You Won't Get Me

Therapist Responses to Patient Impression Management Tactics

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Abstract: In psychotherapy, therapist and patient influence each other constantly. We aimed to investigate how therapists respond to patient impression management and influence tactics. For 60 videotaped intake interviews, judges rated therapist responses to patient tactics as neutral, desired, or undesired from the patient perspective. Judges rated the therapist responses in 57% as neutral, in 40% as desired, and in 2% as undesired by the patients. The proportions of response outcomes varied across tactics. Therapist responses were unrelated to therapist and patient sex. Therapist experience was related to their responses to the tactic *Supplication*. Overall, some patient tactics seem to be more challenging for therapists than others. Awareness of such response tendencies can help therapists prepare their reactions to certain patient impression management and influence tactics. Implications for training and research are presented.

Key Words: Therapeutic alliance, psychotherapy, impression management, self-presentation, social influence

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In a therapeutic relationship, the patient and the therapist depend on each other. People use different strategies to control the impressions others form of them, a process which is referred to as impression management (Leary and Kowalski, 1990) or self-presentation. In an earlier study (Frühauf et al., 2015) we hypothesized that patients use impression management tactics to influence their therapists' cognitions and behaviors. As people are particularly motivated to manage the impression they make on strangers (Leary et al., 1994), we focused on impression management and influence tactics in the intake interview. Indeed, we found that patients used such tactics in roughly 30% of all utterances, with the most frequent of 12 predefined categories of tactics (see Table 1) being *Supplication, Provoking a response*, and *Self-promotion*.

To examine patient impression management further, we now focus on therapist responses to such attempts of influencing. Hereby, we distinguish between neutral, desired, and undesired responses (referring to the presumed patients' perspective; see Methods). We take an instrumental perspective of human behavior, which has been elaborated in the Plan Analysis approach of Caspar (Caspar, 1995, 2007, p. 251 ff.). The focus of the Plan Analysis is on instrumental relations. The fundamental underlying question is: For what conscious or nonconscious aim does a person behave in a certain way? All noninstrumental behavior is labeled as reactive (Caspar, 1995). For example, crying as an immediate reaction after a loss is considered reactive, whereas demonstrative crying obviously serving the purpose of getting pity is considered instrumental. This study focuses on tactics, that is, the observable aspect of instrumental (conscious and nonconscious) behavior. Instrumental behavior is normal interactional behavior. It can however create problems if the principle of reciprocity is broken, that is, if the other person feels forced to react in a certain way (Sachse et al., 2013, p. 13). Recognizing such problematic behavior, confronting patients with it, and helping them to interact in a more adaptive way are vital parts of psychotherapy (Strong and Claiborn, 1982).

The idea that psychotherapy has an effect not only on the patient but also on the therapist has been discussed under different terms in the literature: Freud's concept of countertransference relates to the therapist's emotional entanglement with a patient (Freud, 1957). Stiles uses the term therapist responsiveness, which he defines as "behavior that is affected by emerging context, including emerging perceptions of others' characteristics and behavior" (Stiles et al., 1998). He has developed a system to classify therapist verbal response modes (Stiles, 1992). Each utterance can be classified into one of eight modes (*e.g.*, reflection, question, interpretation). The classification is based on theoretical principles—source of experience, frame of reference, and focus—which can have the value "speaker" or "other" (Stiles, 1999). Stiles' research on response modes has contributed significantly to the understanding of the psychotherapy process (*e.g.*, Kramer and Stiles, 2015; Stiles, 1988, 2009). In addition, interpersonal theory (Horowitz and Strack, 2010; Kiesler, 1983; Leary, 1957; Sullivan et al., 1953) conceptualizes interpersonal behavior in psychotherapy. Kiesler's circumplex model, in particular, specifies how patients' self-presentations (organized along the axes of control and affiliation) shape the behavior of the therapist (Kiesler, 1996).

Literature on Therapist Responses to Patients

Empirical research on therapist responses to patients on a broad level has dealt with their responses to patient suicide, secondary traumatization and therapist burnout (Canfield, 2005), sexual attraction to clients (Pope, 1990), and responses to patient interpersonal (*i.e.*, friendly versus hostile) behavior (Bandura et al., 1960; Caspar et al., 2005; Gamsky and Farwell, 1967; Russell and Snyder, 1963). Researchers have also examined therapist responses on a more immediate, situational level. For example, observers judged a patient actor who expressed internal attributions for his problems as more motivated and attractive than one who made situational attributions (Schwartz et al., 1986). Hill et al. (1988) found that therapists used different response modes depending on patient variables such as level of anxiety, degree of self-disclosure, or level of experiencing. In a single-case study, Jones et al. (1993) observed that in the course of treatment, the patient's depressed affect pulled the therapist from a nonjudgmental and facilitative toward a more authoritative and emotionally reactive posture. Summarizing, it is obvious that patients directly influence therapist behavior in session. However, no study has yet examined therapist responses to patient impression management tactics in a large clinical sample of psychotherapy patients.

Findings of the present research provide insight into the interactional process that is taking place between the therapist and the patient. So far, a multitude of studies have examined the therapeutic relationship (for an overview, see Horvath, 2001); however, it is surprisingly unclear what accounts for a good relationship and how it can be established (Norcross and Hill, 2002). Therapist reactions to certain patient behavior provide information that can be used to infer important motives and needs of patients, so that the therapeutic relationship can be tailored accordingly (Caspar, 2007).

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TABLE 1. Patient Impression Management Tactics

Tactic	Fleiss' κ	Definition	Example of Tactic From Our Sample	Example of Therapist Response From Our Sample
Good mood	0.36	Establishing a positive atmosphere by joking, chatting; "breaking the ice"	Therapist asks the patient how he can distract himself from the separation from his girlfriend. The patients says that he likes to read, then he begins to chat about literature in general and recommends a book he has recently read to the therapist.	Desired (listens attentively, interested smile)
Positive feedback	0.69	Positive reactions to statements, behavior, or the person of therapist	Patient says: "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."	[a]
Negative feedback	0.14	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 been through that before and it is happening again. I do not need this again. I have a big problem with this" (critical look).	Desired (apologizes and thanks patient for coming)
Agenda setting	0.79	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."	Desired (nods in an encouraging way)
Provoking a response	0.77	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 toward the therapist).	Desired (makes comments about sleeping pills)
Negative reports about third persons	0.67	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."	Neutral (no reaction)
Fait accompli	0.08	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."	Neutral (no reaction)
Supplication	0.66	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 in my apartment. But if I cannot take my medication, really, the only thing left to do is pray."	Desired (asks what else is helpful)
Self-promotion	0.65	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."	Desired (commends patient: "You were very disciplined!")
Psychologizing	0.34	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 ehavioral 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…"	Neutral ("mmhm")
Avoidance of contents	0.33	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 effected you in a negative way?" Patient: "Yes, my parents' divorce. And then there was something about 2 years ago. On my way back from work someone pulled me on a meadow. Afterwards I had a blackout."	Undesired (asks what has happened)
Emotional avoidance	−0.02	Trying to keep an emotional distance; incongruent affect (*e.g.*, laughing when talking about traumata)	A patient talks about a fire that destroyed her parents' house when she was a child. While she talks she is smiling.	Undesired (asks about patient's feelings when that happened)

Therapist responses to the tactic *Positive feedback* have not been assessed. [This table has already been presented in Frühauf et al. (2015)].

[a]In the course of the coding, it was decided not to assess therapist responses to the tactic *Positive feedback,* because it was difficult to decide what a desired or undesired reaction to this tactic would be and because most therapists only reacted nonverbally to this tactic (*i.e.*, they nodded or smiled).

Content Process Divergence in Therapist Responses

Numerous authors with some conceptual variation have proposed the notion of complementarity to patients, first as interpersonal complementarity (Carson, 1969; Kiesler, 1983; Leary, 1957) and later as therapist-specific complementarity to patient needs or Plans, referred to as Plan compatibility (Silberschatz et al., 1986) or as Motive Oriented Therapeutic Relationship (Caspar, 2007; Kramer et al., 2011). We follow the two latter approaches, which overlap but are not identical.

Interpersonal complementarity is based on the observation that when two individuals interact, some interpersonal patterns fit together better and therefore form more stable relationships than others. In terms of the interpersonal circle based on the two dimensions control (dominant versus submissive) and affiliation (hostile versus friendly), positions on the same side of the affiliation and on the opposite side of the control dimension are complementary. That is, hostility elicits hostility, friendliness friendliness, dominance submissiveness, and submissiveness dominance. For example, a patient wishing his therapist to be friendly and to take responsibility should be friendly-submissive to make his therapist take this desired interpersonal position.

Complementarity in the sense of Motive Oriented Therapeutic Relationship means that a therapist satisfies a patient's motives. The underlying idea is that patient problematic behavior used to make the therapist satisfy his motives will thus become superfluous. A therapist should not act complementary to problematic behavior (*e.g.*, show pity with a patient whining for an entire session), as such therapist behavior would reinforce undesired patient behavior. He or she should rather try to understand which motives guide the problematic behavior. A possible motive of a patient who is whining a lot could be to convince the therapist to fully support and not overstrain him. Generally, it is assumed that even the most problematic behavior ultimately serves acceptable motives if one looks high enough in the instrumental hierarchy. A therapist would actively try to satisfy these motives in a way noncontingent to problem behavior. In this example, he or she would express his or her readiness to help the patient without overstraining him.

Caspar et al. (2000) further refined Silberschatz et al.'s (1986) approach by distinguishing between content and process Plan compatibility: content refers to the explicit meaning of the therapist's words for a patient's Plan. For example, a therapist might tell a patient who is working on becoming independent from his family: "You must become more independent!" Process, on the other hand, refers to a statement's implication for the interpersonal relationship between the patient and the therapist. The process aspect of a statement may or may not correspond with its content. In our example, there is a divergence between content and process: on the content level, the therapist behaves complementarily to the patient's striving for autonomy. On the process level, however, the therapist behaves Plan incompatible: by using the imperative, he or she undermines the patient's autonomy. In this example, the divergence between content and process is obviously not therapeutically sensible. However, there are situations where a content process divergence can be used as a therapeutic means: imagine a therapist wanting to confront a patient with dysfunctional behavior but at the same time not wanting to put the therapeutic alliance at risk. Here, a content process divergence can be used to satisfy both of these goals, by confronting on the content level and behaving complementary on the process level. For example, a patient who is skipping from one topic to another and thereby avoiding being emotionally involved could be confronted the following way: "You are avoiding your feelings by changing the topic all the time. Yet, it is necessary to fully understand a problem to solve it." In this example, the therapist does not satisfy the patient's immediate wish to touch several topics in a short time and even confronts him with his avoidance behavior. At the same time, however, he indirectly expresses his support by saying that he wants to fully understand the patient's concern. In their first attempt to empirically distinguish content from process, Caspar (2007) analyzed written transcripts of the three cases of psychotherapy used in Silberschatz et al. (1986). They found that content and process differed in 40% of all therapist interpretations. An analysis of these interpretations showed that content and process contributions to patients' experience varied from case to case. Further investigation of this subject thus seems worthwhile. A next methodological step is to assess content and process on the basis of videotaped material to see if that leads to a different proportion of cases in which such distinctions can be detected. In addition, and more related to the content of this study, it will be evaluated which particular tactics give rise to therapist responses in which content and process diverge.

Sex Differences Among Responses to Impression Management Tactics

Studies have found that men and women tend to apply different impression management tactics (for an overview, see Guadagno and Cialdini, 2007). In our study of patient impression management tactics, male patients did not differ from female patients. However, when the therapist was female, male patients used significantly more tactics overall. Moreover, they used the tactic *Negative reports about third persons* significantly more often toward female therapists (Frühauf et al., 2015). There is evidence that impression management and influence behavior that fits the socially expected gender role are evaluated more positively by the interaction partner (Bolino and Turnley, 2003; Kipnis and Schmidt, 1988). The sex of the evaluator can play a role in this process. Rudman (1998) found that females evaluated women who used the tactic *Self-promotion* more negatively than men who used this tactic. For males, this pattern was not found. To our knowledge, only one study has investigated sex-specific therapist responses: Mann (1988) examined therapist reactions to patients who devaluated therapy. He found that female therapists tended to tolerate more patients' devaluations, whereas male therapists reacted in a more authoritarian stance. These findings point to a potential impact of patient and therapist sex upon therapist responses to patient influence behavior. More specifically, it can be expected that female therapists would respond more often in an undesired fashion to the tactic *Negative feedback,* whereas female therapists would respond more often in a neutral or desired fashion.

Differences in Therapist Experience Among Responses to Impression Management Tactics

Studies have reported differences between expert and novice therapists with respect to their responses to patients. For example, responses of expert therapists were more present centered, more confrontational, less dominant, and less verbose (Tracey et al., 1988), and more often interpersonally complementary (Tracey and Hays, 1989). In addition, their self-reported confidence was higher (Hillerbrand and Claiborn, 1990; Stucki, 2004), and they were able to establish a better therapeutic relationship, as rated by their patients (Mallinckrodt and Nelson, 1991). These research results suggest that therapist experience might impact their susceptibility to patient influence attempts. Parallel to the findings that inexperienced therapists responded more complementary, whereas experienced therapists responded in a more confrontational fashion to patients, it can be expected that in our study inexperienced therapists would respond more often in a desired fashion than experienced therapists, whereas experienced therapists would respond more often in an undesired fashion than inexperienced therapists.

Purpose of the Present Study

As mentioned before, empirical studies on therapist responses to psychotherapy patient impression management and influence tactics in psychotherapy are still missing. The aim of our work was thus to

examine therapist responses to patient tactics. That is, we aimed to assess if patients got what they presumably intended to get from the therapists by using a tactic. On the basis of the considerations above, the following exploratory research questions were addressed:

1. How frequently do different therapist response types (undesired, desired, neutral) occur? Do therapist response types differ with regard to the different patient impression management tactics?
2. Which tactics give rise to a divergence between content and process in the therapist response?
3. Are therapist responses associated with therapist and patient sex and with therapist experience?

METHODS

Participants

Patients

The sample was drawn according to a priori formulated selection criteria, a principle referred to as selection by natural variation (Grawe, 2002). This approach allows to investigate constellations that are difficult to produce with strictly randomized sampling procedures. The original data base consisted of a pool of 3863 videotaped intake interviews. From each configuration of patients' and therapists' sex, 15 dyads were randomly selected, so that the final sample consisted of 60 intake interviews. Patient characteristics of the sample were representative of the entire data base. Patients (age: mean, 39.76 years; range, 18–75; all Caucasian) were seeking treatment at the psychotherapy outpatient clinic of the University of Bern, Switzerland during the years 2001 to 2012. This university-based clinic accepts patients with a wide range of problems and disorders, except psychotic disorders and substance use disorders. The patients are mostly nonstudent self-payers and correspond generally to patients in private practice. The first three sessions are devoted to a detailed assessment, including the intake interview, which was subject of the current study. Experienced therapists, who have been working at the clinic for many years, carry out most intake interviews. At the end of the assessment, the assessors choose the therapist that they judge to be best suited to patient characteristics. The available therapists are partly postgraduate trainees in years 2 to 4 of their 4-year psychotherapy training program and are partly experienced therapists. Trainees are in weekly supervision (Grosse Holtforth and Grawe, 2003). The most frequent diagnoses were affective (27%), anxiety (30%), and somatoform disorders (11%). Half of the patients had comorbid disorders. The intake interview covers certain specified topics but leaves enough freedom so that interactional idiosyncrasies of patients can unfold.

Therapists

Twelve therapists (seven female, five male, Caucasian) carried out the intake interviews (the actual therapy was conducted by a different therapist). Two therapists carried out one of the interviews, one carried out four interviews, two carried out five interviews, five carried out six interviews, and two carried out seven interviews. Their therapeutic orientation was cognitive-behavioral with an interpersonal focus. Experience was assessed as a dichotomous variable: licensed therapists with several years of clinical experience were regarded as experienced therapists. Therapists who were trainees at various stages of their 4-year psychotherapy training were regarded as inexperienced therapists. Experienced therapists in our sample had a range of 12 to 20 years of clinical practice, whereas inexperienced therapists had a range of 4 to 7 years of clinical practice. Hence, nine therapists (16 interviews) were considered as experienced therapists and three (44 interviews) as inexperienced therapists.

Measures and Coding

Patient Impression Management Tactics

Judges used a structured manual (the German manual will be made available by the corresponding author upon request) for impression management tactics. In this manual, patient impression management tactics are defined on the basis of conceptions of the therapeutic relationship (Carson, 1969; Caspar, 2007; Kiesler, 1983; Sachse, 2001; Sampson and Weiss, 1986; Strong and Claiborn, 1982; Sullivan et al., 1953) and on previous studies (Friedlander and Schwartz, 1985; Howard et al., 1986; Kipnis et al., 1980; Pratkanis, 2007). During the development of the manual, a preliminary list of tactics was discussed with 10 practicing psychotherapists and tested on five interviews. On the basis of this, the list was modified and shortened until the final list consisted of 12 tactics (see Table 1).

Therapist Responses to Impression Management Tactics

The interviews were assessed on an utterance-by-utterance basis. An utterance was defined as an uninterrupted speech unit of either patient or therapist (most often complete sentences, but also short expressions such as “mmhm” and nonverbal behavior such as laughing or covering the face with the hands). The codings were performed by two groups of advanced master al students (the first group consisting of four raters, and the second of two) who had undergone a systematic training. Trainings of both groups lasted 16 weeks, during which raters trained for several hours per week.

The first group was trained to assess patient impression management behavior. Training consisted of several steps: first, raters met with the principal investigator of the study and watched videos of selected practice cases that stemmed from the same data base as the cases included in the study. For each utterance, the group discussed if influence tactics could be observed. This step served the purpose of raters becoming familiar with the tactics. In a second step, raters individually rated the same intake interview. Later, the video was watched in the group, and divergent codings were discussed. This procedure continued until satisfactory interjudge agreement was reached and further training no longer improved agreement. Judges were instructed to distinguish patients' instrumental behavior from reactive behavior by using certain cues (Brunner, 1996; Caspar, 2007, p. 159). In the manual, tactics were defined and outlined with some illustrative behaviors (see Table 1). However, judges were encouraged to use their clinical intuition when judging behaviors that were not on the list. Videos were evenly and randomly allocated to judges, who did not know the research questions. The judges carried out the codings individually and were instructed not to discuss the codings with each other. During the rating, judges watched each video three times. In the first run, they noted the time of the beginning and ending of 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 to 10 scale (Frühauf et al., 2015). Only tactics with an intensity rating of higher than 3 were used for calculations.

The second group of judges was trained to assess therapist responses to patients' impression management tactics. Training lasted 16 weeks and consisted of the same steps as in the first group. Judges were provided with the same training cases and with the codings of patient impression management tactics, made by the first group. Twenty percent of the cases were coded independently by two raters, and interjudge agreement and reliability were calculated using these cases. Judges rated these interviews at the same time during the rating process to periodically check if interjudge reliability was maintained. For the coding, judges watched each video twice. The first run served the

purpose of getting familiar with the dyad's interactional style and of understanding the coding of the tactics. In the second run, judges watched only those sequences for which a patient tactic was coded (if more than one tactic was coded in one utterance, they only considered the one with the highest intensity), and they were instructed to code the subsequent therapist's response. Codings were made on a nominal scale. For each therapist response, judges coded whether the response seemed undesired, desired, neutral, or unclear from the patient's point of view, both on content and on process level. They assessed if the patient got what she or he presumably intended to get from the therapist by using the tactic. The codings were focused on the question if a patient's intention, which was presumably expressed by the tactic, was satisfied by the therapists' response (for examples, see Table 1). In the course of the coding, it was decided not to assess therapist responses to the tactic *Positive feedback,* because it was difficult to decide what a desired or undesired response to this tactic would be and because most therapists only reacted nonverbally to this tactic (*i.e.*, they nodded or smiled).

Interjudge Agreement

Cohen's kappa was calculated to assess interjudge agreement (Cohen, 1960). The mean agreement rates for therapist responses to the different patient impression management tactics are shown in Table 2. Agreement varied substantially according to the different tactics. For 7 of the 10 tactics, agreement rates were clearly above chance level. Agreement rates can be interpreted and categorized as follows: very good agreement (κ = 0.80 to 1.00) was found for responses to *Good mood* and *Emotional avoidance;* good agreement (κ = 0.60 to .79) was found for responses to *Psychologizing, Provoking a response, Self-promotion* and *Negative feedback;* acceptable agreement (κ = 0.40 to 0.59) was found for responses to *Supplication;* fair agreement (κ = 0.20 to 0.39) was found for responses to *Agenda setting*; and poor agreement (κ < 0.20) was found for responses to *Fait accompli, Negative reports about third persons,* and *Avoidance of contents.* Agreement rates (Fleiss' κ) (Fleiss, 1973) for judges' classifications of impression management tactics to patient utterances can be found in Table 1. For calculations including total numbers of responses across all tactics (research question 2), tactics with poor agreement rates and tactics to which responses were of low agreement were excluded. As reported in Frühauf et al. (2015), patients showed impression management tactics in roughly 30% of their utterances. This made up a total of 3037 cases of tactics, for which the subsequent therapist responses were evaluated.

Statistical Analyses

Calculations were completed using the program SPSS version 21.0. Nonparametric tests were used because the majority of the data were not normally distributed. For research question 3, the Mann-Whitney *U* test was used to compare whether therapist responses differ with respect to therapist and patient sex and to level of therapist experience. To control for the fact that interviews varied in number of tactics and responses, frequencies of response type (undesired, desired, and neutral) were weighed according to the total number of responses to each tactic.

Because of the exploratory nature of this study, open research questions were formulated instead of a priori hypotheses. Significant results can be used to state a priori hypotheses in future studies. They cannot be interpreted as a confirmation of a posteriori stated hypotheses relating to the data of the present study.

RESULTS

How Frequently Do the Different Therapist Responses (Undesired, Desired, and Neutral) Occur? Do They Differ With Regard to the Different Patient Impression Management Tactics?

Across all tactics, therapist responses were roughly in 57% (1718 cases) neutral, in 40% (1233 cases) desired, and in 2% (74 cases) undesired. One percent (12 cases) could not be classified. Therapist responses varied with regard to single tactics. The largest proportion of neutral responses was observed with the tactic *Supplication* (88% or 58 cases), *Negative reports about third persons* (84% or 38 cases) and *Psychologizing* (72% or 46 cases). The largest proportion of desired responses was observed for *Provoking a response* (93% or 57 cases), *Good mood* (78% or 25 cases), and *Emotional avoidance* (68% or 17 cases). The largest proportion of undesired responses was observed for *Avoidance of contents* (49% or seven cases), *Emotional avoidance* (30% or nine cases), and *Negative feedback* (18% or 5 cases). The distribution of the responses to all tactics can be found in Figure 1.

Which Tactics Give Rise to a Divergence Between Content and Process in the Therapist Response?

Of 60 interviews, 20 included responses with a divergence between content and process. Content process divergence was found in 1.28% of all cases (39 of 3037). The most frequent type of divergence was a response that was neutral in content and desired in process (0.79% of total responses, 1.39% of all neutral responses, or n = 24).

TABLE 2. Mean Interjudge Agreement for Therapist Responses to the Different Patient Tactics

	Content				Process			
Tactic	***n***	P_o	P_c	κ	***n***	P_o	P_c	κ
Good mood	8	100%	77.50%	1.00**	8	100%	77.50%	1.00**
Negative feedback	13	84.70%	36.15%	0.76***	13	77.00%	37.69%	0.63**
Agenda setting	47	63.80%	47.45%	0.31*	47	63.80%	45.32%	0.34**
Provoking a response	111	94.60%	84.68%	0.65***	111	94.60%	84.68%	0.65***
Negative reports…	69	87.00%	87.68%	−0.06 (ns)	69	85.50%	86.38%	−0.06 (ns)
Fait accompli	11	54.50%	58.18%	−0.08 (ns)	11	54.50%	58.18%	−0.08 (ns)
Supplication	73	89.00%	78.36%	0.49***	73	90.40%	77.26%	0.58***
Self-promotion	53	90.60%	67.92%	0.71***	53	88.70%	66.60%	0.66***
Psychologizing	34	82.30%	54.12%	0.61***	34	82.30%	54.12%	0.61***
Avoidance of contents	3	66.70%	66.67%	0 (ns)	3	66.70%	66.67%	0 (ns)

P_o indicates percent of agreement; P_c, chance agreement; κ, Cohen's kappa; ns, not significant.
*p < 0.05, **p < 0.01, ***p < 0.001.

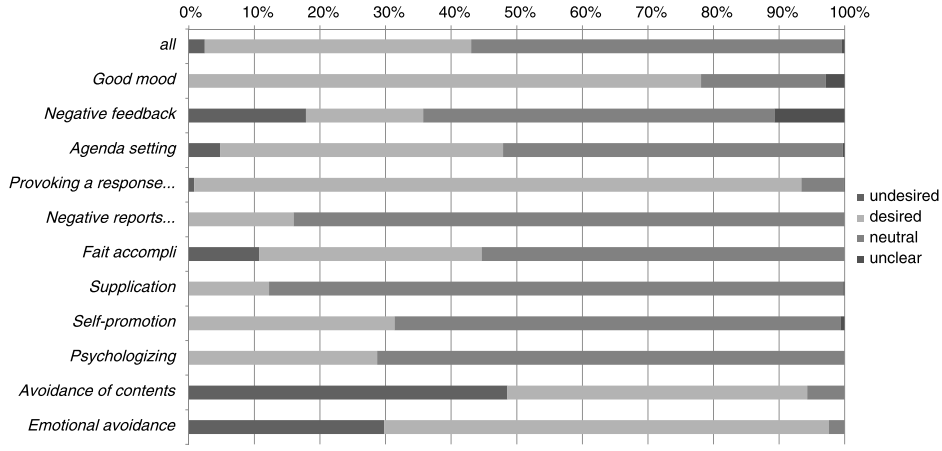

FIGURE 1. Proportions of the different response types per tactic.

This type of divergence occurred most often in responses to *Supplication* (1.72% of all responses to this tactic or $n = 16$) and *Negative reports about third persons* (2.64% of all responses to this tactic or $n = 7$). The second most frequent type of divergence was a response that was undesired in content and desired in process (0.43% of total responses, 17.60% of all undesired responses, or $n = 13$). This type of divergence occurred most often in responses to the tactics *Agenda setting* (1.41% of all responses to this tactic or $n = 5$), *Emotional avoidance* (4.85% or $n = 5$), and *Avoidance of contents* (7.69% or $n = 3$). Divergences of the type undesired in content and neutral in process and desired in content and neutral in process did not occur. No divergences were observed in responses to the tactics *Good mood, Negative feedback, Provoking a response,* and *Psychologizing.* For most of the tactics, divergences occurred in several interviews. All frequencies for the different types of divergences in responses to different tactics are shown in Table 3.

Are the Therapist Responses Associated With Therapist and Patients Sex and With Therapist Experience?

Across all tactics, male therapists did not differ from female therapists with respect to the relative frequencies of different responses types (desired, undesired, or neutral). The relative frequencies of different response types to tactics shown by male patients did not differ from those to tactics shown by female patients. Experienced therapists did not differ from inexperienced therapists with respect to the relative frequencies of different responses types. On the level of single tactics, however, one difference was found: inexperienced therapists gave significantly more desired responses (Mdn = 25.00) to the tactic *Supplication* than experienced therapists (Mdn = 11.27; $U = 54.00$, $p = 0.001$, $r = 0.53$). Simultaneously, experienced therapists gave significantly more neutral responses (Mdn = 95.00) to the tactic *Supplication* than inexperienced therapists (Mdn = 82.85; $U = 217.50$, $p = 0.035$, $r = 0.28$).

DISCUSSION

This exploratory study examined therapist responses to patient behaviors interpreted as attempts to influence the therapist during the intake interview. It is an extension of an earlier study about patient impression management and influence tactics. This is the first study that examined therapist responses to patient tactics using a large clinical sample of psychotherapy patients. Furthermore, it is the first study implementing Friedlander and Schwarz' (1985) proposition of investigating therapists responses to patient tactics.

Frequency of Therapist Responses to Patient Tactics

Across all tactics, the most frequent type of response was neutral. This finding needs to be interpreted within the context of the intake interview: its main purposes are to get to know the patient, to identify problems, and to create an atmosphere that allows the patient to open up. Therapists at this stage mainly ask open questions. Therapeutic interventions (*e.g.*, confronting patients with maladaptive self-presentations) are usually not yet carried out. On the other hand, this finding might also have a methodological cause: we registered therapists' immediate responses to patient utterances. It is possible that in many cases, the reaction of therapists was not fast enough to be detected in the immediate response.

The second most common response type was desired, which accounted for 40% of the responses. The importance of creating a trusting atmosphere at intake might explain the substantial proportion of this response type: therapists are aware that seeking psychological

TABLE 3. Frequencies of Divergences Between Content and Process

	Type of Divergence Between Content and Process				
Tactic	**Undesired/Desired**	**Desired/Undesired**	**Neutral/Undesired**	**Neutral/Desired**	**Interviews**
Agenda setting	5 (1.41%)	1 (0.28%)		1 (0.28%)	7 (11.66%)
Negative reports…				7 (2.64%)	5 (8.33%)
Fait accompli	1 (1.96%)				1 (1.66%)
Supplication				16 (1.72%)	17 (28.33%)
Self-promotion			1 (0.29%)		1 (1.66%)
Avoidance of contents	3 (7.69%)				1 (1.66%)
Emotional avoidance	5 (4.85%)				4 (6.66%)

Interviews indicates number of interviews in which a divergence in responses to the respective tactic occurred; Percentages, number of response with content process divergence in relation to total number of responses to this tactic.

help is a big step for patients, potentially associated with feelings of shame and failure. What they need in that moment is positive feedback to experience remoralization, which is the first phase of patients' improvement, according to the three-phase model of psychotherapy outcome (Howard et al., 1993). Hence, one important goal of the intake interview is that the patient leaves with a good feeling and the intention to come back and start treatment.

Undesired responses accounted only for a few of all cases (2%). This response type can have a confrontational quality. It makes sense to avoid this at intake, given the therapist's goal to establish a good relationship in the first encounter with the patient. Confronting patients with their maladaptive self-presentations requires a stable therapeutic relationship (Sachse, 2001) and, to be therapeutically effective, should be combined with simultaneous resource activation, that is, highlighting patient strengths and positive sides (Gassmann and Grawe, 2006).

The frequency of response types varied widely across the different tactics: the largest proportion of neutral responses was given to the tactics *Supplication* and *Negative reports about third persons.* From a therapeutic point of view, these tactics are problematic and should not be reinforced: *Supplication* or excessive moaning is a passive, maladaptive way of dealing with problems and should be replaced by more constructive strategies. Similarly, the tactic *Negative reports about third persons* indicates an external attribution of problems or an avoidance of relating to oneself. In addition, neutral responses were frequently given to the tactic *Psychologizing.* This is not necessarily a negative tactic, yet therapists seem to be cautious with reinforcing patients' explanatory models and instead listen to them without commenting.

Desired responses were most often given to the tactic *Provoking a response.* Asking questions is an indicator of patient active communication, which has been shown to have positive effects on treatment outcome in medical settings (Greenfield et al., 1985, 1988; Kaplan et al., 1989; Thompson et al., 1990). Psychotherapists seem to support this kind of patient behavior as well. Desired responses were also given frequently to the tactic *Good mood.* A positive atmosphere between patient and therapist is desirable as it helps build a good therapeutic relationship. A great proportion of desired responses were also observed in cases of *Emotional avoidance* and *Avoidance of contents,* that is, therapists tended to co-avoid. It might be that they registered such avoidance tendencies and planned to address them at a later point in therapy. Consistent with the abovementioned ideas about confrontations, at intake, it is too early to evoke strong emotions or to confront patients with their avoidance of potentially highly problematic or traumatic contents.

Undesired responses were often given to the tactic *Avoidance of contents.* When patients did not want to reveal important information, therapists often did not refrain from further questioning. The tactic *Emotional avoidance* also resulted in a large proportion of undesired responses, that is, therapists confronted patients with their avoidance of certain feelings. It is difficult to draw general conclusions about this finding, because it is based on a small number of observations. One therapist tended to co-avoid (23 desired responses *vs.* 3 undesired responses), whereas the other gave more desired ($n = 8$) than undesired responses ($n = 6$). It seems to be an individual decision to either avoid or encourage the patient to face strong emotions. Finally, therapists often gave undesired responses to the tactic *Negative feedback,* that is, they tended to defend themselves. This finding is a warning signal: patients' negative feedback has been found to be a marker of alliance ruptures. Safran et al. (2001) have found that many poor outcome cases include a vicious cycle of patient-therapist interactions, in which therapists respond in a hostile fashion to patients' negative comments. The authors propose interventions, which they have found facilitative for the resolution process, such as exploring patients' negative feelings about therapy, and responding to those feelings in an open and nondefensive fashion.

Our findings correspond well with interpersonal theory, according to which hostile interpersonal behavior elicits a reciprocal, hostile response, whereas friendly interpersonal behavior pulls for reciprocal friendly responses (Kiesler, 1996). The patient tactics *Provoking a response* and *Good mood* reflect friendly interpersonal behavior. These two tactics more often gave rise to desired therapist responses than all other tactics. At the same time, the tactic *Negative feedback,* which can be understood as hostile behavior, was among the tactics that elicited the largest proportion of undesired responses from therapists. These findings, however, are incidental. They should be interpreted with caution and verified by future studies using directed hypotheses.

Tactics That Give Rise to Content Process Divergence in the Therapist Response

In one third of the interviews, at least one response with a divergence between content and process was observed. We could thus replicate Caspar et al.'s (2000) finding that process-content divergence is a frequent phenomenon. At first sight, it is striking that Caspar et al. (2000) found a much higher proportion of divergences, that is, in 40% of all interpretations, compared with only 1.28% of responses in our data. Several differences in their study, compared with ours, might explain this finding. First, they chose therapist interpretations as the unit of analysis, whereas we investigated spontaneous responses to patient tactics. Second, they used therapy transcripts, whereas we used observer ratings of videotaped sessions. Last, they followed a slightly different definition of divergences (one point divergence on the 7-point Plan Compatibility of Interventions Scale, that is, an interval-scale measure) than we did (divergences between categories of responses, *i.e.*, a nominal-scale measure).

The most frequent type of divergence was neutral in content and desired in process and hence combines the two most frequent response types. The reason why divergences occur seems to be related to the particular tactic. Apparently, there are tactics to which therapists do not immediately know how to respond to. Indeed, this type of divergence occurred most frequently in responses to the tactics *Supplication* and *Negative reports about third persons.* These tactics probably face therapists with a conflict: on the one hand, they want to give their patients what they need in the sense of a Motive Oriented Therapeutic Relationship. On the other hand, they do not want to reinforce maladaptive patient behavior. To meet both of these goals, they show both responses concurrently, yet on different levels (*i.e.*, on the content and on the process level). The following exemplary dialogue (see also Table 1) between a female patient and a therapist from our sample aims to illustrate these considerations:

Patient: "When my migraine is really bad all I can do is pray. If I take my medication, I can at least vegetate in my apartment. But if I cannot take my medication, really, the only thing left to do is pray."

Therapist: "So medication helps. What else is helpful?"

The therapist in this example is not responding to the patients' immediate complaint, as she does not refer to the patient's suffering (*i.e.*, her response is neutral on the content level). At the same time, however, she offers help to find ways to alleviate the pain (*i.e.*, her response is desired on the process level).

The second most frequent type of divergence was undesired in content and desired in process. This type of divergence occurred most frequently in responses to the tactic *Agenda setting.* Therapists showed this response in cases when they generally wanted to support the patients' tendency to set their own goals, but the specific goal was inappropriate for psychotherapy. The same type of divergence also occurred in responses to the tactics *Emotional avoidance* and *Avoidance of contents.* As indicated above, therapists most likely tried to prepare patients for the fact that avoidance behavior will not be supported in therapy. At the same time, they tried to remain friendly on the relational (process) level. No divergences occurred in responses to the tactics *Good mood, Provoking a response, Psychologizing,* or *Negative feedback.* These tactics seem to be unproblematic for the therapists in the sense that they immediately knew how to respond. Interestingly, divergences occurred in several interviews. Thus, it seems to be a phenomenon that is not attributable to a certain therapist but instead can happen to virtually any therapist.

Sex Differences Among Therapist Responses

We did not find effects of therapist and patient sex on therapist responses. Findings from social psychological studies suggesting that impression management tactics are evaluated differently according to the actor's (Bolino and Turnley, 2003; Kipnis and Schmidt, 1988) and evaluator's sex (Rudman, 1998) could not be transferred to the therapeutical setting on the basis of our data. In addition, Cooke and Kipnis' (1986) findings on sex differences in therapist interventions do not correspond with therapist responses to patient impression management tactics in our sample. Consistent with the results of our first study (Frühauf et al., 2015) showing that female patients do not differ from male patients in their overall impression management behavior, therapists responded similarly to female and male patients' impression management tactics. Psychotherapy seems to provide a setting where behavior that does not conform to the gender role is not sanctioned (Rudman, 1998). Indeed, the findings of the present study might even explain our earlier findings on patient behavior—because therapists did not censure nonconformist behavior and thereby did not steer them into a certain direction, patients might have felt free to act authentically.

Responses of Experienced Versus Inexperienced Therapists

Experienced therapists did not differ significantly from inexperienced therapists regarding the overall distribution of response types. Both groups responded neutrally in most cases. Yet, responses to one tactic varied: inexperienced therapists gave more desired responses to the tactic *Supplication* than experienced therapists, whereas experienced therapists gave more neutral responses to this tactic than inexperienced therapists. Thus, our expectation that inexperienced therapists respond more often in a desired fashion than experienced therapists was confirmed for this tactic. Contrary to our expectations, experienced therapists did not respond more often in an undesired way than inexperienced therapists did. However, undesired responses were generally rare, and possible explanations for this finding have been discussed above. These findings are in line with Tracey and Hayes' study, which showed that inexperienced therapists responded significantly more often complementarily than experienced therapists (Tracey and Hays, 1989). Their tendency to give in to the patients' influence attempts might be a consequence of the lower degree of confidence reported by inexperienced therapists (Hillerbrand and Claiborn, 1990; Stucki, 2004), but possibly also of their greater sympathy for patients (Stucki, 2004). Furthermore, responses of inexperienced therapists to patients are characterized by a stronger emotional involvement, higher arousal, and heightened self-awareness. Their focus of attention is thus more self-centered (Becker and Sachse, 1998). As these processes use cognitive capacity, which could otherwise be used to carefully plan the responses, therapists might become more susceptible to therapist action tendencies triggered by the patients.

Clinical Implications

This study showed that therapists responded neutrally to their patients' impression management and influence tactics in most instances. This indicates that therapists mostly resist their patients' influence attempts. However, proportions of undesired, desired, and neutral responses varied according to the different tactics. Presumably, therapists find it easier to respond positively to certain tactics, such as *Good mood* and *Provoking a response* whereas they seem to avoid reinforcing other tactics, such as *Negative reports about third persons* and *Supplication*. Coming back to Friedlander and Schwartz' (1985) proposition, from a therapists viewpoint, apparently some patient tactics are more desirable than others (which are mainly self-promotion and ingratiation, the latter overlapping with our *Good mood*). This overview of the frequencies of difficult patient influence tactics and the therapist responses can help therapists to be wary of their own response tendencies. This knowledge can help them prepare their responses to certain patient tactics, which might include confronting patients with negative consequences of these.

Strengths, Limitations, and Directions for Future Research

This study's strengths are the use of behavioral observations, which provide external validity, a fairly high number of cases compared with earlier studies on this topic, the use of double codings to estimate interjudge reliability, and good agreement rates for most variables. However, the following restrictions need to be acknowledged: data were drawn from intake interviews, and results can therefore not be generalized to psychotherapy sessions in general; all patients were Caucasian, and findings can therefore not be generalized across all ethnic groups; interjudge reliability was insufficient for some variables, and the consideration of certain patient behaviors as impression management and influence tactics is based on recognized theoretical assumptions used to distinguish instrumental from noninstrumental behavior (Brunner, 1996; Caspar, 2007, p. 159). This study relied on observer ratings. Values of many psychotherapy process variables (*e.g.*, empathy, therapeutic relationship) differ according to the perspective from which they are assessed (Orlinsky et al., 2004). Future studies might have patients and therapists watch the influence tactics and assess them to compare the three perspectives. This study focused on influence behavior in the intake interview. A next step would be to examine how influence tactics of patients and responses of therapist to these evolve in the course of therapies and how they are linked to the therapeutic relationship and outcome.

CONCLUSIONS

In most of the cases, therapists resisted their patients' influence attempts, that is, they responded in a neutral way. In a good proportion of cases, however, they responded in a desired manner, and in a marginal proportion in an undesired manner. Response tendencies varied widely across different tactics. Awareness of such response tendencies can help therapists prepare their responses to certain patient tactics to avoid reinforcement of maladaptive behavior.

DISCLOSURE

The authors declare no conflict of interest.

REFERENCES

Bandura A, Lipsher DH, Miller PE (1960) Psychotherapists approach-avoidance reactions to patients' expressions of hostility. *J Consult Psychol*. 24:1.

Becker K, Sachse R (1998) *Therapeutisches Verstehen* [Therapeutic Understanding]. Göttingen: Hogrefe.

Bolino MC, Turnley WH (2003) More than one way to make an impression: Exploring profiles of impression management. *J Manag*. 29:141–160.

Brunner A (1996) *Widerstand in Psychotherapien. Eine explorative Untersuchung* [Resistance in Psychotherapies. An exploratory Investigation]. (Unpublished doctoral dissertation). University of Bern.

Canfield J (2005) Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies Social Work*. 75:81–101.

Carson RC (1969) *Interaction concepts of personality.* Chicago, IL: Aldine.

Caspar F (1995) *Plan Analysis. Toward optimizing psychotherapy.* Seattle, WA: Hogrefe-Huber.

Caspar F (2007) Plan Analysis. In Eells TD (Ed), *Handbook of psychotherapy case formulation* (pp 251–289). New York; London: Guilford Press.

Caspar F, Grossmann C, Unmüssig C, Schramm E (2005) Complementary therapeutic relationship: Therapist behavior, interpersonal patterns, and therapeutic effects. *Psychother Res*. 15:91–102.

Caspar F, Pessier J, Stuart J, Safran JD, Samstag LW, Guirguis M (2000) One step further in assessing how interpretations influence the process of psychotherapy. *Psychother Res*. 10:309–320.

Cohen JA (1960) A coefficient of agreement for nominal scales. *Educ Psychol Meas*. 20:37–46.

Cooke M, Kipnis D (1986) Influence tactics in psychotherapy. *J Consult Clin Psychol*. 54:22–26.

Fleiss JL (1973) *Statistical methods for rates and proportions*. New York, NY: John Wiley & Sons.

Freud S (1957) The future prospects of psycho-analytic therapy. In *The standard edition of the complete psychological works of Sigmund Freud, Volume XI (1910): Five lectures on psycho-analysis, Leonardo da Vinci and other works* (pp 139–152). London: The Hogarth Press and the Institute of Psycho-Analysis.

Friedlander ML, Schwartz GS (1985) Toward a theory of strategic self-presentation in counseling and psychotherapy. *J Couns Psychol*. 32:483–501.

Frühauf S, Figlioli P, Oehler D, Caspar F (2015) What to expect in the intake interview? Impression management tactics of psychotherapy patients. *J Soc Psychol Clin Psychol*. 34:28–49.

Gamsky NR, Farwell GF (1967) The effect of client demeanor upon the verbal responses of school counselors. *Pers Guid J*. 45:477–481.

Gassmann D, Grawe K (2006) General change mechanisms: The relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. *Clin Psychol Psychother*. 13:1–11.

Grawe K (2002) Paper presented at the Tagung der Fachgruppe Klinische Psychologie. In *Selektion aus natürlicher Variation Eine. Alternative zur experimentellen Forschungsstategie* [Selection by natural variation: An alternative research strategy]. Germany: DGPs, Konstanz.

Greenfield S, Kaplan S, Ware JE Jr (1985) Expanding patient involvement in care: Effects on patient outcomes. *Ann Intern Med*. 102:520–528.

Greenfield S, Kaplan SH, Ware JE, Yano EM, Frank HJ (1988) Patients' participation in medical care. *J Gen Intern Med*. 3:448–457.

Grosse Holtforth M, Grawe K (2003) About birds and stones—Research, training, and practice at a university outpatient clinic. *Paper presented at the Annual Meeting of the North American Society for Psychotherapy Research (NASPR)*. Springdale, UT.

Guadagno RE, Cialdini RB (2007) Gender differences in impression management in organizations: A qualitative review. *Sex Roles*. 56:483–494.

Hill CE, Helms JE, Tichenor V, Spiegel SB, O'Grady KE, Perry ES (1988) Effects of therapist response modes in brief psychotherapy. *J Couns Psychol*. 35:222–233.

Hillerbrand E, Claiborn CD (1990) Examining reasoning skill differences between expert and novice counselors. *J Couns Devel*. 68:684–691.

Horowitz LM, Strack S (2010) *Handbook of interpersonal psychology: Theory, research, assessment and therapeutic interventions*. Hoboken, NJ: John Wiley & Sons.

Horvath AO (2001) The alliance. *Psychotherapy*. 38:365.

Howard JA, Blumstein P, Schwartz P (1986) Sex, power, and influence tactics in intimate relationships. *J Pers Soc Psychol*. 51:102–109.

Howard KI, Lueger RJ, Maling MS, Martinovich Z (1993) A phase model of psychotherapy outcome: Causal mediation of change. *J Consult Clin Psychol*. 61:678–685.

Jones EE, Ghannam J, Nigg JT, Dyer JF (1993) A paradigm for single-case research: the time series study of a long-term psychotherapy for depression. *J Consult Clin Psychol*. 61:381.

Kaplan SH, Greenfield S, Ware JE Jr (1989) Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care*. 27:S110–S127.

Kiesler DJ (1983) The 1982 interpersonal circle: A taxonomy for complementarity in human transactions. *Psychol Rev*. 90:185–214.

Kiesler DJ (1996) *Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy*. New York: John Wiley & Sons.

Kipnis D, Schmidt SM (1988) Upward-influence styles: Relationship with performance evaluations, salary, and stress. *Adm Sci Q*. 33:528–542.

Kipnis D, Schmidt SM, Wilkinson I (1980) Intraorganizational influence tactics: Explorations in getting one's way. *J Appl Psychol*. 65:440–452.

Kramer U, Rosciano A, Pavlovic M, Berthoud L, Despland JN, de Roten Y, Caspar F (2011) Motive-oriented therapeutic relationship in brief psychodynamic intervention for patients with depression and personality disorders. *J Clin Psychol*. 67: 1017–1027.

Kramer U, Stiles WB (2015) The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychol*. 22:277–295.

Leary MR, Kowalski RM (1990) Impression management: A literature review and two-component model. *Psychol Bull*. 107:34–47.

Leary MR, Tchividijian LR, Kraxberger BE (1994) Self-presentation can be hazardous to your health: impression management and health risk. *Health Psychol*. 13:461–470.

Leary TF (1957) *Interpersonal diagnosis of personality*. New York, NY: Ronald Press.

Mallinckrodt B, Nelson ML (1991) Counselor training level and the formation of the psychotherapeutic working alliance. *J Couns Psychol*. 38:133.

Mann CH (1988) Male and female in a changing analytic world. *Contemp Psychoanal*. 24:676–684.

Norcross JC, Hill CE (2002) Empirically supported therapy relationships. *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp 3–16). Cary, NC: Oxford University Press.

Orlinsky DE, Ronnestad MH, Willutzki U (2004) Fifty years of psychotherapy process-outcome research: Continuity and change. *Handbook of psychotherapy and behavior change* (Vol. 55, pp 307–389). New York: John Wiley & Sons.

Pope KS (1990) Therapist-patient sexual involvement: A review of the research. *Clin Psychol Rev*. 10:477–490.

Pratkanis AR (2007) Social influence analysis: An index of tactics. *The science of social influence: Advances and future progress* (pp 17–82). Hove, UK: Psychology Press.

Rudman LA (1998) Self-promotion as a risk factor for women: the costs and benefits of counterstereotypical impression management. *J Pers Soc Psychol*. 74: 629–645.

Russell PD, Snyder WU (1963) Counselor anxiety in relation to amount of clinical experience and quality of affect demonstrated by clients. *J Consult Psychol*. 27:358–363.

Sachse R (2001) Persönlichkeitsstörung als Interaktionsstörung: Der Beitrag der Gesprächspsychotherapie zur Modellbildung und Intervention [Personality disorder as interaction disorder: The contribution of client-centered psychotherapy to model building and intervention]. *Psychotherapie*. 5:282–292.

Sachse R, Breil J, Fasbender J (2013) *Klärungsorientierte Paartherapie* [Clarification-oriented couples therapy]. Göttingen: Hogrefe.

Safran JD, Christopher J, Samstag LW, Stevens C (2001) Repairing alliance ruptures. *Psychotherapy*. 38:406–412.

Sampson H, Weiss J (1986) Testing hypotheses: The approach of the Mount Zion psychotherapy research group. In Greenberg & Pinsof LS (Ed), *The psychotherapeutic process: A research handbook* (pp 591–614). New York, NY: Guildford Press.

Schwartz GS, Friedlander ML, Tedeschi JT (1986) Effects of clients' attributional explanations and reasons for seeking help on counselors' impressions. *J Couns Psychol*. 33:90.

Silberschatz G, Fretter PB, Curtis JT (1986) How do interpretations influence the process of psychotherapy? *J Consult Clin Psychol*. 54:646–652.

Stiles W (1999) Signs and voices in psychotherapy. *Psychother Res*. 9:1–21.

Stiles WB (1988) Psychotherapy process-outcome correlations may be misleading. *Psychotherapy*. 25:27–35.

Stiles WB (1992) *Describing talk: A taxonomy of verbal response modes*. Newbury Park, CA: Sage Publications.

Stiles WB (2009) Responsiveness as an obstacle for psychotherapy outcome research: It's worse than you think. *Clinical Psychol*. 16:86 –91.

Stiles WB, Honos-Webb L, Surko M (1998) Responsiveness in psychotherapy. *Clinical Psychol*. 5:439–458.

Strong SR, Claiborn CD (1982) *Change through interaction: Social psychological processes of counseling and psychotherapy*. New York, NY: Wiley.

Stucki C (2004) *Die Therapiebeziehung differenziell gestalten. Intuitive Reaktionen, Patientenwahrnehmung und Beziehungsverhalten von Therapeuten in der Psychotherapie* [Creating differential therapeutic alliances. Intuitive reactions, patient perception and therapeutic alliance in psychotherapy]. (Unpublished doctocal dissertation). Switzerland: University of Bern.

Sullivan HS, Perry HS, Gawel ML (1953) *The interpersonal theory of psychiatry*. New York, NY: W.W. Norton.

Thompson SC, Nanni C, Schwankovsky L (1990) Patient-oriented interventions to improve communication in a medical office visit. *Health Psychol*. 9: 390–404.

Tracey TJ, Hays K (1989) Therapist complementarity as a function of experience and client stimuli. *Psychotherapy*. 26:462.

Tracey TJ, Hays KA, Malone J, Herman B (1988) Changes in counselor response as a function of experience. *J Couns Psychol*. 35:119–126.