Client Interpersonal Problems and the Initial Working Alliance

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Abstract

This study examined the relationship of client pretreatment interpersonal problems (measured by the Inventory of Interpersonal Problems) to the therapeutic alliance (as measured early in treatment by a self-report version of the Working Alliance Inventory—Short), using multilevel modeling to account for client and counselor variables. Specifically, the correlations of dominance, affiliation and vindictive/self-centered interpersonal problems with the initial working alliance were investigated. Participants consisted of 144 clients and 44 graduate student counselors at a university training clinic in the southwest. Multilevel modeling revealed that there was an interaction between dominance and counselor gender with working alliance scores. Clients who had problems with dominance reported higher working alliance scores with male counselors while clients who had problems with non-assertiveness reported higher working alliance scores with female counselors. Vindictive/self-centered interpersonal problems were associated with lower initial working alliance scores regardless of counselor gender. Implications for clinical practice are discussed.

Keywords: working alliance, interpersonal problems, multilevel modeling

Introduction

Although there is evidence regarding the efficacy of psychological therapies, there is less information regarding client factors that may influence outcomes and the therapy process (Eames & Roth, 2000). The therapeutic alliance is seen as an important aspect of client outcomes (Horvath & Symonds, 1991), however, only recently have researchers begun to attempt to disentangle the client and therapist factors that contribute to building a good therapeutic alliance (Baldwin, Wampold, & Imel, 2007).

A key phase of therapy process is the initial establishment of the therapeutic alliance as it sets the basis of subsequent work. Early alliance ratings are more predictive of outcome and dropout compared to the middle or late phases (Horvath, 1981; Horvath & Symonds, 1991). When difficulties occur during this initial phase of the therapeutic alliance it is unlikely that the client will adhere to the treatment plan and engage in a productive therapeutic relationship and early termination is probable (Horvath, 1991). Hence it is crucial to understand issues related to this early alliance development.

One aspect hypothesized to be related to early alliance establishment is the type of interpersonal problem experienced by the client. Kiesler (1996) has hypothesized that clients manifest their interpersonal difficulties in the therapeutic relationship. Given this, it is expected that the interpersonal difficulties that clients experience will have an impact on the therapeutic alliance. The most researched model of interpersonal problems is that proposed by
Horowitz, which was operationalized in the Inventory of Interpersonal Problems Circumplex Scales (IIP-C; Horowitz, Alden, Wiggins, & Pincus, 2000). The IPC has been segmentalized into sixteenths (Kiesler, 1983), most commonly octants (Wiggins, Trapnell, & Phillips, 1988), and quadrants (Carson, 1969). Within this model interpersonal problems can be represented on the interpersonal circle defined by the orthogonal dimensions of dominance and affiliation. The blending of these two dimensions form the different specific types of interpersonal problems. A visual depiction of specific interpersonal problem octant scores mapped on the interpersonal circle dimensions of dominance and affiliation is presented in Figure 1. In the middle of the circle are the quadrants in the middle of the circle represented by the two orthogonal dimensions of affiliation and dominance (Carson, 1969).

![Figure 1. Circumplex of interpersonal problems (IIP-C dimensions).](image)

While interpersonal behaviors are not necessarily problematic, some individuals experience a deficit or excess of certain interpersonal behaviors, attitudes, or feelings, which can become problematic (Gurtman & Lee, 2009). The Inventory of Interpersonal Problems (IIP; Horowitz et al., 2000) is a self-report questionnaire that measures the most common interpersonal problems through the circumplex model. The descriptions of the eight octant scores can be found in Table 1.

Interpersonal problems are presumed to shape the interactional patterns that emerge in counseling, which promotes or hinders the work in session (Henry, Schacht, & Strupp, 1986). The need for dominance, patterns of hostility (Paivio & Bahr, 1998) and the need for intimacy (Saunders, 2001) have been found to be negatively correlated with the therapeutic alliance. Client vindictive/self-centered interpersonal behaviors were more likely to inhibit the client’s ability to form a good therapeutic alliance than therapist vindictive/self-centered interpersonal behaviors during the early stages of therapy (Kiesler & Watkins, 1989). The results revealed that the more extreme the client’s vindictive/self-centered interpersonal behavior, the more likely the client perceived a less positive working alliance (Kiesler & Watkins, 1989). Kiesler and Watkins discuss that these results may indicate that clients with maladaptive vindictive/self-centered interpersonal behaviors are more likely to selectively ignore or misperceive the positive aspects of the therapist’s helping behavior and attend to the negative aspects of the therapist’s alliance behaviors; results suggest this makes building a strong working alliance more difficult and time consuming. In
Table 1

Interpersonal circumplex octant descriptions (Alden, Wiggins, & Pincus, 1990)

<table>
<thead>
<tr>
<th>Octant</th>
<th>High Score Descriptions</th>
</tr>
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<tbody>
<tr>
<td>Domineering (PA)</td>
<td>Problems related to controlling, manipulating, aggressing toward, and trying to change others.</td>
</tr>
<tr>
<td>Vindictive (BC)</td>
<td>Problems related to distrust and suspicion of others and an inability to care about other’s needs and happiness.</td>
</tr>
<tr>
<td>Cold (DE)</td>
<td>Inability to express affection toward another person, difficulty making long term commitments to others, and an inability to be generous, get along with, and forgive others.</td>
</tr>
<tr>
<td>Socially Inhibited (FG)</td>
<td>Anxiety and embarrassment in the presence of others, difficulty initiating social interactions, expressing feelings and socializing.</td>
</tr>
<tr>
<td>Nonassertive (HI)</td>
<td>Difficulties making their needs known to others, discomfort in authoritative roles, and an inability to be firm with and assertive toward others.</td>
</tr>
<tr>
<td>Overly Accommodating (JK)</td>
<td>Difficulties to feeling anger and expressing anger for fear of offending others. Describe themselves as gullible and readily taken advantage of by others.</td>
</tr>
<tr>
<td>Self-Sacrificing (LM)</td>
<td>Try too hard to please others, too generous, trusting, caring and permissive in dealing with others.</td>
</tr>
<tr>
<td>Intrusive/Needy (NO)</td>
<td>Inappropriate self-disclosure, attention seeking, and difficulty spending time alone.</td>
</tr>
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</table>

In other words, for clients with more severe interpersonal problems the counselor may be flexible and accepting but the client may not perceive the counselor this way, leading to therapeutic alliance difficulties. In contrast, some client interpersonal problems are positively associated with the therapeutic alliance. Clients with overly accommodating and self-sacrificing problems (indicated by the subscales of the IIP) have been found to establish a better initial working alliance (Beretta et al., 2005; Muran, Segal, Samstag, & Crawford, 1994). Those with lower dominance scores may be less likely to engage in power struggles within the therapeutic relationship and more willing to relinquish dominance to engage in a productive working relationship (Beretta et al., 2005). Therefore, interpersonal problems related to non-assertiveness may be helpful to building a good therapeutic alliance. While on the other hand, interpersonal difficulties such as cold/distance, hostility, and the need for dominance may hinder the initial therapeutic alliance (Beretta et al., 2005; Gurtman, 1996; Muran et al., 1994; Paivio & Bahr, 1998; Saunders, 2001).

These results, however, do not account for the influence counselors have in the relationship. Previous cited studies regarding the connection between interpersonal difficulties and the early therapeutic alliance (Beretta et al., 2005; Gurtman, 1996; Muran et al., 1994; Paivio & Bahr, 1998; Saunders, 2001) have not taken nested data into account. It is important to account for counselor differences because according to Baldwin and colleagues (2007), 5-10% of outcome variance is due to therapist differences. Ignoring nested data of individual clients that exist within counselor caseloads can have disastrous inferential consequences (Kahn, 2011). Baldwin, Murray, and Shadish (2005) re-analyzed data from 33 studies regarding group administered treatments that did not initially account for nested data. After accounting for nested data only 12-68% of the findings from all 33 studies were still significant (Baldwin et al., 2005). Therefore, individual client data should only be analyzed within therapist caseloads. While the education field has been using multilevel modeling for some time to analyze nested data, the counseling field has been slower to adapt such practices, however without using multilevel modeling the analyses assumption is that client variables are independent from and not influenced by the therapist (Reise & Duan, 1999).

According to a literature review by Ackerman and Hilsenroth (2003), several therapist factors are correlated to the therapeutic alliance ratings. Significant relationships have been found between early alliance and therapist
attributes (Hersoug, Høglend, Monsen, & Havik, 2001; Horvath & Greenberg, 1989; Kivlighan, Clements, Blake, Arnzen, & Brady, 1993; Najavits & Strupp, 1994; Mallinckrodt & Nelson, 1991). Specifically, therapist gender is an important factor to consider based on the research findings regarding client preferences for therapist gender (Boulware & Holmes, 1970; Jones & Zoppel, 1982; Kirshner, 1978; Simons & Helms, 1976). However, conflicting results have been produced; a preference for male counselors (Boulware & Holmes, 1970), a preference for female counselors (Jones & Zoppel, 1982; Simons & Helms, 1976) and a preference for same sex counselors (Kirshner, 1978) have been reported. Further, client perceptions of counselors (experienced, trustworthy, affirming, flexible, interested, alert, relaxed, confident, and warm) have been found to be influential to the initial working alliance (Ackerman & Hilsenroth, 2003). Therapist gender could affect the client perception of the therapist on these variables. Therefore therapist gender is an important factor to consider.

The central aim of this study is to examine how client pre-treatment interpersonal problems are related to the initial development of the therapeutic alliance. Within this study the association between client pretreatment interpersonal problems and the client’s perception of the therapeutic alliance at the third session was investigated utilizing a model with nested data. The first hypothesis was that there would be a correlation between the pretreatment affiliation and dominance dimensions of the client IIP scores and the overall score of the working alliance self-report at the third session. Based on previous studies (Beretta et al., 2005; Muran et al., 1994; Paivio & Bahr, 1998), it was hypothesized that cold/distant and dominant interpersonal problems would be negatively associated with the quality of the initial therapeutic alliance, and non-assertiveness problems would be positively associated with the quality of the initial therapeutic alliance. The second hypothesis was that vindictive/self-centered interpersonal problems would be negatively associated with the quality of the initial working alliance based on prior research (Gurtman, 1996; Muran et al., 1994; Paivio & Bahr, 1998). Lastly, based on numerous conflicting findings documenting preferences for male counselors (Boulware & Holmes, 1970) female counselors (Jones & Zoppel, 1982; Simons & Helms, 1976), and same sex counselors (Koile & Bird, 1956; Walker & Stake, 1978) it was hypothesized that counselor and client gender would play a role in the development of the initial therapeutic alliance.

**Method**

**Participants**

Participants consisted of 144 clients (80 females, 63 males and one transgendered client) who received outpatient-counseling services weekly at a university training clinic in the southwest U.S. Clients included both college students (40.6%), faculty (4.2%) and community members (50.3%). Age was measured categorically, and the majority of clients were Caucasian (64.8%) and between the ages of 19-49 years old (90.2%). Treatment consisted of weekly sessions with the same counselor. Treatment was provided by 44 masters or doctoral graduate students in counseling or counseling psychology (33 females and 11 males) in their first or second year of practicum. Many of the students in their first year of practicum have not yet selected a theoretical orientation and are primarily focused on learning basic counseling skills. Counselors saw three participating clients on average with a range of one to six clients.
Measures

The Inventory of Interpersonal Problems – Circumplex – Item Response Theory (IIP-C-IRT)

The IIP-C-IRT (Sodano & Tracey, 2011) was used as a measure of interpersonal problems. This 32 item version of the original 64 item version of the IIP has respondents rate the level of difficulty for each interpersonal problem using a five point Likert scale (0=not at all, 4=extremely) just as the original version does (Alden, Wiggins, & Pincus, 1990). Eighteen items address behaviors that are hard to do (i.e. "It is hard for me to take instructions from people who have authority over me") and 14 items address behaviors that occur too often (i.e. "I try to please other people too much"). The instrument was designed to yield interpersonal circumplex octant scores on the dimensions of affiliation (cold-distant vs. self-sacrificing) and dominance (non-assertive vs. controlling), and also a total distress score. For the purposes of this study the dimensions of affiliation and dominance were utilized. The affiliation and dominance scores can range from -9.8 to 9.8. Dominance (DOM) and affiliation (AFF) scores are calculated with equations (shown in Equation 1-2) positively or negatively weighting the octant scales of domineering/controlling (PA), vindictive/self-centered (BC), cold/distant (DE), socially inhibited (FG), non-assertive (HI), overly accommodating (JK), self-sacrificing (LM) and intrusive needy (NO).

\[
\text{DOM} = 1^{*}\text{PA} + 71^{*}\text{BC} + 0^{*}\text{DE} - 0.71^{*}\text{FG} - 1^{*}\text{HI} - 0.71^{*}\text{JK} + 0^{*}\text{LM} + 0.71^{*}\text{NO} 
\]

\[
\text{AFF} = 0^{*}\text{PA} - 0.71^{*}\text{BC} - 1^{*}\text{DE} - 0.71^{*}\text{FG} + 0^{*}\text{HI} + 0.71^{*}\text{JK} + 1^{*}\text{LM} + 0.71^{*}\text{NO} 
\]

Research supports the psychometric properties of the IIP (Horowitz et al., 2000; Soldz, Budman, Demby, & Merry, 1995; Tracey, Rounds, & Gurtman, 1996). Sodano and Tracey (2011) constructed the IIP-C-IRT based on the original IIP-C version by item response theory to select fewer items, which maximally discriminate individuals along the interpersonal circumplex. The precision of the subscales was examined across varying levels of interpersonal problems, and IRT based reliability levels were found to be adequate or better across the score levels in all subscales and demonstrated precision in discriminating individuals on levels of the latent trait (Sodano & Tracey, 2011). Within the present study the dominance dimension scale items (α = .85) and affiliation scale items (α = .86) demonstrated adequate internal reliability. The vindictive/self-centered octant subscale (BC) was also utilized in the present study. The items in this subscale are, “It’s hard for me to trust other people”, “It’s hard for me to put somebody else’s needs before myself”, “I am too suspicious of other people” and “I want to get revenge against other people too much”. While in prior studies the BC scale demonstrated adequate internal reliability (Sodano & Tracey, 2011), in this sample an internal consistency estimate of α = .41 was obtained. It should be noted that while the expectations for acceptable Cronbach’s alpha scores vary, this may be seen as below acceptable level for a homogeneous scale (Clark & Watson, 1995). Thus interpretations of findings related to the vindictive self-centered scale should be interpreted with caution.

The Working Alliance Inventory Short (WAI-S)

The WAI-S (Tracey & Kokotovic, 1989) is a shortened version of the original 36-item WAI. The 12-item questionnaire is given to clients and therapists to measure therapeutic alliance. Each item is rated on a 7-point scale and yields three sub-scale scores (goal, task, and bond) in addition to one overall general alliance score. The sub-scales represent three components of alliance. The goal component is the degree to which the therapist and client agree on the goals of therapy (i.e. “My therapist does not understand what I am trying to accomplish in therapy”). The task component is the degree to which the client and therapist agree on how to reach these goals (i.e. “My counselor and I agree about the things that I need to do in therapy to help improve my situation”). The bond component is the personal attachment developed between the counselor and the client (i.e. “My therapist and I trust one another”).
For the purposes of this study the overall general alliance score completed by the client was utilized. Client report of working alliance has been found to have the strongest association with outcome (compared to therapist or observer reports) regardless of who assesses the client outcome (Horvath & Symonds, 1991). Therefore client perception of the working alliance appears to be more important to client outcome than the therapist’s perception, and was utilized for the current study. Tracey and Kokotovic (1989) demonstrated the construct validity of these sub-scale scores and the overall general alliance score. In this sample an internal consistency estimate of = .94 was obtained for the general alliance score.

Procedures

Prior to the first session of counseling, clients were informed about the study and 165 chose to participate, completed a consent form and filled out demographic information identifying their gender, age, ethnicity and income. Age and income were split up as categorical variables. Participants were identified by a code number to protect their confidentiality. The Inventory of Interpersonal Problems (IIP-C-IRT) was completed prior to the first session and clients completed the Working Alliance Inventory Short (WAI-S) before the third session.

Due to client termination or cancelations, 21 of 165 clients were excluded from the study. Four clients did not complete the IIP, while seventeen dropped out of the study prior to completing the WAI-S. Analyses were conducted to test if the IIP scores of participants who dropped out differed from the rest of the sample. The two groups did not differ in dominance scores $F(1, 153) = 1.29, p = .26$ or affiliation scores $F(1, 153) = .01, p = .94$.

Plan of Analysis

Of the clients that were included in the sample, 0.57% of the data were missing. Five multiple imputations of the missing data at the item level were conducted and input into the multilevel model. For this study multilevel modeling (MLM) was used to model variation in overall working alliance ratings at session three at both the client and counselor level. MLM techniques facilitate the analyses of data sets with hierarchical structure when one unit of observation (e.g. participants) is nested within another unit (e.g. clinics, schools, couples, therapists) (Reise & Duan, 1999). With nested data it is often the case that participants within the same group are not statistically independent but instead clustered (Reise & Duan, 1999). Clients who see the same therapist are typically not independent participants, but share a common therapeutic environment, similar to students in the same school (Reise & Duan, 1999). “Statistical analyses that fail to account for this dependence are usually invalid. By incorporating clustering effects directly into the data analyses model MLM accounts for the statistical dependencies that occur in nested data and allows for valid statistical inferences” (Reise & Duan, 1999, p. 530). Furthermore, MLM allows researchers to study how the relationship between a dependent and predictor variable differ across groups (Reise & Duan, 1999).

Within the present study, the level 1 (client) variables included were the client dominance (DOM) and affiliation dimension scores (AFFI) from the Inventory of Interpersonal Problems and client sex (CLSEX). DOM and AFFI variables were entered as group centered variables to facilitate interpretation of the parameters and CLSEX was entered un-centered to interpret the difference between dummy coded female and male genders. The Level 2 (therapist) variable in the model was counselor gender (CO_Gender). Counselor gender was entered un-centered to be able to interpret the difference between female and male genders. Equation 3 below represents the Level 1 equation and Equations 4-7 represent the Level 2 equations where i represents the individual and j the group level.
Level 1

\[
\text{WAITOTAL}_{ij} = \beta_0j + \beta_1j \ast (\text{DOM}_{ij}) + \beta_2j \ast (\text{AFFI}_{ij}) + \beta_3j \ast (\text{CLSEX}_{ij}) + r_{ij}
\]  

(3)

Level 2

\[
\begin{align*}
\beta_0j &= \gamma_{00} + \gamma_{01} \ast (\text{CO\_GENDER}_j) + u_{0j} \\
\beta_1j &= \gamma_{10} + \gamma_{11} \ast (\text{CO\_GENDER}_j) + u_{1j} \\
\beta_2j &= \gamma_{20} + \gamma_{21} \ast (\text{CO\_GENDER}_j) + u_{2j} \\
\beta_3j &= \gamma_{30} + \gamma_{31} \ast (\text{CO\_GENDER}_j) + u_{3j}
\end{align*}
\]  

(4) - (7)

In order to investigate the unique correlation between vindictive self-centered interpersonal problems and the working alliance, another model was investigated. The vindictive/self-centered octant score (BC) was entered as a client variable at Level 1 and counselor gender was entered as a counselor variable at Level 2. The octant score was entered as a group centered variable and gender was entered un-centered again to facilitate interpretation. Equation 8 below represents Level 1 and Equations 9 and 10 represent Level 2 in the model.

Level 1

\[
\text{WAITOTAL}_{ij} = \beta_0j + \beta_1j \ast (\text{BC}_{ij}) + r_{ij}
\]  

(8)

Level 2

\[
\begin{align*}
\beta_0j &= \gamma_{00} + \gamma_{01} \ast (\text{CO\_GENDER}_j) + u_{0j} \\
\beta_1j &= \gamma_{10} + \gamma_{11} \ast (\text{CO\_GENDER}_j) + u_{1j}
\end{align*}
\]  

(9) - (10)

Results

We predicted that client interpersonal problems would correlate strongly with the client’s overall alliance ratings at session three, specifically, that clients who were more cold and distant (those with low affiliation scores) and those who were more dominant (higher dominance scores) would self-report lower working alliance ratings. An initial analysis of the correlations between the dominance and affiliation scores, the WAI-S and client demographics was conducted and shown below in Table 2. Age was the only client demographic variable significantly correlated with the WAI-S ($r = .18$, $p < .05$).

The analysis of the nested data allows for the investigation of the contribution each level of the data contributes to the variation in the dependent variable (individual clients, and therapists). The ICC for the multilevel model was .23 indicating that 23% of the variance in client alliance ratings was due to which therapist the client was working with. This could be related to any number of variables (e.g. therapist characteristics or client perceptions of certain therapist attributes). The design effect (10.73) indicates that the standard errors obtained from a traditional single-level analysis would be about ten times smaller than they should be. Analyzing the data without accounting for the clustered nature of the data would produce highly inflated type I error rates.
The hypothesized negative relationship of interpersonal problems with the working alliance was not supported although the parameters were in the expected direction; for dominance problems (un-standardized coefficient = -1.53, \( p = .18 \)) and for affiliation problems (un-standardized coefficient = 0.25, \( p = .79 \)). So while there was a relation between interpersonal problems and the WAI-S when examined using zero-order correlations, the result disappeared when examined using the multilevel model which accounted for therapist effects. Model 1 did reveal an interaction between counselor gender and client dominance problems. The slope between dominance and the WAI-S increases by 3.94 points between female and male counselors (un-standardized coefficient = 3.94, \( p = .04 \)). Table 3 shows the parameter estimates for Level 1 and Level 2.

Clients who reported more interpersonal problems with dominance (according to the dominance dimension score) reported higher initial working alliance ratings with male counselors; for each standard deviation increase in dominance from the mean, the working alliance rating is predicted to increase by 2.80. Clients who reported lower scores on the dominance dimension reported higher initial working alliance ratings with female counselors; for each standard deviation decrease in dominance from the mean, the working alliance rating is predicted to increase by 1.53. Figure 2 shows the simple slopes for the dominance counselor gender interaction.
The hypothesis that clients with vindictive/self-centered interpersonal problems would report lower WAI-S scores was supported (un-standardized coefficient = -4.32, \( p = .02 \)). For every unit increase in the vindictive/self-centered octant score (BC), the WAI-S is predicted to decrease by 4.32. The counselor gender by BC interaction was not significant (un-standardized coefficient = 1.11, \( p > .05 \)). Regardless of counselor gender, clients with more vindictive/self-centered interpersonal problems report lower initial working alliance scores.

Figure 2. Client Dominance and Alliance by Counselor Gender Interaction

Discussion

Little is known about how therapist and client attributes interact in forming the initial therapeutic alliance. Prior studies have investigated client interpersonal problems contribution to the therapeutic alliance, however, no studies to our knowledge have ever investigated client interpersonal problems relation to the initial therapeutic alliance utilizing multilevel modeling to account for nested data. The present study is the first to analyze the correlation between client interpersonal problems and the initial therapeutic alliance, accounting for nested data which accounts for the variations between individual therapists in building the initial therapeutic alliance. Further understanding of the interaction between therapist and client variables could allow therapists across the globe to attend to these variables and improve the therapeutic relationship.

In regard to the first hypotheses, the proposed relation between client interpersonal problems and the initial working alliance was found in the expected direction; cold/distant and dominant client interpersonal problems were negatively correlated with initial working alliance scores. However, this correlation was not significant in contrast to previous findings (Beretta et al., 2005; Muran et al., 1994; Paivio & Bahr, 1998). It is possible that with a larger sample size this correlation would be significant, however, it is more likely the result of accounting for therapist differences using the multilevel modeling. We did find zero-order correlation results between interpersonal problems and WAI-S scores but these vanished when nested data (individual clients within therapist caseloads) was appropriately accounted for. Hence correlational analyses which does not account for nested data and incorporate overall differences between therapists, may lead to inaccurate conclusions.
Although client dominance interpersonal difficulties were not significantly correlated to the initial working alliance alone, in support of the third hypothesis, there was a significant interaction of counselor gender and dominance with the initial working alliance. Clients with more dominance interpersonal problems reported higher working alliance ratings with male counselors. On the other hand, clients with more non-assertiveness interpersonal problems reported a higher working alliance with female counselors. The same interaction was present for both male and female clients.

It is possible clients with dominance or non-assertiveness problems stereotype counselor genders to perceive their relationships with male or female counselors differently. According to stereotypic beliefs about gender, women tend to be viewed as more self-sacrificing and less self-assertive than men (Eagly & Steffen, 1984). Therefore, clients with non-assertiveness problems may perceive male counselors as more controlling and intimidating, leading them to be more comfortable with female counselors. Clients with dominance problems may perceive male counselors as more controlling and capable of dealing with their problems than female counselors and thus feel more comfortable with male counselors. Clients with non-assertiveness problems may also feel they have a more equal role with a female counselor and clients with more dominance problems may feel they would have a more equal role with a male counselor. More equal roles between the counselor and client are especially beneficial in the early stages of therapy for the client to gain trust and confidence in the counseling process (Hersoug et al., 2001; Tracey & Ray, 1984). Further studies are needed to explore what client perceptions or counselor behaviors are related to the counselor gender/client dominance interaction with working alliance. It would be interesting to explore client perceptions and stereotypes about male and female counselors before they begin therapy and counselors’ actual interpersonal behaviors in therapy.

The results supported the second hypothesis that vindictive/self-centered interpersonal problems are negatively correlated with the initial working alliance. Regardless of counselor differences or counselor gender, vindictive/self-centered interpersonal problems were negatively correlated with the client initial working alliance. This aligned with Kiesler and Watkins’ findings (1989) that focused on interpersonal behaviors as opposed to interpersonal problems. Findings suggest client vindictive/self-centered interpersonal problems are correlated negatively with the initial therapeutic alliance, regardless of counselor differences. Counselors could utilize the IIP measure to detect vindictive/self-centered interpersonal problems and work with clients to address possible working alliance difficulties. Further studies regarding methods to build the therapeutic alliance with clients who have vindictive/self-centered interpersonal problems could be beneficial. For example, specific therapist attributes that contribute to building a high therapeutic alliance with clients who have vindictive self-centered interpersonal problems could be studied. This would be especially beneficial for settings in which more clients struggle with vindictive/self-centered difficulties.

While these findings are thought provoking and extend the literature on the factors that contribute to building the initial therapeutic alliance, limitations of this study must be acknowledged. The sample was conducted with beginning counseling trainees within one counseling program in the United States and may not be representative of the overall psychotherapy population. For example, licensed professionals are likely to have an established theoretical orientation, while beginning trainees may not. Furthermore, with time and experience, it is possible that the differences between therapist’s ability to build a therapeutic alliance are lower than the differences of trainee therapists. Another large limitation in the present study was the lack of analysis of specific therapist variables. While demographic therapist variables were collected, personality assessments of the therapists and specific client perceptions of therapists were not collected. Many beginning trainees and even licensed professionals may be hesitant to fill...
out personality assessments for research, however, this data could be helpful to further understand the therapist attributes that contribute to the individual differences in therapist abilities to build the initial therapeutic alliance. For, example, within this study there was an interaction between therapist gender and the client vindictive/self-centered interpersonal problem, however, there is no way to definitively know the specific therapist attributes contributed to this finding. Lastly, the internal reliability of the Vindictive/Self-centered octant scale reliability was below standards of acceptable Cronbach’s alpha.

Overall, the results of the study indicate the importance of using multilevel modeling when exploring the factors that contribute to the working alliance. The need to further explore counselor variables in addition to client variables was supported, as 5-10% of the outcome variance has been attributable to therapist differences (Baldwin et al., 2007). Some counselors are better than others at building a good initial relationship with the client (Baldwin et al., 2007), therefore counselor variables in addition to client variables should be explored in future studies investigating the working alliance. Learning what specific therapist and client variables facilitate or hinders the growth of the initial therapeutic alliance allows counselors to be aware of potential difficulties that may arise in the therapeutic relationship to address these issues.

The therapeutic alliance is an essential ingredient in counseling (Bordin, 1979) and one of the most robust factors connected to outcome (Castonguay, Constantino, & Holtforth, 2006). Knowledge about what pre-treatment interpersonal problems are associated with lower client reports of initial alliance can help counselors across the globe be more aware and prepared. Results indicate vindictive/self-centered interpersonal problems are associated with lower therapeutic alliance scores. Awareness that clients with non-assertive interpersonal problems report higher initial working alliances with female counselors, while clients with dominant interpersonal problems report higher initial working alliances with male counselors is useful for clinical practice. This allows counselors to identify these potential situations for initial alliance difficulties early on.

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