Received: 12 December 2017 | Revised: 22 March 2018 | Accepted: 23 March 2018

DOI: 10.1002/cpp.2197

RESEARCH ARTICLE

WILEY

A therapist version of the Alliance Negotiation Scale

Jennifer M. Doran[1,2] | Juan Martín Gómez-Penedo[3] | Jeremy D. Safran[4] | Andrés Roussos[3]

[1] VA Connecticut Healthcare System, CT, USA

[2] Department of Psychiatry, Yale School of Medicine, CT, USA

[3] CONICET, Universidad de Buenos Aires, Buenos Aires, Argentina

[4] The New School for Social Research, New York, NY, USA

Correspondence

Jennifer M. Doran, Ph.D., VA Connecticut Healthcare System, CT, USA
Email: jenniferdoranphd@gmail.com

Abstract

The aim of the current study was to design and evaluate a therapist version of the Alliance Negotiation Scale (ANS). The ANS was created in order to operationalize the construct of dyadic negotiation in psychotherapy and to augment existing conceptualizations of the working alliance. The ANS has existed only as a client self-report form since its inception and has demonstrated promise as a psychotherapy process measure. This research intended to develop a complementary therapist self-report version of the measure. The scale creation process is discussed in detail, and the results of a preliminary psychometric investigation are reported. The ANS-Therapist version (ANS-T) was developed using a sample of therapists (n = 114) through a principal components analysis procedure. The ANS-T contains 9 unidimensional items and was moderately correlated with therapist-reported working alliance (r = .468). The results of the study support the composition of the ANS-T and provide initial support for the reliability and validity of the measure.

KEYWORDS

Alliance Negotiation Scale, psychotherapy process measure, therapist self-report, working alliance

1 | INTRODUCTION

The Alliance Negotiation Scale (ANS; Doran, Safran, Waizmann, Bolger, & Muran, 2012) was created in 2012 in an effort to operationalize the theoretical construct of dyadic negotiation in psychotherapy (Safran & Kraus, 2014; Safran & Muran, 2000, 2006) and in order to augment existing conceptualizations of the working alliance. Bordin is credited with developing the modern definition of the working alliance, framed as a collaborative stance between a patient and therapist emerging from agreement on the tasks and goals of therapy, as well as the quality of their relational bond (Bordin, 1979). Although the working alliance has become a foundational concept in the practice and study of psychotherapy and has decades of literature to support it, historical conceptualizations are not without their limitations or critiques. The working alliance and its measurement are generally positively valenced in nature, with the hallmark feature of existing measures described as "collaboration and consensus" (Cushman & Gilford, 2000; Horvath, Re, Fluckiger, & Symonds, 2011). Safran and Muran (2006) have argued that the more traditional concept has become somewhat outdated and have pushed for the definition to evolve to include more modern theories and concepts. Their foundational work emerged in the context of the relational therapy model (e.g., Mitchell & Aron, 1999) and has focused more on negative interpersonal processes in therapy. The importance of tension, disagreements, and upset feelings between a patient and therapist began to be seen as critically important aspects of the therapeutic process (Safran, Crocker, McMain, & Murray, 1990). Such negative therapy events are known as *ruptures* in the therapeutic relationship (Safran, 1993), and a body of literature has grown supporting the importance of ruptures and their resolution (Safran & Muran, 2000), their relationship to treatment outcome (Aguirre McLaughlin, Keller, Feeny, Youngstrom, & Zoellner, 2014; Safran, Muran, & Eubanks-Carter, 2011), and their role in the change process (Stiles et al., 2004; Strauss et al., 2006).

The ANS was developed in this context and the theoretical argument to augment the current conceptualization of the working alliance to include the constructive dyadic process of *negotiation* over the more traditional focus on agreement and compliance (for a more detailed review of this and aforementioned issues, see Doran, 2016; Doran, Safran, & Muran, 2016; Safran & Muran, 2000, 2006). Alliance negotiation represents what patients and therapists do when ruptures or other negative processes occur in

therapy sessions and reflect if the quality of the therapeutic relationship facilitates or hinders these issues being addressed and resolved. Theoretically, a high level of dyadic negotiation is expected to be related to positive treatment outcome, whereas problems in negotiation are expected to negatively impact the therapy process and outcome. Constructive alliance negotiation is conducive to identifying and working through ruptures and other negative therapy processes, paving the way for positive therapeutic and interpersonal change. Research is beginning to support these ideas (Doran, Safran, & Muran, 2017).

Although there are numerous existing patient and therapist measures of psychotherapy process (e.g., the Individual Therapy Process Questionnaire; Mander et al., 2015) and the working alliance specifically (see Bachelor, 2013, for an overview of the three most common measures of the alliance), the ANS is viewed as offering a unique contribution in its explicit focus on negative therapy process related to patient/therapist feelings, behaviour, and perceptions of the other and their dyad during treatment. Although some existing alliance measures may contain a few items that assess the presence of negative thoughts or feelings, the ANS is unique in its focus on what the client and therapist actually do with these feelings when they occur. The ANS moves beyond assessing the presence of disagreement, for example, to examining how the client and therapist respond to and address disagreement when it occurs. The ANS is also the first measure to explicitly operationalize and assess the construct of alliance negotiation.

The ANS was modelled in structure and form after the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989), one of the most commonly used measures of the working alliance, with the intention to augment the measurement of the alliance construct by including an explicit focus on negative therapy process and the presence and resolution of ruptures in therapy (Doran et al., 2016). Although the original WAI has been transformed into several versions, including shorter forms as well as therapist self-report and observer-based coding versions, the ANS was initially created only as a client self-report version of the measure (Doran et al., 2012). It was determined that the reliability, validity, and utility of the construct of negotiation, and the ANS as an independent measure, should be examined before investing resources into the creation of parallel versions.

The ANS is a 12-item client self-report measure consisting of two factors: *Comfort with Negative Feelings* (Factor 1) and *Flexible and Negotiable Stance* (Factor 2). ANS items assess both client feelings and behaviour (such as "I am comfortable expressing disappointment in my therapist when it arises"), client perceptions of the relational dyad ("I feel that I can disagree with my therapist without harming our relationship"), and client perceptions of the therapist's behaviour ("My therapist is able to admit when he/she is wrong about something we disagree on"). Items are rated on a 7-point Likert scale, with responses ranging from *Never* to *Always*, and Factor 2 items are negatively valenced and reverse scored. Appendix A includes a copy of the measure.

Since its inception, the ANS has been translated into Spanish and adapted for use in an Argentinean population (ANS-A; Waizmann et al., 2015), with several other cultural adaptations in progress.

Key Practitioner Message:

- Alliance negotiation is emerging as an important topic of study in psychotherapy research
- The Alliance Negotiation Scale (ANS) and ANS-Therapist version may be important tools for tracking alliance negotiation in psychotherapy
- The ANS and ANS-T may provide clinicians with important information about the quality of the therapeutic relationship and help identify potential problems in negotiation
- The ANS and ANS-T can be used by clinicians to track alliance negotiation throughout treatment and may serve as an important bidirectional feedback tool
- The ANS and ANS-T can help clients and therapists identify their ability and willingness to work through negative feelings and difficult therapy process when it occurs

Results of a preliminary study on the ANS-A were comparable with that of the original ANS, demonstrating relative cultural equivalence and potential utility of the construct cross-culturally (Waizmann et al., 2015). Both English and Spanish versions of the ANS have continued to demonstrate psychometric integrity through investigations of their reliability as well as content, criterion, and construct validity (Doran et al., 2012; Doran et al., 2016; Doran et al., 2017; Gomez Penedo, 2017; Roussos, Gomez Penedo, Doran, Olivera, & Horowitz, 2017).

Studies using the ANS have demonstrated relationships between negotiation and other process and outcome variables of interest, including both client and therapist factors. Client self-reported interpersonal problems, such as nonassertiveness and social avoidance, as well as the presence of a personality disorder, were associated with lower levels of negotiation in the therapeutic relationship (Doran et al., 2016; Doran et al., 2017). Client perceptions of therapist empathy were positively associated with negotiation (Doran et al., 2016). Lower levels of negotiation have been associated with more client-identified ruptures in session, as well as with client behaviours aimed at avoiding tension in the therapeutic relationship. In contrast, higher levels of negotiation have been found to be associated with the resolution of ruptures and greater session impact (Doran et al., 2017), as well as increased client satisfaction with treatment (Doran et al., 2016). The ANS has also proven useful in helping to explain some variance in treatment outcome, with higher negotiation scores correlated with decreased symptom levels on measures of general psychiatric distress and interpersonal functioning. Furthermore, lower ANS scores have demonstrated a predictive relationship with premature termination from treatment (Doran et al., 2017). A study on the ANS-A found that hostile-dominant and hostile-submissive interpersonal problems were related to lower negotiation scores overall (Gomez Penedo, 2017). The ANS-A has also demonstrated a

relationship with treatment outcome, with higher early negotiation scores predicting improvement in interpersonal problems of low agency (social avoidance, nonassertiveness, and being overly exploitable), as well as predicting change on a global outcome measure (Roussos et al., 2017).

Negotiation, as measured by the ANS, has been found to be highly correlated with both the working alliance, as measured by the WAI, and the real relationship, as measured by the Real Relationship Inventory (Gelso et al., 2005), indicating substantial convergence across constructs and measures (Doran et al., 2012; Doran et al., 2016). The relationship between the ANS and WAI has been found to vary over the course of treatment, with more distinction occurring in the early and middle phases of treatment. Also, less overlap has emerged between the ANS and WAI when comparing "low" versus "high" negotiation cases, indicating that the ANS may capture some unique relational difficulties (Doran et al., 2017).

Differences have not emerged in levels of negotiation across client symptom levels or modalities of treatment, though negotiation scores have been found to be higher for dyads who had been working together for longer periods of time and who met more regularly for treatment (Doran et al., 2016). Relationships between negotiation and demographic characteristics have varied across studies. One study found that negotiation scores were slightly higher for female clients and identified a positive linear relationship between negotiation and client age. In the same study, clients endorsing a racial/ethnic minority identity reported lower negotiation scores overall, and negotiation was lower in culturally "mismatched" therapy dyads, for example, a minority client with a White therapist (Doran et al., 2016).

As in any interpersonal occurrence, the therapeutic relationship and the working alliance are dyadic constructs. Understanding the thoughts, feelings, and perceptions of both client and therapist is needed in order to fully understand the psychotherapy process and any associated relational construct. It is therefore critical to investigate the presence and perception of negotiation from both the client and therapist in determining the impact of negotiation on treatment outcome. Research using previous working alliance measures has demonstrated a lack of convergence in perceptions of the alliance across reporters (Hersoug, Hoglend, Monsen, & Havik, 2001; Tichenor & Hill, 1989), with differential impact on the process–outcome relationship as well (Horvath & Symonds, 1991; Piper, Azim, Joyce, & McCallum, 1991).

The absence of a therapist version of the ANS has limited existing research efforts, providing psychotherapy process data only from the perspective of the patient. Given this, a therapist version of the ANS is greatly needed in order to fully understand the dyadic process of alliance negotiation in psychotherapy, as well as to continue to validate the construct of negotiation itself and more clearly determine its relationship with treatment outcome. The aim of the present study was to create a psychometrically sound therapist version of the ANS. It was hypothesized that a therapist version of the ANS would closely parallel the existing client version in terms of factor structure and content. Based on research using the client versions of both scales (Doran et al., 2017), a moderate-to-large correlation between the ANS and WAI was also expected.

2 | METHOD

Given the popularity of the ANS in both American and Argentinean cultures, the creators of the respective versions of the scale decided to collaborate on the development of a therapist version of the measure. Traditionally, assessment measures are created in one language or culture and then tested in another culture for equivalence and utility or adapted/translated as needed. This approach to assessment often results in very Western-centric tools and places the country of origin (typically the United States) in a position of privilege and as the point of reference for subsequent versions. As the concept of negotiation has been found to be useful cross-culturally, and it is likely that the ANS-T will be used in multiple cultural contexts, it was determined that a collaborative cross-cultural effort to create a therapist version would be preferable. Members of the research teams involved in the validation of both the ANS and ANS-A worked together in order to *simultaneously* (rather than sequentially) create and develop parallel versions of the ANS-T. This paper presents the final English/American version of the scale; an identical Argentinean version of the measure was also created as part of this process and will be presented in a separate paper in a Spanish-language journal (Gomez Penedo, Doran, & Roussos, 2017).

2.1 | Procedure

The present study was designed to mirror the original ANS development study (for a detailed review of this process, see Doran et al., 2012). The first step was to create an item pool for potential items that would comprise the ANS-Therapist version (ANS-T). The item creation process for the client version of the ANS was a long and iterative process that involved collaboration with a core research team of clinician-researchers. Content validity checks also occurred through review by senior members of the research team and an external expert panel of psychotherapy researchers who reviewed and rated all potential items as part of the original ANS study (additional information about the item construction process can be found in Doran et al., 2012). Building on the theoretical groundwork that was part of this original item creation process, existing ANS client-centred items were directly translated into a parallel item from the perspective of the therapist. For example, in the client version of the ANS Item 1 is "I feel that I can disagree with my therapist without harming our relationship." The directly translated item for the ANS-T would therefore be "I feel that I can disagree with my patient without harming our relationship." Although reasonable translations were able to be made for all original ANS items, it was acknowledged that the most direct translation might not provide the clearest or most psychometrically sound way of assessing the concept of interest. Therefore, at least one alternate wording was created for each item in an effort to reframe the item wording or increase clarity of the concept. For Item 1, additional wordings that were tested included "My patient and I are able to constructively work through disagreements in therapy" as well as "My patient seems to feel that he/she can disagree with me without harming our relationship." As in the original ANS, items in the initial item pool were framed both to capture the perspective of the individual completing the self-report (the client in the original version; the

therapist for the ANS-T), as well as to assess their perception of the "other" in the dyad. As another example, Item 2 in the original ANS is "My therapist encourages me to express any concerns I have with our progress." For the ANS-T, parallel items for testing included "I encourage my patient to express any concerns he/she has with our progress" (direct translation), as well as "I am comfortable hearing my patient's negative feelings about me or our work" (alternate phrasing/wording). Although both tested items are similar in nature, one assesses the therapist's feelings while the other their actual behaviour. This was done purposefully, as the item pool in the original ANS (and the actual final version of the measure itself) contains both types of items. The goal for the ANS-T was to test items that captured (a) therapist feelings, (b) therapist behaviour, and (c) therapist perceptions of the patient/dyad.

Participants for the current study were recruited through psychology graduate student university departments, listserves for psychologists, and psychologist social networking sites using a snowball sampling procedure. An initial invitation to participate was sent via email or as a discussion post and requested participation from clinicians. Participants who were interested in the study were invited to click on a link to learn more, which directed them to a data collection website (Survey Monkey) where they were provided with informed consent and given the option to participate. Informed consent was obtained from all participants prior to their participation. The survey consisted of 60 questions and first assessed therapist demographic and professional information, followed by de-identified client demographic information. This information was collected through the use of multiple-choice questions with the option to include a unique, open-ended response where applicable. Clinicians also provided information about their theoretical orientation, modality of treatment, frequency of sessions, duration of treatment, and their client's presenting problems and diagnoses.

In order to encourage a range of responses and assess the quality of the therapeutic relationship in both positive and more challenging dyads, participants were randomly assigned to answer subsequent questions while thinking about a current client who they perceive as either *easy* or *difficult to work with*. Participants then responded to each of the 26 potential ANS-T items as well as the 12 items from the short version of Working Alliance Inventory–Therapist version (WAI-T; Tracey & Kokotovic, 1989) to provide preliminary data on convergent and discriminant validity. Items from the ANS-T pool and WAI-T were presented together and randomly interspersed in an effort to control for order effects. Finally, clinicians were asked how much they liked their client overall and how they felt about their work together given a Likert-style scale.

2.2 | Participants

All participants (N = 114) were mental health providers who were currently seeing patients under their own licence or as a trainee under the supervision of a licensed professional. Participants came from 15 countries (n = 20 respondents were from outside of the United States) and 18 U.S. states. The majority of respondents was female (70.2%), heterosexual (80.7%), and White (93%). A minority of respondents identified as Asian (4.4%) or Hispanic/Latino (2.6%), as well as endorsed a sexual minority status (14.1%). Therapist age ranged from 23 to 75 (M = 44.1, SD = 14.6). Therapists primarily identified as psychologists (60.5%) or psychology trainees (27.2%). Several respondents also identified as being a psychiatrist, a mental health counsellor, a social worker, or a psychoanalyst (12.3%). The majority of participants held a doctoral degree (69.3%) and worked in either a clinical practice (57.0%), hospital or medical centre (28.1%), or other mental health clinic (14.9%). Years of clinical experience ranged from 1 to 47 (M = 15.2, SD = 11.5).

The sample was close to evenly split between being assigned to answer the survey questions while thinking about a "difficult" (49.1%) versus an "easy" (50.9%) client. Therapists reported that more than half of their clients were female (57.0%). The majority of clients was also described as White (76.3%), heterosexual (82.5%), and younger than their therapists (64.9%). Client diagnoses included depressive disorders (50.9%), anxiety disorders (6.8%), a trauma or stressor-related disorder (24.6%), or other clinical syndrome such as an eating disorder or adjustment disorder (24.6%). A subset of the sample was diagnosed with a personality disorder (21.1%).

3 | RESULTS

All data were analysed using the SPSS (version 23) statistical program. All data were checked for errors and screened for outliers prior to running any analyses. Data were also checked to ensure that no statistical assumptions were violated that would prevent the use of parametric tests in the data analysis (Kendall & Stuart, 1958). Any case with more than 5% of missing data was excluded from subsequent analyses. No items were excluded from the pool of potential ANS-T items on the basis of violating a statistical criterion.

3.1 | Principal components analysis

The Kaiser–Meyer–Olkin test of sampling adequacy for factor analytic techniques exceeded the recommended threshold (Kline, 1994), producing a score of .801. An exploratory principal components analysis (PCA) was performed on the data in order to identify any underlying dimensions in the scale items and to reduce the item pool down to a simplified measure. A direct translation of the client version of the ANS was first tested before examining the differential functioning of directly translated versus alternate items. The final scale was created through careful analysis of both theoretical and statistical criterion, with the goal of retaining the most psychometrically sound items across both the English- and Spanish-language versions of the scale. The PCAs were run simultaneously in order to find the best fit for both sets of data. From a statistical standpoint, established criteria were utilized to qualify an item for retention (Bryant & Yarnold, 1995; Clark & Watson, 1995; Tabachnick & Fidell, 2001). Retained items were required to have an eigenvalue above 1, factor loadings above .4, and a minimum difference of .4 on an item that loaded on multiple factors.

The final solution was obtained through running a PCA with a one-factor solution and without rotation. Table 1 presents each item with its corresponding factor loading. As with all factor analytic

TABLE 1 ANS-T items and factor loadings

ANS-T item	Factor loadings
I believe my patient feels comfortable expressing frustration in me when it arises	.78
I believe my patient feels comfortable expressing disappointment in me when it arises	.77
My patient and I are able to constructively work through and resolve tension or ruptures in our relationship	.76
I encourage my patient to express any anger he/she feels towards me	.73
I am comfortable hearing my patient's negative feelings about me or our work	.72
I regularly "check in" with my patient to see if he/she feels that the way we are working together is correct	.61
I am able to admit to my patient when I am wrong about something we disagree on	.59
I feel that I can disagree with my patient without harming our relationship	.54
I believe my patient feels like he/she has a say regarding what we do in therapy	.46

Note. ANS-T = Alliance Negotiation Scale–Therapist version.

procedures, multiple solutions were tested as part of the data analysis process in order to identify the best fit. Utilizing a PCA versus principal axis factoring would not have changed the composition of the scale, as both methods yielded highly similar results. Many different versions of the ANS-T were also tested and subject to scrutiny, replacing directly translated items with alternates in a sequential fashion in order to determine the optimal composition of the scale. As the original ANS includes two orthogonal subscales, and the present item pool was closely modelled after the original items, a forced two-factor solution was also tested. Contrary to expectations, this solution was not a good fit of the data, and the absence of an underlying factor structure in the ANS-T was confirmed by graphical representations on both the scree plot and the component plot in rotated space (*not shown*). The principles of psychometric theory (Gregory, 2004) were closely adhered to in reviewing and evaluating alternate versions of the ANS-T throughout the scale construction process.

3.2 | The ANS-T

The final version of the ANS-T includes nine unidimensional items. Six of these items were direct translations of the original ANS wording, and three of these items included alternate versions of an original item (ANS Items 2, 7, and 12). Three items were also dropped from the measure due to inadequate performance on either the original or alternate versions of the item (ANS Items 8, 10, and 11). A final therapist version of the ANS, the ANS-T, is presented in Appendix B.

3.3 | Psychometric properties

Cronbach's alpha coefficient was adequate for the final version of the ANS-T, $\alpha = .843$, exceeding the recommended threshold of .80 (Clark & Watson, 1995; Gregory, 2004), and 44.9% of the variance in scores was explained by the final version of the ANS-T. A bivariate Pearson correlation between the ANS-T and the WAI-T was run in order to provide preliminary evidence for the construct validity of the measure. The correlation between the two measures was moderate, at $r = .468$, reflecting 21.9% shared variance and offering evidence of both convergent and discriminant validity. Bivariate Pearson correlations demonstrated significant relationships between ANS-T scores and how much therapists reported liking their clients overall, $r = .26$, $p = .006$, as well as how positively they felt about their work together, $r = .25$, $p = .01$. These small correlations can also be taken as evidence of both convergent and discriminant validity. Although there is some relationship between the constructs, alliance negotiation also appears to be fairly distinct from liking the client or overall feelings about the work. In contrast, correlations on these variables with the WAI-T were higher, at $r = .64$, $p < .001$, and $r = .70$, $p < .001$, respectively, indicating a much larger degree of overlap and conflation between the constructs. These correlational data are presented in Table 2.

3.4 | Treatment characteristics

Treatment modality varied across therapists, with over half of the sample identifying as integrative or eclectic (56.1%). A substantial number of therapists endorsed the use of psychodynamic psychotherapy/psychoanalysis (57.9%) and/or cognitive behaviour therapy or another cognitive–behavioural treatment (52.6%). Several also selected humanistic/existential therapy (19.3%). Given that the majority of therapists endorsed more than one modality and very few selected only one, analysing differences on ANS-T scores between individual types of treatment was not appropriate in this sample. Most therapy sessions occurred at a frequency of once a week or more (80.7%), and just under half of the dyads under study had been working together for 1 year or longer (45.6%). No significant differences on ANS-T scores emerged when comparing treatment frequency or duration using one-way analyses of variance and independent *t* tests (all *p*s > .05).

3.5 | Demographic and diagnostic characteristics

Independent *t* tests, bivariate Pearson correlations, and one-way analyses of variance were run to analyse demographic and diagnostic

TABLE 2 Correlations between the ANS-T and other study variables

	ANS-T	WAI-T
WAI-T	.47 *	
Feelings about client	.26 **	.64 ***
Perceptions of work	.25 *	.70 ***

Note. ANS-T = Alliance Negotiation Scale–Therapist version; WAI-T = Working Alliance Inventory–Therapist version.

*Correlation significant at $p < .05$.

**Correlation significant at $p < .01$.

***Correlation significant at $p < .001$.

differences on ANS-T scores. No significant differences emerged across therapist or client demographic variables, including age, gender, race/ethnicity, or sexual orientation (all *p*s > .05). Having therapeutic dyads that were "matched" in terms of race/ethnicity (e.g., a White therapist with a White client) was not significantly different than those that were "mismatched" (e.g., a White therapist with an African American client, or vice versa), $F(1, 112) = .12$, $p = .73$, $t = -1.60$, $p = .11$. No diagnostic differences emerged as statistically significant, including the presence versus absence of a personality disorder, $F(1, 112) = 2.74$, $p = .10$, $t = .48$, $p = .64$.

4 | DISCUSSION

The present study was designed in order to create a therapist self-report version of the ANS, previously only available in a client self-report version. This paper presents the results of the initial scale development process. This research built on previous work (Doran et al., 2012) and involved a cross-cultural collaboration with members of the research team behind the development of the Spanish-language ANS-A (Waizmann et al., 2015). The ANS and ANS-A have demonstrated promise since their inception and have been met with interest from the psychotherapy research community. The absence of therapist versions of these measures has been limiting, and the present study aimed to address this gap, so that negotiation could begin to be measured dyadically from the perspective of both client and therapist.

The ANS-T is similar to the original client version of the ANS, though not an identical translation. Although the client version of the ANS contains 12 items and two factors, the ANS-T is unidimensional and contains only nine items. Although it may have seemed preferable to have a version of the ANS-T that more closely mirrored the client ANS (12 items and/or two factors), it was deemed more important to create the most psychometrically sound scale possible. The resulting ANS-T appears to offer a nice complement to the ANS. Future research will be needed to determine how well these measures complement and interact with each other, as well as to identify the unique contributions of each. Another difference in the two scale development processes is that the ANS and the ANS-A (Spanish version of the client measure) were created *sequentially*, with the ANS developed in English and then tested as a translation in Spanish. In contrast, the ANS-T and ANS-TA (Gomez Penedo et al., 2017) were developed *simultaneously*. Of note, one of the three items that was dropped from the ANS-T was previously identified as statistically problematic in the initial ANS-A validation study (Item 8: "I pretend to agree with my therapist's goals for our therapy so the session runs smoothly"). Developing the ANS-T and ANS-TA in tandem is advantageous in that it does not privilege one culture over the other and has resulted in two identical measures that are both psychometrically strong in their respective populations.

In the present study, the ANS-T emerged as a psychometrically sound measure, with evidence for both the reliability and validity of the final version of the scale. An internal consistency analysis offered support for the reliability of the measure, despite the relatively small number of items comprising the scale. Content validity can be gleaned from the factor loadings of each item, which all fall above the recommended benchmark for inclusion. The full scale meets all of the specified criteria outlined above and was determined to be both theoretically and statistically acceptable.

Evidence of construct validity is provided by the moderate correlation between the ANS-T and WAI-T. Although substantial overlap between the client versions of the ANS and WAI initially raised some concerns about the distinction between the constructs and the utility of a new alliance measure (Doran et al., 2016; Doran et al., 2017; Waizmann et al., 2015), convergence between the two measures was lower in the present study. The ANS-T and WAI-T shared only 21.9% of variance in scores. The magnitude of the correlation between the two measures ($r = .468$) offers important support for convergent validity, demonstrating that the constructs are significantly related to each other as would be theoretically expected. However, the correlation is also low enough to offer important evidence of discriminant validity, showing that the two constructs are somewhat operationally distinct.

In contrast with previous research on the ANS (Doran et al., 2016), a lack of significant differences emerged in the current study across demographic variables (both therapist and client), diagnostic variables, and treatment characteristics. Prior relationships of interest have included the finding that negotiation is lower in clients with racial/ethnic minority identities, including in "mismatched" therapeutic dyads, as well as in clients with self-reported personality disorders. These findings were not replicated in the present study, which may be explained by the homogeneous nature of the sample (resulting in relatively small subgroups across categories), or the fact that data were provided from the perspective of therapist rather than the client. It is noteworthy that alliance negotiation, as measured by the ANS-T, demonstrated relationships with both therapist liking of their client and feelings about their work overall. Larger correlations emerged on these same variables when using the WAI-T, which indicate that the ANS-T may offer more independence from these related constructs.

The ANS and ANS-T are important and unique contributions to the psychotherapy research literature. They are very short, focused measures designed to assess both client and therapist feelings, behaviours, and perceptions of the therapeutic dyad. Their brief nature lends them to repeated measures assessment and reduces the burden of measurement that can occur in complex psychotherapy studies. Questions directly focus on reactions and responses to negative therapy process, providing a measurement of the quality of the therapeutic relationship related to the ability to identify and address ruptures or other negative therapy process when it occurs. The ANS includes more negatively valenced items than other alliance measures and focuses specifically on what happens when negative process occurs. This goes beyond traditional self-report measures that may assess if negative process exists but fail to capture what is done with it. There is broad consensus in the literature that negative therapy events such as ruptures are important aspects of the therapy process, and the successful resolution of such events can be a catalyst for therapeutic change (Norcross & Wampold, 2011; Safran et al., 2011). Existing research on the presence of ruptures and their repair have traditionally relied on observer-based coding methods rather than client and therapist self-report (e.g., Eubanks-Carter, Muran & Safran, 2015).

Although interesting and informative, such methods are very costly and time consuming in nature. The ANS is the first measure that we are aware of to assess the conditions conducive to the resolution of alliance ruptures using a brief self-report format.

The ANS may also be an important tool in helping to further ongoing work related to the concepts of sudden gains and sudden losses—the appearance of abrupt therapeutic changes during therapy. *Sudden gains* refer to rapid improvement or indicators of significant change between sessions and have been found to be related to both short-term and long-term treatment outcomes (Aderka, Nickerson, Bøe, & Hofmann, 2012; Stiles et al., 2003). *Sudden losses* refer to rapid deteriorations during treatment and are associated with worse overall outcome (Lutz, Ehrlich, Rubel, Hallwachs, & Röttger, 2013). This phenomenon has demonstrated some relationship to overall alliance levels and changes in the alliance (Lutz et al., 2013; Wucherpfennig, Rubel, Hofmann, & Lutz, 2017). The ANS and ANS-T have the potential to offer important insight about alliance negotiation quality and changes related to these constructs. For example, low alliance negotiation, or sudden dips in alliance negotiation, may show a relationship to sudden losses in treatment.

Despite decades of research focused on the relationship between session process, the therapeutic relationship, and treatment outcome in psychotherapy research (Lambert, 2013; Norcross, 2011), there remains ample unexplained variance and critical gaps in our understanding about what processes produce therapeutic change. Although the client version of the ANS and ANS-A have demonstrated some promise in explaining incremental variance beyond what has been previously accounted for by more traditional alliance measures (Doran et al., 2017; Roussos et al., 2017), more research is needed utilizing both client and therapist versions of the measure. Dyadic study of negotiation is necessary in order to more fully understand the relationship and the impact negotiation has on treatment outcome. Recent studies have demonstrated that convergence over time between client- and therapist-rated working alliances resulted in greater improvement of symptoms at termination (Coyne, Constantino, Laws, Westra & Anthony, 2017; Laws et al., 2017). Whether increased convergence in perceived negotiation also impacts treatment outcome will be important to examine in future studies.

The present study has several limitations. First, in order to obtain a sufficient sample for factor analytic techniques, online data collection methods were employed. Although online data collection has several advantages, it also makes it impossible to confirm the accuracy of participant responses and may limit the representativeness and generalizability of the sample. Furthermore, it is possible that the results may have been different if data were collected in person and/or immediately following therapy sessions rather than on the therapists' own time via an online survey. The study design was also cross-sectional in nature, and observations were limited to a single point in time. It is possible that responses would have been different or more variable if data had been collected using a repeated measures design to allow for fluctuation in therapist perceptions. Although the sample size was sufficient for the analyses that were conducted, it was nevertheless relatively small, and it would have been preferable to have had a larger and more diverse sample. Another limitation is the use of only therapist self-report data without collecting complementary client data from the therapy dyads under study. However, the major aim of the study was to develop a therapist version of the scale for use in future studies, and the feasibility of collecting dyadic data in large samples would have limited these efforts. Therefore, it was determined that future work should focus on analysing data from both client and therapist measures. The current study also focused primarily on item and scale construction and preliminary reliability/validity analyses. The accumulation of validity evidence is a long-term and ongoing process. Additional studies focused on assessing criterion and construct validity in more comprehensive ways will be necessary to fully evaluate the utility of the scale. The lack of clinical outcome data in the current study is a limitation that will need to be addressed in future studies, and the relationship between client- and therapist-ANS should be carefully examined. Furthermore, although the cross-cultural collaboration described above is primarily a strength of the current study, the novelty of and lack of precedence for this approach is nevertheless limiting. Finally, although factor analytic procedures and recommendations were closely adhered to during data analysis, any factor analytic procedure necessarily involves some subjective decision-making, and which items to include or discard during scale development may be viewed as somewhat arbitrary in nature. To address this, careful attention was given to adhering to the principles of psychometric theory, and the authors tested and evaluated multiple factor analytic solutions and configurations of the scale prior to selecting a final version. All scale items were subject to both rigorous statistical and theoretical scrutiny during this multiphasic process.

Despite these limitations, the creation of a therapist version of the ANS-T is overdue and will be useful to clinicians and researchers interested in the construct of alliance negotiation. Having a psychometrically strong therapist measure to complement ongoing negotiation research will add to the literature and better inform future investigations of negotiation and the ANS. Much more work will be needed in order to further examine and validate the ANS-T. The accumulation of additional reliability and validity data will be needed to confirm the psychometric integrity of the measure, and studies will also be needed to examine its utility as a clinical and research tool. Given ongoing cross-cultural interest in the ANS, cross-cultural research on the strengths and limitations of the measure in other languages and cultural contexts will be important. It is recommended that future studies parallel existing work on the client versions of the ANS, investigating the relationships between negotiation and both psychotherapy process and outcome. Finally, the ANS and ANS-T should be used together in subsequent studies going forward so that the relationship between them can also be analysed and understood.

CONFLICT OF INTEREST

The authors have no conflicts of interest to report.

ORCID

Jennifer M. Doran http://orcid.org/0000-0003-0921-4999

REFERENCES

Aderka, I. M., Nickerson, A., Bøe, H. J., & Hofmann, S. G. (2012). Sudden gains during psychological treatments of anxiety and depression: A

meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*(1), 93–101. https://doi.org/10.1037/a0026455

Aguirre McLaughlin, A., Keller, S. M., Feeny, N. C., Youngstrom, E. A., & Zoellner, L. A. (2014). Patterns of therapeutic alliance: Rupture-repair episodes in prolonged exposure for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *82*, 112–121. https://doi.org/10.1037/a0034696

Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences, and relationship to therapy outcome. *Clinical Psychology & Psychotherapy*, *20*, 118–135. https://doi.org/10.1002/cpp.792

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, *16*, 252–260. https://doi.org/10.1037/h0085885

Bryant, F. B., & Yarnold, P. R. (1995). Principal components analysis and exploratory and confirmatory factor analysis. In L. G. Grimm, & P. R. Yarnold (Eds.), *Reading and understanding multivariate statistics*. Washington DC: American Psychological Association Books.

Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, *7*(3), 309–319.

Coyne, A. E., Constantino, M. J., Laws, H. B., Westra, H. A., & Antony, M. M. (2017). Patient–therapist convergence in alliance ratings as a predictor of outcome in psychotherapy for generalized anxiety disorder. *Psychotherapy Research*. 1–16. Online First Publication. https://doi.org/10.1080/10503307.2017.1303209

Cushman, P., & Gilford, P. (2000). Will managed care change our way of being? *American Psychologist*, *55*(9), 985–996. https://doi.org/10.1037/0003-066X.55.9.985

Doran, J. M. (2016). The working alliance: Where have we been, where are we going? *Psychotherapy Research*, *26*(2), 146–163. https://doi.org/10.1080/10503307.2014.954153

Doran, J. M., Safran, J. D., & Muran, J. C. (2016). The Alliance Negotiation Scale: A psychometric investigation. *Psychological Assessment*, *28*(8), 885–897. https://doi.org/10.1037/pas0000222

Doran, J. M., Safran, J. D., & Muran, J. C. (2017). An investigation of the relationship between the Alliance Negotiation Scale and psychotherapy process and outcome. *Journal of Clinical Psychology*, *73*(4), 449–465. https://doi.org/10.1002/jclp.22340

Doran, J. M., Safran, J. D., Waizmann, V., Bolger, K., & Muran, J. C. (2012). The Alliance Negotiation Scale: Psychometric construction and preliminary reliability and validity analysis. *Psychotherapy Research*, *22*(6), 710–719.

Eubanks, C.F., Muran, J.C. & Safran, J.D. (2015). Rupture resolution rating system (3RS): Manual. Unpublished manuscript, Mount Sinai-Beth Israel Medical Center, New York.

Gelso, C. J., Kelley, F. A., Fuertes, J. N., Marmarosh, C., Holmes, S. E., & Costas, C. R. (2005). Measuring the real relationship in psychotherapy: Initial validation of the therapist form. *Journal of Counseling Psychology*, *52*, 640–649. https://doi.org/10.1037/0022-0167.52.4.640

Gomez Penedo, J.M. (2017). Variables del paciente y del proceso psicoterapéutico vinculadas a predictores tempranos de cambio. Doctoral dissertation, Universidad de Buenos Aires, Buenos Aires, Argentina.

Gomez Penedo, J.M., Doran, J.M. & Roussos, A. (2017). Perspectiva del terapeuta acerca de la negociación de la alianza: Un instrumento para su evaluación. *Under review*.

Gregory, R. J. (2004). *Psychological tests: History, principles, and applications* (4th ed.). Boston, MA: Pearson Education.

Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy. *The Journal of Psychotherapy Practice and Research*, *10*, 205–216.

Horvath, A. O., & Greenberg, L. S. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg, & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). New York: The Guildford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223–233.

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *48*(1), 9–16.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*, 139–149. https://doi.org/10.1037/0022-0167.38.2.139

Kendall, M. G., & Stuart, A. (1958). The advanced theory of statistics. (Vol. 1). London: Griffin.

Kline, P. (1994). *An easy guide to factor analysis*. London: Routledge.

Lambert, M. J. (Ed.) (2013). *Bergin & Garfield's handbook of psychotherapy and behavior change* (sixth ed.). Hoboken, New Jersey: John Wiley & Sons.

Laws, H. B., Constantino, M. J., Sayer, A. G., Klein, D. N., Kocsis, H., Manber, R., … Arnow, B. A. (2017). Convergence in patient–therapist therapeutic alliance ratings and its relation to outcome in chronic depression treatment. *Psychotherapy Research*, *27*(4), 410–424. https://doi.org/10.1080/10503307.2015.1114687

Lutz, W., Ehrlich, T., Rubel, J., Hallwachs, N., & Röttger, M. (2013). The ups and downs of psychotherapy: Sudden gains and sudden losses identified with session reports. *Psychotherapy Research*, *23*, 37–41. https://doi.org/10.1080/10503307.2012.693837

Mander, J., Schlarb, A., Teufel, M., Keller, F., Hautzinger, M., Zipfel, S., … Sammet, I. (2015). The Individual Therapy Process Questionnaire: Development and validation of a revised measure to evaluate general change mechanisms in psychotherapy. *Clinical Psychology & Psychotherapy*, *22*(4), 328–345.

Mitchell, S., & Aron, L. (1999). *Relational psychoanalysis: The emergence of a tradition*. Hillsdale, NJ: The Analytic Press.

Norcross, J. C. (Ed.) (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (second ed.). New York: Oxford University Press.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.) (pp. 423–430). New York: Oxford University Press.

Piper, W. E., Azim, H. F. A., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance and outcome in short-term individual therapy. *Archives of General Psychiatry*, *48*, 946–953. https://doi.org/10.1001/archpsyc.1991.01810340078010

Roussos, A., Gomez Penedo, J. M., Doran, J. M., Olivera, J., & Horowitz, L. (2017). Early alliance negotiation as a predictor of therapeutic change in psychotherapy. *Journal of Clinical Psychology*. *Under review*

Safran, J. D. (1993). Breaches in the therapeutic alliance: An arena for negotiating authentic relatedness. *Psychotherapy*, *30*(1), 11–24. https://doi.org/10.1037/0033-3204.30.1.11

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy*, *27*, 154–165. https://doi.org/10.1037/0033-3204.27.2.154

Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, *51*, 381–387.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the alliance outlived its usefulness? *Psychotherapy*, *43*, 286–291.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy*, *48*, 80–87. https://doi.org/10.1037/a0022140

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R., … Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology*, *51*, 81–92. https://doi.org/10.1037/0022-0167.51.1.81

Stiles, W. B., Leach, C., Barkham, M., Lucock, M., Iveson, S., Shapiro, D. A., … Hardy, G. E. (2003). Early sudden gains in psychotherapy under

routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology*, *71*, 14–21. https://doi.org/10.1037/0022-006X.71.1.14

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., … Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology*, *74*, 337–345. https://doi.org/10.1037/0022-006X.74.2.337

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston, MA: Allyn and Bacon.

Tichenor, V. U., & Hill, C. E. (1989). A comparison of six measures of the working alliance. *Psychotherapy*, *26*, 195–199. https://doi.org/10.1037/h0085419

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment*, *1*(3), 207–210. https://doi.org/10.1037/1040-3590.1.3.207

Waizmann, V., Doran, J. M., Bolger, K., Gomez Penedo, J. M., Safran, J. D., & Roussos, A. J. (2015). Escala de Negociación de Alianza Terapéutica (ANS-A): Evidencias de su validez y confiabilidad. *Revisita Argentina de Clínica Psicológica*, *XXIV*(3), 243–254.

Wucherpfennig, F., Rubel, J. A., Hofmann, S. G., & Lutz, W. (2017). Processes of change after a sudden gain and relation to treatment outcome: Evidence for an upward spiral. *Journal of Consulting and Clinical Psychology*, *85*, 1199–1210. https://doi.org/10.1037/ccp0000263

How to cite this article: Doran JM, Gómez-Penedo JM, Safran JD, Roussos A. A therapist version of the Alliance Negotiation Scale. *Clin Psychol Psychother*. 2018;1–9. https://doi.org/10.1002/cpp.2197

APPENDIX A.

The Alliance Negotiation Scale–Client version

Doran et al. (2012)

Please answer the following questions based on how you feel with your therapist overall.							
	Never		**Sometimes**			**Always**	
1. I am comfortable expressing frustration with my therapist when it arises.	1	2	3	4	5	6	7
2. I feel that I can disagree with my therapist without harming our relationship.	1	2	3	4	5	6	7
3. My therapist encourages me to express any concerns I have with our progress.	1	2	3	4	5	6	7
4. My therapist and I are not good at finding a solution if we disagree.	1	2	3	4	5	6	7
5. My therapist is inflexible and does not take my wants or needs into consideration.	1	2	3	4	5	6	7
6. I am comfortable expressing disappointment in my therapist when it arises.	1	2	3	4	5	6	7
7. My therapist encourages me to express any anger I feel towards him/her.	1	2	3	4	5	6	7
8. I feel like I do not have a say regarding what we do in therapy.	1	2	3	4	5	6	7
9. 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
10. I pretend to agree with my therapist's goals for our therapy so the session runs smoothly.	1	2	3	4	5	6	7
11. My therapist is rigid in his/her ideas regarding what we do in therapy.	1	2	3	4	5	6	7
12. My therapist is able to admit when he/she is wrong about something we disagree on.	1	2	3	4	5	6	7

Note. The measure was first published in Doran et al., 2012

APPENDIX B.

The Alliance Negotiation Scale–Therapist version

Please answer the following questions based on how you feel with your patient overall.							
	Never		**Sometimes**			**Always**	
1. I feel that I can disagree with my patient without harming our relationship.	1	2	3	4	5	6	7
2. I am comfortable hearing my patient's negative feelings about me or our work.	1	2	3	4	5	6	7
3. I believe my patient feels comfortable expressing disappointment in me when it arises.	1	2	3	4	5	6	7
4. I encourage my patient to express any anger he/she feels towards me.	1	2	3	4	5	6	7
5. I am able to admit to my patient when I am wrong about something we disagree on.	1	2	3	4	5	6	7
6. I believe my patient feels comfortable expressing frustration in me when it arises.	1	2	3	4	5	6	7
7. My patient and I are able to constructively work through and resolve tension or ruptures in our relationship.	1	2	3	4	5	6	7
8. I believe my patient feels like he/she has a say regarding what we do in therapy.	1	2	3	4	5	6	7
9. I regularly “check in” with my patient to see if he/she feels that the way we are working together is correct	1	2	3	4	5	6	7