data. Graphical representations of the items (e.g., scree plot, component plot in rotated space) confirmed that the items in the two factors of the scale were distinct. The correlation between Factors 1 and 2 was $r = .34$, indicating that the degree of shared variance between the two factors is 12%, again suggesting that the two factors are not simply mirror images of one another. To further investigate this issue, the two factors were sent to an experienced group of psychotherapy researchers via an email listserve for review. Combining the feedback that was received yielded a general consensus that the two factors appeared to be conceptually distinct. This was

in line with our own conceptualization, and increased our confidence in retaining the two-factor solution.

Internal Consistency and Construct Validity

Cronbach's alpha coefficients were adequate for the full scale and for each factor, based on the minimum threshold of .80 (Clark & Watson, 1995; Gregory, 2004). Full scale $\alpha = .84$, Factor 1 $\alpha = .86$, and Factor 2 $\alpha = .81$. In order to provide preliminary evidence regarding construct validity of the ANS we correlated both ANS factors and the full scale with the total WAI score. Bivariate Pearson correlations revealed the expected relationships. The correlation between the ANS mean and WAI mean was large in magnitude, $r = .754$, $p < .001$, with WAI scores accounting for 56% of the variance on the ANS ($R^2 = .568$). Correlations between the two ANS factors and the WAI total score were $r = .650$, $p < .001$ and $r = .619$, $p < .001$, respectively. A linear regression analysis found that WAI scores significantly predict both ANS

Table III. The Alliance Negotiation Scale

The Alliance Negotiation Scale							
Please answer the following questions based on how you feel with your therapist overall							
	Never		Sometimes		Always		
I am comfortable expressing frustration with my therapist when it arises	1	2	3	4	5	6	7
I feel that I can disagree with my therapist without harming our relationship	1	2	3	4	5	6	7
My therapist encourages me to express any concerns I have with our progress	1	2	3	4	5	6	7
My therapist and I are not good at finding a solution if we disagree about what we should be working on in therapy	1	2	3	4	5	6	7
My therapist is inflexible and does not take my wants or needs into consideration	1	2	3	4	5	6	7
I am comfortable expressing disappointment in my therapist when it arises	1	2	3	4	5	6	7
My therapist encourages me to express any anger I feel towards him/her in the course of treatment	1	2	3	4	5	6	7
I feel like I do not have a say regarding what we do in therapy	1	2	3	4	5	6	7
I feel that my therapist tells me what to do, without much regard for my wants or needs	1	2	3	4	5	6	7
I pretend to agree with my therapist's goals for our therapy so the session runs smoothly	1	2	3	4	5	6	7
My therapist is rigid in his/her ideas regarding what we do in therapy	1	2	3	4	5	6	7
My therapist is able to admit when he/she is wrong about something we disagree on	1	2	3	4	5	6	7

Factor 1 ($\beta = .839, p < .001$) and Factor 2 ($\beta = .578, p < .001$). Regressing the two individual ANS factors on the WAI mean resulted in an increase in shared variance, with the ANS factors together accounting for 64% of the variance on the WAI ($R^2 = .647$).

Mean scores of expert ratings also support the construct validity of the scale (see Table II). Mean scores ranged from 4 to 5, with all items with an average rating of “good” or “very good.” The mean for all 12 scale items was $M = 4.5, SD = .39$. Furthermore, the authors feel that the retained items adequately reflect the underlying theory and represent the various implicit (e.g., discomfort with relational tension) and explicit (e.g., working together to change a task of the therapy) components of alliance negotiation. The authors feel that the measure in its present form represents both a theoretical and statistical improvement over earlier versions.

Discussion

This paper provides the results of the initial stage of the development of a patient self-report measure designed to operationalize the construct of negotiation and to augment existing measures of the alliance by focusing on the negotiation of tension and resolving alliance ruptures. The current measure assesses the patient’s perception of the extent to which the therapist is (1) comfortable with the patient disagreeing or expressing negative feelings about the treatment or the therapeutic relationship, and (2) able to negotiate the tasks and goals of therapy in a flexible fashion.

Our findings provide preliminary support for the two-factor structure of the ANS: (1) *Comfort with negative feelings*, and (2) *Flexible and negotiable stance*, with the individual factors demonstrating good internal consistency. In light of research demonstrating the importance of therapist flexibility (Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002) as opposed to rigid adherence to a treatment model (Castonguay et al., 1996; Henry, Schacht, Strupp, Butler, & Binder, 1993), the second factor may prove to be particularly useful. These factor names have been given provisionally and are subject to change as a more nuanced understanding of what they represent is gleaned from future validation studies. Preliminary evidence of construct validity was provided through a combination of content validity ratings of items by a panel of experts and an exploratory factor analysis. Finally, initial evidence for convergent validity of the ANS is provided by the finding that it shares substantial variance with the 12-item version of Working Alliance Inventory, with the full scale mean sharing 56% of the variance and the two factors together sharing 64%, with Factors

1 and 2 individually sharing 42% and 38% of the variance, respectively. These findings suggest that the ANS and WAI tap constructs that are overlapping but not identical in nature. Taken together, the results of this study offer a small but important step towards establishing the construct validity of the ANS.

Despite many advances in psychotherapy research in recent years, there remains no sufficient explanatory link between technique, post-session change, and treatment outcome (Greenberg, 1986; Stiles, Shapiro, & Firth-Cozens, 1990). It has been shown that therapists who form stronger alliances with their patients tend to produce better outcome (Baldwin, Wampold, & Imed, 2007), yet little is known about what contributes to a positive working alliance. Furthermore, less than 10% of the variance in outcome scores can be accounted for by strength of the alliance as it is currently measured (Beutler et al., 2004), which suggests a need to augment research on the alliance by developing ways of operationalizing additional components of the alliance that have not received empirical attention to date.

There are several limitations to this study. The data for this study were collected online, making it impossible to confirm the accuracy of participants’ replies (e.g., age, gender, type of therapy received). The fact that the data were collected online may also limit the overall representativeness of the sample. It would have been preferable to collect data on psychiatric symptomatology or diagnoses in order to have a better sense of what types of patients participated in this study and how this scale might or might not generalize to more heterogeneous patient populations. Another limitation comes from using only patient self-report to assess the degree of negotiation in a therapeutic dyad. It is possible that the use of a therapist-report or observer-based coding system would yield different results and capture additional variables, such as therapist ability and willingness to express negative feelings or disagreement to their patient and therapist perception of patient compliance and openness to disagreement.

A statistical limitation comes from making the decision of which factor solution is the most appropriate for a given data set, which can be somewhat of an arbitrary process. To address this concern multiple solutions were carefully evaluated, using the underlying theory to inform all decisions. As is the case with all scale construction, deciding what items to retain is a long and arduous process with no firmly established guidelines for inclusion. The creation of a scale thus always involves some subjectivity. Despite these limitations, every attempt was made to select the final items on the basis of both theoretical and statistical grounds. The scale construction method that was employed diligently adhered to

recommended protocol, taking care to respect the multiphasic process inherent in psychometric theory. At each step in the construction and revision process, our data and decisions were reviewed with members of the core work group and other colleagues.

While the factor structure emerging from our data analysis appears theoretically meaningful, this study represents a very preliminary attempt to evaluate the psychometric properties of the ANS. It will be essential to evaluate the stability of this factor structure with additional samples in the future. In addition, although preliminary evidence of convergent validity was obtained by comparing participants' ratings on the ANS with their ratings on the WAI, future research will be required to collect more extensive data regarding the construct validity of the ANS. A large-scale investigation of convergent and discriminant validity with other constructs will be required, as well as examining the predictive validity of the ANS on treatment outcome.

There are also a number of important conceptual and empirical questions that should be addressed in the future. While the current study demonstrates a relationship between the collaboration dimension of the alliance (as assessed by the WAI) and the dimension of negotiation (as assessed by the ANS), the nature of this relationship remains unclear. Negotiation may be an important component of alliance development (more negotiation leads to higher levels of collaboration), or, alternatively, a strong collaborative bond may facilitate the process of negotiation. If the ANS is found to predict treatment outcome, it will be important to assess whether this relationship is direct or involves moderating or mediating variables. It will also be necessary to determine whether the ANS accounts for any additional variance in outcome over and above the contributions of current alliance measures.

Finally, it is important to consider whether the process of negotiation is more relevant to some forms of therapy than to others. For example, since the exploration of the therapeutic alliance tends to be more of a central focus in psychoanalytic treatments than in cognitive-behavioral treatments, it is possible that the dimension of negotiation may be more relevant to the former. On the other hand the therapist's capacity to assume a negotiable stance (perhaps at an implicit level by, for example, shifting tasks or goals) may be an important precursor of change even in those treatments which do not focus extensively on the exploration of the therapeutic relationship, especially with patients who do not readily take to the relevant therapeutic tasks and goals. Questions of this type need to be explored in future research.

The preliminary findings from this initial validation study suggest that the ANS may prove to be a useful tool in psychotherapy research. More evidence will be needed to further investigate the construct validity of the measure, to examine patterns of change in ANS ratings over the course of therapy, and to investigate whether ANS ratings are differentially predictive in different types of psychotherapy and with different types of outcome measures.

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Notes

- ¹ The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989); The Penn Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986).
- ² Rupture Resolution Questionnaire (RRQ; Safran, Muran, & Proskurov, 2009); 3RS (Eubanks-Carter, Mitchell, Muran, & Safran, 2009).

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Appendix A

Construct and Definition

In an effort to address concerns over current conceptualizations of the working alliance, and in line with our interest in the process of addressing and resolving alliance ruptures, we have advanced a conceptualization of the alliance as negotiation rather than as agreement (e.g., Safran & Muran, 2000a). This conceptualization is consistent with the last article Bordin (1994) published, in which he explicitly emphasized the negotiation of agreement on task and goals and the facilitative effect of this negotiation on the bond as central to the change process. In contrast to traditional psychoanalytic conceptualizations of the alliance that implicitly assume that there is only one therapeutic goal or task, or at least privilege one type of goal or task over others (e.g., Greenson, 1967; Sterba, 1934; Zetzel, 1956), this conceptualization is more dynamic and mutual. It assumes that there will be an ongoing negotiation between therapist and patient at both conscious and unconscious levels about the tasks and goals of therapy and that this process of negotiation both establishes the

necessary conditions for change to take place and is an intrinsic part of the change process.

This conceptualization is also consistent with an increasingly influential way of thinking about the therapeutic process emerging from contemporary relational psychoanalytic thinking (e.g., Mitchell & Aron, 1999). This perspective holds that learning to negotiate the needs of the self versus the needs of others is both a critical developmental task as well as an ongoing challenge of human existence. Many of the problems that people bring into therapy are thus influenced, at least in part, by difficulties they have in negotiating this tension in a constructive fashion. The development of a relationship with the therapist inevitably involves this type of ongoing negotiation between two different subjectivities at both conscious and unconscious levels. This process can have an important impact upon the patient's fundamental sense of the extent to which he or she lives in a potentially negotiable world or needs to compromise his or her own sense of integrity in order to hold onto relationships (Benjamin, 1990; Mitchell, 1993).

What we are thus arguing is that therapeutic tasks and goals, in Bordin's terms, provide an important part of the substance of the negotiation that inevitably takes place in any therapy. This negotiation is always taking place—sometimes explicitly and sometimes implicitly. When things are running smoothly, the negotiation may take place out of awareness. For example, the therapist may decide, without thinking, to not use a particular intervention because he or she has a sense that the patient will not find it helpful; or the patient may give the therapist the benefit of the doubt and try on an interpretation for size, or try a behavioral assignment even though he or she is initially skeptical. But when things break down, and there is an overt rupture in the therapeutic alliance, this process of negotiation becomes foregrounded.

It should be emphasized, that as we see it, this process of negotiation is not a superficial negotiation towards consensus, but rather a genuine confrontation between individuals with conflicting views, needs or agendas. Both patient and therapist struggle to sort out how much they can accommodate the other's perspective without compromising themselves in some fundamental way. This conceptualization is thus less vulnerable to the previously mentioned criticism, which equates the alliance with compliance. Finally, we find it useful to distinguish between the conceptualization of alliance as negotiation versus the conceptualization of alliance as collaboration. Of course, one can certainly make the case that genuine collaboration by definition involves some form of mutual accommodation between patient and therapist, rather than a unidirectional accommodation of the patient or the therapist.