

The Alliance Negotiation Scale: Portuguese adaptation

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ABSTRACT

The transtheoretical conceptualization of the working alliance and the ensuing evaluation tools tend to overestimate the collaboration between therapist and patient and to disregard the negotiation. The degree to which therapists and patients are able to negotiate their disagreements between goals and tasks is an important variable for establishing and maintaining the alliance. The purpose of this study was to adapt the Alliance Negotiation Scale – which operationalizes the theoretical construct of negotiation – to the Portuguese population. A translation and study of the psychometric traits of the scale are presented. After a backward-translation of the scale it was distributed, with the help of therapists, to a sample of 120 participants, all patients in therapeutic process. The scale showed a similar structure to its previous versions, and adequate levels of internal consistency ($\alpha=.82$). These results reinforce the quality of the scale, construct's relevance and its transtheoretical nature. These results are a step forward for Portuguese therapists' and researchers' ability to evaluate the bond between patient and therapist and to compare results from different countries.

Key words: Negotiation; Alliance Negotiation Scale; Psychometric validation.

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See online Appendix for additional materials.

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Introduction

Therapeutic alliance: the evolution of the concept

From its psychodynamic origins (Zetzel, 1956) to its transtheoretical formulations, the concept of working (or therapeutic) alliance has been defined in different ways and is one of the most studied concepts in psychotherapy research (Horvath, Del Re, Fluckiger, & Symonds, 2011).

Currently, the most popular concept of alliance used in psychotherapy is based on the work carried out by Bordin (1979) who defined it as a collaborative stance between patient and therapist, with three characteristics: an agreement on the therapeutic goals to be reached, an agreement on the tasks to be developed and the quality of the relational bond (the affective quality of the relationship between patient and therapist). Bordin also hypothesized that different therapies would emphasize different aspects of the alliance, as different therapies emphasize different tasks and goals. Recent studies show that it would be important to add a fourth element to this definition: an agreement on the representation of the problem (Conceição & Vasco, 2004).

As it is a transtheoretical definition, Bordin's (1979) conceptualization allowed the concept of alliance to spread beyond the psychoanalytic orientation, and achieve a central status in the research in psychotherapy. The therapeutic alliance proved to be, systematically and regardless of the therapists' theoretical orientation, a solid predictor of the therapeutic results, *i.e.* a therapeutic alliance that is perceived as satisfactory at the onset of the therapy predicts a faster progress of the therapeutic process (Safran & Muran, 2000; Zuroff & Blatt, 2006).

Bordin's definition offered an alternative to the tradi-

tional dichotomy of technical-relational factors (goals and tasks-bond) by highlighting that these two poles are not independent, rather interdependent (Safran, Muran, & Proskurov, 2009). He also provided therapists with a flexible intervention structure which should not be based on rigid and idealized criteria, rather it should be guided by the meaning and impact a task has on a patient, at a given time (Safran & Muran, 2000).

Therapeutic alliance: collaboration and negotiation

Regardless of the extensive research, some literature suggests that the current conceptualization of the alliance may be limiting (Doran, Safran, & Muran, 2016). Criticism of its definition is related to the great emphasis given to the dimension of collaboration and agreement between therapist and patient, disregarding the dimension of negotiation.

The dimension of collaboration stresses the degree of agreement between patient and therapist on the goals and tasks of therapy and the degree to which the patient trusts the therapist and feels that the therapist cares for them, at any given moment during therapy. Conversely, the dimension of negotiation stresses the degree to which the patient perceives the therapist's ability to change or adjust actions to suit the needs and is aware of the tensions in the existing bond between them (Doran, Safran, Waizmann, Bolger & Muran, 2012). It is important to emphasize that the dimensions of collaboration and negotiation are not mutually exclusive and offer complementary points of view of the therapeutic alliance (Doran et al., 2016).

The negotiation is present at all moments of therapy and plays a key role by defining our role in the relationship with others and is a chance to negotiate the needs of the self and of the other. It is a balancing act between the patient's and the therapist's characteristics where they work over the problems of the therapeutic relationship (Safran & Muran, 2000). It should not derive from a superficial agreement, rather it should stem from a genuine confrontation between individuals with different visions, goals and needs (Coutinho, Ribeiro, & Safran, 2009).

All through the therapeutic process, the negotiation happens both in an explicit and in an implicit manner. Whenever there is a rupture in the therapeutic alliance, which may occur at any moment during therapy, the negotiation process becomes more relevant. The ruptures in therapeutic alliance may be defined as a rupture in the collaboration over the therapeutic goals and tasks and/or an erosion of the relationship between therapist and patient, varying in intensity, duration and frequency, depending on the particular characteristics of the therapeutic dyad (Safran & Muran, 2000). These are crucial and inevitable moments that allow the therapist and patient to – in the context of their relationship – work on the disagreement and discomfort. Fluctuations in the quality of the alliance over the course of treatment is common and that process of repairing strains or ruptures in the therapeutic alliance

may be related to positive therapeutic outcome (Horvath & Luborsky, 1993; Norcross & Wampold, 2011; Safran, 1993). 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). If the ruptures are not worked on, it may lead to a failure in the therapeutic process.

Repairing the alliance promotes therapeutic change, which will lead the therapist to give the patient a constructive interpersonal experience and boost the development of an interpersonal scheme that represents the other as being potentially available and the self as being able to negotiate proximity, even in a context of rupture (Safran, 1993). A key aspect in the area of alliance ruptures involves helping patients to understand that they can express their needs without having the therapeutic relationship destroyed (Safran & Muran, 2000), promoting the psychotherapeutic context, a continuous process of *rebonding* and *resocialization* (Vasco, Conceição, Silva, Fojo, & Vaz-Velho, 2018). Ruptures in the alliance may be a hurdle to the development of the therapeutic process, but they allow for an exploration and understanding of the patient's relationship patterns and the processes that maintain the representations of others and that may create barriers to authentic relationships in their daily lives (Safran, 1993; Safran & Muran, 2000).

Ruptures in the alliance mean that therapists must be ready to understand and deal in a therapeutic context with the ruptures and be ready to change their approach so as to be more responsive to the patient's needs (Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2002).

Thusly, it seems useful to re-conceptualize the therapeutic alliance as a continuous negotiation of the needs of two independent subjects involved in the relationship and reflect on how far disagreements and tension are processed by and within the therapeutic relationship (Safran & Muran, 2000; Safran et al., 2009). From this perspective, the negotiation process both allows for change to occur and is itself a central component to the process of change (Doran, 2014). Furthermore, considering the relationship between the process of rupture-repair and the therapeutic results, it is important to understand the mechanisms underlying and facilitating this process. Negotiation is one of those mechanisms (Doran, Safran, & Muran, 2017).

Therapeutic alliance: how to assess it

Based on the transtheoretical definition of therapeutic alliance (Bordin, 1979), instruments were developed such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), one of the most frequently used instruments of psychotherapeutic research. This instrument assesses the quality of the therapeutic alliance considering the agreement over the therapeutic goals and tasks as well as the quality of the bond.

Instruments like the WAI, focusing on the collabora-

tion dimension, include items that analyse the presence of differences between patient and therapist, but that do not directly assess the degree to which they can negotiate, in a constructive manner, those disagreements or drops in the quality of their bond (Waizmann et al., 2015). For this reason, they are insufficient to completely assess the way in which patients perceive the therapeutic relationship.

In spite of the recurring presence of the concept of negotiation in literature, there are few validated instruments to assess this dimension and, as such, this has remained at a theoretical level without empirical data (Doran, 2014). Negotiation has been studied by qualitative investigations and by instruments capable of identifying and examining the existence of ruptures in the therapeutic alliance. However, it has become essential to develop an instrument to assess this dimension in a direct manner (Doran et al., 2012).

The Alliance Negotiation Scale (ANS; Doran et al., 2012) allows the assessment of the degree of negotiation present in the therapeutic relationship and to understand if the disagreements are expressed and worked on in a productive way by the therapeutic relationship. This instrument was not created to replace the existing measures for the assessment of the therapeutic alliance, rather to increase the understanding of this construct by including and assessing a dimension that is not usually studied (Doran et al., 2016).

The ANS is made up of 12 items, to be answered by the patient. The English (North-American population) and Spanish (adapted to the Population of Argentina) versions (Doran et al., 2012; Waizmann et al., 2015) are divided into two factors, each with 6 items. Factor 1 is labelled *Comfort with negative feelings* and the corresponding items reflect how comfortable the patient and the therapist are with the patient expressing a disagreement or displeasure regarding the therapist or therapy. High results in this factor show the patient's ability to express to the therapist dysphoric emotions regarding the relation, the ability to disagree with the therapist and the ability to realise that the therapist is open to criticism and that they are able to admit to mistakes. Factor 2 is labelled *Flexible and negotiable stance* and its items reflect the patient's perception of the therapist's lack of flexibility or inability to negotiate goals and tasks. High results in this factor mirror the patient's ability to realise that the therapist is flexible and respects the patient's autonomy and to realise that patient and therapist work in a collaborative manner.

This study

The fact that there is an instrument, adapted to the Portuguese population, able to empirically study the negotiation and its degree of presence in the therapeutic relationship, allows as well as increases the understanding of this construct of the therapeutic alliance, as it assesses a dimension that was not assessed by any prior instrument.

This study was designed to adapt the ANS to the Por-

tuguese population. Considering this main goal, two research goals were drafted: i) to translate and study the psychometric properties of reliability and validity of the ANS on the Portuguese clinical population (patients undergoing psychological counselling or psychotherapy); ii) to analyse the relation between the two dimensions of the therapeutic alliance - collaboration and negotiation – and it is expected that the results of the WAI (assessment of the collaboration) and the ANS (assessment of the negotiation) have a moderate correlation.

Methods

Process

Translation

The translation of the items from English into Portuguese was made by three translators with knowledge of both languages and of the topic of therapeutic alliance (topic of the instrument to translate). This heterogeneity of translators eliminates biases. Two of the translators were psychotherapists with different amounts of experience. One of them has approximately 40 years' experience as an integrative psychotherapist, is a tenured college professor, researcher in the field of integrative psychotherapy and clinical supervisor. The other one is a cognitive-behavioural and integrative psychotherapist with 15 years' experience. This translator is also a guest lecturer, researcher in the field of emotional and relational processes in psychotherapy and a clinical supervisor. The third one was a master's student in clinical psychology, on its first year of clinical experience in the supervised internship.

Each translator drafted an individual translation and these translations were later discussed jointly until a final version of the translation was reached. Later, the Portuguese items were again translated by a bilingual translator. The original items were compared with the new items in English, the result of the backward translation (Hambleton, Merenda, & Spielberger, 2005), and there were no significant differences between both versions.

Before applying the instrument, there was a survey of 10 people both with and without knowledge of the field of psychology and not participating in the study so as to test how clear the translated items were. This process helped confirm the clarity of the items and of the application procedure.

Data collection

The participants were recruited by their own therapists, who invited them to take part in this study. Participating patients received an envelope with a set of assessment instruments and the informed consent form explaining that the goal of the study was to see what happens in the psychotherapeutic process and how patients feel about their therapists. Each respondent provided only one set of answers and each individual participation took

no longer than 10 minutes. After filling in the form, outside the therapeutic context (therapy session), the patient handed the sealed envelope to the therapist, who in turn gave it back to the researcher.

The therapists were the middlemen between researchers and participants and helped uphold the inclusion criteria (see *Participants* below) for this study. The therapists were asked to provide their theoretical orientation outside the envelope, after the patient had handed them the sealed envelope.

Participants

A total of 120 people took part in this study. In order to take part in this study the participants needed to be Portuguese adults and patients in a psychotherapeutic process with at least five sessions. As well as the criteria above, a further exclusion criterion was a psychotic disorder and a number of missing data above 5%. Two participants were excluded through previously established exclusion criteria.

The final sample is comprised of 118 participants, 94 women, 22 men and two who failed to indicate gender. Their ages are between 18 and 72 years ($M=34.17$; $SD=11.13$).

At the time of taking the study, the duration of counselling was from under six months (43.20%) to more than five years (3.40%) and the frequency of sessions was between once a week (60.20%) to once a month (3.40%). Patients were undergoing private treatment. As well as psychological counselling, 31.40% of the participants had psychiatric counselling and 38.10% were on psychiatrist-prescribed medication. See online Appendix for the full characteristics of the sample in question.

Instruments

Questionnaire on demographic data

For the purposes of this research a short questionnaire was created to compile the demographic data of the participants. Respondents indicated gender, age, nationality, level of education and frequency of psychological counselling/psychotherapy, main current complaint and whether they'd been previously involved in any other therapeutic processes. Respondents also reported on whether, as well as the current therapeutic process, they were undergoing psychiatric counselling and were or psychiatric drugs and if so they were asked to indicate the type of medication.

Alliance Negotiation Scale

The purpose of the Alliance Negotiation Scale (Doran et al., 2012) is to assess the degree of negotiation in the therapeutic alliance, from the patient's perspective. It includes 12 items, that, in their North-American and Argentinian versions are divided into two factors: Comfort with negative feelings and Flexible and negotiable stance. The items are rated on a 7-point Likert-type scale ranging from

1 (Never) to 7 (Always). The patients are asked to indicate the number that best applies to the way they feel about their relation with their therapist. The total average result reflects the patient's perception of the degree of negotiation in the therapeutic alliance. High results indicate a higher level of negotiation.

Working Alliance Inventory – Short Form

The Portuguese version of the Working Alliance Inventory – Short Form (WAI-S; Short Form: Tracey & Kokotovic, 1989; Portuguese version: Machado & Horvath, 1999) consists of a short version (12 items) of the original version of the instrument (36 items), that illustrates the conceptualization of therapeutic alliance proposed by Bordin (1979) in its three components: goals, tasks and bond. Each dimension is represented by 4 items and these are assessed by a 7-point Likert-type scale ranging from 1 (Never) to 7 (Always). The total average result reflects the strength of the therapeutic alliance, from the patient's perspective. Higher results indicate a higher level of quality of the therapeutic alliance. The internal consistency of this instrument, in this study, proved adequate, both in the full scale ($\alpha=.91$) and for each of the sub-scales (Tasks and Goals $\alpha=.89$, Bond $\alpha=.78$).

Results

Data was analysed with statistics program SPSS – version 24. Before this analysis, those cases ($n=2$) that met the previously-defined exclusion criteria were excluded (participants reporting psychotic disorder and/or cases with more than 5% missing data).

Analysis of the main components

The results from the Kaiser-Meyer-Olkin sampling adequacy tests ($KMO=.79$) and Bartlett's sphericity ($\chi^2=398.65$, $P<.001$), made it possible to conduct the exploratory factor analysis. In order to identify the number of factors of the instrument an exploratory analysis was conducted of the principal components (PCA) of the data supplied by the patients in response to the ANS. This method is adequate and widely used to study the factor structure of psychological assessment instruments (Kellow, 2006). The principal components method used in creating the scale (North-American population) and in the adaptation to the Argentine population, made it possible to compare the results from the Portuguese population with the prior studies.

The final result was obtained by using a PCA with a forced two-factor solution and a varimax rotation. Other factor analysis methods were considered, such as principal axis factoring, and no significant differences were found, both in the factor structure and in the factorial loading of each item.

Without forcing the number of factors, an initial three-

factor solution was apparent, which was observed so as to ascertain whether the items were distributed according to the dimensions of the definition of therapeutic alliance (Bordin, 1979): goals, tasks and bond. This structure was not verified, as the third factor, even as it contributed to the properties of the scale, is made up of only two items and, from a theoretical and interpretative standpoint it has become more useful to restrict it to two factors. A one-factor structure was also tested because of the positive and negative division of the items, raising the possibility that they are not conceptually separate factors, rather one single factor with positive and negative items. The psychometric properties (commonalities, explained variance and factor loadings) proved more robust in the two-factor solution, which allows for an interpretation with more theoretical and statistical sense. The correlation of both factors of the ANS ($r=.41$) and the shared variance between the two factors (16.81%), suggest that the factors do not replicate one another.

In the final result, Factor 1 includes seven items and had an initial eigenvalue of 4.28, with factor loadings ranging from .40 to .80 and an explained variance of 35.63%. The first factor is titled *Conforto com o desacordo (Comfort with Negative Feelings)* and its items reflect how comfortable a patient and therapist are with the patient's expression of disagreement or displeasure towards the therapist or the therapeutic process. Factor 2 includes five items and had an initial eigenvalue of 1.74, with factor loadings range from .45 to .89. and an explained variance of 14.47%. The second factor is titled *Postura flexível e negociável (Flexible and Negotiable Stance)* and its items reflect the patient's perception of the lack of flexibility of the therapist or the inability to negotiate goals and tasks. Together, both factors explain 50.10% of the variance in results. Table 1 shows the factorial loadings of each item and they all present adequate loadings, above .40 (Maroco, 2007; Tabachnick & Fidel, 2001). The original version of each item is presented to-

Table 1. Alliance Negotiation Scale subscales and factor loadings.

Original item	Item (Portuguese)	Factor loadings		h ²
		1	2	
I am comfortable expressing disappointment in my therapist when it arises.	<i>Quando me sinto decepcionado(a) com o(a) meu(minha) terapeuta, sinto-me suficientemente confortável para o expressar. (Item 6)</i>	.80	.09	.65
I am comfortable expressing frustration with my therapist when it arises.	<i>Sempre que me sinto frustrado(a) com a terapia, sinto-me confortável em expressar essa frustração ao(à) meu(minha) terapeuta. (Item 1)</i>	.78	.09	.62
I feel that I can disagree with my therapist without harming our relationship.	<i>Sinto que posso discordar do(a) meu(minha) terapeuta sem que isso prejudique a nossa relação. (Item 2)</i>	.77	.09	.60
My therapist encourages me to express any anger I feel towards him/her in the course of treatment.	<i>O(A) meu(minha) terapeuta encoraja-me a expressar qualquer zanga que possa sentir relativamente a ele(a). (Item 7)</i>	.68	.23	.51
My therapist is able to admit when he/she is wrong about something we disagree on.	<i>O(A) meu(minha) terapeuta é capaz de admitir quando está errado(a) sobre algo em que discordamos. (Item 12)</i>	.57	.12	.34
My therapist encourages me to express any concerns I have with our progress.	<i>O(A) meu(minha) terapeuta encoraja-me a expressar quaisquer preocupações que possa ter relativamente ao progresso do processo terapêutico. (Item 3)</i>	.54	.33	.40
I pretend to agree with my therapist's goals for our therapy so the session runs smoothly.	<i>Faço de conta que concordo com o(a) meu(minha) terapeuta, relativamente aos objectivos da terapia, para que a sessão decorra sem incidentes. (Item 10)</i>	.40	.38	.31
I feel like I do not have a say regarding what we do in therapy.	<i>Sinto que a minha opinião não é tida em conta para o que fazemos em terapia. (Item 8)</i>	.05	.89	.80
My therapist is inflexible and does not take my wants or needs into consideration.	<i>O(A) meu(minha) terapeuta é inflexível e não toma em consideração aquilo que quero ou necessito. (Item 5)</i>	.21	.82	.72
I feel that my therapist tells me what to do, without much regard for my wants or needs.	<i>Sinto que o(a) meu(minha) terapeuta me diz o que fazer, sem tomar em consideração os meus desejos ou necessidades. (Item 9)</i>	.31	.67	.54
My therapist and I are not good at finding a solution if we disagree about what we should be working on in therapy.	<i>Eu e o(a) meu(minha) terapeuta temos dificuldade em encontrar uma solução em caso de desacordo. (Item 4)</i>	.05	.56	.32
My therapist is rigid in his/her ideas regarding what we do in therapy.	<i>O(A) meu(minha) terapeuta é rígido(a) nas suas ideias sobre aquilo que devemos fazer em terapia. (Item 11)</i>	.11	.45	.22

Bold is used to differentiate the items by factor.

gether with the item in Portuguese, so as to make it easier for non-Portuguese-speaking readers to analyse it.

Internal consistency

Internal consistency, expressed by Cronbach's alpha, proved adequate both in the full scale ($\alpha=.82$) and for each factors (Factor 1 $\alpha=.79$; Factor 2 $\alpha=.72$).

Construct validity

In order to analyse preliminary evidence regarding construct validity of the ANS, both factors and the full scale were correlated with the total score of the WAI. Later, correlations were made between the factors of the ANS and the sub-scales of the WAI.

Before conducting analysis, the distribution of the answers was analysed and it was shown that the necessary criteria for the conduction of parametric tests were respected.

Pearson's bivariate correlations revealed the expected relationships. The correlation between ANS mean and WAI mean was large in magnitude ($r=.72$, $P<.01$), with WAI scores accounting for 52.23% of the variance on ANS ($R^2=.52$). The correlations between factors 1 and 2 of ANS and the WAI total score were $r=.66$ ($P<.01$) and $r=.56$ ($P<.01$), respectively.

Table 2 shows the correlations, small to moderate, significant in total, between WAI sub-scales and ANS factors. These correlations show, in a preliminary manner, the convergent and discriminant validity of the scale, showing that there are elements connected to goals, tasks and bonds in both factors. They further display an overlap between the dimensions of collaboration and negotiation, however, their degree ensures the differentiation between both constructs.

A linear regression analysis shows that WAI scores significantly predict both ANS Factor 1 ($\beta=.66$, $P<.001$) and Factor 2 ($\beta=.56$, $P<.001$).

Discussion

This scale assesses the patient's perception of the therapist's degree of comfort with the patient's expression of displeasure or disagreement about the therapeutic process or relationship (Factor 1) and the patient's perception of the therapist's ability to flexibly negotiate tasks and goals of the therapy (Factor 2). The items reflect the theory un-

derlying the construction of the scale and represent implicit (discomfort with relational tension) and explicit (working together to change a task of the therapy) components of the negotiation in the therapeutic alliance.

The results support a two-factor factor structure, as in the original version of the instrument (Doran et al., 2012) and the Argentinian adaptation (Waizmann et al., 2015). The factors are titled *Conforto com o desacordo* (Factor 1) and *Postura flexível e negociável* (Factor 2) and account for 50.10% of the variance of results (Factor 1=35.53%, Factor 2=14.47%). These results were similar to the ones in previous studies, and the explained variance in the original version is 57% (Factor 1=38%, Factor 2=19%) and in the Argentinian version is 46% (Factor 1=30%, Factor 2=16%).

Table 3 presents, for comparison purposes, the factorial loading for each item in the three versions of the scale (Portuguese, North American and Argentinian). The items are listed in a descending way, considering their factorial loading in the version under appreciation.

Despite maintaining the number of factors, the structure was different in the Portuguese population. In the original version of the scale, item 10 (*Faço de conta que concordo com o(a) meu(minha) terapeuta, relativamente aos objetivos da terapia, para que a sessão decorra sem incidentes; I pretend to agree with my therapist on the goals of therapy so that the session runs smoothly*) showed a higher factorial loading in factor 2 (.60). In the Portuguese version, like in the Argentinian one, there was a higher factorial loading in factor 1 (.40, in this study). Although the factorial loading is the lowest recommended for interpretation (Maroco, 2007; Tabachnick & Fidell, 2001), there is not enough discrimination from factor 2, as the factorial loading in the latter factor was .38. In future studies it is necessary to keep testing the contribution of the item, as it seems to contribute to the psychometric properties of the scale and to the result total, despite the low discrimination between factors.

The difference in item distribution may be related to cultural aspects or to their theoretical interpretation. From a theoretical standpoint it is possible to understand the relation between item 10 and factor *Conforto com o desacordo* as Factor 1 concerns the patient's perception of the therapist's ability to be comfortable with a demonstration of disagreement or displeasure. A patient pretending to agree with the goals suggested by the therapist may not

Table 2. Correlations between Working Alliance Inventory sub-scales and Alliance Negotiation Scale factors.

Working Alliance Inventory	Alliance Negotiation Scale	
	Comfort with Negative Feelings	Flexible and Negotiable Stance
Goals and Tasks	.64	.58
Bond	.54	.42

All correlations are significant at .01.

be exclusively connected to an inflexible stance (Factor 2) but, also, with an inability by the therapist, as perceived by the patient, to deal with a disagreement between them.

Each of the ANS factors and of the full scale showed evidence of internal consistency. The results were adequate (Full scale $\alpha=.82$, Factor 1 $\alpha=.79$; Factor 2 $\alpha=.72$) and not substantially different from the previous results (Full scale (North-American version) $\alpha=.86$, Full total (Argentinian version) $\alpha=.78$; Factor 1 (North-American version) $\alpha=.85$, Factor 1 (Argentinian version) $\alpha=.92$; Factor 2 (North-American version) $\alpha=.81$, Factor 2 (Argentinian version) $\alpha=.86$) (Doran et al., 2012; Waizmann et al., 2015).

Results of convergent and discriminant validity were found, as in the English- and Spanish-language versions of the scale. These results are reached by analysing the link between the results in the ANS and the WAI. These instruments operationalize constructs, negotiation and collaboration, respectively, which overlap as they are both dimensions of the therapeutic alliance. Even though they are part of the same construct, they are separate and this separation is demonstrated by the results. The correlation between the ANS mean and the WAI mean was large ($r=.72$, $P<.01$; $R^2=.48$), just like in the original version ($r=.76$, $P<.001$; $R^2=.57$). The Argentinian version shows a moderate correlation magnitude ($r=.69$, $P<.001$; $R^2=.49$).

Regarding the correlations between the ANS factors and the WAI sub-scales, a few differences in the Portuguese population were observed. These differences are owed to the factor structure in the Portuguese version of the WAI, which is not structured into three, rather two sub-scales (*Goals and Tasks* and *Bond*) (Ramos, 2008). This structure had already been mentioned in the studies

for the development of the instrument, in the original version (Horvath & Greenberg, 1989), because of the high covariance found between the sub-scales *Goals* and *Tasks* and of the theoretical relation between goals and tasks of psychotherapy. Despite the difference in structure, significant correlations were found between the factors and the sub-scales with values ranging between $r=.42$ and $r=.64$. As was the case for the Argentinian population, there is still a link between the scores in the scales, but with a larger discrimination between the instruments than in the original version.

There is a direct linear correlation between the quality of the negotiation, through the ANS factors, and the WAI sub-scales. This correlation may be interpreted taking into consideration the theoretical relation between the constructs of negotiation and collaboration. By viewing negotiation and collaboration as co-existing in the process of establishing a therapeutic alliance, better negotiation enhances the agreement and collaboration and collaborative work enables a continued negotiation (Waizmann et al., 2015).

Conclusions

This study achieved results for an initial validation of the Alliance Negotiation Scale, in the Portuguese version. This way there is an instrument in Portugal that operationalizes the construct of negotiation and focuses on the negotiation of the tensions between therapist and patient and in the resolution of ruptures in the therapeutic alliance.

This instrument is essential so that Portuguese thera-

Table 3. Comparison of Alliance Negotiation Scale factorial loadings at item level.

	Portuguese Factor Loadings		North-American Factor Loadings		Argentinian Factor Loadings	
	1	2	1	2	1	2
Item 6	.80	.09	.84	.06	.83	-.05
Item 1	.78	.09	.84	.06	.83	-.05
Item 2	.77	.09	.67	-.36	.55	-.13
Item 7	.68	.23	.81	.02	.75	-.09
Item 12	.57	.12	.65	-.33	.61	-.24
Item 3	.54	.33	.74	-.09	.62	-.14
Item 10	.40	.38	-.39	.60	-.25	.26
Item 8	.05	.89	-.07	.69	-.15	.51
Item 5	.21	.82	-.19	.82	-.07	.81
Item 9	.31	.67	-.12	.83	-.12	.81
Item 4	.05	.56	.09	.59	-.03	.68
Item 11	.11	.45	-.14	.70	-.11	.43

Bold is used to differentiate the items by factor.

pists and researchers may assess, in a more complete fashion, the quality of the relationship of the therapeutic dyad and comparing results with those from other countries, making it possible to study the negotiation in a transcultural way. Despite the differences found in the factor structure, such as item 10 with a higher factorial loading in Factor 1, it is possible to see transcultural validity, considering the similarity of the psychometric properties of the three versions of the scale.

Considering the psychometric properties of the instrument, it is important to reflect on the limitations of the study and future researches arising from these properties, as well as their clinical implications.

First, it is necessary to increase the construct validity by studying the relation of the negotiation with other theoretical constructs. In the future, research must be done on whether the negotiation process is more relevant to some forms of therapy than to others and whether it happens in the same way in different cultures.

Future studies will have to re-analyse the stability of the factor structure of the instrument, through confirmatory factor analysis with new and wider sampling. As well as increasing the number of participants it is necessary to increase the diversity of its characteristics, such as, for example, its geographic distribution across the country, to enable a better generalization of the data. The need to contact therapists to collect data contributed to a decrease in variability of the sample. Simultaneously, by mediating and monitoring the participants' inclusion criteria, the therapists assure the participants are right for the study, something impossible to do in online formats.

In this study, even if no theoretical orientation collected from the therapist was used, the data collection was made in contexts that skewed the contact with different theoretical orientations, with a majority of therapists that considered themselves to be Integrative. This data, though influenced by the places of collection, respond to the increase in interest and acceptance of the Integrative orientation in Portugal (Vasco, 2008).

In this study it was impossible to monitor characteristics and personality disorders. Although it is known that the interpersonal difficulties experienced by patients with personality disorders tend to hinder the negotiation of the therapeutic alliance (Doran et al., 2017; Lipner et al., 2016), this variable could not be monitored, because the existing instruments adapted for the Portuguese population are too large (too many items). Future studies should consider the assessment of personality disorders, which influence the resistance to therapy, the quality of the alliance and premature dropouts (Lipner et al., 2016). As well as the personality disorders, it may be useful to include the study of other indicators of human function, such as psychological needs.

It is important to consider that the assessment of the negotiation was conducted in one single moment and may not be the most reliable indicator of the degree of negoti-

ation in the dyad. For a more complete assessment, it seems important to conduct longitudinal studies, ones that enable the observation of the variation of the quality of the negotiation, along the therapeutic process. Together with the longitudinal studies, there is also the importance of studying the negotiation from the patient's standpoint, as well as the measure of negotiation for the therapist, since they also are part of the dyad. However, it is known that the patient's perspective of the therapeutic relation, is one of the best predictors of therapeutic result (Norcross & Wampold, 2011).

While collecting data, it was possible to realise that the replies to the instrument might be useful as a tool for the awareness increase of both patient and therapist about their alliance. It is important to stress that this instrument may be used in a therapeutic context, as a basis for sharing and working in session, and not only in the context of research. In order to ascertain how useful it is in a therapeutic context, qualitative studies may enable the understanding of the meaning of the quantitative results.

Finally, for future studies, it seems relevant to study the relation between ANS scores and the therapeutic results, since the negotiation seems to improve the quality of the therapeutic alliance and higher levels of negotiation seem to be linked to larger impact of the session, as perceived by the patient (Doran et al., 2017). Studies correlating negotiation with therapeutic results may give some insight on the clinical usefulness of the construct of negotiation. In a clinical context, the second factor of the scale may be especially useful, considering how relevant the therapist's flexibility is for the therapeutic outcome, when compared to a rigid restriction to an intervention model (Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002).

References

- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252-260.
- Conceição, N., & Vasco, A. B. (2004, June). *Is it time for another time? Alliance Development according to sequence of strategic objectives*. Communication presented at the 35th Annual Meeting of the Society for Psychotherapy Research, Rome, Italy.
- Coutinho, J., Ribeiro, E., & Safran, J. (2009). Resolution of ruptures in therapeutic alliance: its role on change processes according to a relational approach. *Análise Psicológica*, 4, 479-491.
- Doran, J. M. (2014). The working alliance: Where have we been, where are we going? *Psychotherapy Research*, 26(2), 1-18.
- Doran, J. M., Safran, J., & Muran, J. C. (2016). The Alliance Negotiation Scale: A psychometric investigation. *Psychological Assessment*, 28(8), 855-897.
- Doran, J. M., Safran, J., & 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.

- Doran, J., Safran, J., Waizmann, V., Bolger, K., & Muran, J. C. (2012). The Alliance Negotiation Scale: Psychometric construction and preliminary reliability and validity analysis. *Psychotherapy Research, 22*, 710-719.
- Hambleton, R. K., Merenda, P. F., & Spielberger, C. D. (Eds.). (2005). *Adapting educational and psychological tests for cross-cultural assessment*. New Jersey: Lawrence Erlbaum Associates Publishers.
- Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, and Training, 48*(1), 9-16.
- 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., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.
- Kellow, J. T. (2006). Using principal components analysis in program evaluation: Some practical considerations. *Journal of MultiDisciplinary Evaluation, 5*, 89-107.
- Lipner, L. M., Muran, J. C., Zilcha-Mano, S., Gardner, J., Eubanks, C. F., & Safran, J. (2016). *Differences in patterns of alliance in patients diagnosed with and without a personality disorder in two time-limited psychotherapies*. Retrieved from: https://www.researchgate.net/publication/305044004_Differences_in_Patterns_of_Alliance_in_Patients_Diagnosed_with_and_without_a_Personality_Disorder_in_Two_Time-Limited_Psychotherapies
- Machado, P. P. & Horvath, A. O. (1999). Inventário da Aliança Terapêutica – W.A.I. In M. R. Simões, M. M. Gonçalves & L. S. Almeida (Eds.), *Testes e Provas Psicológicas em Portugal [Psychological Tests and Examinations in Portugal]* (vol. II, pp. 87-94). Braga: S.H.O. – Sistemas Humanos e Organizacionais, Lda.
- Maroco, J. (2007). *Análise estatística: com utilização do SPSS [Statistical analysis: Using SPSS]*. Lisbon: Edições Sílabo.
- Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102.
- Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry, 13*(2), 57-70.
- Piper, W. E., Joyce, A. S., McCallum, M., Azim, H. F., & Ogrodniczuk, J. S. (2002). Clinical illustrations of dropping out from interpretive psychotherapy: The importance of flexibility. In W. E. Piper, A. S. Joyce, M. McCallum, H. F. Azim, & J. S. Ogrodniczuk (Eds.), *Interpretive and supportive psychotherapies: Matching therapy and patient personality* (pp. 153-171). Washington DC: American Psychological Association.
- Ramos, M. A. F. (2008). *Análise das Características Psicométricas da Versão Portuguesa da Working Alliance Inventory* (Master's thesis). Instituto de Educação e Psicologia, Universidade do Minho, Braga, Portugal.
- Safran, J. (1993). Breaches in the therapeutic alliance: An arena for negotiating authentic relatedness. *Psychotherapy, 30*, 11-24.
- Safran, J., & Muran, J. C. (2000). *Negotiating the therapeutic alliance – A relational treatment guide*. New York: The Guilford Press.
- Safran, J., Muran, J. C., & Proskurov, B. (2009). Alliance, negotiation, and rupture resolution. In R. A. Levy & J. S. Ablon (Eds.), *Handbook of evidence-based psychodynamic psychotherapy*. New York: Humana Press.
- Safran, J., Muran, J. C., Samstag, L. W., & Stevens, C. (2002). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 235-254). New York: Oxford University Press.
- Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston, Massachusetts: Allyn and Bacon.
- Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment, 1*, 207-210.
- Vasco, A. B. (2008). Psychotherapy integration in Portugal. *Journal of Psychotherapy Integration, 18*(1), 1-4.
- Vasco, A. B., Conceição, N., Silva, A. N., Fojo, J. F., Vaz-Velho, C. (2018). O (Meta)modelo de Complementaridade Paradigmática [(Meta)model of paradigmatic complementarity]. In I. Leal (Ed.), *Psicotherapys* (pp. 339-361). Lisbon: Pactor.
- Waizmann, V., Doran, J., Bolger, K., Penedo, J. M. G., Safran, J., & Roussos, A. J. (2015). Escala de negociación de alianza terapéutica (ANS-A): evidencias de su validez y confiabilidad [Therapeutic alliance negotiation scale (ANS-A): evidence of its validity and reliability]. *Revista Argentina de Clinica Psicología, 24*(3), 243-254.
- Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psycho-Analysis, 37*, 369-375.
- Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74*, 130-140.