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RESEARCH ARTICLE

Turkish Adaptation of the Alliance Negotiation Scale: Preliminary Study for Validity and Reliability

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ABSTRACT

It is suggested to expand Bordin's pan-theoretical therapeutic alliance concept, with the dimension of the negotiation. This study aimed to adapt the Alliance Negotiation Scale (ANS), which assesses the negotiation dimension in the therapeutic alliance, into Turkish. After translation processes, ANS Turkish Form was created. ANS, Working Alliance Scale Short Form (WAI-S) and the Personal Information Form created by the researchers, was applied to a sample (N = 172) of clients who are continuing psychotherapy. CFA results showed that the fit indices of the two-factor structure of ANS were acceptable (S-Bχ^2 = 103.58 (52), p < .001, S-Bχ^2 /df = 1.99, CFI = .92, TLI = . 90, RMSEA = .08 (90% CI: 0.06 - 0.10), SRMR = .06). Significant correlations were observed between ANS and WAI-S scores (r = .676, p < .01). Internal consistency coefficients were good level for ANS Turkish Form (α = .84, ω = .89). These findings demonstrate the validity and reliability evidence of the ANS Turkish Form. ANS makes possible researchers in Türkiye to assess the degree of negotiation in therapy.

Following studies showing that different therapy approaches are similarly effective (Luborsky et al., 1975; Smith & Glass, 1977; Stiles et al., 1986; Wampold et al., 1997), interest in common factors has increased in psychotherapy research. *The therapeutic alliance*, one of these common factors, is one of the most studied research topics in the literature of psychotherapy research (Horvath et al., 2011). A wide range of studies has shown that a strong therapeutic alliance is a significant predictor of psychotherapy outcomes (Flückiger et al., 2018; Horvath et al., 2011; Martin et al., 2000; Zuroff & Blatt, 2006). This is also true for different psychotherapy conditions (Horvath & Bedi, 2002). According to researchers, the therapeutic alliance is a fundamental component for therapeutic change (Horvath & Greenberg, 1986; Lambert & Barley, 2001; Lambert & Simon, 2008; Norcross, 2002). It is recommended that clinicians focus on building a strong alliance with their clients (Horvath & Bedi, 2002).

The pan-theoretical conceptualization of the therapeutic alliance, which has its origins in the psychoanalytic literature, introduced by Bordin (1979), is widely accepted today. Bordin defines the therapeutic alliance as a collaborative stance between client and therapist. Three processes foster this collaborative stance: (1) agreement about therapeutic goals, (2) agreement about therapeutic tasks, and (3) the relational bond between therapist and client. The degree of agreement between the therapist and client about tasks and goals and the

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quality of the bond between them indicate the strength of the alliance. These three components can affect each other during the therapy process. For instance, an agreement about tasks and goals can strengthen the bond, or a strong bond can facilitate the resolution of disagreements (Safran et al., 2002). With this conceptualization, the concept of the therapeutic alliance could also be addressed in therapy approaches other than psychoanalytic psychotherapy. In addition, another point emphasized by the conceptualization is that technique and relationship factors in therapy are not independent of each other, contrary to what was previously thought (Safran et al., 2009).

According to the meta-analysis study of Horvath et al. (2011), the most distinctive feature of Bordin's pan-theoretic conceptualization is its emphasis on *collaboration* and *agreement*. However, there are also arguments that Bordin's conceptualization may be limiting as it emphasizes collaboration and agreement (Doran et al., 2016). Cushman and Gilford (2000) stated that Bordin's conceptualization, which focuses too much on the agreement, ignores disagreements and conflicts in the therapy process. In addition to positive processes such as collaboration and agreement, negative processes such as rupture, disagreement, and tension in the relationship are also part of therapy. Indeed, Bordin himself, in a later work (1983), mentioned the central role of *repairing* too as well as building the alliance in the therapy process. In the same study, Bordin (1983) emphasized that the process of building and repairing the alliance is in itself healing.

The ruptures in the therapist-client relationship consist of disagreements in therapeutic tasks or therapeutic goals, or problems in the therapist-client bond (Safran & Muran, 2000). Safran (1993) stated that the moments when the agreement between the therapist and the client is interrupted are inevitable and emphasized that it is vital to work with these ruptures. According to the researcher, ruptures are also an opportunity to understand the client's relational processes.

Ruptures in the relationship between client and therapist can occur in a variety of ways. The client may withdraw, minimizing involvement. Or, the client may resist the therapist, attempting to show anger or dissatisfaction. On the other hand, the therapist must be sensitive to ruptures and implement strategies to resolve them. A recent meta-analysis has supported the theoretical explanation: a moderate relationship was shown between rupture resolution and positive client outcomes (Eubanks et al., 2019). Researchers have a consensus that the ruptures in the therapy process are important and that the emergence of therapeutic change will be facilitated by the resolution of the ruptures (Eubanks et al., 2023; Eubanks et al., 2019; Norcross & Wampold, 2011; Safran et al., 2011; Strauss et al., 2006).

The prominence of the rupture and repair process in psychotherapy research has directed the attention of theorists to the question of what can be done when the agreement is disrupted (Doran, 2016). Safran and Muran (2000; 2006) emphasized that the therapeutic alliance is not a static variable but a construct that changes throughout the therapy process. The authors stated that negotiation is an important change mechanism and suggested that the construct of the alliance concept should be expanded with the *dimension of negotiation*. Studies suggest that the negotiation between therapist and client can be a strategy to help reduce premature termination (Ogrodniczuk et al., 2005; Reis & Brown, 1999). Although negotiation is gaining more and more importance in the therapeutic relationship, the concept generally remained a theoretical construct, devoid of empirical studies for a long time (Doran et al. 2016).

Doran et al. (2012) introduced the definition of *the negotiation dimension* in the therapeutic alliance in line with Safran and Muran's (2000; 2006) proposal to expand the construct of the therapeutic alliance with the negotiation. By definition (Doran et al., 2012), an ongoing negotiation, consciously or unconsciously, takes place between therapist and client about therapeutic tasks and goals. This negotiation process creates the conditions for therapeutic change as well as an internal part of the therapeutic change process. Negotiation, which is constantly present in the therapy process, is sometimes explicit and sometimes implicit. In addition, the negotiation process is not superficial; It is a real confrontation between individuals with conflicting views, needs, and agendas. The client and the therapist strive to find out how well they can fit in with the other without sacrificing themselves.

Doran et al. (2012) stated that negotiation in the therapeutic alliance should be distinguished from collaboration in the therapeutic alliance. By Bordin's conceptualization, *the collaboration dimension* reflects the degree of

agreement between therapist and client about therapeutic tasks and goals in the therapy process and the strength of the relational bond between them. On the other hand, *the negotiation dimension* reflects the extent to which the therapist and client negotiate when they have disagreements about therapeutic tasks and goals or when strains arise in the emotional bond between them. Both dimensions are complementary aspects of the therapeutic alliance.

Considering the intensity of these two dimensions in therapeutic alliance research, it is seen that research mostly focus on collaboration, based on Bordin's conceptualization. This situation is also reflected in the measurement tools used in the research. There are many measurement tools that assess the degree of collaboration in the therapist-client relationship (Horvath et al., 2011). Popular measurement tools for therapeutic alliance have a common theme of "confident collaborative relationship" (Hatcher & Barends, 1996). One of these measurement tools, the Working Alliance Scale (WAI - Horvath & Greenberg, 1986; 1989), and its Short Form (WAI-S - Tracey & Kokotovic, 1989), are extensively used and have sub-dimensions of task, objective, and bond in line with Bordin's conceptualization.

However, the need for an operational measurement tool for the negotiation dimension arose. For this reason, Doran et al. (2012) developed the Alliance Negotiation Scale (ANS; Turkish: Terapötik İttifakta Müzakere Ölçeği - TİMÖ), which also considers the disagreements and tensions in the therapeutic relationship. Developed in parallel with Safran and Muran's (2000, 2006) suggestion to expand the concept of therapeutic alliance through negotiation, the ANS measures the degree of therapist-client negotiation in the therapeutic alliance based on clients' self-report. In this way, the ANS differs in that it considers the possible negative processes of the therapeutic relationship, unlike the WAI based on Bordin's conceptualization and other "confident collaborative relationship" themed measurement tools. The scale consists of 12 items and exhibits a two-factor structure: the "Comfort with Negative Feelings" factor, which aims to determine how comfortable the therapist feels when the client expresses an unpleasant emotion or objection, and the "Flexible and Negotiable Stance" factor, which reflects the client's perception of the therapist's flexibility and openness to negotiation. (Doran et al., 2012). Evidence regarding the validity and reliability of the ANS was examined in two different studies (Doran et al., 2012; Doran et al., 2016). Both studies demonstrated the two-factor structure of the ANS and provided evidence of internal consistency.

There are several studies on the relationships between the ANS and psychotherapy process and outcome variables. Negotiation has strong positive relationships with the therapeutic alliance, the real relationship, and the client’s perceived therapist empathy (Doran et al., 2016). In addition, the ANS has been found to have a positive relationship with the client's satisfaction with therapy and a negative relationship with the client's interpersonal problems (Doran et al., 2016). Negotiation and the client's perception of the session impact are positively related (Doran et al., 2017). The ANS also has a positive relationship with identifying and resolving ruptures in therapy (Doran et al., 2017). On the other hand, high levels of negotiation have been shown to be associated with a decline in the client's symptoms (Doran et al., 2017; Manubens et al., 2023). The scale strengthens its place in the literature with the therapist version (Doran et al., 2018) and the supervision version (Presseau et al., 2020). Both versions aim to measure the level of negotiation from different perspectives.

The literature demonstrates the importance of the ANS in relation to therapeutic processes and outcomes. Negotiation is not a variable specific to a particular type or condition of therapy, but a variable that manifests itself in every therapy. From this perspective, negotiation can be considered meaningful in different conditions, with different individuals, and in different cultures.

Indeed, the ANS has been adapted to different languages and cultures. The scale has Argentinian (Spanish; Waizmann et al., 2015) and Portuguese (Galvão et al., 2019) versions. In both versions, two-factor structure emerged. In the Portuguese version, one item (Item 10) is in the other factor. The relationship between scores obtained from the ANS and WAI was examined in both the Argentinian and Portuguese versions, and moderate to large correlations were found, consistent with the original ANS development study. These two versions support the cross-cultural adaptability of the ANS.

Although the psychotherapy literature in Türkiye is limited compared to abroad, the concept of therapeutic alliance has entered the literature. Both the original and short versions of the WAI have been adapted to Turkish (TİÖ - Soygüt & Işıklı, 2008; TİÖ-KF - Gülüm et al., 2018). Therapeutic alliance is being studied in Türkiye with its original structure. On the other hand, the positive results of repairing the ruptures in the therapeutic

alliance have been shown (Gülüm et al., 2018). While the literature on the therapist-client relationship in Türkiye is gradually developing in accordance with the original studies, it can be thought that the ANS will also be experienced in Türkiye in accordance with the original studies.

This study aims adapt the ANS client version into Turkish. In this way, it will be possible to quantitatively examine the degree of negotiation between the client and the therapist in studies conducted in Türkiye or with Turkish participants. To achieve this aim; translation processes for the Turkish form of the ANS, examination of the factor structure of the Turkish form of the ANS, examination of evidence regarding the internal consistency and criterion validity of the scale, and finally interpretation of the findings in terms of Turkish culture were implemented.

Method

Research Design

This study is a scale adaptation study. In this section, firstly, the participants, sampling strategy and measurement tools are introduced. Then, the procedures followed are presented. Finally, a framework is presented regarding the steps followed in the translation process and which steps will be followed in data analysis.

Participants

Data were collected from participants through convenience sampling (Gravetter and Forzano, 2018) from May 2021 to January 2022. Convenience sampling was chosen because the participants belonged to a specific and hard-to-reach population. The sample of the study consists of 172 people who are in the counseling and psychotherapy process and have completed at least five sessions. Participants participated from 20 different cities, mostly Istanbul (n = 117; 68%). The ages of the participants ranged from 19 to 51 ($\bar{X}$ = 28.76, Sd = 5.83). Most of the respondents were women (n = 164; 95.3%), nearly half were current university students (n = 83; 48.3%), and nearly two-thirds were employed when they participate the study (n = 109; 63.4%).

Most of the participants reported that their therapists were female (n = 135, 78.4%), and they were older than them (n = 143, 83.1%). More than half of the participants reported that their therapists' theoretical orientation was psychoanalytic/psychodynamic psychotherapy (n = 90, 52.3%). Other reported theoretical orientations are respectively; cognitive behavioral therapy (n = 24, 14%), eclectic approach (n = 15, 8.7%), integrative psychotherapy (n = 10, 5.8%), humanistic/existential therapy (n = 8, 4.7%) other therapy orientations (n = 11, 6.4%). Some of the participants reported that they did not know or were unsure about the theoretical orientation of their therapist (n = 13, 7.6%).

More than half of the participants reported their session frequency as once a week (n = 97, 56.4%). 33 participants reported that they continued their sessions every two weeks (19.2%), and 19 participants reported that they continued two or three sessions a week (11%). While there were 6 participants (3.5%) who attended a session once a month, 17 participants reported that the frequency of sessions was not specific or depended on needs (9.9%). In terms of therapy duration, the largest part of the participants reported that they continued therapy between 6 months and 1 year (n=40, 23.3%). This is followed by 2 years – 5 years (n = 31, 18%), 3 months or less (n = 30, 17.4%), 3 months – 6 months (n = 25, 14.5%), 18 months – 2 years (n = 19, 11%), 1 year – 18 months (n = 18, 10.5%) and more than 5 years (n = 9, 5.2%), respectively. In addition, more than half of the participants reported that they received another therapy before their current therapy (n = 101; 55.8%).

Instruments

Personal Information Form. The authors prepared this form to gather data about the participants and their therapy processes. In this form, participants are asked about their age, gender, city of residence, educational status, student status, whether they are employed or not, how long they have attended current counseling/psychotherapy, the frequency of their current counseling/psychotherapy, the reasons for participating in current counseling/psychotherapy, the age of their therapists, the gender of their therapists, the

theoretical orientation of their therapists, and whether they have received any other psychological counseling/psychotherapy before the current counseling/psychotherapy processes.

Alliance Negotiation Scale (ANS). In this study, the Turkish version of the ANS, which was created after the translation process, was used. The ANS was developed by Doran et al. (2012) to assess the degree of negotiation in the therapeutic alliance based on the client's self-report. It consists of 12 items. The scale is a 7-point Likert-type measurement tool ranging from 1 (*never*) to 7 (*always*). The total score on the ANS reflects the client's perception of the degree of negotiation in the therapeutic alliance. High scores indicate a high degree of negotiation in the therapeutic alliance. The exploratory factor analysis performed in the original study (Doran et al., 2012), in which the scale was developed, revealed two sub-dimensions: "Comfort with Negative Feelings" (Factor 1) and "Flexible and Negotiable Stance" (Factor 2). The total variance explained by the two dimensions is 58.03% and there are 6 items in each dimension. In another study (Doran et al., 2016), CFA was applied, and the two-factor structure was confirmed (RMSEA = .09, SRMR = .07, χ^2=156.03(53), $p < .001$, CFI = .93). In the original study (Doran et al., 2012), Cronbach's alpha internal consistency values were $\alpha = .84$ for the full scale, $\alpha = .86$ for Factor 1, and $\alpha = .81$ for Factor 2. The internal consistency values calculated within the scope of this study were $\alpha = .84$ for the full scale, $\alpha = .81$ for Factor 1, and $\alpha = .80$ for Factor 2.

Working Alliance Inventory - Short Form (WAI-S). In this study, the Turkish version of the WAI-S (Gülüm et al., 2018) was used. WAI-S was created by Tracey and Kokotovic (1989) with 12 items selected from the original 36-item Working Alliance Inventory (Horvath & Greenberg 1989). Based on Bordin's conceptualization, the WAI-S is divided into three sub-dimensions, each consisting of 4 items: Task, Goal, and Bond. There are client and therapist versions of the scale. In this study, the client form was used. The total scores obtained from the scale reflect the strength of the collaboration of the therapeutic alliance from the client's point of view. High scores indicate a high level of collaboration in the therapeutic alliance. In the study conducted by Gülüm et al. (2018) to examine the psychometric properties of the Turkish form of the WAI-S, CFA results show that the Turkish version of the WAI-S preserves its original factor structure ($\chi^2 = 59.9(47)$, $p < .12$, CFI =.97, TLI = .95, RMSEA = .05.). In the same study, Cronbach's alpha internal consistency values were $\alpha = .86$ for the entire scale, $\alpha = .71$ for the Task sub-dimension, $\alpha = .67$ for the Bond sub-dimension, and $\alpha = .65$ for the Goal sub-dimension. The scale is a 7-point Likert-type measurement tool ranging from 1 (*never*) to 7 (*always*). The internal consistency values calculated in this study were $\alpha = .90$ for the entire scale, $\alpha = .74$ for the Task sub-dimension, $\alpha = .71$ for the Goal sub-dimension, and $\alpha = .86$ for the Bond sub-dimension.

Procedure

Before the study was initiated, permission was obtained with the decision number 58, dated April 29, 2021, of the Bursa Uludağ University, Social and Human Sciences Research and Publication Ethics Committee. First, an online form (Google Forms) with measurement tools was created. Participants were reached from psychological counseling units of universities, associations, and mailing groups with the theme of psychotherapy and psychological counseling and social media sites. A message was sent to the participants introducing the aims of the study and the conditions of participation. Participants who reported that they were in compliance with the conditions and approved to participate were directed to the site where the Personal Information Form, the ANS, and the WAI-S are located (Google Forms). Participants who initially approved the informed consent answered questions that took approximately 10 minutes to answer.

Translation Process

To create the Turkish version of the ANS, first of all, permission was obtained from the corresponding author Jennifer M. Doran (Doran et al., 2012). The English version of the scale was translated into Turkish by three different academicians from the field of Psychological Counseling and Guidance who were educated in English-medium universities. Three additional academicians at the Department of Psychological Counseling and Guidance assessed these translations.

The evaluations revealed that the Turkish versions of Item 1 and Item 6 were very similar to each other. Item 1 is as follows: "*I am comfortable expressing frustration with my therapist when it arises. /Terapistimle ilgili hüsrana uğradığımda bunu rahatça ifade ederim.*". Item 2 is as follows: *I am comfortable expressing disappointment in my therapist when it arises. /Terapistimle ilgili hayal kırıklığı yaşadığımda bunu rahatça ifade ederim.*". The concepts of "disappointment" and "frustration" have close meanings in Turkish. To

eliminate this confusion, the opinions of two bilingual academicians from the Department of English Language Teaching were sought. The opinions were that the concept of disappointment is an emotion close to sadness, while the concept of frustration is an emotion close to anger and pain. In Turkish Dictionary (TDK, 2023), "hayal kırıklığı" is defined as: "The sadness felt due to the failure to achieve something that is desired or hoped for." "Hüsran" is defined as: "The pain felt due to not being able to achieve what was expected." For this reason, the "hayal kırıklığı" was used for disappointment. The "hüsran" was used for frustration.

Based on the evaluations, the ANS Turkish Form (see in Appendix 1) was developed by the authors. The final Turkish form was translated back into English by a bilingual academician from the Department of Psychological Counseling and Guidance. When the backward translation and original scale items were compared, no significant difference was observed. Finally, the form's appropriateness for the Turkish language was assessed by a Turkish linguist and Ph.D. candidate in the Turkish Education doctoral program and it was decided to suitable for use.

Data Analysis

In this study, confirmatory factor analysis (CFA) was applied first to examine the validity evidence of the Turkish Form of the ANS. For criterion validity, the relationships between ANS and WAI-S scores were examined using the Pearson Product-Moment Correlation. The Cronbach Alpha Coefficient was calculated for internal consistency. Due to the conceptual differences between the dimensions of collaboration and negotiation, a moderate positive relationship is expected, not a complete overlap between the results of both scales (Doran et al., 2012). Negative items in the scales were scored reverse while applying the statistics. Before starting the analysis, mahalanobis distances were examined by using SPSS AMOS 24 program to determine the extreme values. In the whole data set (N = 181), 9 outliers were detected and removed. In the subsequent analyzes of the study, the data which the extreme values were removed (N = 172) were used. There are various recommendations in the literature for the minimum sample size in CFA analysis, such as 10 people for each indicator (Nunnally & Bernstein, 1967 quoted by Wang & Wang, 2012), and a minimum of 200 participants (Hoe, 2008; Singh et al., 2016). Power analyses have also been suggested to calculate the sample size (Kyriazos, 2018). Kim's Method (Kim, 2005) was used to test whether the sample size (N = 172) in this study was sufficient. When the expected CFI value was calculated as .90, the expected statistical power as .80, the significance level as $\alpha = .05$, the average factor loading as .60, and the average factor correlation as .30, it was seen that the minimum sample size required to validate the model was 154. Based on this calculation, and considering the specificity of the target participants of the ANS, it was concluded that the current sample size was sufficient. For comparision, in the Argentinian adaptation of ANS (Waizmann et al., 2015), the sample size is N = 147, and in the Portuguese adaptation (Galvâo et al., 2019), it is N = 120.

Before factor analysis, SPSS AMOS 24 program was used to examine whether the data (N = 172) provided multivariate normality. When the Mardia skewness and kurtosis coefficients were examined, it was seen that multivariate normality was not provided in the data set.

The Maximum Likelihood estimation method, which is frequently used when applying CFA, requires the multivariate normality criterion to be satisfied. Corrected statistics are recommended to apply confirmatory factor analysis in nonnormal data (Kline, 2023). Therefore, in the R 4.1.1 program (R Core Team, 2021) with the lavaan package (Rosseel, 2012); the Robust Maximum Likelihood (MLM) estimator which is calculated on the basis of the Satorra-Bentler correction (Satorra & Bentler, 1994) was used. For acceptable model fit; χ^2 $p < .001$, $\chi^2/df \leq 3$, RMSEA ≤ 0.10 (Browne & Cudek, 1993), SRMR ≤ 0.10 (Bentler, 1995), CFI ≥ 0.90 (Hu & Bentler, 1995), TLI ≥ 0.90 (Bentler & Bonett, 1980) values are sought.

Results

The ANS and WAI-S scales were used in the study. According to the data (N = 172), after the negative items were reverse scored, the lowest score for ANS was 27 points and the highest score was 84 points. The mean score was 70.73 (Sd = 9.63). The lowest score for WAI-S was 27 points and the highest score was 84 points. The mean score was 68.73 (Sd = 10.47).

Validity Analysis

Two types of validity were analyzed in this study. Confirmatory factor analysis (CFA) was conducted for construct validity. For criterion validity, correlations between ANS and WAI-S were examined.

Findings regarding CFA

Data (N = 172) were subjected to CFA using the Robust Maximum Likelihood (MLM) estimator. The two-factor structure from the original study (Doran et al., 2012) was introduced to the program, and the fit indices were examined to test whether the model was fit or not. The CFA results performed in the first stage showed that the model fit was not at an acceptable level: Satorra-Bentler (S-B)χ^2 = 165.01(53), p < .001, S-Bχ^2 /df = 3.11, CFI = .82, TLI = .78, RMSEA = .13 (90% CI: 0.10 - 0.15), SRMR = .12. Modification indices were examined in order to improve the model. Modification indices suggested establishing covariance between Item 1 and Item 6 (mi = 110). Both items belong to the Factor 1. When the model was reanalyzed by adding covariance to the model, the results showed that this improved model (Figure 1) is acceptable: S-Bχ^2 = 103.58(52), p < .001, S-Bχ^2 /df = 1.99, CFI = .92, TLI = .90, RMSEA = .08 (90%CI: 0.06 - 0.10), SRMR = .06. The items had factor loadings from .56 to .77 for the Factor 1 and from .48 to .80 for the Factor 2 (Table 1).

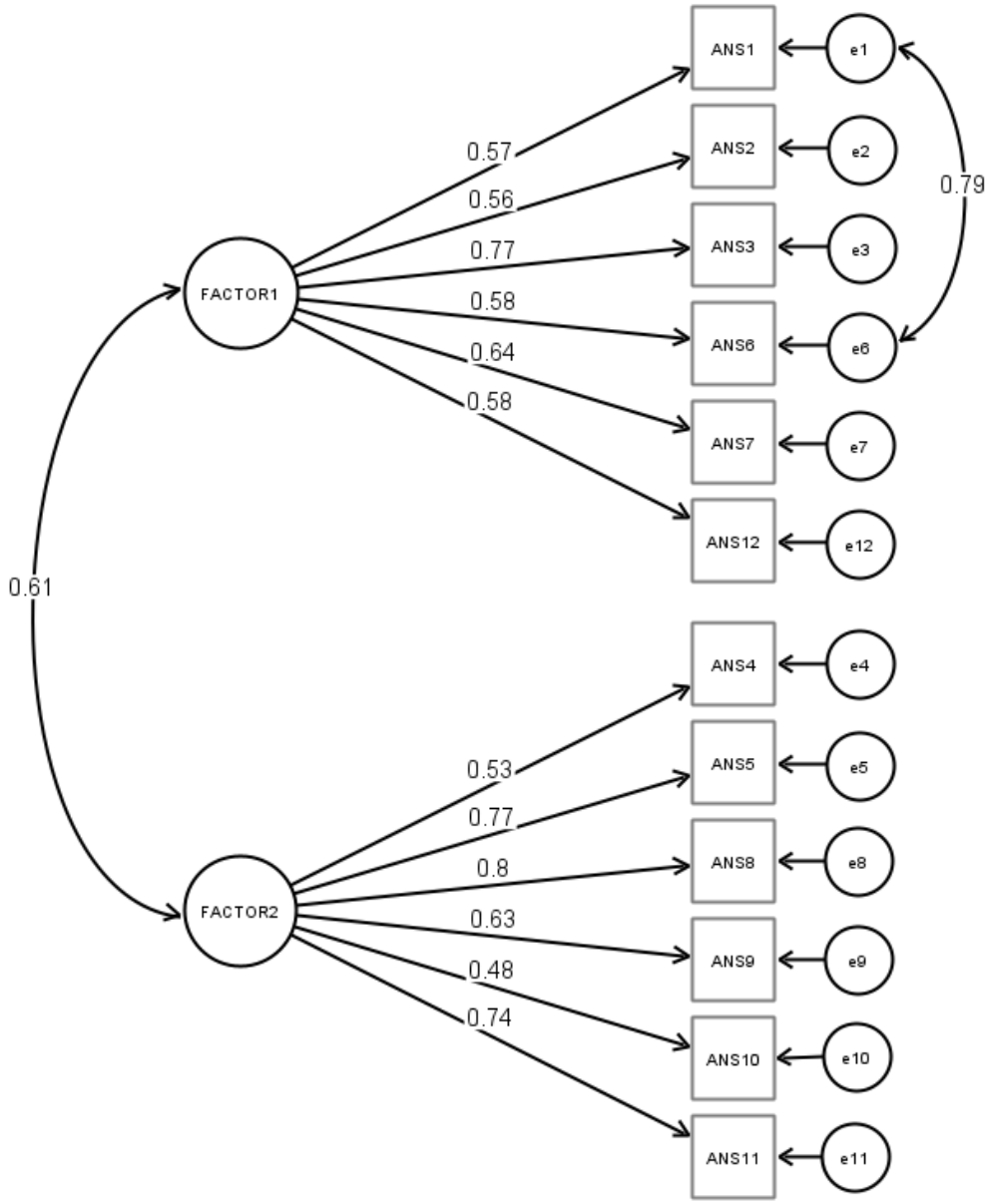
Table 1. ANS Turkish Form Confirmatory Factor Analysis Factor Loadings.

Item	Factor Loading	
	1	**2**
3. Terapistim, ilerlememizle ilgili herhangi bir endişemi ifade etmem için beni cesaretlendirir.	**.77**	
7. Terapistim, terapi sırasında herhangi bir nedenle ona karşı hissettiğim öfkeyi ifade etmem için beni cesaretlendirir.	**.64**	
6. Terapistimle ilgili hayal kırıklığı yaşadığımda bunu rahatça ifade ederim.	**.58**	
12. Terapistim, üzerinde anlaşamadığımız bir konuda yanıldığı zaman bunu kabul edebilir.	**.58**	
1. Terapistimle ilgili hüsrana uğradığımda bunu rahatça ifade ederim.	**.57**	
2. İlişkimize zarar vermeden terapistimle farklı fikirde olabileceğimi hissediyorum.	**.56**	
8. Terapide ne yaptığımıza ilişkin söz hakkım yokmuş gibi hissediyorum.		**.79**
5. Terapistim esnek değil ve benim isteklerimi veya ihtiyaçlarımı dikkate almıyor.		**.77**
11. Terapistim, terapide ne yaptığımıza ilişkin fikirlerinde katıdır.		**.74**
9. Terapistimin isteklerime veya ihtiyaçlarıma pek aldırış etmeden bana ne yapacağımı söylediğini hissediyorum.		**.63**
4. Terapistim ve ben, terapide ne üzerinde çalışmamız gerektiği konusunda aynı fikirde değilsek buna bir çözüm bulmada iyi değiliz.		**.53**
10. Terapistimin terapideki amaçlarına katılıyormuş gibi yapıyorum, böylece seans sorunsuz ilerliyor.		**.48**

Model improvement methods should be consistent with the theoretical structure to which the model is attached (Kline, 2023). When Item 1 and Item 6 are examined in terms of their contents, it is seen that they have very similar expressions to each other (see Appendix 1 for the items). During the Turkish translation of the scale,

the translators stated that the words "frustration/hüsran" and "disappointment/hayal kırıklığı" were not sufficiently differentiated in Turkish. In addition, the opinions of four different academicians, two from the English Language field and two from the Turkish Language field, were taken. Opinions have consistently been that these two items are very closely related. Therefore, it is considered that there is sufficient justification for the improvement made in the model. As a result, the CFA results have acceptable fit values for the improved model (Figure 1).

Figure 1. Improved Model of Turkish Version of the Alliance Negotiation Scale.



Criterion Validity

In this study, the relationships between the scores obtained from the whole of the ANS and the WAI-S scales and their factors were examined to reveal the evidence for criterion validity. Pearson Product-Moment Correlation analysis yielded expected results. A positive, significant, and moderate correlation was observed between ANS and WAI-S scores (r = .676, p < .01, R^2 =.456). When the relationship between the scores obtained from the ANS factors and the WAI-S scores was examined; For the Factor 1 and WAI-S relationship, r = .548, p < .01, R^2 = .301, for the Factor 2 and WAI-S relationship, r = .615, p < .01, R^2 = .378 values. These values show that there is a positive, significant, and moderate relationship between ANS factors and WAI-S scores.

There are positive, moderate, and significant relationships between the scores obtained from the factors of ANS and WAI-S. These values are shown in Table 2. These relationships observed between ANS and WAI-S both in full scales and at the level of factors provide evidence of criterion validity.

Table 2. Correlations of ANS and WAI-S factors.

	ANS Factors	
WAI-S Factors	**Comfort with Negative Feelings**	**Flexible and Negotiable Stance**
Task	.490*	.485*
Goal	.507*	.625*
Bond	.473*	.536*

* p < .01

Reliability Analysis

To provide evidence of reliability of the ANS, Cronbach's Alpha and McDonald's Omega internal consistency coefficients were calculated.

Internal Consistency

The Cronbach's Alpha internal consistency coefficient was calculated as α = .84 for the entire ANS, α = .81 for the "Comfort with Negative Feelings" factor, and α = .80 for the "Flexible and Negotiable Stance" factor.

McDonald's Omega coefficient is recommended because it provides more accurate results for constructs with unequal factor loadings (Goodboy & Martin, 2020). McDonald's Omega coefficient was calculated as ω = .89 for the entire ANS, ω = .79 for the "Comfort with Negative Feelings" factor, and ω = .82 for the "Flexible and Negotiable Stance" factor. These findings show that the internal consistency is at a good level.

Discussion

This study aimed to adapt ANS, which was developed by Doran et al. (2012), to Turkish culture to assess the negotiation dimension in the therapeutic alliance. The scale assesses the client's perception of the therapist's level of comfort with negative feelings (Factor 1), and the client's perception of the therapist's ability to negotiate therapeutic tasks and goals flexibly (Factor 2) during the therapeutic process or relationship.

CFA was applied in this study to reveal the factor structure of the Turkish version of ANS. After adding the covariance between Item 1 and Item 6 to the two-factor structure in the original study (Doran et al. 2012), the improved model (Figure 1) was found to have acceptable fit. Items have strong factor loadings (Table 1). The CFA findings are consistent with the CFA findings conducted on the original scale (Doran et al., 2016).

Item 1 (*Terapistimle ilgili hüsrana uğradığımda bunu rahatça ifade ederim.*) and Item 6 (*Terapistimle ilgili hayal kırıklığı yaşadığımda bunu rahatça ifade ederim*.) are two items that are similar in concept and appearance. In addition, both items belong to the same factor (Comfort with Negative Feelings). The opinions received from two academicians from the Turkish Language field and two from the English Language field are that the two items have very close meanings. It was concluded that this situation explains the covariance added to the model. This may be due to the characteristics of the sample or cultural differences. Although distinctions have been made between the concepts of "disappointment/hayal kırıklığı" and "frustration/hüsran"

in the translation process, for the Turkish population these two concepts may have been perceived as different degrees of the same concept. Future studies are needed to clarify whether this situation is due to a cultural difference or the characteristics of this sample.

In the Turkish version, the two-factor structure was confirmed in accordance with the original ANS. In the Argentinian (Waizmann et al., 2015) and Portuguese (Galvâo et al., 2019) versions, Item 10 (*I pretend to agree with my therapist's goals for our therapy so the session runs smoothly*) had both relatively low factor loadings and close loadings on both factors. Although it is stated that this item could theoretically be related to both factors in the Portuguese version (Galvâo et al., 2019), this is not the case in the Turkish version.

In the reliability analysis, it was seen that the Turkish version of the ANS had good internal consistency. While Cronbach's Alpha coefficients showed results consistent with other studies (Doran et al., 2016; Doran et al., 2012; Galvâo et al., 2019; Waizmann et al., 2015), this study also calculated the McDonald's Omega coefficient and presented new evidence for reliability.

In the study, to test the criterion validity, the relationship between the ANS, which assesses the negotiation dimension of the therapeutic alliance, and the WAI-S, which assesses the collaboration dimension, was examined. The relationship between the ANS and the WAI-S scores was moderate-large and significant. The relationship between the factors of the ANS and the WAI-S is moderate and significant for both factors. Significant relationships were found between the ANS factors and the WAI-S factors. The findings of this study show that although ANS and WAI-S are overlapping structures, they are not exactly the same. Furthermore, the ANS and WAI-S relationship is also present in the original, Argentinian and Portuguese versions, reinforcing the cross-cultural relevance of both scales. WAI, which is based on the collaboration dimension of the therapeutic alliance, has been used in various studies in the Turkish literature (Avunduk, 2020; Erus & Zeren, 2020; Gülüm et al., 2018; Soygüt & Işıklı, 2008; Öztürk & Duran, 2024). ANS is a construct based on the negotiation dimension of the therapeutic alliance. Both dimensions are complementary. The ANS and WAI-S relationship shown in this study, consistent with other adaptation studies, shows that ANS is a theoretically meaningful construct in the Turkish population.

Considering all these, it is seen that the ANS Turkish Form has sufficient validity and reliability in this study. The scale contributes to the psychotherapy research literature in terms of reflecting the client's perception of the degree of negotiation with the therapist. The ANS Turkish Form is promising for future studies in the Turkish literature, as it allows for examining the negotiation between the therapist and the client empirically.

On the other hand, there are some limitations of this study. First, the online collection of data in this study makes it difficult to confirm whether the responses are representative of the participants. In future studies, the collection of data through face-to-face processes may help reduce doubts about the representativeness of the data. Secondly, although the sample in this study varied in terms of age, education, and therapy orientation, it did not differ in terms of gender due to the superiority of women. It is known that women seek mental health help more than men (Çebi & Demir, 2020; Galdas et al., 2005, Oliver et al., 2005). However, to increase generalizability, it is recommended to work with more diverse samples in future studies. Another limitation is that the scales used in this study are based on the client's self-report. There are therapist (Doran et al., 2018) and supervision (Pressau et al., 2020) versions of the ANS. Assessing the negotiation dimension from the point of view of the therapist and supervisor in future studies is considered beneficial in terms of obtaining more comprehensive results. In this regard, it is important for the literature to bring the therapist and supervision versions of the ANS into Turkish with future studies. Another limitation of the study is that the measurements were obtained in a cross-section of the therapy process and by applying only once. The therapeutic alliance in the treatment process because it is considered a dynamic structure would be more appropriate to overcome this limitation in the name of conducting longitudinal research. Finally, in this study, the structure of the negotiation dimension was examined in terms of its relationship with the collaboration dimension. Although these results show that the negotiation and collaboration dimensions of the therapeutic alliance are related to each other, how this relationship occurs is not discussed in this study. It is possible that a healthy negotiation environment can strengthen collaboration, and a negotiable environment can be created through strong collaboration. What

kind of mechanisms the concepts we have discussed have in clinical reality may be an important research topic for future studies.

In future studies, it is recommended to examine the relations of negotiation with other theoretical constructs to reveal the criterion validity of the ANS in more detail. The mechanisms of the relationship between the negotiation dimension and the collaboration dimension and whether it predicts therapy outcomes are important research topics. In this study, it was not examined whether ANS findings vary according to different therapy approaches and conditions (frequency and length, etc.). If the relationships between negotiation and various therapy approaches and conditions are examined in future studies, answers can be sought to questions such as which therapy approaches and conditions are more suitable for negotiation and how new approaches suitable for negotiation can be developed. In addition, such studies can shed light on intercultural differences.

In conclusion, this study presented preliminary evidence that the ANS Turkish Version is valid and reliable. It has been seen that the ANS is an operational and useful measurement tool for psychotherapy research. In future studies, it is recommended to expand the validity of the ANS with more comprehensive studies.

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Appendices

Appendix 1. Alliance Negotiation Scale Turkish Form. / Terapötik İttifakta Müzakere Ölçeği (TİMÖ)

Terapötik İttifakta Müzakere Ölçeği

Lütfen aşağıdaki soruları terapistinizle beraberken genel olarak nasıl hissettiğinizi dikkate alarak cevaplayınız.

	Hiçbir Zaman			Bazen			Her Zaman
Terapistimle ilgili hüsrana uğradığımda bunu rahatça ifade ederim.	1	2	3	4	5	6	7
İlişkimize zarar vermeden terapistimle farklı fikirde olabileceğimi hissediyorum.	1	2	3	4	5	6	7
Terapistim, ilerlememizle ilgili herhangi bir endişemi ifade etmem için beni cesaretlendirir.	1	2	3	4	5	6	7
Terapistim ve ben, terapide ne üzerinde çalışmamız gerektiği konusunda aynı fikirde değilsek buna bir çözüm bulmada iyi değiliz.	1	2	3	4	5	6	7
Terapistim esnek değil ve benim isteklerimi veya ihtiyaçlarımı dikkate almıyor.	1	2	3	4	5	6	7
Terapistimle ilgili hayal kırıklığı yaşadığımda bunu rahatça ifade ederim.	1	2	3	4	5	6	7
Terapistim, terapi sırasında herhangi bir nedenle ona karşı hissettiğim öfkeyi ifade etmem için beni cesaretlendirir.	1	2	3	4	5	6	7
Terapide ne yaptığımıza ilişkin söz hakkım yokmuş gibi hissediyorum.	1	2	3	4	5	6	7
Terapistimin isteklerime veya ihtiyaçlarıma pek aldırış etmeden bana ne yapacağımı söylediğini hissediyorum.	1	2	3	4	5	6	7
Terapistimin terapideki amaçlarına katılıyormuş gibi yapıyorum, böylece seans sorunsuz ilerliyor.	1	2	3	4	5	6	7
Terapistim, terapide ne yaptığımıza ilişkin fikirlerinde katıdır.	1	2	3	4	5	6	7
Terapistim, üzerinde anlaşamadığımız bir konuda yanıldığı zaman bunu kabul edebilir.	1	2	3	4	5	6	7