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WHAT TO EXPECT IN THE INTAKE INTERVIEW? IMPRESSION MANAGEMENT TACTICS OF PSYCHOTHERAPY PATIENTS

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The therapeutic alliance consists of a mutual dependency between patient and therapist. Whereas earlier studies have focused on the therapists' behavioral influence, the present study examined patients' impression management tactics. The motivation to manage the impressions one has on others is particularly strong during first contact. Patients' behavioral influence was thus examined in the intake interview. Twelve possible impression management tactics were defined on the basis of theoretical conceptions of the therapeutic alliance and discussions with practicing psychotherapists. After a comprehensive training, judges rated 60 videotaped interviews. Interjudge agreement was fair to good. Influence attempts could be observed in roughly 30% of all patients' utterances. The most frequent tactics were Supplication, Provoking a response from the therapist, and Self-promotion. Patients could be grouped into three different clusters of tactic employers: Negative self-presenters, positive self-presenters, and response provokers. Male and female patients did not differ with respect to the total amount of tactics used and to the choice of specific tactics. However, when the therapist was female, male patients used significantly more tactics overall and significantly more often the tactic Negative reports about third persons.

Being sensitive to patients' behavioral influence can help therapists to better understand their interactional goals and to better tailor the therapeutic alliance.

The therapeutic alliance is an important condition for psychotherapy, and when assessed especially early in treatment, predicts ultimate therapeutic success (Martin, Garske, & Davis, 2000). Patient-

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therapist interactions can be understood as processes of social influence (Heppner & Claiborn, 1989; Heppner & Dixon, 1981; Strong, 1968). Social influence is defined as the process of changing someone else's behavior, cognitions, or feelings (Schneider, Gruman, & Coutts, 2005). This process of influence has long been understood in a unilateral way: the psychotherapist uses certain strategic behaviors in order to foster change in the patient (Strong, 1968). Over time, this understanding has changed to a reciprocal view of social influence which assumes a mutual influence between therapist and patient (Strong & Claiborn, 1982). Human behavior largely consists of attempts of the individual to fulfill his or her basic needs. Over the course of one's life, one develops different strategies to satisfy these needs (Caspar, 2007, p. 37). Many of these are interactional strategies that are shown in interpersonal contexts. In the context of psychotherapy, these tendencies should become especially apparent, as the patient is in a state where important needs are not satisfied. The patient is therefore motivated to make the therapist help him satisfy these needs. Different authors have conceptualized the reasons and modes of how patients influence therapists. According to interpersonal theory (Sullivan, Perry, & Gawel, 1953), social relations are the primary determinants of personality development and psychopathology. During their developmental history, humans learn to shape their social relationships in such a way that basic needs are satisfied and frustrations are avoided. Interpersonal reflexes evoke complimentary or reciprocal behaviors from interaction partners (Carson, 1969, p. 112; Kiesler, 1983). Another way in which patients can exert influence upon their therapists is tests. The control-mastery theory of Sampson and Weiss (1986; Weiss, 2002) posits that people try to master problematic experiences they have had in relationships in every new relationship. In the therapeutic relationship, patients test therapists in order to disprove the pathogenic beliefs they have developed during early interaction with attachment figures. For example, a patient who was rejected by his parents as a child may develop the belief that he is not lovable. In order to test this, he might behave unfriendly towards the therapist and thereby provoke the therapist to reject him. Subconsciously, he will hope that the therapist will not accede to the demand, and thus help him to disconfirm the frightening belief. If the therapist does not accede to the demand, the patient may be reassured and become less anxious and more productive in the therapy. Beier and Young (1998) posit that patients subconsciously try to impact their thera-

pists by silent rules. For example, by complaining that the therapist did not help the patient enough in the last session, a patient may set up the therapist to feel guilty so that he will undertake actions to make it up to him (pp. 4–6).

According to Sachse (2001), patients with personality disorders tend to influence therapists particularly often. As certain interactional goals (e.g., being important to another person) have not been met in their life, they develop non-transparent actions in order to push their agenda. Thereby they bring the interaction partner to show certain behaviors that the person thinks he or she would not demonstrate voluntarily. Sachse posits that patients with personality disorders will show such behaviors toward the therapist particularly during the beginning of therapy. Similar to the abovementioned concepts, Plan-Analysis (Caspar, 2007) is based on the assumption that interaction partners try to control the behavior of the counterpart in a way that serves their own goals. Plans, which can be conscious or unconscious, are inferred from the patients' behavior in interaction with others. For example, a patient's excessive wailing could serve the higher-order Plan "make sure the therapist takes my problem seriously", which could again serve the Plan "make the therapist fully commit to helping me". Having an idea of which higher Plans motivate certain behaviors can help therapists tailor the therapeutic relationship so that these Plans or needs are satisfied, a concept Caspar (2007) calls motive-oriented relationship.

People use different strategies to control the impressions others form of them, a process which is referred to as impression management (Leary & Kowalski, 1990). Impression management, or self-presentation, has received growing attention within social psychology during the past years (for an overview see Leary & Kowalski, 1990). It is by now understood as a fundamental, interpersonal process (Leary & Kowalski, 1990).

Impression management has most often been studied in nontherapeutic settings, such as organizations (Higgins, Judge, & Ferris, 2003, Kipnis, Schmidt, & Wilkinson, 1980), marketing (McFarland, Challagalla, & Shervani, 2006), romantic relationships (Howard, Blumstein, & Schwartz, 1986; Pontari & Schlenker, 2004), and politics (Schütz, 1995). A few studies have examined social influence processes in psychotherapy. One experimental study explored patients' use of impression management strategies as a strategy to satisfy their wish to either leave or stay in a mental hospital (Braginsky, Grosse, & Ring, 1966). Some studies used trained patients who

reinforced certain counselor behaviors (Dustin, 1971; Lee, Hallberg, Hassard, & Haase, 1979; McFarland et al., 2006). Friedlander and Schwartz (1985) developed a taxonomy for classifying certain patient self-presentations. Only one study (Schütz, 1995) has investigated impression management in an actual therapy context. The researchers analyzed videotapes of 13 therapy sessions with the method of sequential Plan Analysis to identify self-presentational Plans for the patient and the therapist.

To date, no study had analyzed the ways in which patients influence their therapists in a larger sample. Being aware of and sensitive to patients' influence behaviors can help therapists understand their patients' interactional goals better, and to better tailor the therapeutic alliance. The three primary research questions for this study were thus:

1. How frequently can diverse influence behaviors be observed?

   People usually try to control the desired impression with regard to several dimensions (Leary & Allen, 2011). Thus, they use a combination of different tactics. According to Bolino and Turnley (2003), it is important to identify different profiles of tactics.

2. Can patients be grouped into clusters that vary with regard to their influence behavior?

   Many studies have found men and women differ with regard to the frequency of their impression management and their choice of specific tactics (e.g., Bolino & Turnley, 2003; Guadagno & Cialdini, 2007). Such sex differences have so far not been investigated in the psychotherapeutic setting. As Cooke and Kipnis (1986) suggest, patients' impression management could depend both on the patients' and the therapists' sex.

3. Are the influence behaviors related to the patients' and therapists' sex?

   It is assumed that the motivation to influence the therapists' impressions and behavior is especially strong in the first contact. First impressions are built within seconds, as is known from social psychological research (Asch, 1946). People seem to be particularly motivated to impression manage with

strangers (Leary, Tchividijian, & Kraxberger, 1994). Therefore, this study primarily focused on influence behavior in the intake interview.

METHOD

Sixty videotaped intake interviews were analyzed. Selection criteria of the sample will be described in detail.

PATIENTS

Patients were randomly selected from a pool of n = 3,863 patients who were treated at the psychotherapeutic outpatient clinic of the University of Bern, Switzerland, during the years 2001 to 2012. Patients had a mean age of 39.76 (ranging from 18 to 75) years. Half of them were female, half male. Patients are treated according to an integrative form of CBT which is based on a detailed case conceptualization that is formulated using Plan Analysis (Caspar, 2007; Grawe, 1999). The intake interview follows a certain procedure, but leaves enough freedom so that interactional peculiarities of patients can unfold. The duration of the interview is flexible, and in this sample ranged from 50 to 100 minutes. The clinic accepts patients suffering from 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 different therapists conducted the interviews. Half of the therapists were trainees at various stages of their 4-year psychotherapy training course. The other half were experienced therapists who are 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.

RATING MANUAL

Patients' tactics were defined based on conceptions of the therapeutic alliance (see above) and on previous studies (Friedlander & Schwartz, 1985; Howard et al., 1986; Kipnis et al., 1980; Pratkanis, 2007). The preliminary list of tactics was refined after discussions with ten practicing psychotherapists and after being tested by applying them to five videotaped interviews. The final list consisted of 12 tactics (see Table 1).

RATING PROCEDURE

The interview was assessed on an utterance-by-utterance basis using a structured manual. (The manual is available from the corresponding author upon request). The ratings were performed by four advanced Masters students (at least 4 years of psychology and psychotherapy education) who had undergone a systematic training. The training lasted approximately 12 weeks and was finished when further training no longer improved interjudge agreement. 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 behavior using certain cues of the patients' behavior (see Brunner, 1996; Caspar, 2007, p. 159). In the rating manual, each tactic was outlined with an illustrative example in order 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 pre-defined. During the rating, judges watched each video three times. In the first run, they noted the beginning and end times of the utterances. In the second run, they judged, for each utterance, if the patient was trying to influence the therapist or not. In the third run, only the utterances in which influence behavior had been detected were inspected. For these utterances, judges could note up to three different tactics. For each tactic, an intensity rating was given on a 1–10 scale. Tactics that appeared either very frequently or with a low intensity could be coded as meta-tactics.

TABLE 1. Patients' Influence Tactics

Tactic	Definition/exemplary behaviors	Example of our sample	Fleiss' κ
Good mood	Establishing a positive interpersonal atmosphere by joking, chatting, etc., "breaking the ice"	Therapist asks the patient how he can distract himself from the separation from his girlfriend. The patient says that he likes to read, and then he begins to chat about literature in general and recommends a book he has recently read to the therapist.	.36
Positive feedback	Positive reactions to statements, behavior, or the person of therapist	Patient: "I was not satisfied with my last therapist at all. With you it is all different. You ask more questions. And your feedbacks have a deep analytical component."	.69
Negative feedback	Criticism for actions or statements of the therapist	Therapist: "Thank you for coming." Patient: "I find it problematic that you have postponed the session twice. We have been through that before and it is happening again. I do not need this again. I have a big problem with this" (critical look).	.14
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
Negative reports about third persons	Complaining about absent persons who are relevant for the patient	Patient talks about his former therapist: "I don't know why he is a psychologist. He didn't understand me at all. He couldn't even look me in the eye. Extremely suspect."	.67
Fait accompli	Creating a sense that a certain fact or outcome of action is inevitable	Therapist: "Have you ever had a session with the three of you?" Patient: "Yes, but this always escalates."	.08
Supplication	Moaning, 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
Psychologizing	Using psychological expressions or concepts to describe or explain one's situation	Patient about his ex-girlfriend, "My sister gave me the keyword narcissism. I did some research on narcissism, read a reader by Kernberg and articles by Sachse. Then I wrote down six pages with behavioral examples that apply to my ex. Also things she told me about her parents. Lack of empathy, fears to be abandoned...But every narcissist is looking for a complementary narcissist..."	.34
Avoidance of contents	Trying to avoid certain topics; not answering questions, giving evasive or vague answers	At the end of the interview the therapist asks: "Have you ever had an experience that has affected you in a negative way?" Patient: "Yes, my parents' divorce. And then there was something about two years ago. On my way back from work someone pulled me into a meadow. Afterwards I had a blackout" (talks about a presumed rape).	.33
Emotional avoidance	Trying to keep an emotional distance, incongruent affect (e.g., laughing when talking about trauma)	A patient talks about a fire that destroyed her parents' house when she was a child. While she talks she is smiling.	–.02

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. For the second research question, a hierarchical cluster-analysis was calculated. The Kruskal-Wallis test was used as a global test to verify if the clusters differentiate with respect to the tactics. The Mann-Whitney U test was subsequently used to test which of the groups differ with respect to their use of tactics and also to examine if male and female patients differ with respect to their use of tactics.

RESULTS

INTERJUDGE AGREEMENT

As suggested by Wirtz and Caspar (2007), 20% of the videos (12 out of the 60 videos) were double-coded to calculate interjudge agreement and reliability. Interjudge agreement describes the extent to which different people judge an object similarly. It can only be calculated for nominally scaled data. Interjudge reliability describes the extent to which a judgment deviates from the mean value that the other judges have assigned to an object. It can only be calculated for data on an interval scale (Wirtz & Caspar, 2007, p. 39). A frequently reported measure for interjudge reliability is Cohen's kappa. This measure is appropriate if marginals (i.e., the number of cases for which a judgment must be made) are fixed a priori. Cohen's kappa can, however, underestimate agreement rates if marginals are free to vary. Brennan and Prediger (1981) suggest a corrected kappa, which is reported here in addition to Cohen's kappa. The McNemar-Test elucidates if raters have different thresholds; i.e., if one judge detects an object more often than another judge. Yules 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 interjudge agreement. The same holds for the phi-correlation ($\varphi = .55$). Both values were significant. The McNemar-Test was significant for half of the videos. This raises the expectation that Yules Y leads to higher agreement rates. The mean Y was .87, which refers to good to very good interjudge agreement. The corrected kappa yielded a value of .75, which refers to good interjudge

agreement. Interjudge agreement referring to the different tactics was calculated using the category-specific kappa by Fleiss (Fleiss & Cohen, 1973). Good agreement (κ = .6 to .79) was found for the tactics Self-promotion, Supplication, Negative reports about third persons, Positive feedback, Provoking a response from the therapist, and Agenda setting. Fair agreement (κ = .2 to .39) was found for the tactics Avoidance of contents, Psychologizing, and Good mood. Poor agreement (κ = .0 to .19) was found for the tactics Emotional avoidance, Fait accompli, and Negative feedback. Tactics with poor interjudge agreement were excluded from the further analyses. This was decided because low interjudge agreement reduces the chance to detect relationships in the data.

How Frequently Can Diverse Influence Behaviors Be Observed? The mean percentage of patients' influence attempts (relative to the total number of utterances) per interview was 28.74 (SD = 12.35). The most frequently shown tactics were Supplication (M = 30.25, SD = 15.93), Provoking a response from the therapist (19.70, SD = 13.30), and Self-promotion (M = 10.40, SD = 10.90). The frequencies for all tactics are shown in Figure 1.

Can Patients Be Grouped Into Clusters That Vary with Regard to Their Influence Behavior? Hierarchical cluster-analysis resulted in three clusters. Clusters were characterized by partly clear differences in the mean use of tactics. The large standard deviations, however, showed that there were large differences within the clusters. The Kruskal-Wallis test showed that the three groups differed significantly with respect to the use of single tactics. No differences were found between the groups regarding the use of the tactics Positive feedback, $H(2) = 5.43$, $p = .660$, and Agenda setting, $H(2) = 3.16$, $p = .206$. These tactics were therefore not included in further analyses. Table 2 shows how the groups differed with regard to the use of tactics. No significant differences were found regarding the total number of tactics between groups 1 and 2, $U(23,12) = 130$, $p = .791$, and between groups 2 and 3, $U(12,24) = 103$, $p = .177$. Groups 1 and 3 differed significantly: patients in group 3 showed more tactics than patients in group 1, $U(24,23) = 147$, $p = .005$, $r = .40$. As can be seen in Table 2, groups differed significantly in the use of single tactics. These differences are more clearly illustrated in Figure 2. Patients in group 1 were characterized by a frequent use of the tactics Supplication, Negative reports about third persons, and Avoidance of contents. This group was thus named negative self-presenters.

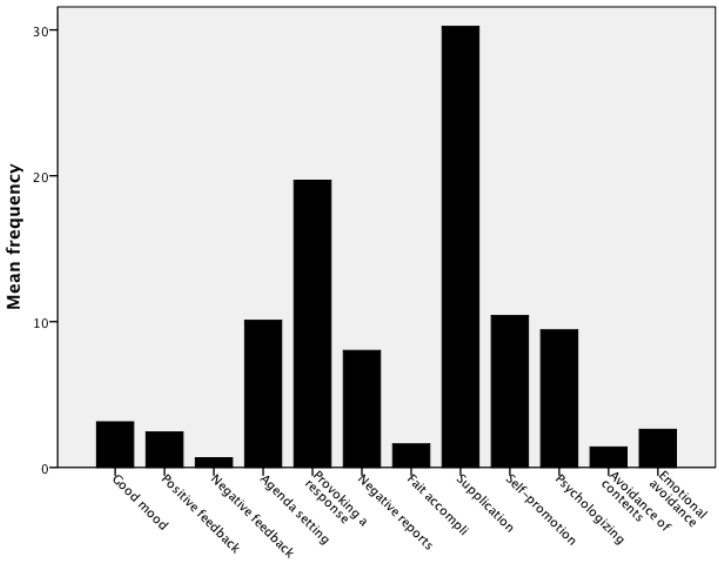

FIGURE 1. Mean frequency of tactics

Patients in group 2 were characterized by a significantly greater use of the tactics Good mood, Psychologizing, and Self-promotion, compared to the other groups. This group was thus named positive self-presenters. Group 3 was characterized by a frequent use of the tactic Provoking a response from the therapists. This group was thus named response-provokers.

Are the Influence Behaviors Related to the Patients' and Therapists' Sex? There was no significant difference in the total number of tactics between female (M = 53.18, SD = 22.42) and male patients, M = 57.40, SD = 28.10, U(30,30) = 423.50, p = .700.

Similarly, no sex differences were found on the level of single tactics. Female patients showed the same amount of tactics towards female therapists (M = 54.83, SD = 21.42) as towards male therapists, M = 51.52, SD = 24.01, U(15,15) = 94.50, p = .467. Conversely, male patients showed more tactics towards female therapists (M = 70.07, SD = 29.06) than towards male therapists (M = 44.74, SD = 21.14). This difference was significant and had a medium to large effect size, U(15,15) = 56.50, p = .019, r = .42, see Figure 3. The large standard deviations revealed large differences within the groups. For female patients, no difference could be found in the use of single

tactics towards male compared to female therapists. Male patients more frequently used the tactics Negative reports about third persons, $M = 4.40$, $SD = 3.66$ versus $M = 1.87$, $SD = 2.85$, $U(15,15) = 61$, $p = .029$, $r = .40$, and Supplication ($M = 21.60$, $SD = 15.82$ versus $M = 12.47$, $SD = 6.22$) toward female therapists. This difference did not, however, reach significance, $U(15,15) = 68.50$, $p = .069$. Regarding the other tactics, no significant difference could be found between the patients' behavior towards male versus female therapists.

DISCUSSION

This study was designed to examine the influence behavior of patients in the intake interview. All of the theoretically defined impression management tactics could be observed. They support and extend categories theoretically described (Friedlander & Schwartz, 1985; Jones & Pittman, 1982) and empirically observed (Schütz, Richter, Köhler, & Schiepek, 1997) in earlier studies. This was the first study that examined influence behavior in a large clinical sample of 60 patients from behavioral observations using video-ratings.

How Frequently Can Diverse Influence Behaviors Be Observed? Influence tactics could be observed in roughly 30% of all utterances. This shows that patients are not passive recipients of the therapists' service, but instead make efforts to manage the impression that they want to make upon the therapists. The most frequently observed tactics were Supplication, Provoking a response from the therapist, and Self-promotion. These results largely replicate the findings of Schütz, Richter, Köhler, & Schiepek (1997), who found that a female patient used the Plans Presenting helplessness, Problem-solving efforts, and Being a good client most frequently in 13 psychotherapy sessions. This pattern shows that patients want to make the therapist aware of their suffering in order to pronounce the urgency of their needing help, and at the same time, to show their strengths and competences. Psychotherapy is a novel setting for most people. The patients therefore need guidance from the therapist; this is expressed through the tactic Provoking a response from the therapist. Needing professional help is a threat to most people's self-esteem: it is an admission that they feel overburdened and cannot find a way out by themselves. This threat to the ego is counteracted by the pro-

TABLE 2. Differences In Tactic Use In the Three Groups Built by Cluster Analysis

	Group 1 (n = 23)	Group 1 – Group 2		Group 2 (n = 12)	Group 2 – Group 3		Group 3 (n = 24)	Group 1 – Group 3	
Tactics	***M* (*SD*)**	***U***	***p*1**	***M* (*SD*)**	***U***	***p*[1]**	***M* (*SD*)**	**U**	***p*[1]**
Total	27.87 (9.75)	130	n.s.	35.16 (23.60)	103	n.s.	39.47 (18.01)	147	.005**
Good mood	1.72 (2.66)	115.50	n.s.	0.93 (1.86)	77	.018*	6.36 (9.07)	179	.031*
Provoking a response from the therapist	27.93 (16.85)	6.50	.000***	41.60 (18.01)	0	.000***	15.43 (9.88)	189.50	n.s.
Negative reports about third persons	10.40 (7.92)	97	n.s.	6.80 (6.79)	108	n.s.	4.18 (5.42)	133	.002**
Supplication	23.27 (9.12)	21	.000***	10.80 (7.08)	104.50	n.s.	15.23 (6.91)	70	.000***
Self-promotion	4.62 (5.82)	115	n.s.	5.08 (4.85)	28	.000***	21.92 (9.33)	56.50	.000***
Psychologizing	6.98 (6.40)	111	n.s.	8.76 (7.85)	76	.022*	16.15 (11.10)	101	.000***
Avoidance of contents	4.32 (5.44)	128	n.s.	2.68 (4.14)	98	.024*	0.81 (1.69)	166.50	.002**

Note. 1 = exact significance (2-tailed). *$p < .05$; **$p < .01$; ***$p < .001$, n.s. = non-significant.

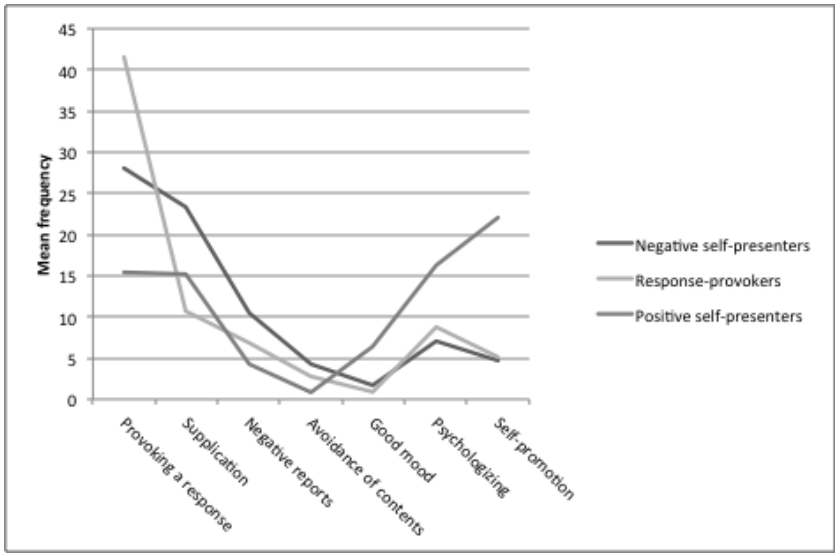

FIGURE 2. Differences in use of tactics by group

nunciation of their strengths and competences, which is reflected in the tactic Self-promotion.

Can Patients Be Grouped Into Clusters That Vary with Regard to Their Influence Behavior? Patients could be grouped into clusters, which differed with respect to the use of several tactics. Effect sizes were medium to large. These results show that a majority of patients used different tactics conjointly. They support Leary und Allen's (2011) claim that people try to manage impressions with regard to several dimensions. In our sample, this applies to the group of positive and negative self-presenters. Only the group of response-provokers, which consisted of 12 patients, predominantly used one tactic and rarely used other tactics. For these patients, it seems to be important to obtain a reaction from the therapist. A motive for using this tactic could be to reduce uncertainties.

The groups of positive and negative self-presenters were named in accordance to the literature. Mummendey, Eifler, and Melcher (2006), distinguishes between positive and negative impression management tactics. Positive tactics include Self-promotion, Ingratiation, and Enhancing one's status through contact with important persons. Negative tactics include Presenting oneself as needy, Em-

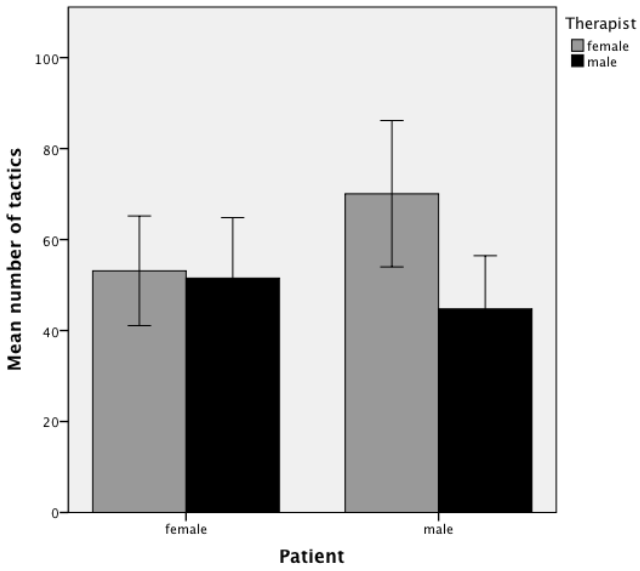

FIGURE 3. Total number of tactics by patients' and therapists' sex (mean and 95% CI)

phasizing disease symptoms, or Downgrading other persons. Accordingly, positive self-presenters in our sample predominantly used tactics that place them in a favorable light: they tried to establish a good mood and emphasized their expertise and competences through Self-promotion and Psychologizing. Possible motives behind these tactics are to gain recognition and to protect oneself from a negative evaluation. It needs to be acknowledged that patients in this group also showed the tactics Supplication and Provoking a response from the therapist more frequently than the group of negative self-presenters. It seems, therefore, that it is also an important motive for them to highlight their suffering. This is in accordance with the findings of Schütz, Richter, Köhler, & Schiepek (1997), where the patient's self-presentation included an ambivalence of presenting competence and helplessness. Their interpretation is that the patient avoids presenting herself as overly competent, as the presentation of competence can mean a loss of support and sympathy. At the same time she wants to avoid appearing too helpless, as such an image can result in stigmatization. The negative self-presenters, on the other hand, presented themselves as needy

by using the tactics Supplication and Avoidance of contents. In contrast to the positive self-presenters, patients in this group tended to avoid contents more often. Yet, this finding should be interpreted with caution, as the distribution for the tactic Avoidance of contents is skewed to the left and the high mean values compared to the group of positive self-presenters might be caused by single extreme values. However, the frequency of this tactic might have been underestimated in our study. Indeed, 65% of long-term psychotherapy patients admit leaving things unsaid during sessions, and almost 50% have secrets, most often comprising topics such as relationship difficulties, sexuality, or feelings of failure (Hill, Thompson, Cogar, & Denman, 1993; Kelly, 1998). Reasons for nondisclosure include anxiety and shame, not wanting to overburden the therapist, but also wanting to address other, more important concerns (Farber, 2003). Furthermore, the length of therapy and the quality of the therapeutic alliance are predictors of disclosure (Hall & Farber, 2001). As patients in our sample were seeing the therapist for the very first time and knew that a different therapist would conduct the actual treatment, the alliance was most likely not strong enough to disclose personally distressing information. The fact that this cluster of patients used the tactic Avoidance of contents conjointly with Supplication fits well to Farber's interpretation that patients are ambiguous towards disclosing difficult topics: They want their therapist to know about it but at the same time protect themselves from shame and scrutiny (2003). The negative self-presenters also showed other tactics, but to a lower extent. Their tactical behavior could be interpreted as more passive, compared to the group of positive self-presenters, who try to manage the images that they convey proactively. It must be emphasized that the groups that have been built by cluster analysis differed with respect to some tactics, but they overlapped with respect to others: standard deviations were quite large.

Are the Influence Behaviors Related to the Patients' and Therapists' Sex? Earlier studies have found that men use more tactics than women. These results could not be replicated in the present study. Male patients used slightly more tactics than female patients, but this difference was minimal and not significant. The large standard deviations point to large differences within the groups. Social psychological studies have found that impression management of men and women is often in accordance with traditional role stereotypes

(Eagly, 2013). Men emphasize their strength and dominance by using tactics like Self-promotion or Bragging about third persons. Women, conversely, present themselves as cooperative and needy (Guadagno & Cialdini, 2007; Sadler, Hunger, & Miller, 2010). In the present study men did not use different tactics than women. The findings of social psychological studies can thus not be transferred to this clinical sample. Even though people usually try to be socially acceptable (Tetlock & Manstead, 1985), it is possible that such a kind of self-presentation is not the main focus in a psychotherapeutic setting. Jones and Pittman (1982) argue that patients present themselves often as weak and needy. Our results support this argument, as Supplication was the most frequently used tactic for both male and female patients. The second most frequent tactic in both sexes was Provoking a response from the therapist. Hence, the assumption of Cooke and Kipnis (1986) that female patients try more than male patients to get help and instructions from the therapist could not be confirmed. In fact, it seems to be important for both sexes that the therapist notices suffering and provides security during the intake interview. The reason why patients did not conform to sex role stereotypes in the present sample could be that psychotherapy provides a setting where nonconformist behavior is not sanctioned (Rudman, 1998).

A final reason why results of the abovementioned studies could not be replicated might be that they assessed impression management by self-report questionnaire. This bears the risk that data are distorted by social desirability (Mummendey et al., 2006). It is possible that participants tend to report mainly the tactics that conform to their sex role stereotype.

In the present study male patients used more tactics with female therapists. The effect size was medium to large. This result supports Leary's (1994) hypothesis that self-presentational motives are stronger in opposite-sex compared to same-sex interactions. Male patients might think that they can influence female therapists more effectively than male therapists. When the therapist was female, male patients used the tactic Negative reports about third persons significantly more often. For female patients, however, no difference in the frequency and choice of tactics could be found when they were talking to a male compared to a female therapist.

CLINICAL IMPLICATIONS

Knowing which tactics patients use frequently can serve as a guide for therapists to tailor the therapeutic alliance according to the patients' needs. According to the idea of a motive-oriented therapeutic relationship (Caspar, 2007), a prescriptive concept for establishing a solid therapeutic alliance, therapists should behave in a way that is compatible with the patients' most important motives. These motives can be inferred through Plan Analysis (Caspar, 2007). It is essential to behave complementary on the level of superordinate Plans, not complementary to behavior, which is often problematic. For the most frequent tactic, Supplication, therapists should not react on the behavioral level (e.g., show pity) but rather try to find a superordinate Plan (e.g., Show the patient that I take his problems seriously and that I am fully committed to helping him).

According to various conceptions of the therapeutic alliance (Grawe & Grawe-Gerber, 1999; Sachse, 2001), it is important to focus not only on the patients' problems but also on their strengths. Resource activation is particularly important in the beginning of psychotherapy. As mentioned above, needing help from a therapist is a threat to the self-esteem for most people. Emphasizing the patients' strengths may help them alleviate the psychological strain and serve as a sort of start-up financing for the therapy. According to Sachse (2001), this is particularly important when working with patients who have narcissistic tendencies: therapists should praise such patients generously, especially in the first sessions, in order to build up "relationship credit". If patients show the tactic Self-promotion, this is a great help for the therapists, as they will draw the therapists' attention to their strengths and competences. The therapists need only to reinforce them at this point.

One important basic human need is the need for orientation and control. Similar to self-esteem, having to see a therapist can mean a loss of control for patients (Grawe & Grawe-Gerber, 1999). This need is reflected in the use of the tactic Provoking a response from the therapist, which was the third most frequent of the tactics. Information from the therapist about the disorder and effective treatment options should have a positive impact on the patients' need for orientation and control. The satisfaction of this need should lead to positive feelings like hope and relief. Having control means being

active. The therapist should thus give the patient opportunities to become active in the resolution of his goals right from the start of therapy. Transparency and a clear structure in the therapeutic process also have a positive impact on the patients' need for orientation and control (Grawe & Grawe-Gerber, 1999).

STRENGTHS AND LIMITATIONS

This study gave insight into a new facet of the therapeutic alliance: the way patients try to influence their therapists. Unlike most earlier studies on this topic, it was based on behavioral observations. Studies based on video ratings can measure complex process variables that cannot be assessed by self-report. Even though video ratings are very time-consuming, a large sample of 60 patients was assessed.

After a training period of several months to learn the use of the rating manual, judges achieved fair to good interjudge agreement for most tactics, which could not be improved by further training. For three tactics, however, only poor interjudge agreement could be achieved. These tactics were thus excluded from further calculations. Poor interjudge agreement can have different reasons. In this sample, the tactics with poor interjudge agreement were those that were observed infrequently. It is difficult to estimate if these tactics were coded rarely because they really occurred infrequently, because they were difficult to rate, or because the judges had little training in rating them.

It needs to be kept in mind that the decision as to whether certain patients' behaviors are instrumental or not is ultimately a question of interpretation. We based this decision on recognized assumptions that are used to distinguish instrumental from reactive behavior (see Brunner, 1996; Caspar, 1996, p. 159).

Two restrictions for interpretation of our data should be acknowledged. First, ratings were only done for intake interviews. Although we had good reasons to restrict ratings to this sample (motivation for self-presentation should be most prevalent in the first contact), results cannot be transferred to psychotherapy in general. Second, this was an exploratory study with no a priori formulated hypothe-

ses. Although significant results were found, they must not be interpreted as confirmations in retrospect of formulated hypotheses. For this reason, we reported effect sizes in addition to the significance of an effect. Significant results with a large effect size are thus of particular relevance and should be pursued in future studies.

This study pursued the modern understanding of the therapeutic alliance, namely that the patient and therapist influence each other mutually and constantly (Strong & Claiborn, 1982). This paper focused on the patient as the agent of influence. The therapists' reactions to these influence attempts are part of ongoing research.

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