

Alliance negotiation as a predictor of early treatment outcome

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Funding information

Society for Psychotherapy Research; Universidad de Buenos Aires

Abstract

Aim: The therapeutic alliance is a robust predictor of treatment outcome. However, little is known about the way alliance negotiation contributes to psychotherapy outcome. The aim of the present study was to analyze the effects of alliance negotiation on treatment outcome in the first four sessions of psychotherapy.

Methods: Ninety-six patients diagnosed with emotional disorders received weekly Solution-Focused Brief Therapy. Each patient completed both the Alliance Negotiation Scale (ANS) and the Outcome Questionnaire 45 (OQ.45) after each of the first four sessions. Both between- and within-patients effects of alliance negotiation on symptom severity were analyzed using Hierarchical Linear Models.

Results: Results showed significant between and within patient effects of alliance negotiation on symptom severity. Patients with higher levels of alliance negotiation across treatment showed lower levels of symptom severity (between-patient effect). Also, in a session with higher alliance negotiation compared to the average session of this patient, symptom severity was lower than in the average session (within-patient effect).

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Discussion: The results indicate that therapies characterized by higher alliance negotiation and sessions with higher alliance negotiation are beneficial for early outcome.

Conclusion: From a clinical point of view, the results suggest that alliance negotiation is a meaningful factor for therapy outcome and that therapists may benefit from training and monitoring alliance negotiation during the early stages of treatment.

KEYWORDS

alliance negotiation, between-patient effects, symptom severity, within-patient effects

1 | INTRODUCTION

The therapeutic alliance is probably the most studied phenomenon in the history of psychotherapy research. To date, there is an evidence-based consensus between researchers about its value for predicting treatment outcome. In a meta-analytic synthesis that included more than 250 studies and 30,000 patients, Flückiger et al. (2018) concluded that the alliance is a moderate yet robust predictor of therapeutic change, explaining about 8% of outcome variance. In addition, its association with treatment outcome persisted across treatment types, alliance scales, patient characteristics and countries where the studies were conducted (Flückiger et al., 2018). These effects were not only observed in conventional face-to-face treatments but also in internet-based and pharmacological treatments (Flückiger et al., 2018).

Despite its popularity in the last years, several concerns have been raised about the classical conceptualization of the alliance proposed by Bordin in 1979. It is worth noting that these concerns and critics are not intended to replace one definition with other. Instead, the aim of these is to further the debate regarding alliance and its conceptualization. For example, Safran and Muran (2006, p.286) stated that the classical perspective of the alliance may have "outlived its usefulness" as it overemphasizes the collaborative and consensus-based aspects of the alliance. Doran et al. (2012) attested the same bias to Bordin's definition in the selection of items for the majority of existing alliance scales: most instruments miss the negotiation dimension about disagreements and tension in the relationship. In that regard, the authors point out that collaboration and negotiation are not mutually exclusive. On one hand, collaboration focuses in the degree of agreement between therapist and patient regarding therapeutic tasks and goals. This dimension also considers patient's feelings of trust and being cared for by the therapist (Doran et al., 2012). On the other hand, the negotiation of the alliance refers to the degree in which the patient feels that the therapist is responsive to tensions in their bond. The negotiation aspect also takes into the account the therapist's ability to change their response according to the patients' needs (Doran et al., 2012; Safran & Muran, 2006). Due to these characteristics, alliance negotiation is an emergent of the therapeutic alliance and reflects its dynamic nature (Safran & Kause, 2014).

Evidence for the dynamic nature of the alliance can be found in longitudinal studies. After measuring the alliance each session, Khivlighan and Shaugnessy (2000) found specific patterns of alliance development, one of which was a quadratic U-shape. This high-low-high typical trajectory of the alliance was associated with better treatment outcome. In the last decades, evidence of different alliance patterns has been found: stable (de Roten et al., 2004), linear growth (Ardito & Rabellino, 2011) and a V-shaped pattern (Stiles et al., 2004). However, it has been suggested that alliance development requires further and more in-depth research to fully understand its

dynamic nature and relationship with outcome (Castonguay et al., 2006). A further step in this direction is to study ruptures and resolutions of the alliance.

Alliance ruptures refer to the breakdown of the collaboration between patients and therapists and resolution strategies serve to resolve such conflicts (Safran et al., 2002). Over the last 25 years, there has been a growing body of evidence that ruptures are common events, being reported by patients in 20%–45% of sessions, therapists in 40%–55% of sessions and third-party observers in 40%–75% of sessions (Muran & Safran, 2017). It seems that ruptures occur in every form of therapy and with therapists of all skill levels (Eubanks-Carter et al., 2015), with contributions to such ruptures from the patient and the therapist (Coutinho et al., 2011; Safran & Kraus, 2014). Therefore, the processes of ruptures and resolutions in the alliance may not only be common, but also an essential mechanism of change in psychotherapy, as Safran and Muran point out (2006). In more recent years, research has even proposed alliance as a mediator of change (e.g., Baier et al., 2020; Leibovich et al., 2020).

In the last years, efforts have been made to elucidate the association between rupture-resolution process and treatment outcome. In a study conducted by Larsson et al., 2016; they found that the pattern associated with better outcome was the repair one, surpassing the no-rupture pattern. In addition, Zilcha-Mano and Errázuriz (2017) reported that a gradual strengthening pattern of alliance was the most common one, appearing in 48.8% of cases in their sample. This pattern was also linked with a stronger alliance during the treatment. On the contrary, patients that had an unrepaired pattern did not have an alliance improvement over the course of the treatment. These results also indicate a relationship between early alliance (i.e., first four sessions of treatment) and outcome. In a meta-analysis that included 11 studies and 1314 patients, Eubanks et al. (2018) found a moderate association between rupture-resolution processes and clinical severity. While patients' clinical severity may play an important role, it is probable that therapist characteristics also influence the processes of alliance resolutions (e.g., Talbot et al., 2019). Another possibility is that certain alliance negotiation capabilities exist in a dyad. This means that when ruptures emerge, both patients and therapists may be able to renegotiate their own expectations while not suppressing their underlying needs, avoiding a submissive pseudo-alliance (Safran & Muran, 2006; Wachtel, 2008).

In the last decades, there has been more research of the contribution of alliance negotiation to treatment outcome. For example, Doran et al. (2016) found that higher levels of alliance negotiation, measured with the Alliance Negotiation Scale (ANS), were associated with lower clinical symptom severity and interpersonal problems. Alliance negotiation may affect clinical severity in two ways: First, when generally higher for some patients relative to others (between-patient effects); second, when shifting in individual patients over time (within-patient effects) (Gómez Penedo et al., 2019). In the last decade, these efforts have been directed mainly towards studying between patient effects (Falkenström et al., 2014) or therapist's effects (e.g., Del Re et al., 2021). We have found scarce research focus on the within patient effects of alliance negotiation on treatment outcome (i.e., Rubel et al., 2018) which points out the need to continue studying within patient effects of alliance on outcome to shed light of alliance as a change mechanism in psychotherapy. At the same time, we have only found one study regarding early alliance negotiation (Zilcha-Mano & Errázuriz, 2017). This points out the importance to further study a critical moment of treatment which can impact outcome. However, previous studies have failed to address early changes in alliance negotiation from session-to-session and its effect on early treatment outcome across sessions.

This study aims to analyze the effect of alliance negotiation on outcome early in treatment (i.e., during the first four sessions of treatment) and to disaggregate between- and within-patient effects of the predictor variable. Furthermore, we will investigate if there are interactive effects of the between-and within-patient alliance negotiation effects on treatment outcome. The following three hypotheses will be tested:

- (1) Alliance negotiation will display significant between-patient effects on clinical severity.
- (2) Alliance negotiation will display a significant within-patient effects on clinical severity.
- (3) There will be an interactive effect of the between- and within-patient alliance negotiation effects on clinical severity.

2 | METHOD

2.1 | Participants

The sample consisted of 96 adult patients who attended an outpatient clinic in Buenos Aires, Argentina. All participants had to meet DSM-V criteria for emotional disorders to participate in this study (Allen et al., 2007; 5th ed.; DSM-5; American Psychiatric Association [APA], 2013). Comorbidity with borderline personality disorder, bipolar disorder, suicide risk, cognitive impairment or substance abuse were used as exclusion criteria.

61.5% of the sample were female and the average age was 36.44 years (standard deviation [SD] = 11.84). Regarding diagnoses, the distribution was the following: 29.8% major depressive disorder, 24.5% panic disorder without agoraphobia, 16% generalized anxiety disorder, 8.5% panic disorder with agoraphobia, 6.4% dysthymia, 4.3% unspecified anxiety disorder, 3.2% specific phobia, 3.2% obsessive-compulsive disorder, 2.1% social phobia and 2.1% unspecified mood disorder. Twenty-two patients (22.92%) abandoned treatment before completing the first four sessions.

2.2 | Therapists

Clinicians in this study were eight therapists, six female (75%) and two male with a mean age of 32.83 years (SD = 5.15; range = 28–42). All therapists underwent a complete 2-year training and specialization program course in Solution-Focused Brief Therapy (SFBT; SFBT Research Committee, 2007; De Shazer et al., 1986) before treating patients in this study. Supervision took place on a weekly basis and therapists were selected for each patient based on time availability. Therapists treated between 5 and 27 patients each.

2.3 | Treatment

Treatment was delivered weekly at an outpatient clinic in Buenos Aires, Argentina, which had a SFBT clinical orientation (De Shazer and Berg 1997; De Shazer et al., 1986). SFBT is a Rogerian clinical orientation that focuses on patient's strengths and resources to resolve their daily concerns. In its beginnings, SFBT was grounded in a systemic paradigm. However, it has added techniques from frameworks such as cognitive-behavioral therapy and motivational interviewing (SFBT Research Committee, 2007). A main assumption in SFBT is that patients have the resources to overcome their difficulties but they might not be aware of that. The therapeutic work focuses in recognize and generalize these resources and apply them to other situations (De Shazer et al., 1986; SFBT Research Committee, 2007). Following the spirit of the framework, the average number of sessions per treatment was only 10.83 (SD = 6.70 sessions) in the completer sample (those who completed the first four sessions).

2.4 | Measures

2.4.1 | Alliance Negotiation Scale (ANS)

The Spanish version of the ANS (client version) was used to measure the degree of alliance negotiation (Doran et al., 2012; Waizmann et al., 2015). The instrument measures the degree to which the patient experiences the therapist's ability to modify or adjust his actions in relation to the patient's needs and being attentive to tensions in the bond between them (p., 245, Waizmann et al., 2015). The ANS contains 12 items with two sub-scales: Comfort with Negative Feelings and Flexible and Negotiable Stance. Comfort with Negative Feelings reflects the client's

perception of the degree of negotiation in the therapeutic relationship, with items such as “I am comfortable expressing frustration with my therapist when it arises.” Flexible and Negotiable Stance considers the therapist’s willingness to negotiate treatment goals and tasks with the patient and includes items like “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 ranging from 1 (“never”) to 7 (“always”); higher overall scores reflect higher alliance negotiation. The Spanish ANS version showed adequate psychometric properties in a patient sample from Buenos Aires, Argentina. (Waizmann et al., 2015). Specifically, internal consistency of the total score ($\alpha = 0.78$) and its two subscales (Subscale 1 $\alpha = 0.92$ and subscale 2 $\alpha = 0.87$). In the sample of the study, the ANS showed adequate internal consistency ($\alpha = 0.70$).

2.4.2 | Outcome Questionnaire 45.2 (OQ 45.2)

The Outcome Questionnaire 45.2 (OQ 45.2; Lambert et al., 1996) is a self-report instrument that was designed for repeated measurement of patient change occurring over the course of treatment. It includes 45 items, rated on a 5-point Likert scale, ranging from 1 (“never”) to 5 (“almost always”). Higher scores correspond to higher levels of distress. An Argentine version of the OQ.45.2 was used in the present study (Fernández Álvarez et al., 2005). This version showed adequate internal consistency ($\alpha = 0.92$) and test–retest reliability ($r = 0.86$). It also presented evidence of concurrence validity based on strong correlations ($r = 0.71$; $p < 0.01$) with other outcome measures such as the Symptom Checklist Revised (SCL-90-R; Casullo & Perez, 1999/2008; Derogatis, 1994). The OQ.45.2 showed excellent internal consistency in the current sample ($\alpha = 0.94$).

2.5 | Procedure

Patients followed an admission process at the outpatient clinic. First, they had an interview with a senior therapist who then made an assessment of the patient. Based on the DSM-V criteria (APA, 2013), they were interviewed and diagnosed. Those patients who met criteria for an emotional disorder (and not the exclusion criteria described above) were invited to participate in the study. Those who accepted to participate were assigned to a therapist, based on time availability. Patients completed both ANS and OQ.45.2 after each of the first four sessions. No therapist had access to the results. The procedure of the present study was approved by the Research Ethics Committee of the Psychology Faculty of Universidad de Buenos Aires.

2.6 | Analytic strategy

To test the hypothesis, we ran hierarchical linear models (HLM; Raudenbush & Bryk, 2002) using R Studio version 4.0.4 (RStudio Team, 2020). HLM allow working with a repeated measures design where observations are nested within patients and patients are nested within therapists. The between- and within-patient effects of alliance negotiation on symptom severity were disaggregated. We computed intra-class correlation coefficients (ICC) to get the percentage of variance in the outcome variable (OQ 45.2) explained by patients (Raudenbush & Bryk, 2002), which yielded a result of 83%. Although testing for therapist effects was not the aim of the present study, we also tested whether it accounted for variability in the outcome variable (OQ 45.2). By running an unconditional model with no predictors, we computed the ICC to get the percentage of variance explained by the therapist. Being less than 1%, we discarded a three-level conditional model (Westra et al., 2016). Instead, a two-level conditional model was run with ANS scores as the predictor variable of symptom severity (Level 1: within-patient effect of the alliance negotiation; Level 2: between-patient effect of the alliance negotiation). Next, we ran a two-level model including

time as the only predictor (level 1). This model allowed to estimate symptom severity rate of change within sessions, along with its levels at the end of session 1.

A *hybrid* two-level HLM was also run, with OQ.45.2 scores as the dependent variable, disaggregating between- and within-patient effects of alliance negotiation on symptom severity (Falkenström et al., 2017). In this model, two predictors of OQ.45.2 were included: (i) average level of alliance negotiation during the first four sessions (level-2 predictor; between-patient effect) and (ii) the degree of deviation of the alliance negotiation scores in each session from each patient's individual mean (level-1 predictor; within-patient effect). Between-patient effects estimate the general association of the alliance negotiation with symptom severity (i.e., if patients with greater levels of alliance negotiation tend to exhibit higher/lower symptom severity). Within-patient effects reflect the impact of variations in alliance negotiation throughout the sessions on symptom severity.

There is an ongoing debate about how to deal with time effects on outcome variables in these types of models (Falkenström et al., 2017). Some authors recommend taking into account the time effect by adding it into the model as a covariate (a technique named "detrrending"; Curran & Bauer, 2011). Others consider it a conservative strategy that threatens the scope of inferences; within-patient effects occur as time goes by (Wang & Maxwell, 2015). We followed Falkenström et al. (2017) middle-way recommendation by running two conditional models with and without controlling for time effects. If the effects remained significant when adding time effects, stronger causal inferences could be made (Falkenström et al., 2017). Finally, a *hybrid* two-level conditional model including interactive within- and between patient effects on symptom severity was run to test hypothesis three. In the same model, general level of alliance negotiation (level 2 predictor) was included as a predictor of the within-patient effect (level 1 predictor). As with the models ran for hypothesis one and two, we estimated the effects with and without controlling for time effects.

3 | RESULTS

3.1 | Sample descriptives

In Table 1, we present the descriptive statistics of the main variables of the study at baseline. We also present Pearson's *r* Correlation between ANS and OQ.45.2.

3.2 | Preliminary analyses

The results of the main models conducted in the present study are summarized in Table 2 and Table 3. Next, we present the results of each model in detail.

TABLE 1 Mean, standard deviation, and pearson's *r* correlation between the targeted variables.

Variables	M	SD	Pearson's <i>r</i> correlation	
			ANS	OQ.45.2
ANS				
Total score	5.69	0.70	-	-0.12
OQ.45.2				
Total score	1.70 ^a	0.47	-0.12	-

Abbreviations: ANS, Alliance Negotiation Scale; OQ.45.2, Outcome Questionnaire 45.2; SD, standard deviation.

^aThe total average score (in its original range) for the OQ.45 was 63.28 (SD = 35.35). The average for the first session was 73.37 (SD = 24.53); second session 65.83 (SD = 30.03); third session 59.33 (SD = 34.72); and fourth session 53.74 (SD = 36.47).

TABLE 2 Results of the unconditional model, and time-as-only predictor model.

Fixed Effects	OQ.45 levels		ANS Effect (within-patient)		OQ.45 change session to session	
	Coefficient	SE	Coefficient	SE	Coefficient	SE
Two-level unconditional model						
Intercept	1.63**	0.05				
Time-as-only predictor model						
Intercept	1.70**	0.05			-0.06**	0.01
Model comparison		$\chi^2(3) = 59.47, p < 0.001$				

Note: both time-as-only predictor model and the conditional models were with the unconditional two-level model.

Abbreviations: ANS, Alliance Negotiation Scale; SE, standard errors.

** $p < 0.001$.

3.3 | Unconditional model

The results of the two-level unconditional model showed an average symptom severity of 1.63 at the end of session 4 ($\beta_{00} = 1.63$, $EE = 0.05$, 95% confidence interval [CI] [1.53–1.73], $t(95) = 32.1$, $p < 0.001$). When including time (defined as session number) as the only predictor of symptom severity, the model showed a significant effect ($\beta_{100} = -0.06$, $EE = 0.01$, 95% CI [-0.08 to -0.04], $t(81) = -4.51$, $p < 0.001$). This means that on average, symptom severity decreased by 0.06 units each session. Also, including time as a predictor significantly improved the model fit, $\chi^2(3) = 59.47$, $p = 0.001$.

3.4 | Conditional model

3.4.1 | Between-patient effect

Compared with the unconditional model, the results of the *hybrid* model that included alliance negotiation as the only-predictor improved the model fit, $\chi^2(2) = 18.62$, $p < 0.001$. We found a significant between-patient effect of alliance negotiation on symptom severity during the first four sessions, ($\gamma_{01} = -0.23$, $SE = 0.08$, 95% CI [-0.38 to -0.07], $t(96) = -2.8$, $p < 0.001$). A one-unit greater alliance negotiation level was associated with 0.23 units lower symptom severity during the first four sessions of therapy.

3.4.2 | Within-patient effect

The *hybrid* model indicated a significant within-patient effect of alliance negotiation on symptom severity, ($\gamma_{10} = -0.10$, $SE = 0.03$, 95% CI [-0.15 to -0.03], $t(234) = -3.4$, $p < 0.001$). A one-unit fluctuation of alliance negotiation from the individual patient's mean was associated with 0.10 units less in symptom severity for that same session.

When running the same model but controlling for time effects (detrrending), both the between-patient, ($\gamma_{01} = -0.23$, $SE = 0.08$, 95% CI [-0.38 to -0.07], $t(96) = -2.9$, $p < 0.001$) and within-patient-effects, ($\gamma_{10} = -0.07$, $SE = 0.04$, 95% CI [-0.12 to -0.01], $t(68) = -2.02$, $p < 0.01$) remained significant.

TABLE 3 Results of the condition model, and interactive model.

Fixed effects	OQ45 levels		ANS effect (within-patient)	
	Coefficient	SE	Coefficient	SE
Two-level conditional model				
Intercept	1.63**	0.05	-0.10**	0.03
ANS effect (between-patient)	-0.23**	0.08		
Model comparison			$\chi^2(2) = 18.62, p < 0.001$	
Interactive between- and within-patient effects				
Intercept	1.63**	0.05	-0.13**	0.04
ANS effect (between-patient)	-0.23**	0.08	-0.03	0.06
Model comparison			$\chi^2(1) = 0.22, p = 0.64$	

Note: Both time-as-only predictor model and the conditional models were with the unconditional two-level model. Abbreviations: ANS, Alliance Negotiation Scale; SE, standard errors.

** $p < 0.001$.

3.5 | Cross-level interaction between- and within-patients

The results of the interactive model showed no significant effect of the general levels of the alliance negotiation (between-patient) on the within-patient effect, ($\gamma_{11} = -0.03$, $SE = 0.06$, 95% CI [-0.16 to 0.10], $t(96) = -0.47$, $p = 0.64$).

We also performed a post-hoc power analysis using the software *simr* in R. The models showed an appropriate power to estimate alliance negotiation effects on clinical severity between-patient effects ($1-\beta = 0.05$) and within-patient effects ($1-\beta = 0.05$). However, the power analysis showed a very low power to detect interactive effects ($1-\beta = 0.05$).¹

4 | DISCUSSION

The aim of the present study was to analyze the effect of alliance negotiation on early treatment outcome and to disaggregate its between- and within-patient effects. In fact, results showed significant between- and within-patient effects of alliance negotiation on symptom severity, but no interaction of the between- and within-patient effects.

In line with our first hypothesis, ANS showed a significant between-patient effect on symptom severity; those patients who exhibited higher alliance negotiation levels, also presented lower levels of symptom severity. This is consistent with the only previous study that demonstrated the predictive power of alliance negotiation on symptom severity (Doran et al., 2016). Together, these findings underscore the importance of creating a therapeutic space where interpersonal problems and ruptures in the alliance can manifest during treatment. This can be related with therapist's responsiveness, which is defined as therapists' interventions in response to patient's characteristics (Stiles et al., 1998). Furthermore, responsiveness reflects the therapists' ability to make changes to be attuned to their clients' needs. For example, after a rupture, therapists can change certain interventions or the way they deliver them, making the patient feel understood and listened to, improving their relationship. Whenever disagreements between patients and therapists appear, a process of alliance negotiation can emerge so that a readjustment of the therapy goals and tasks can take place and resolution processes can flourish. However, therapists' detection of ruptures and its consecutive resolution (or not) are associated with their training, and personal characteristics such

as empathy and attachment style (Talbot et al., 2019) and this can have direct consequences for treatment outcome (e.g., Chen et al., 2016)

Some authors suggest that alliance negotiation processes constitute a mechanism of change itself (e.g., Muran & Safran, 2017). It is further likely that certain patient characteristics enhance the alliance negotiation process. For example, Gómez Penedo et al. (2019) found that more severe interpersonal problems were associated with poorer early alliance and symptom severity. Dinger et al. (2013) also observed that interpersonal problems associated with communion predicted slower symptomatic improvement. In this line, a patient who shows hostile-dominant behavior could pose a greater deal of difficulties to navigate the ebbs and flows of the therapeutic alliance on the therapist (e.g., difficulties establishing therapeutic goals and complains about the therapeutic process).

Regarding the second hypothesis, results showed that positive variations on evolution of the alliance along the first four sessions significantly predicted an improvement in clinical severity. The HLM methodology allowed to catch the dynamic nature of alliance negotiation and results reinforced its relevance as a mechanism of change. From a clinical point of view, the results showed that alliance negotiation is a meaningful factor for therapy outcome and that therapists may benefit from monitoring alliance negotiation during the early stages of treatment (Eubanks et al., 2018). It is recommendable to be attentive to variations in alliance negotiation levels between sessions, given it is not a stable variable and is associated with important gains for the patient. Also, it may be important for therapist training to strengthen those characteristics associated with alliance negotiation ability, such as empathy and cognitive flexibility (Constantino et al., 2017). Focusing on those therapist characteristics may stimulate an openness to have difficult conversations with the patient during treatment.

As for our third hypothesis, the results did not show a significant effect of general levels of the alliance on the within-patient effect. Those patients who exhibited higher mean levels of alliance negotiation throughout the four sessions did not have a different effect of variations in alliance negotiation on symptom severity. This further highlights the importance of working on the alliance negotiation session by session, regardless of the average level across treatment.

The present study has several limitations. First, results cannot be generalized to the whole psychotherapy process, given that the variables were measured only in the first four sessions. Second, given both ANS and OQ.45.2 were patient self-report measures, the results are not exempt of the "halo effect," a cognitive bias where positive impressions of one person in one area positively correlate with impressions of the same person in another area (Nisbett & Wilson, 1977). In this case, it would be probable that good impressions of the patient about the therapeutic relationship would correlate with their perceived outcome severity, leading to exaggerated relations between the alliance and outcome (Safran et al., 2009). Furthermore, patients completed the measures at the end of the session instead of the beginning due to lack of infrastructure in their therapists' offices. Due to this, patients' subjective assessment of their well-being could be tangled up with how they felt during (and after) the session, which in turn, could affect their assessment of alliance negotiation. Third, even though HLM analysis allows to establish a stronger relationship between variables, we cannot dismiss other variables that might influence our results such as diagnosis or interpersonal problems. Fourth, given the nature of the clinic where the study take place, a high rate of drop out is expected. This also happen with the sample used in our study, which could also have impacted our results. Finally, regarding interactive effects, the results may be restricted due to a statistical power problem. The post-hoc power analysis we ran showed a very low power to detect interactive effects, due to this, the finding of no significant results should be considered with caution.

Future investigations may use a larger sample that augments statistical power to identify potential interactive effects. Future studies are needed in alliance negotiation. For example, an analysis of alliance negotiation and symptom severity related to patient diagnoses. Despite the alliance negotiation being considered a consistent predictor of outcome at the end of treatment, new studies that cover the entire psychotherapy process are needed.

This study has presented preliminary evidence for the importance of early alliance negotiation on early treatment outcome. To our knowledge, this is the first study that addresses both between- and within patient effects of early alliance negotiation on symptom severity using HLM for analyses. This disaggregation allows to

reach a more granular comprehension of alliance negotiation as a key process variable in psychotherapy. Specifically, two main findings emerge from our study. First, higher overall levels of alliance negotiation in the first four sessions are associated with lower levels of symptom severity (between-patient effect). Second, in a session with higher alliance negotiation compared to the average session of this patient, symptom severity was lower than in the average session (within-patient effect). These results highlight the importance of therapist training in and monitoring of alliance negotiation.

ACKNOWLEDGEMENT

Funding for this study was provided by Universidad de Buenos Aires: UBACyT 20020120100052, 2013-2016: “La percepción del paciente sobre el cambio en psicoterapia y su relación con el vínculo terapéutico, las intervenciones psicoterapéuticas y los resultados del tratamiento [Patient perception of change in psychotherapy and its relationship to therapeutic bonding, psychotherapeutic interventions, and treatment outcomes]”. The study was also funded by a 2014 Small Grant from the *Society for Psychotherapy Research* (SPR): “Relationships among interpersonal problems, psychotherapy interventions, and early predictors of outcome”.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Data set of Gómez Penedo's Doctoral Project (2013-2018) at <https://osf.io/pb79d/>.

PEER REVIEW

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1002/jclp.23498>.

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ENDNOTE

¹ To further replicate these findings, we ran a cross lagged panel model (Falkenström et al., 2022) with alliance as a predictor. We found that alliance levels predicted early responses ($\gamma_{000} = -0.11$, $EE = 0.02$, 95% CI [0.17–0.25], $t(499) = 22$, $p < 0.001$).

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How to cite this article: Manubens, R. T., Babl, A., Doran, J., Roussos, A., Alalu, N., & Gómez Penedo, J. M. (2023). Alliance negotiation as a predictor of early treatment outcome. *Journal of Clinical Psychology*, 1–12. <https://doi.org/10.1002/jclp.23498>

