Patients' Self-presentational Tactics as Predictors of the Early Therapeutic Alliance

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Objectives: *The early therapeutic alliance is an important predictor for therapy outcome. However, knowledge about predictors of the therapeutic alliance is still limited. We examined if patients' self-presentational behaviors can predict the early therapeutic alliance.*
Method: *Videotaped intake interviews of 60 randomly selected patients were coded for patients' self-presentational tactics. The therapeutic alliance was measured with the Bern Post-Session Report.*
Results: *From the therapists' perspective,* Agenda setting *and* Self-promotion *were positively related and* Supplication *was negatively related to the therapeutic alliance. From the patients' perspective,* Agenda setting *was negatively related and* Self-promotion *was positively related to the therapeutic alliance.* Provoking a response from the therapist *was unrelated to the therapeutic alliance as judged from both therapist and patient perspectives. Correlations were of small-to-moderate size. These findings have important implications for building a constructive therapeutic alliance and identifying patients' needs.*
Conclusions: *Patients' self-presentational behavior is a promising predictor of the early therapeutic alliance.*

KEYWORDS: early therapeutic alliance; self-presentation; agenda setting; self-promotion; supplication

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PATIENTS' SELF-PRESENTATIONAL TACTICS AS PREDICTORS OF THE EARLY THERAPEUTIC ALLIANCE

The therapeutic alliance is one of the most important predictors for therapy outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The quality of the alliance at the beginning of therapy seems to be of particular importance as it predicts the further development of the alliance and outcome (for an overview see Horvath, 2001). The quality of the alliance is plausibly a product of other factors; however, only few studies have investigated predictors of the therapeutic alliance. Extant research shows that therapist variables, including good communication skills, empathy, openness, and collaboration, are related to a good alliance, while client variables, such as more severe problems, personality disorders, and insecure attachment styles, are related to a poor alliance (Horvath, 2001).

SOCIAL INFLUENCE AND THE THERAPEUTIC ALLIANCE

From a social psychological perspective, the therapeutic alliance can be understood as a process of social influence. Strong and Claiborn (1982) claimed a constant mutual influence exists between therapist and patient. While numerous studies have investigated the ways in which therapists use these methods to influence patients to cope with problems (e.g., Abraham & Michie, 2008; Frank, 1971; Heppner & Claiborn, 1989), only a few have focused on how patients influence their therapists (Friedlander & Schwartz, 1985; Schütz, Richter, Köhler, & Schiepek, 1997). Friedlander and Schwartz elaborated on an impression management perspective in the therapeutic process (1985). They argued that as a novel social situation, the therapeutic alliance would render the interactional peculiarities of the patient salient and induce him or her to think about how best to present himself or herself to the therapist. These tendencies are further increased because psychotherapy is an image-threatening situation for the patient (Baumeister, 1982). Because of the asymmetrical relationship between patient and therapist, the patient not only wants to be perceived by the therapist as friendly, disclosing, attractive, and motivated (Carkhuff & Alexik, 1967; Goldstein & Simonson, 1971; Heller, Meyers, & Kline, 1963), but also show that he takes responsibility for problematic behavior or failure (Batson, 1975; Sherrard & Batson, 1979).

SELF-PRESENTATIONAL TACTICS

Self-presentational (or impression management) tactics are defined as the behaviors used to create, modify, or maintain impressions. The moti-

Table 1. PATIENTS' SELF-PRESENTATIONAL TACTICS

Tactic	Definition/exemplary behaviors	Example of our sample	Fleiss' κ
Agenda setting	Determining the topics, goals and process of therapy	Therapist: "Would you like to tell me about this?" Patient: "I do not really know where to start. I will have to do it in chronological order. I am a very structured person."	.79
Provoking a response from the therapist	Direct questions, hints, searching look	Patient talks about which means he uses to kill himself in his suicidal fantasies: "... I suppose nowadays you cannot kill yourself with sleeping pills!?" (questioning look towards the therapist)	.77
Supplication	Report of difficulites, complaining, slumped posture	"When my migraine is really bad all I can do is pray. If I take my medication I can at least vegetate around in my apartment. But if I cannot take my medication really the only thing left to do is pray."	.66
Self-promotion	Highlighting one's competences and achievements	Patient: "I started to do bodybuilding.". Therapist: "With a certain goal?" Patient: "Yes - to be the best. I was considered a super talent."	.65

vation to use these behaviors is believed to be strongest in the first contact, and people are particularly motivated to manage the impressions they make on strangers (Leary et al., 1994). Hence, we investigated self-presentational tactics of patients during the intake interview where patients are meeting their therapist for the first time, and we found that patients use such tactics in roughly 30% of their utterances (Frühauf, Figlioli, Oehler, & Caspar, 2015). Given that researchers have indicated a constant influence between therapist and patient, and that first impressions are critical in the development of a relationship, it seems plausible that patients' attempts to influence their therapists' perceptions of them have an effect on the therapeutic alliance. The aim of the present study was thus to investigate if the self-presentational tactics of *Agenda setting, Provoking a response from the therapist, Self-promotion, and Supplication* (see Table 1) can predict the early therapeutic alliance.

Agenda Setting

Agenda setting is a means for patients to present themselves as motivated and cooperative. In medical environments patients are trained to use *Agenda setting* as a self-management skill (Frankel, Salyers, Bonfils, Oles,

& Matthias, 2013). Researchers have found that the use of *Agenda setting* was associated with better treatment outcomes, reduced treatment costs (Bodenheimer, Lorig, Holman, & Grumbach, 2002), higher satisfaction of patient (Michie, Miles, & Weinman, 2003) and physician (Beckman, Markakis, Suchman, & Frankel, 1994; Roter, Hall, Blanch-Hartigan, Larson, & Frankel, 2011), less premature acceptance of hypotheses by the physician (Beckman et al., 1994), and higher treatment adherence (Michie et al., 2003). It is possible that *Agenda setting* will produce similar outcomes with psychotherapy patients where they may have a clearer idea about what they want to achieve in therapy and practitioners in turn would appreciate this. Conversely, an overly concrete conception about what should be accomplished in a therapy could render patients less open towards the therapists' suggestions. Nevertheless, results of the aforementioned studies seem to provide more support for *Agenda setting* to have a positive effect. Therefore we proposed the following hypothesis:

Hypothesis 1: *Agenda setting* is positively associated with the early therapeutic alliance.

Provoking a Response from the Therapist

Similar to Agenda setting, the tactic of *Provoking a response from the therapist* is indicative of an active communication between patient and therapist. Studies in medical settings have found that patients who asked more questions had better outcomes as measured by level of anxiety (Thompson, Nanni, & Schwankovsky, 1990), role limitations, physical limitations (Greenfield, Kaplan, Ware Jr, Yano, & Frank, 1988; Greenfield, Kaplan, & Ware, 1985; Kaplan, Greenfield, & Ware Jr, 1989), functional status (Greenfield et al., 1985; Kaplan et al., 1989), and physiological status (Greenfield et al., 1988; Kaplan et al., 1989).

Asking questions is a means for patients to actively participate in the treatment, which should, similarly to *Agenda setting*, be welcomed by practitioners. We therefore hypothesize that it is positively associated with the therapeutic alliance in psychotherapy.

Hypothesis 2: *Provoking a response from the therapist* is positively associated with the early therapeutic alliance.

Self-Promotion

The tactic of *Self-promotion* has been investigated most often in organizational settings. Barrick, Shaffer, and DeGrassi (2009) found that

people who used *Self-promotion* in job interviews were evaluated more positively by interviewers than those who did not. Because people use this tactic to highlight their competencies (Jones & Pittman, 1982), it makes sense for it to have a positive impact on the person's evaluation. In psychotherapy, the use of *Self-promotion* signals the patients' awareness of their resources and thereby draws the therapists' attention to these, so that they can be used for therapy. Being focused on one's resources activates the approach mode (Gassmann & Grawe, 2006), which makes patients more open for therapeutic interventions. The use of this tactic should thus be positively associated with the early alliance.

Hypothesis 3: *Self-promotion* is positively associated with the early therapeutic alliance.

Supplication

The burden of suffering is generally viewed as a prerequisite for therapy motivation. Klauer, Maibaum and Schneider (2007) found that a high burden of suffering at the beginning of therapy was associated with fewer dropouts. The explicit expression of suffering, *Supplication,* is not necessarily perceived as positive for the therapeutic alliance. Caspar (2007) sees *Supplication* as a problematic behavior, possibly driven by motives that are in the way of straightforward change unless one deals with them appropriately. He recommends therapists not respond to it on the behavioral level to avoid reinforcement. Instead, he advises therapists to try to comprehend the motives behind it, trace them back to unproblematic higher motives, and behave complementarily to these. These goals are associated with a prescriptive concept referred to as motive oriented therapeutic relationship, which has been shown experimentally to improve therapies (e.g. Berthoud, Kramer, Roten, Despland, & Caspar, 2013). Establishing such a relationship in the intake interview seems to be challenging for therapists. The intake interview is a situation in which the therapist and patient do not know each other, and yet, the patient is expected to talk about his/her problems. Finding a balance between responding empathically to patients' reports of difficulties, but at the same time avoiding reinforcement of *Supplication* might be difficult for the therapist to achieve. Furthermore, a large amount of *Supplication* might indicate avoidance in addressing problems (Sachse, Fasbender, & Sachse, 2011), which is a suboptimal basis for psychotherapy in general and also for the therapeutic alliance specifically. We, therefore, suggest:

Hypothesis 4: *Supplication* is negatively related to the therapeutic alliance.

METHODS

Sixty videotaped intake interviews were analyzed. The design and selection of the sample has been described in detail elsewhere (Frühauf et al., 2015).

PARTICIPANTS

Patients

Participants (n = 60; 30 women, 30 men; age M = 39.05, SD = 14.55 years) were randomly selected from a pool of patients (n = 3,863) who were treated at the psychotherapeutic outpatient clinic of the University of Bern, Switzerland. Patients are treated according to an integrative form of cognitive behavior therapy (CBT) which is based on a detailed case conceptualization formulated using Plan analysis (Caspar, 2007; Grawe, 1999). The clinic accepts patients who have a wide range of problems and disorders, with the exception of psychotic disorders and substance dependency. The most frequent disorders in this sample were affective, anxiety, and somatoform disorders.

Therapists

Twelve therapists conducted the interviews (five men, seven women). Half of the therapists were trainees at various stages of their four-year psychotherapy training course. The other half were experienced therapists involved in the weekly supervision of the trainees. The combination of patients' and therapists' sex was chosen so that 15 dyads were male-male, 15 male-female, 15 female-male, and 15 female-female.

Research team

The ratings were performed by four advanced masters students (one man, three women), who had at least four years of psychology and psychotherapy education. They had undergone systematic training to learn to apply the rating manual.

MEASURES

Rating Manual

We defined patients' tactics based on previous studies (Friedlander & Schwartz, 1985; Howard, Blumstein, & Schwartz, 1986; Kipnis, Schmidt, & Wilkinson, 1980; Pratkanis, 2007). We refined the preliminary list of tactics after discussing with ten practicing psychotherapists and testing the

tactics by using them to assess five videotaped interviews. The final list consists of 12 tactics. For the present study, four tactics were chosen based on the quality of their inter-judge reliability.

Bern Post-Session Report

The Bern Post-Session Report (Flückiger, Regli, Zwahlen, Hostettler, & Caspar, 2010) is a process measure. It is comprised of a patient form with eight scales and a therapist form that includes 11 scales. At the psychotherapeutic outpatient clinic both patient and therapist complete the Post-Session Report immediately after each session. For this study we examined the "therapeutic alliance" scale, which is comprised of three items. The patient items are:

"My therapist and I understand each other."

"Today I felt comfortable in the relationship with the therapist."

"I think the therapist is really interested in my well-being."

The therapist items are:

"My patient and I understand each other."

"Today I felt comfortable in the relationship with the patient."

"My patient and I are working on the same goals."

The items were measured on a 7-point Likert scale where negative three (−3) = "not at all" and plus three (+3) = "exactly." The internal consistency for the present study included the values from the first three sessions and was .82 for the patient form and .83 for the therapist form, indicating good internal consistency.

PROCEDURES

Interviews

All interviews were conducted during the years 2001 to 2012. The intake interview had the purpose of gathering information on the patient's problem(s), previous treatments, family circumstances, demographic information, current living conditions, personal resources, and expectations towards psychotherapy. Although the interview was structured, it left enough freedom so that interactional distinctiveness of patients could unfold. The duration of the interview was flexible, and in this sample ranged from 50 minutes to 100 minutes.

Training

Judges completed systematic training lasting approximately 12 weeks; training was completed when inter-judge agreement no longer improved.

Coding

The interview was assessed on an utterance-to-utterance basis using a structured manual. (The German manual is available from corresponding author upon request). Videos were randomly allocated to judges, who were blind to the research questions. Each judge rated 18 videos. The judges were instructed to distinguish instrumental from reactive behaviors using cues of the patients' behavior (Brunner, 1996; Caspar, 2007, p. 159). We defined instrumental behavior as being purposeful, even if the patient was not aware of it being so; all other behaviors were categorized as reactive. In the rating manual, each tactic was outlined with an illustrative example to give the judges more confidence in detecting the tactics (see Table 1). Of course, the list of possible behaviors was not comprehensive, and thus judges were told to use their intuition when judging behaviors that were not defined. During the rating, judges watched each video three times. In the first run, they noted the beginning and the end times of the patients' utterances. In the second run, they judged each utterance, determining if the patient was trying to influence the therapist or not. In the third watch, only the utterances in which influencing behavior had been detected, were inspected. For these utterances, judges were told to note a maximum of three different tactics. For each tactic, an intensity rating was given on a 1 to 10 scale with one being very low and 10 high. Tactics that appeared either very frequently or with a low intensity could be coded as meta-tactics.

Statistical analyses

Calculations were completed with the program SPSS version 21.0. Nonparametric tests were used because the majority of the data was not normally distributed.

RESULTS

Inter-judge Agreement

The calculation of inter-judge agreement and reliability have been described in detail elsewhere (Frühauf et al., 2015). Twenty percent of the videos (12 out of the 60 videos) were double-coded to calculate inter-judge agreement, as suggested by Wirtz and Caspar (2002). Both inter-judge agreement and inter-judge reliability were calculated. Cohen's kappa is an appropriate measure if marginals (i.e. the number of cases for which a judgment must be made) are fixed a priori. It can, however, underestimate agreement ratings if marginals are free to vary. The corrected kappa (Brennan & Prediger, 1981) is more appropriate for free marginals and is reported here in addition to Cohen's kappa. The McNemar-Test elucidates if raters have different thresh-

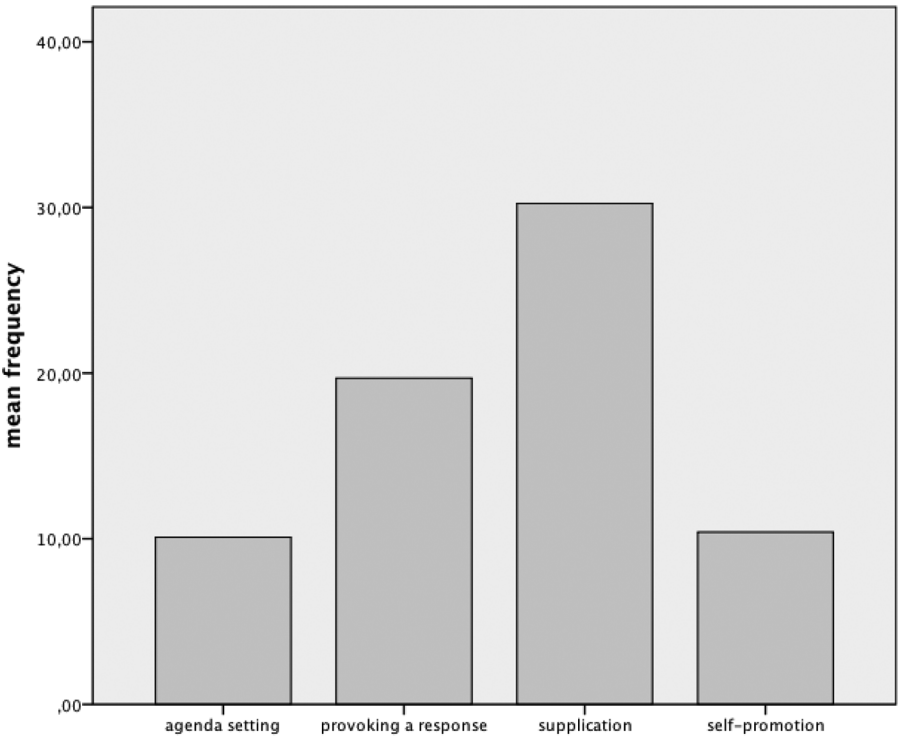

Figure 1
MEAN OCCURENCE OF SELF-PRESENTATIONAL TACTICS PER INTERVIEW
(Percent of Total Tactics)

olds (i.e., one judge detects an object more often than another judge). Yule's Y is an adjusted measure which is independent of the judges' thresholds. Cohen's kappa yielded a mean value of .55, which refers to acceptable inter-judge agreement. McNemar-Test yielded significant results in six of the 12 videos. This suggests that Yule's Y might produce higher agreement rates. Yule's Y yielded a mean value of .87, which refers to good to very good inter-judge agreement. Inter-judge agreement referring to the different tactics was calculated using the category specific kappa by Fleiss (Fleiss & Cohen, 1973). Values can be found in Table 1.

FREQUENCY OF SELF-PRESENTATIONAL TACTICS

Social influence attempts were found in roughly 30% of all patients' utterances. The distribution of the four tactics investigated in the present study relative to the total number of tactics observed can be found in Figure 1. Of these, *Supplication* was the most frequently used tactic with a

Table 2. THERAPISTS' AND PATIENTS' RATING OF THE THERAPEUTIC ALLIANCE

	Session 1 (Th)	Session 2 (Th)	Session 3 (Th)	Session 1 (Pat)	Session 2 (Pat)	Session 3 (Pat)
N	45	46	43	38	42	46
mean	1.48	1.54	1.69	1.30	1.26	1.43
SD	0.79	0.85	0.62	0.81	1.01	0.91
min	−1.00	−2.00	−.33	−1.00	−1.00	−2.00
max	3.00	3.00	2.67	3.00	3.00	3.00

Note. (Th) = therapist's perspective, (Pat) = patient's perspective.

mean occurrence of 30%, followed by *Provoking a response from the therapist* with a mean occurrence of 20%. The tactics *Agenda setting* and *Self-promotion* appeared in 10%.

RATING OF THE THERAPEUTIC ALLIANCE

Table 2 shows the descriptive statistics of the therapeutic alliance. The mean values for the therapist's perspective show an ascending trend from sessions one to three. The same holds for the patient's perspective, although there is a slight decline in session two. Furthermore, the means of the therapeutic alliance as judged by the therapist are higher than those as judged by the patient. Table 3 shows the association between the ratings of

Table 3. CORRELATIONS OF PATIENTS' AND THERAPISTS' RATING OF THE THERAPEUTIC ALLIANCE

		Session 1 (Th)	Session 2 (Th)	Session 3 (Th)	mean (Th)
Session 1 (Pat)	*r*	−0.066	0.090	0.034	0.099
	p	0.353	0.302	0.423	0.294
	N	35	36	34	32
Session 2 (Pat)	*r*	0.215	0.253	0.128	0.248
	p	0.100	0.058	0.225	0.082
	N	37	40	37	33
Session 3 (Pat)	*r*	−0.003	0.120	0.004	0.078
	p	0.493	0.221	0.491	0.329
	N	41	43	40	35
mean (Pat)	*r*	−0.008	0.234	0.170	0.153
	p	0.484	0.099	0.185	0.219
	N	30	32	30	28

Table 4. ASSOCIATIONS BETWEEN THE SELF-PRESENTATIONAL TACTICS AND THE THERAPEUTIC ALLIANCE

		Session 1 (Th)	Session 2 (Th)	Session 3 (Th)	Session 1 (Pat)	Session 2 (Pat)	Session 3 (Pat)
Agenda setting	*r*	.421**	−.001	.298*	−.392**	−.268*	−.238
	p	0.002	0.497	0.026	0.007	0.043	0.056
	N	45	46	43	38	42	46
Provoking a response from the therapist	*r*	−.022	−.046	−.002	.004	−.163	−.059
	p	0.443	0.381	0.494	0.491	0.151	0.347
	N	45	46	43	38	42	46
Self-promotion	*r*	.462**	.364**	.296*	0.107	.274*	−.081
	p	0.001	0.006	0.027	0.262	0.040	0.296
	N	45	46	43	38	42	46
Supplication	*r*	−.186	−.287*	−.411**	.151	.018	.144
	p	0.110	0.026	0.003	0.183	0.455	0.169
	N	45	46	43	38	42	46

Note. (Th) = therapist's perspective, (Pat) = patient's perspective, r = Spearman correlation, ** = significant at the 0.01 alpha-level, * = significant at the 0.05 alpha-level.

the therapeutic alliance from the two perspectives. There was no significant correlation between the therapists' and the patients' ratings.

Hypothesis 1: Agenda Setting and the Therapeutic Alliance

Correlation coefficients and *p*-values for the associations between the tactics and the therapeutic alliance can be found in Table 4. There was a significant positive and moderate association between the tactic *Agenda setting* and the therapeutic alliance, as judged by the therapist in session 1 and 3 ($r = .421$, $p = .002$ and $r = .298$, $p = .026$, respectively), but not for the judgements in session 2 ($r = -.001$, $p = .497$). There was a significant negative and moderate association between *Agenda setting* and the therapeutic alliance as judged by the patient for session 1 and session 2 ($r = -.392$, $p = .007$ and $r = -.268$, $p = .043$, respectively). For session 3 there was also a negative and small to moderate association, which was moderately significant ($r = -.238$, $p = .056$). Hypothesis 1 can thus be accepted for the association between *Agenda setting* and the therapeutic alliance as judged by the therapist. However, the association between *Agenda setting* and the therapeutic alliance from the patient's perspective was in the opposite direction from the predicted.

Hypothesis 2: Provoking a Response from the Therapist and the Therapeutic Alliance

No significant correlations were found between the tactic *Provoking a response from the therapist* and the therapetic alliance as judged by the therapist ($r = -.022$, $p = .443$; $r = -.046$, $p = .381$ and $r = -.002$, $p = .494$,

respectively) and by the patient (r=.004, p=.491; r=−.163, p=.151 and r=−.059, p=.347, respectively). Therefore, hypothesis 2 is rejected.

Hypothesis 3: Self-Promotion and the Therapeutic Alliance

The association between the tactic *Self-promotion* and the therapeutic alliance as judged by the therapist was significantly positive and moderate in all three sessions (r=.462, p=.001; r=.364, p=.006; and r=.296, p=.027, respectively), whereas the strength of the association decreased in the course of the sessions. The association between *Self-promotion* and the therapeutic alliance as judged by the patient was significantly positive and small to moderate only in session 2 (r=.274, p=.040), but there were no significant associations in session 1 (r=.107, p=.262) and session 3 (r=−.081, p=.296). Hypothesis 3 can thus be accepted for the therapists' perspective and partly for the patient's perspective.

Hypothesis 4: Supplication and the Therapeutic Alliance

The associations between the tactic *Supplication* and the therapeutic alliance as judged by the therapist were negative and small to moderate in all sessions, with significant correlations in sessions 2 and 3 (r=−.287, p=.026 and r=−.411, p=.003, respectively), but not in session 1 (r=−.186, p=.110). There was no association between *Supplication* and the therapeutic alliance as judged by the patient (r=.151, p=.183; r=.018, p=.455 and r=.144, p=.169, respectively). Hypothesis 4 can thus be accepted regarding the relation between *Supplication* and the therapeutic alliance as judged by the therapist, but not for the therapeutic alliance as judged by the patient.

DISCUSSION

This study examined the association between patients' self-presentational tactics and the early therapeutic alliance. First, it should be noted that the therapists' and the patients' ratings of the therapeutic alliance in the first three sessions were unrelated. This finding is in line with other studies that also found therapists and patients viewed the alliance differently (e.g., Bachelor & Salamé, 2000; Cecero, Fenton, Frankforter, Nich, & Carroll, 2001; Fitzpatrick, Iwakabe, & Stalikas, 2005; Hilsenroth, Peters, & Ackerman, 2004). Other studies, however, have found correlations between therapists' and patients' alliance ratings (Casey, Oei, & Newcombe, 2005; Kivlighan & Shaughnessy, 1995; Mallinckrodt & Nelson, 1991). Unlike most other studies (Shick Tryon, Collins Blackwell, & Felleman Hammel, 2007), therapists in our sample gave higher ratings for the therapeutic alliance than patients. A possible explanation is that the

clinic of Bern puts a strong emphasis on the therapeutic alliance. The therapists might thus feel quite comfortable about their ability to build a good alliance, which is reflected in the higher ratings as compared to the patients' ratings. Another reason could be the sample. A meta-analysis found that the divergence between patients' and therapists' ratings was higher when patients had severe disturbances (i.e. patients with severe substance abuse disorders evaluated the alliance more favorably). Patients in our sample were outpatients, who mostly pay for therapy themselves, which might make them more critical in the evaluation of the therapist.

We found that three out of four self-presentational tactics were correlated with ratings of the early therapeutic alliance.

Agenda Setting

As predicted, there was a positive association between this tactic and the therapeutic alliance, as judged by the therapist. Therapists probably appreciate when patients participate actively in therapy by introducing their own ideals and goals. There was, however, a negative correlation between the patients' ratings of the alliance and the use of *Agenda setting*, meaning that patients who judged the therapeutic alliance more negatively demonstrated this tactic to a greater extent. A possible reason for a frequent use of this tactic is these patients' need for autonomy or control. Negatively put, patients who do not trust their therapists or doubt their ability to help them may feel the need to take matters into their own hands. One way of doing so is setting their goals for the therapy. Another possibility is that patients who come to therapy with already defined goals are more demanding and critical. These high standards may be reflected in their more critical evaluation of the therapeutic alliance, compared to other patients.

Provoking a Response from the Therapist

This tactic was not associated with the therapeutic alliance as judged by both therapist and client. The simplest explanation is that this tactic is not relevant for the therapeutic alliance. This would, however, be contradictory to the findings of studies from medical setting. Some of these studies have found that patients who asked more questions had better outcomes (Greenfield et al., 1988, 1985; Kaplan et al., 1989; Thompson et al., 1990). It is possible that these studies measured something different from what we did. Specifically, we included organizational and technical questions, whereas in the medical studies patients were explicitly instructed to ask questions pertaining to their medical condition. Another possibility is that the intake interview with a physician is fundamentally different from a

psychotherapy intake interview. The traditional role of a patient in medical settings is a passive one − patients are not expected to get very involved. Asking more questions can thus be expected to lead to a better exchange between physician and patient. In psychotherapy, on the other hand, an active participation of the patient is understood and necessary. The tactic *Provoking a response from the therapist* might hence not be an appropriate operationalization for an active exchange between the therapist and the patient.

Self-Promotion

As predicted, this tactic was positively associated with the therapeutic alliance from the therapists' perspective and partly also from the patients' perspective. These results suggest that patients who use the tactic *Self-promotion* in the intake interview might build up a better therapeutic alliance. Patients who are capable of *Self-promotion* likely have more psychological resources and more confidence that they can benefit from psychotherapy. Being aware of their resources activates the approach mode, in which one is oriented towards positive goals. Being in the approach mode is beneficial for the development of the therapeutic alliance (Grawe, 2007). Additionally, it is conceivable that *Self-promotion* helps the therapist identify the patient's resources better, and the therapist can more easily reinforce them. This would result in a further activation of the approach mode, and set up a positive feedback effect. It is likely that these patients have a better treatment outcome than patients who are less aware of their resources. The non-consistent positive association between *Self-promotion* and the therapeutic alliance as judged by the patient could indicate an unstable activation of the approach mode: It is likely that patients who use *Self-promotion* often are aware of their resources, but not consistently so.

Supplication

As predicted, this tactic was negatively related to the therapeutic alliance, but only from the therapists' perspective. Several reasons might explain the therapists' negative evaluation of the alliance with these patients. First, it might be difficult for therapists at this early stage of therapy to identify the unproblematic higher motives of these patients that underlie the *Supplication* on the behavioral level, and respond complementary to them as the motive oriented therapeutic alliance approach suggests. Furthermore, excessive use of *Supplication* might indicate an avoidance of approaching the problem (Sachse et al., 2011). It is evident that therapists respond less positively to patients who do not seem to be motivated to

change. *Supplication* might also point to relationship issues. For example, the excessive report of difficulties might play an instrumental role in these patients' lives to fulfill goals like getting attention or not having to take responsibilities or fulfill a duty. It is probable that such behavioral patterns evoke negative reactions like anger or helplessness in the therapist, like they do in the other relationships of the patient.

Taken together, patients' self-presentational behavior can be regarded as a promising predictor for the early therapeutic alliance: We found moderate associations between the tactics *Agenda setting*, *Self-promotion,* and *Supplication* and the therapeutic alliance.

STRENGTHS AND LIMITATIONS

This study had several strengths. The investigation of real psychotherapy sessions yielded a high external validity, using double ratings of a proportion of videos ensured coding reliability. The investigation of predictors of the early therapeutic alliance provides an important contribution to this young field of research. However, one limitation must be considered: Self-presentational behavior was assessed during the intake interview, whereas the therapeutic alliance was measured during the first three therapy sessions, which were conducted by a therapist other than the one who conducted the intake interviews. It cannot be ruled out that the patients' self-presentational behavior was at least partly dependent on the interviewer. However, it is generally presumed that self-presentational behavior is not primarily determined by the counterpart, but rather by the situation (Brown, 2007, pp. 3–7). The situation of the psychotherapy intake interview, and to a smaller degree the person who conducts it, should thus be relevant for the self-presentational behavior. We expect thus that patients would show a very similar amount of self-presentational behavior in the first sessions with the actual therapist.

PRACTICAL IMPLICATIONS

Because of the correlational nature of our findings, it is premature to conclude that patients' self-presentations are causal factors in the development of the therapeutic alliance. However, the consistent and moderate associations suggest that they play a role in it, and might be worth the therapists' attention.

Generally, our findings provide hints about with which patients it may easier to build a therapeutic alliance (namely, those who use the tactics *Agenda setting* and *Self-promotion* more often than *Supplication*). Also, the findings point at potentially important patient needs (e.g., the need for

affirmation with patients who use *Self-promotion* a lot or the need for orientation and control for those who use *Agenda setting*), which can be explored more thoroughly in the interview. Taking these needs into account is essential for establishing a motive oriented therapeutic relationship. Furthermore, our findings indicate which psychological reactions certain patient behaviors may evoke in the therapists: potentially rather positive ones in the case of *Agenda setting* and *Self-promotion* and rather negative ones in the case of *Supplication*. Knowing this may make the therapist more aware of possible spontaneous and unintended reactions to the more difficult patient behaviors.

It can generally be recommended that therapists should reinforce the tactic *Agenda setting*. First, we found this tactic to be positively associated with the therapeutic alliance from the therapists' perspective. It seems plausible that by setting their own therapy goals patients contribute actively to a positive therapeutic alliance and process. Second, self-set goals are related to higher self-efficacy (Schunk, 1990), which in turn is an important predictor for treatment effectiveness (Greenberg, Constantino, & Bruce, 2006). Nevertheless, it should be remembered that this tactic was negatively associated with the therapeutic alliance from the patients' perspective. If our interpretation holds that patients take matters into their own hands because they lack trust in their therapist, than therapists should first focus on building up trust and show the patients that they support them in developing therapy goals.

Even though we found the tactic of *Provoking a response from the therapist* to be unrelated to the therapeutic alliance, it may subsume a beneficial behavior for the therapeutic process. Asking questions is certainly a means for patient to actively participate in therapy, which is generally associated with better therapy outcome (Stewart, 1995). Thus, therapists should encourage patients to ask questions.

Emphasizing strengths − *Self-promotion* − is a behavior that therapists should definitely reinforce with their patients. As outlined above, it can provide a valuable source of information about where the patients' strengths lie. Affirming them is an excellent means for therapists to build up relational credit.

According to Caspar (2007) and the present findings, *Supplication* should not be reinforced if it appears to be determined more by relationship than problem issues. Therapists should, in the sense of a motive oriented therapeutic relationship, try to identify the motives behind the Supplication and try to act complementary to them.

This study added knowledge to the still nascent field of research in

predictors of the therapeutic alliance. This study's findings increase our understanding of factors that may be important in the development of the early therapeutic alliance. If patients' self-presentational behaviors affect the alliance in a positive or negative way, therapists must take such behaviors into account and react constructively.

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