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# Therapeutic Immediacy Across Long-Term Psychodynamic Psychotherapy: An Evidence-Based Case Study

Jason Mayotte-Blum
Adelphi University

Jenelle Slavin-Mulford
Massachusetts General Hospital and Harvard Medical School

Meaghan Lehmann, Frank Pesale, Nikaya Becker-Matero, and Mark Hilsenroth
Adelphi University

C. E. Hill (2004) recently developed the concept of therapist immediacy to capture discussion by the therapist about the therapeutic relationship that occurs in the here-and-now of a therapy session. This concept has been expanded to include discussion about the therapeutic relationship by both the client and therapist, captured by the term *therapeutic immediacy* (K. Kuutmann & M. Hilsenroth, 2011). Although prior research has examined the use of therapeutic immediacy across short-term treatment, the present study is the first to examine the use of immediacy across a long-term (4 years) psychotherapy. Also, this is the first study to assess the interrater reliability of therapeutic immediacy, which was found to achieve good to excellent levels across raters. The most frequently used categories of client and therapist immediacy are presented. Finally, the authors provide an in-depth qualitative examination of 5 therapeutic immediacy segments across the treatment judged by the raters to have high levels of depth/intensity (4.5 or higher out of 5) to examine the role of therapeutic immediacy in exploring meaningful treatment issues. Clinical utility, potential limitations, and future research on therapeutic immediacy are discussed.

*Keywords:* therapeutic immediacy, psychodynamic psychotherapy, case study, self-disclosure, transference

A focus on the therapeutic relationship has been established as an important aspect of psychotherapy treatment across a wide range of different therapeutic orientations (Beck, 1995; Freud, 1912; Norcross, 2011). In part due to the various different conceptualizations of an in-session focus on the therapeutic relationship in research, training, and practice, Hill (2004) developed an experience near term *therapist immediacy*, defined as disclosures of how the therapist is feeling about the client, him- or herself in relation to the client, or about the therapy relationship. Recently, in order to capture the more interactive and dyadic nature of the therapeutic relationship, this definition has been broadened to also include any client-initiated disclosures of feelings about the therapist or their relationship, and the revised term of *therapeutic immediacy* has been suggested (Kuutmann & Hilsenroth, 2011). Thus, therapeutic immediacy involves any discussion within the therapy session about the relationship between therapist and client that occurs in the here and now. Typical examples of therapeutic immediacy include exploring parallels between external relationships and the therapy relationship; client or therapist expression of in-session emotional reactions; inquiring about the client's reactions to therapy; the therapist commenting on his or her experience of the client; supporting, affirming, and validating the client's feelings in the therapy relationship; and expressing gratitude. Use of therapeutic immediacy in the therapeutic relationship can then act as a template for interpersonal functioning in the client's outside relationships. Hill and Knox (2009), in a review of the literature on the in-session processing of therapeutic relationship, found that in nearly all cases, exploration of client feelings about what transpires in the treatment led to greater emotional expression, better interpersonal functioning, and an enhanced therapeutic alliance.

There are two prior studies of interpersonal psychotherapy that represent the only research conducted on therapeutic immediacy using the case study method. Kasper, Hill, and Kivlighan (2008) examined the use of immediacy in a 12-session therapy with Dr. N and client Lily. Immediacy was rated through consensus as to its presence or absence in the therapeutic dialogue by a research team (three female undergraduate students, one female graduate student, and one female professor) and was related to important process variables such as client-rated session depth and strength of the working alliance. However, the client initiated none of the immediacy events in this study; Dr. N initiated 100% of the 33 immediacy events observed during the 12 therapy sessions. Results in this case were mixed, as Lily improved on outcome measures of self-understanding; however, her posttreatment outcome scores were actually higher on global symptomatology and lower on

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Jason Mayotte-Blum, Meaghan Lehmann, Frank Pesale, Nikaya Becker-Matero, and Mark Hilsenroth, Derner Institute of Advanced Psychological Studies, Adelphi University; Jenelle Slavin-Mulford, Massachusetts General Hospital and Harvard Medical School.

Correspondence concerning this article should be addressed to Jason Mayotte-Blum, Hy Weinberg Building, 158 Cambridge Avenue, The Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, NY 11530. E-mail: jasonblum@nyc.rr.com

interpersonal functioning. In a second study, Hill et al. (2008) examined therapeutic immediacy in a 17-session treatment with Dr. W and client Jo. Immediacy was again rated via consensus by a research team (one female professor and four advanced female doctoral students) related to the same process variables as above. Although the therapist again initiated most of the immediacy events (80%), the outcome of the treatment was less ambiguous, as Jo achieved reliable change on global symptomatology and improved interpersonal functioning at posttreatment assessment. The raters identified 56 immediacy events across this 17-session therapy.

Recently, Datillio, Edwards, and Fishman (2010) as well as Stiles (2007, 2009) suggest that case studies can help effectively demonstrate figural aspects of clinical models of change. Datillio et al. (2010) believe that context-dependent factors in therapy are ignored in randomized controlled trials (RCTs) and are best identified through the case study model. They feel that case studies are an integral part of a mixed-methods paradigm toward which psychotherapy process and outcome research must move. Consistent with the present study, Datillio and colleagues (2010) note the usefulness of the *systematic case study* (SCS) that uses both qualitative and quantitative measures. Stiles (2007, 2009) also states that by observing and describing the details of what clients and therapists actually do and say, as well as when they do and say it, case studies can address theories in ways that statistical hypothesis testing cannot. He suggests that a key criterion for selection of a case for qualitative research is a rich collection of information about the client and the treatment. In particular, he advises recordings of the treatment sessions, repeated session-by-session assessments, outcome assessments, and posttreatment interviews. The present investigation fulfills all of these criteria.

Where previous case study research on therapeutic immediacy has examined brief interpersonal psychotherapy, in this study, we expand on existing work by evaluating therapeutic immediacy across a successful long-term psychotherapy that is psychodynamic in orientation. Also different from the two prior case studies on therapeutic immediacy, and of key methodological importance, this investigation began after the completion of treatment. Therefore, both the therapist and client were unaware of the purposes of this study and not susceptible to demand characteristics related to our interest in examining therapeutic immediacy. Furthermore, this treatment was, for all intents and purposes, concluded prior to the first case studies on immediacy being published (Hill et al., 2008; Kasper et al., 2008), making it impossible for the therapist (or client) to have known the treatment would be used to study this construct. In using videotaped sessions, we have access to the most detailed information about the treatment, including nonverbal responses. Also, in the present study we used both standardized process and outcome measures to gain further insight into the therapeutic relationship, as well as the client's progress in treatment. We examined therapeutic immediacy at four different points, corresponding to the collection of process and outcome measures, across a 4-year psychodynamic therapy. Our goals were to address the following questions: In this longer treatment, what would be the frequency of immediacy events observed over the rated sessions? Who would initiate the immediacy? That is, what percentage of immediacy events would be initiated by the therapist and the client? What types of immediacy would be used? How would immediacy interventions be used over the course of treatment to address key areas of clinical focus? In addition, this study is the first in which interrater reliability is evaluated for various aspects of rating therapeutic immediacy.

## Method

### Participants

**Client.** Ann (a pseudonym) was a 25-year-old single White female enrolled in an master's of arts program for Social Work. She originally entered psychotherapy experiencing four acute stressors within the same month: the death of her grandmother, the end of a long-term relationship with a boyfriend, problems in her graduate program, and difficulties with her externship supervisor. The initial four events occurred, in that order, all within 4 weeks, early into her second semester of graduate school. Ann was very close with her grandmother, with whom she described herself as having a "special bond." She ended a 3-year relationship with a boyfriend she found to be emotionally unresponsive. Her graduate work suffered with regard to consistency and quality. Ann also found her externship supervisor (a woman) to be hypercritical and attacking toward her and her work. She was transferred to the therapist in this study after 14 months (46 sessions) of therapy with a graduate trainee who left for her clinical internship. She was then a patient of the therapist in this study for 143 sessions over 4 years.

Ann reported that her first treatment was very useful in helping her through these acute crises, developing better emotional tolerance, transitioning from graduate school, and obtaining her first job in the social work profession. She also made progress in understanding maladaptive patterns of avoiding or expressing her emotions. Furthermore, she had begun to express more compassion and acceptance of herself and her abilities. One significant change came in the form of her belief that "it's okay for me to sit here" and that doing things for herself, such as therapy, was not selfish and did not represent taking resources from those who are in greater need. However, she desired to become even more effective in these areas of functioning, and thus remained interested in continuing treatment and requested transfer to a new therapist when given that opportunity. Although improved, Ann continued to experience family and significant others in her life as generally unsupportive, uncommunicative, and inhibited regarding the expression of emotion. As such, she often experienced stressful events that left her struggling to cope with her emotions within the context of her family, relationships, and work environments. At the outset of treatment with the therapist in this study, Ann was also struggling with restricting her affective expression in the moment, leading to ever increasing tension and stress that would ultimately give rise to impulsive actions within the context of her relationships, particularly when she was feeling sad or lonely.

**Therapist.** Dr. M was a 35-year-old married White male at the beginning of treatment with Ann. He was a licensed and board-certified clinical Ph.D. psychologist with (at that time) 9 years of postdoctoral experience. At the time of treatment, he had completed specific postdoctoral training in Short-Term Dynamic Psychotherapy and Psychoanalysis. He identified his clinical orientation as "Contemporary Psychodynamic," "Relational," "Supportive," "Affect-Focused," and "Integrative" with significant clinical influences, including Wachtel (1993; 2008), McCullough et al. (2003), Strupp and Binder (1984), and Luborsky (1984). His

specific approach within this model of treatment was described as emphasizing the following principles: (a) Be an ally to your client's desire for change; underline even small steps of adaptive progress. (b) Understand defense and resistance as old coping strategies, once useful, now gone awry. (c) Support painful affect and experiences first, explore second. (d) Follow the affect, then help the client to experience (in body), express, and explore its' meaning. (e) Explore how interpersonal and affective themes covered during the session might play out across different relationships, especially in the therapeutic relationship, as well as the client's experience of this in-session process. (f) The interactive present is the most helpful venue for changing cyclical maladaptive patterns. That is, rather than just a place to repeat prior behavior, the therapeutic relationship is often an arena where more adaptive relating is first practiced and then can be explored. This information was obtained during the posttherapy interview and is consistent with Dr. M's description of his focus in his graduate courses on technique, individual, and group supervision.

**Qualitative coding team.** The rating team for this study consisted of four clinical Ph.D. graduate students (two men and two women), all White, and ranging in age from 24 to 29. In terms of biases, all researchers were familiar with the applied clinical research of Dr. M, and two had previous clinical supervision under Dr. M. However, the coding team varied as to their comfort level working in this way. Each of the coding team explicitly discussed their biases and expectations regarding therapeutic immediacy in advance of undertaking the qualitative analyses. To prevent bias, Dr. M was not present or involved during the identification, categorization, and exploration of immediacy events. Two out of the four members had prior experience doing clinical ratings of videotaped sessions. Although there was no formal training period on immediacy rating per se, the qualitative coding group reviewed and discussed the criteria and definition of therapeutic immediacy prior to watching the videotaped sessions. The rating team adhered to the consensual qualitative research (CQR) method (Hill et al., 2005) in several ways: A "set" rating team was present throughout the project; the rating team was composed of four people, which exceeded the criteria of "at least three"; the educational level of the rating team members (all clinical Ph.D. students) was sufficient to critically analyze the topic of study; and team members were all students and, thus, could not claim "expert status" within the group.

## Outcome Measures

The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item self-report inventory that assesses symptom distress across nine domain/problem areas using a Likert-type 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). The BSI provides a Global Severity Index (GSI; Derogatis, 1993) that is an indicator of overall psychological distress reflecting information on both the number and severity of symptoms, calculated by averaging responses across all 53 items. The GSI was used as a measure in the present study of global psychological distress. The mean GSI for an adult, nonpatient sample ($n = 719$) was reported to be 0.30 ($SD = 0.31$) (Derogatis, 1993). In addition, Derogatis (1993) reviews several studies that provide evidence of convergent and criterion validity of this scale with other measures of global psychopathology and psychiatric severity, as well as reports of coefficient alpha for all BSI scales being greater than .70 and an excellent test–retest coefficient for the GSI at .90.

The Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) is a 42-item self-report instrument that measures six major areas of functioning: work as a wage earner, housewife, or student; social and leisure activities; relationship with extended family; marital role as a spouse; parental role; and membership in the family unit. The SAS contains a summary score, the Global Adjustment Score (SASG), which was used in the present study as an outcome indicator of social/occupational functioning. Weissman, Prusoff, Thompson, Harding, and Myers (1978) reported the mean SASG for a community sample ($n = 399$) to be 1.59 ($SD = 0.33$), as well as evidence for validity. In addition, both Weissman et al. (1978) as well as Edwards, Yarvis, Mueller, Zingale, and Wagman (1978) reported convergent validity data with related measures of relationship, social and occupational functioning, as well as report coefficient alpha for overall adjustment at .74, and an excellent test–retest coefficient of .80.

The Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) is a 64-item inventory of distressing interpersonal behaviors the respondent identifies as "hard to do" (i.e., behavioral inhibitions) or "does too much" (i.e., behavioral excesses) on a 5-point Likert-type scale ranging from 0 (*not at all*) to 4 (*extremely*). The IIP contains a Total Score (IIP-TOT), which was used in the present study as an outcome indicator of interpersonal functioning. Regarding IIP-TOT, Horowitz et al. (1988) reported an internal consistency of .87, test–retest reliability of .78, a coefficient alpha of .96 in an 800 nonpatient sample ($M = 51.5$, $SD = 34.3$), and ample examples of validity. Horowitz, Alden, Wiggins, and Pincus (2000) reviewed several studies that provide evidence of construct, convergent, and criterion validity of this scale with other measures of interpersonal functioning, relationship dysfunction, and attachment style, as well as reports of coefficient alpha for all IIP scales being greater than .75, and an excellent test–retest coefficient for the IIP-TOT of .79.

## Process Measures

The Session Evaluation Questionnaire–Depth Scale (SEQ-D; Stiles & Snow, 1984) is a five-item, bipolar, adjective-anchored, self-report measure designed to evaluate client and therapist perceptions of the quality of sessions. The SEQ Scale is made up of ratings on the dimensions of powerful/weak, valuable/worthless, deep/shallow, full/empty, and special/ordinary. In addition, previous research has found a coefficient alpha of .86 for the Depth Scale in a sample of clients from the same university-based clinic as the client in this study (Ackerman, Hilsenroth, Baity, & Blagys, 2000). Stiles et al. (1994) reported significant correlations with measures of understanding, problem solving, and relationship, providing evidence of concurrent validity. Good internal consistency has been reported (coefficient alpha = .91, Stiles & Snow, 1984; Stiles et al., 1994).

The Combined Alliance Short Form-Patient Version (CASF-P; Hatcher & Barends, 1996) is a client-rated alliance measure created from a factor analysis of the responses from 231 outpatients at a university-based community clinic from three widely used measures of alliance: (a) the Penn Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986), (b) the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986), and (c) the Cali-

fornia Psychotherapy Alliance Scales (CALPAS; Gaston, 1991). The CASF-P consists of 20 items rated on a 7-point scale consisting of 1 (*never*), 2 (*rarely*), 3 (*occasionally*), 4 (*sometimes*), 5 (*often*), 6 (*very often*), and 7 (*always*). Hatcher and colleagues (Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfreund, 1995) report initial evidence on both the construct and incremental validity of this scale with regard to outcome. In addition, both Ackerman et al. (2000) and Clemence, Hilsenroth, Ackerman, Strassle, and Handler (2005) reported convergent validity data with related measures of psychotherapy process as well as criterion validity with regard to the prediction of treatment outcome using a sample of clients at the same university-based clinic as the client in the present study, as well as a coefficient alpha of .91.

## Procedure

Both the definition of therapeutic immediacy and procedures of this investigation followed those described in Hill et al. (2008) as well as Kasper et al. (2008; Kuutmann & Hilsenroth, 2011; see also CQR; Hill et al., 2005; Hill, Thompson, & Williams, 1997), so as to best replicate and extend this previous research. A treatment with an experienced therapist was chosen to illustrate clearly how immediacy was used at certain points during the treatment to address important clinical issues. Given the video archive of this treatment as well as Dr. M's model for therapeutic change, which values the in-session processing of the therapeutic relationship, we believed this would provide a useful vehicle to examine the nature of therapeutic immediacy within a successful long-term psychodynamic psychotherapy (LTPP).

**Sessions.** All sessions from Ann's treatment were videotaped and conducted at a university-based clinic. The microprocess of 16 sessions across 4 years of treatment were closely examined, the first four sessions, the last four sessions, and then four sessions at the 1-year and 3-year mark corresponding to the collection of process and outcome measures. Prior to treatment, the client signed a consent form to participate in psychotherapy process and outcome research and completed the outcome measures (BSI, IIP, SAS) before her first session with Dr. M. She also completed these measures at the 1-year mark, 3-year mark, at the end of treatment (fourth year), and at an 18-month follow-up session to ascertain the stability of her improvement after treatment had been completed. Process measures (CASF-P, SEQ) were completed 1 month into treatment with Dr. M, and then again concurrent with the outcome measures at 1 year, 3 years, and at the end of treatment (fourth year). Ann was informed both verbally and in writing on the top of these forms that her therapist would not see any of her responses to these process measures. At the end of treatment, Ann completed an exit interview with an independent clinician regarding different aspects of her experiences during the therapy. In addition, at that time she also provided informed consent to be contacted regarding treatment follow-up and specifically to use material from her treatment in a case study format.

**Transcription.** Sessions were transcribed verbatim by two graduate research assistants and checked for accuracy by members of the coding team.

**Qualitative rating process.** Sixteen sessions in all were rated (the first four, the last four, and two sets of four sessions at the 1-year and 3-year mark in treatment corresponding to the collection of process and outcome measures) by four judges who had read and then, as a group, discussed the definition of therapeutic immediacy used for this study (Hill et al., 2008; Kasper et al., 2008; Kuutmann & Hilsenroth, 2011), prior to coding any of the videotaped sessions. In this part of the qualitative rating process, the qualitative rating procedure used by Kasper et al. (2008) and Hill et al. (2008) was replicated so as to compare and contrast the present findings with those of the two previous case studies. First, all sessions were watched by the rating team while concurrently reading the transcript of the session. The session videotape was stopped whenever someone on the rating team believed an *immediacy event* had occurred (broadly defined as any discussion about the therapy relationship). Next, this segment of the session was reviewed by the team and coded as an "immediacy event" only if three out of four raters agreed that it fit the definition of therapeutic immediacy. To reduce pressure for agreement on ratings of presence/absence of immediacy, raters simply indicated "yes" (segment is an immediacy event) or "no" (segment is not an immediacy event). No discussion about the event took place unless three out of four raters had indicated "yes," indicating the segment met rating criteria for an immediacy event. Then, the transcript of the immediacy event was reviewed and discussed in relation to four questions until consensus was reached: (a) Who initiated the immediacy? (b) What type of immediacy was it? (c) What were the effects of immediacy? and (d) Why was the immediacy event used? All immediacy events were initially identified, categorized, and discussed in this manner. During this process, the rating team created a list of preliminary categories that broadly reflected the ways immediacy was being used in these different clinical events (i.e., "client expresses gratitude"). Two lists of categories were developed, one for the therapist-initiated immediacy events and the other for the client-initiated immediacy events.

The procedures used here of answering questions (a) through (d) by consensus as well as using "core ideas" to build our immediacy categories dovetails nicely with the recommendations of the CQR method (Hill et al., 2005) in addition to replicating the methodological design of the two previous case studies on immediacy (Hill et al., 2008; Kasper et al., 2008). After observing all 16 videotaped sessions and coming to consensus on the information described above, a second review of the transcripts for all immediacy events was conducted.

At this time, each member of the rating team independently coded verbatim transcripts of each immediacy event on its overall affective depth/intensity using a 5-point scale: 1 =*Mundane, one-sided exchange*, 2 =*Minimal two-person exchange*, 3 =*Longer two-person exchange, limited affective depth*, 4 = *Prolonged two-person exchange, moderate affective depth*, and 5 =*Prolonged exchange with both participants actively expressing substantial affective depth and immediate feelings*. The procedure for this portion of the qualitative rating process differed from the prior two case studies on immediacy (Hill et al., 2008; Kasper et al., 2008) in that depth/intensity was rated independently by our team members in order to extend the literature on immediacy by providing reliability data for the depth/intensity immediacy scores.

Next, the team reviewed the client/therapist immediacy categories, collapsing those that occurred infrequently into broader categories, which produced a final list of immediacy categories for both client and therapist. After, the rating team again reexamined all 106 immediacy events and attempted to determine by consen-

sus which one category best answered the question: Which immediacy category (for both client and therapist) best captured how immediacy functioned clinically during the event? During this review of the clinical data, the rating team felt strongly that often there were two categories needed to best capture the salient aspects of immediacy. Thus, each event was assigned a "primary" category corresponding to the most important function of immediacy, and some events were given a "secondary" category reflecting not only a different but also a relevant use of immediacy. This procedure resulted in up to two therapist and two client immediacy categories recorded for each immediacy segment, with one identified as a primary and another as a secondary category, although not every immediacy segment was given a secondary category. These categories were assigned by the qualitative rating team without consultation with or input from Dr. M so as to minimize rater bias.

Last, after analyzing all process and outcome data from the sessions, members of the rating team independently conducted ratings of the most "clinically relevant/meaningful" immediacy segments out of the 106 total events identified. All events from which excerpts were selected for inclusion in this article earned average depth/intensity ratings of 4.5 or 5 (indicating a prolonged interaction with at least moderate affective depth). Later in the paper, excerpts and content analysis of five of these events are presented to illustrate key clinical interactions.

## Results

### Outcome Data

Although our findings demonstrate a substantial focus on therapeutic immediacy by both Dr. M and Ann throughout their work together, one might reasonably wonder whether the focus on immediacy had any relevance to the clinical process or outcomes of her treatment. In other words, if Ann failed to demonstrate any significant process or outcome results, then discussion of what techniques were used might be considered largely irrelevant.

As we can see in Table 1, Ann began her treatment with Dr. M at two standard deviations above the norm on both the GSI (overall pathology) of the BSI and on her IIP-TOT, indicating her scores were higher than those found in 97% of the normative sample. By the end of treatment, her scores moved well into the normative range of functioning, which represents an overall change of close to three standard deviations in overall symptomatology and interpersonal functioning. In overall social and occupational functioning, as evaluated by the SAS global score, Ann made clinically significant change by the end of treatment. These positive changes continued beyond the conclusion of treatment when assessed at 18 months posttreatment. When contacted 3 years posttreatment, at the time of final manuscript proofs, Ann reported continued professional success and advancement, an enduring 2-year romantic relationship, engaged to be married, and expecting the birth of her first child within the next few months. This indicates that treatment with Dr. M produced stable changes in Ann's functioning that were in evidence well beyond the end of therapy. Although these results are indicators of a successful treatment, we have no data to directly associate therapeutic immediacy with these changes on the outcome measures. Instead, one goal of this study was to provide examples of how therapeutic immediacy was used in a successful long-term dynamic treatment.

### Process Data

Regarding session process, Ann rated her alliance with Dr. M very positively, over 6 (i.e., *very often*) on a 7-point scale, from the beginning of their work together through the end of treatment. In addition, Ann rated her sessions as possessing a high level of "depth" on the SEQ, that is, the extent to which she considered the session process to be "powerful," "valuable," "deep," "full," and "special," with scores of over 5 and 6 on a 7-point scale (see Table 1). As a point of reference, recent clinical data from a variety of theoretical orientations on both of these measures indicate mean scores of 4.75–5 with standard deviations of 0.5–0.75 (see Hill et al., 2008; Kaspar et al., 2008; Muran et al., 2009), so Ann's ratings were generally well above average at most points of measurement.

### Who Initiated the Immediacy?

Dr. M was an involved collaborator in the therapy, averaging approximately 26% (44,539) of the words spoken during the 16 sessions (171,568 total words), whereas Ann spoke the remaining 74% (127,029 words) of the time. Of all the words spoken across the 16 sessions sampled, 25% (43,546) were rated as immediacy. For the immediacy segments, 61% (26,773) of the words were spoken by Ann, and 39% (16,773) of the words were spoken by Dr. M. Additionally, 21% of all client words spoken used imme-

Table 1
*Ann's Process and Outcome Scores Across Treatment With Dr. M*

| Outcome measure | Pre-tx (at transfer) | Year 1 | Year 3 | Year 4 (end of tx) | 18-month follow-up |
|---|---|---|---|---|---|
| BSI-GSI | T 71 | T 60cs | T 53cs | T 43cs | T 42cs |
| IIP | T 73 | T 52cs | T 50cs | T 39cs | T 46cs |
| SAS | 2.85 | 2.38 | 2.30rc | 1.85cs | 1.69cs |
| Process measure | Early session (1 month) | | | | |
| Pt-Alliance (1–7) | 6.20 | 6.25 | 6.35 | 6.10 | |
| Pt-Session Depth (1–7) | 5.20 | 6.0 | 5.6 | 6.20 | |

*Note*. T = standardized T scores; T 50 is the nonclinical mean, and one standard deviation unit, positive or negative, is equivalent to 10 T score points. Pre-tx = pre-treatment; BSI = Brief Symptom Inventory; GSI = Global Severity Index; IIP = Inventory of Interpersonal Problems; SAS = Social Adjustment Scale; Pt = Patient; cs = clinically significant change (rc + movement into normal distribution); rc = reliable change (adjusted for measurement error and regression to the mean).

diacy, whereas 38% of the total words spoken by Dr. M used immediacy.

The raters were in unanimous agreement about the presence of immediacy 78% of the time (ICC = .63). That is, all four raters agreed, without discussion or input from the other raters that a session segment fit the definition of an immediacy event 78% of the time. This agreement revealed 106 immediacy events across all 16 sessions ($M$ = 6.63, $SD$ = 1.2), with Dr. M initiating 53 immediacy events ($M$ = 3.31, $SD$ = 1.9), and Ann initiating 53 immediacy events ($M$ = 3.31, $SD$ = 2.3).

## What Types of Immediacy Were Used?

Categories of therapist and client immediacy are shown in Tables 2 and 3, along with the raw frequency and percentage of the time that it occurred as a primary or secondary category (recall that we selected one primary category that best fit the immediacy segment and a secondary category that was also prominent if applicable), as well as the amount the category occurred in total. This process resulted in 17 categories of therapist immediacy behaviors (see Table 3) and 18 categories of client immediacy behaviors (see Table 3). Again, the rating team members discussed each of the category decisions until consensus was reached.

## Independent Depth/Intensity Ratings

Independent ratings of immediacy affective depth/intensity by the rating group were found to demonstrate excellent levels of interrater reliability (ICC = .92). The average depth/intensity of 106 immediacy events was 3.2 ($SD$ = 1.2) on the 5-point Depth/Intensity scale. This indicates that an engaged dialogue regarding the therapeutic interaction with at least some affective involvement was commonplace. This level of depth/intensity was slightly higher for the 53 immediacy events initiated by Dr. M ($M$ = 3.4, $SD$ = 1.1) than the 53 immediacy events initiated by Ann ($M$ = 3.00, $SD$ = 1.3)—although, both participants regularly initiated immediacy events that were beyond mundane, minimal, or simplistic with regard to level of engagement and affective depth. To provide a point of comparison for our depth/intensity ratings of immediacy events, of the 56 total immediacy events from the brief interpersonal therapy examined in Hill et al. (2008), the average depth/intensity reported for Dr. W and Jo was 2.18 ($SD$ = 0.87), a full point below the present findings.

## Selection of Immediacy Segments for Analysis

The coding team then conducted independent ratings of the most "clinically relevant/meaningful" of the 106 immediacy segments. This resulted in the identification of 11 separate segments from eight different sessions. Four of these segments were independently identified by three of the four raters and seven segments independently identified by two out of the four raters. All of these immediacy segments had an overall Depth/Intensity scale rating between 4.5 and 5. In analyses of these events, the team identified the context, the effects of the events, and conceptualized how immediacy functioned with respect to the different categories assigned, again using consensus for all judgments. Finally, only after these previously described steps, the team discussed these most "clinically relevant/meaningful" immediacy segments with the therapist. The purpose of the involvement of the therapist at this stage was to gain insight into his use of immediacy and the impact of immediacy on the treatment, as well as his perception of the client's response to immediacy. The therapist's involvement at this point in the study replicates previous research (Hill et al., 2008; Kasper et al., 2008). To follow are excerpts and our in-depth analyses of five of these most clinically relevant/meaningful events during the therapy to provide actual clinical examples of the use of therapeutic immediacy.

Table 2
*Categories of Therapist Immediacy Events*

| | Primary | | Secondary | | Total | |
|---|---|---|---|---|---|---|
| Category | Freq. | Freq.% | Freq. | Freq.% | Freq. | Freq.% |
| 1. Comparing therapeutic relationship to past therapeutic relationship | 0 | 0% | 1 | 1% | 1 | 1% |
| 2. Introducing an alternative viewpoint of events in the relationship | 8 | 8% | 8 | 8% | 16 | 15% |
| 3. Exploration of client's fears and concerns about the therapy relationship | 4 | 4% | 0 | 0% | 4 | 4% |
| 4. Affirming/validating/supporting client's feelings about the relationship | 9 | 9% | 5 | 5% | 14 | 15% |
| 5. Clarifying intentions | 0 | 0% | 1 | 1% | 1 | 1% |
| 6. Exploration of client's fantasies about the therapist | 5 | 5% | 6 | 6% | 11 | 10% |
| 7. Clarifying role expectations | 2 | 2% | 4 | 4% | 6 | 6% |
| 8. Clarifying needs/desires in the relationship | 0 | 0% | 1 | 1% | 1 | 1% |
| 9. Comparison of therapist/client relationships to outside relationships | 3 | 3% | 1 | 1% | 4 | 4% |
| 10. Therapist provides client with information and facts about treatment | 2 | 2% | 1 | 1% | 3 | 3% |
| 11. Therapist expresses gratitude | 5 | 5% | 3 | 3% | 8 | 8% |
| 12. Clarifying therapeutic frame | 5 | 5% | 1 | 1% | 6 | 6% |
| 13. Using the relationship to highlight progress in treatment | 3 | 3% | 2 | 2% | 5 | 5% |
| 14. Therapist comments on his experience of the client | 16 | 15% | 7 | 7% | 23 | 23% |
| 15. Exploration of the evolution of the therapist–client relationship | 6 | 6% | 2 | 2% | 8 | 8% |
| 16. Therapist acknowledges his contribution to therapeutic interaction | 13 | 13% | 9 | 9% | 22 | 21% |
| 17. Therapist directing client toward her immediate affective experience | 10 | 9% | 5 | 5% | 15 | 14% |

*Note*. Freq. = Frequency.

Table 3
*Categories of Client Immediacy Events*

| Category | Primary | | Secondary | | Total | |
|---|---|---|---|---|---|---|
| | Freq. | Freq.% | Freq. | Freq.% | Freq. | Freq.% |
| 1. Comparing therapeutic relationship to past therapeutic relationship | 4 | 4% | 0 | 0% | 4 | 4% |
| 2. Introducing an alternative viewpoint of events in the relationship | 4 | 4% | 5 | 5% | 9 | 9% |
| 3. Exploration of client's fears and concerns about the therapy relationship | 6 | 6% | 2 | 2% | 8 | 8% |
| 4. Client exploration of affect as a consequence of the therapeutic relationship | 14 | 13% | 4 | 4% | 18 | 17% |
| 5. Clarifying intentions | 1 | 1% | 0 | 0% | 1 | 1% |
| 6. Exploration of client's fantasies about the therapist | 4 | 4% | 4 | 4% | 8 | 8% |
| 7. Clarifying role expectations | 0 | 0% | 2 | 2% | 2 | 2% |
| 8. Clarifying needs/desires in the relationship | 11 | 10% | 4 | 4% | 15 | 14% |
| 9. Client stating feelings about the therapeutic relationship | 9 | 9% | 4 | 4% | 13 | 12% |
| 10. Comparison of therapist–client relationship to outside relationships | 2 | 2% | 5 | 5% | 7 | 7% |
| 11. Client stating thoughts or ideas about the therapy | 7 | 7% | 8 | 8% | 15 | 14% |
| 12. Clarifying therapeutic frame | 3 | 3% | 1 | 1% | 4 | 4% |
| 13. Client examines her behavioral reaction | 8 | 8% | 5 | 5% | 13 | 12% |
| 14. Using the relationship to highlight progress in treatment | 7 | 7% | 3 | 3% | 10 | 9% |
| 15. Client comments on therapist behavior | 9 | 9% | 10 | 9% | 19 | 18% |
| 16. Exploration of the evolution of the therapist–client relationship | 6 | 6% | 1 | 1% | 7 | 7% |
| 17. Client expresses gratitude for therapist | 5 | 5% | 5 | 5% | 10 | 9% |
| 18. Client evaluates therapist | 2 | 2% | 3 | 3% | 5 | 5% |

*Note*. Freq. = Frequency.

## Event 1: Session 1; "You're a Guy"

At the end of treatment, both Ann and Dr. M independently identified their first session as one of the most significant and important moments of the entire treatment process. Five minutes into the first session, Ann stated, "And I think, like, one of the big challenges about this is working with a guy." To which Dr. M responded, "That is something . . . what about that?" Each believed that Ann's ability to initiate discussion regarding the challenges of working with a male therapist and the subsequent engagement on and exploration of this issue by both parties for much of the first session set the tone for their work to come. In fact, a quantitative analysis of the session immediacy content revealed that 70% of the first session (44/62 min) was spent discussing and processing aspects of the here-and-now therapeutic relationship. In addition, the manner in which this discussion occurred provided an important metamessage to Ann that she could directly talk about her concerns, fears, and emotions with a man who encouraged and welcomed this discussion, thus providing an important template for adaptive relational functioning. We believe this immediacy segment from the second half of the first session best illustrates the nature of this interaction as well as identifies key material that became an enduring focus over Ann's treatment.

P: I guess I just keep having to say . . . you're a guy . . . well I don't have to keep saying it but . . .

T: (Smiling) You can say it as many times as you want . . .

P: (Laughs) You've been that way your whole life, you know . . . (pulls out Kleenex)

T: That's ok. And you know, actually, it communicates more than just my sex . . . it seems like it means something more to you . . . what do you think that would be, the meaning when you say, "you're a guy" . . . what also is included in that?

P: I just don't want it to be something that . . . I'm . . . I'm shocked with myself right now even sitting here and having this conversation, I must say (laughs) . . . because I just don't want it to get in the way.

T: But you know what, though? I don't know that you talking about these things and you having these experiences are "getting in the way" . . . if they're a natural reaction you're having . . . based on lots of reasonable experiences from your past . . . it makes sense that you'd be having those things . . . it makes sense that there would be something self-protective in that . . . and I'm not saying that's a bad thing or we should push that aside . . . but maybe that isn't "getting in the way," maybe that's getting to the heart of the matter . . .

P: I agree . . . that's why I think I'm putting it out there . . . seriously (laughs) . . . when I say "get in the way" the fact that I wouldn't say that . . . and that's why I'm shocked because that's normally something I would kind of keep back there (gestures to back of her head).

T: So, you're expressing some hopefulness . . . and . . . what would you term you sharing these things with me that's shocking you . . .

P: It could either be really stupid (laughs) . . . or it will hopefully accomplish whatever my "bigger thought" is . . .

T: So what's another way to say that . . . it will either be really stupid or really . . . what?

P: Vulnerable, I don't know.

T: Actually, you know what I was thinking . . . "or really brave" . . . after you said really stupid . . . "it could be really brave" . . . how would you know the difference? Maybe not right now, but somewhere down the road . . . how would you be able to evaluate if today you were really stupid or really brave?

P: You never see me again . . . (laughs) I would definitely feel really stupid . . .

T: How will we know if you're really brave?

P: I think it is. You know what, if you put it in that way I guess it is really brave . . . the stupid part would have been to not saying anything . . . sitting there with it in the back of my mind knowing . . . well, here's my angle . . . and I'm not telling you.

T: But you know, I sort of think that brave and hope; they sort of go together . . . I think if you have hope then it allows you to be brave.

### Clinical Applications of Immediacy

The rating group identified Dr. M's support and validation of Ann's feelings and concerns about their relationship (Therapist Category 4) as the most important element of his contribution to this exchange. In response, Ann explored her fears and concerns in the therapy relationship (Patient. Category 3). In the segment, Dr. M supports Ann's efforts to disrupt a maladaptive interpersonal pattern in reframing her feelings of "stupidity" about her openness as evidence of her bravery and hope. He identifies Ann's courage in speaking about things she would ordinarily keep to herself so early in treatment. The rating group believed this segment was critical in the early alliance-building process between Ann and Dr. M. In contrast to other important people in her life, whom Ann identifies as critical and unsupportive, Dr. M supports her experience and helps her to explore it in new ways. Ann has had prior experiences with men who engaged with her in order to fulfill their own agendas instead of forming a mutual relationship that took her needs into account. Dr. M normalizes her expectations that he would begin a relationship with her in the same way, but he also reframes these beliefs by focusing on her experience and planting the seed of hope for the future. The raters saw this as the beginning of a "corrective emotional experience" that was to continue throughout the treatment, in which Ann learned that there are men who are trustworthy and with whom she could be vulnerable.

### Event 2: Session 2; "A privilege"

As we saw in the first session, an exploration of the therapeutic relationship was figural as were Ann's issues regarding trust and vulnerability. In addition, Dr. M. observed that her forthright discussion of these issues with him also had adaptive qualities of hope and courage that were less apparent to Ann. We see these themes were continued in the second session with a deepening of Ann's emotional vulnerability in regard to Dr. M and his use of the therapeutic relationship to affirm and support that greater emotional awareness and expression.

P: That's why I'm still sitting here . . . with a guy! Are you still aware, of being a guy?

T: And, despite your desire not to, I mean, you cried a lot today. And that's a really, I suspect an important thing of letting those emotions out . . .

P: Definitely. I only got to cry a little bit, when I was talking to my mother (pulls out Kleenex) . . . I didn't even cry. She was far enough away that I don't think she even saw me shed a tear.

T: Then I feel privileged that you saved it to share with me . . .

P: Thanks. I didn't have a choice . . . stupid eyes kept running . . . (wipes eyes, blows nose)

T: No, I think you did have a choice . . . that's what we spoke about last week.

P: I choose not to hold it back.

T: Well, thank you. Like I said, that's a privilege.

P: Is it really a privilege to have somebody sitting here in front of you crying?

T: As opposed to . . . avoiding crying, avoiding the thoughts and feelings and discussion of that . . . yes, I think it is . . .

P: In that manner, allright . . . in that context . . .

T: What this communicates to me, is that, like we've talked about, trust comes over time . . . but there's something in you, like we talked about last week, about hopefulness, and being brave and wanting change, and feeling supported enough.

### Clinical Applications of Immediacy

The rating group felt the most important therapist immediacy intervention in this segment was Dr. M's expressing gratitude (Therapist Category 11) for Ann's willingness to be vulnerable with him. Ann then explores her affect as a consequence of the therapeutic relationship (Patient Category 4) in response. Dr. M's expression of gratitude may have helped Ann to question a working assumption that expressing her feelings in a relationship is somehow off-putting. In addition, in contrast to her mother, with whom Ann restricts her crying, Dr. M creates an environment where crying is appreciated. The rating group felt that Dr. M's expression of gratitude in this segment strengthened the working alliance and served as a critical factor in helping Ann to question a long-standing maladaptive interpersonal pattern of restricting her emotional expression. Dr. M's willingness to be vulnerable early in the treatment had two effects: (a) It served to model a healthy interpersonal pattern and (b) caused Ann to further question her assumption that expressing emotions was something to be avoided. Also, Dr. M highlights Ann's ability to choose an active role in the therapy as opposed to being a passive participant, which likely builds self-esteem and a sense of agency in the relationship.

### Event 3: Year 1;"Teach Me!"

In our postrating interview with Dr. M, when reviewing this segment, he stated that he is rarely moved to tears in a session, perhaps once or twice during the course of a given treatment, if at all. However, he was also quick to add that he believes when a therapist is genuinely, authentically, and deeply moved in such a manner it may be detrimental to uncharacteristically restrict or hide such a response. We believe the following segment at the end of the first year of treatment involves therapeutic immediacy in what may be described in theoretical terms as a corrective emotional experience. Ann has just finished describing a very intense (i.e., sobbing deeply throughout) relational episode with her mother that was characterized by significant neglect. When Ann attempted to express her feelings to her mother, she was met with a vicious verbal attack.

T: So, me tearing up about that as you were crying about it . . .

P: It's comforting.

T: Comforting. In what way . . .

P: Cause it's sad. It's just sad. There's no, there's no, I don't know . . . I guess because sadness is hard for me . . . sadness is so hard for me that I'm like, ok, somebody's sad with me. I'm not on my own going, "Oh my God" . . . I'm always sad by myself so that's something that I'm used to . . . I guess more different this time, so this is different. (pulls out Kleenex)

T: Well, thanks, I appreciate that . . .

P: I'm like, you're making me cry now (crying) . . . because . . . (said in a very soft tone) . . . you're sad with me . . .

T: What's sad about this . . .

P: No, it's just . . . being joined and not just sitting here like . . . I'm having conversations with my Mom, and I'm sitting there crying, and she looks at me like stone cold, and you see her eyes getting red, and I know I do it . . . and you know, it's just . . . (Large gesture) let that fucking emotion out! (said very loud!) Teach me! Teach me!

T: So you feel like something's going on . . .

P: You know what, cause it doesn't make it seem like it's a weakness . . . I guess that's kind of what it is. Cause in my family, it's still such a weak thing to do. (Softly) Such a weak thing to do.

T: So when I sit here and cry with you . . .

P: It reassures me that it's ok. That's really important, though, that is. Because I struggle so much with not being able to do that . . .

T: I know, but look at where you are and what you've done.

P: A crying mess . . .

T: No, no, you're feeling in important ways . . . you really are.

## Clinical Applications of Immediacy

The rating group identified Dr. M's acknowledgement of his contribution to the therapeutic interaction (Therapist Category 16) in discussing his sadness openly as the most powerful therapeutic agent in this segment. This acknowledgement of his emotional experience appears to be a critical aspect of therapeutic immediacy that sets the stage for Ann to further explore her own emotions and judgments about them. In response, Ann expresses gratitude for Dr. M's (Patient Category 17) willingness to "be sad with her," which contradicts her belief, learned in her family, that sadness is weakness. In addition, she is provided with the experience of a man who embraces his emotions, vulnerability and humanity, which may help to create hope for different experiences with men going forward. The rating team felt that this interaction also was important in that the therapist offered an alternative viewpoint of events in the relationship (Therapist Category 2), namely, her sadness as "feeling in important ways" as opposed to her being "a crying mess," and thus garnered a secondary rating.

## Event 4: Year 3: "I'm Frustrated"

During the second year of therapy, Ann passed her Licensed Master's Social Worker exam and soon afterward obtained a significant promotion to an administrative leadership position at an inpatient facility within the agency that she had worked during the last 2 years. This success in her occupational endeavors mirrors the outcome changes observed across the various standardized measures—although with this newfound occupational success came other challenges. In her new position, Ann often had to be available to troubleshoot crises or emerging client situations within this agency, and thus her attendance in therapy became less consistent. Although Ann would never no-show for a session, what would generally occur is her calling Dr. M, 3–4 hr before their appointment, and relating that she was "in the weeds" dealing with a situation that would preclude her from attending that day. Sometimes they would be able to reschedule, but more often that week would be missed. This occurred for the first 6 months after she took this position, and discussion of this issue provided the focus of the session prior to the current segment to be reviewed. That is, the current vignette is from a session after another cancellation, after a session in which their inconsistent meeting had been discussed. Although there were several rupture and repair sequences across the sessions rated for immediacy, we thought this segment from a session in the third year of treatment stood out as the best illustration of the use of immediacy in a therapeutic interaction during the rupture and repair process. We would also note the similarity between the current interaction and the rupture-repair model of Safran and Muran (2000).

P: (As sitting) So, you didn't call me back . . . are you mad at me?

T: Ah, I am a little frustrated . . .

P: I'm like, don't be. I seriously didn't want . . . There was nothing I could do. I'm like "God damn him!"

T: I'm frustrated that it seems like we aren't meeting in a consistent way. It doesn't mean that I'm angry with you, it means that this is something we've talked about . . . it seems like, we meet for a week, we don't meet for a week . . . and it's just, it's frustrating. I'm not going to lie to you . . .

P: I thought so, that's why I was bringing it up.

T: What's it like to hear me say that I was frustrated?

P: I understand that. It's not . . . it's not . . . if I was in your shoes, I probably would feel the same way, and I can only express it and then call it a day . . .

T: Ok, I like that though (smiles) . . . let's say you were in my shoes?

P: If I were in your shoes . . . I would say what you said . . . I probably would have brought it up quicker than I brought it up . . .

T: So if you were in my shoes, you would have brought it up before you sat down . . .

P: Well, I would have brought it up if the person sitting next to me didn't bring it up right away . . . and that would be the first thing I would have to think about . . .

T: Don't you think if you hadn't brought it up that I was going to bring it up?

P: 100 percent. Just didn't know if it was going to be at the beginning or end of the session. But I didn't want to wait until the end because then I'd be thinking about it the whole entire time.

T: Yeah, me either . . .

P: I think I would have a lot stronger feelings if you didn't say anything cause then I'd be like . . . what am I coming here for?

T: So us coming in here and right away getting into this . . .

P: Even more when you brought it up the first time . . . so, I have faith that if something is going on, and again, it could be something else that I'm doing I don't recognize . . .

T: And I think you're absolutely right too, in the sense that generally what I do is to call you back. And I owe you an apology for letting my frustration get in the way of what I would normally do. I guess one reason why I didn't do that is I think it would be better to have this "frustration conversation" in person than over the phone . . .

P: I agree. I agree. And you know, it's funny. I think maybe once or twice you didn't call me, but not really. You don't ever really do that.

T: You're right. Generally, whether I can find a time or not . . .

P: There's been times when you don't, but when I didn't hear from you . . . but I appreciate you saying that and going back to the first time you ever brought it up. That I appreciate. I'm like, good, yes, thank you. I guess it's a part of, well, you do actually pay attention. Not that I think you don't.

T: And what does it communicate that I am paying attention to . . .

P: That you care.

Later in this session, after this rupture and repair segment had been processed, Dr. M and Ann were able to more deeply and fully explore Ann's feelings about a miscarriage she had 6 months prior to the session. Also explored were her concerns regarding the increasing emotional withdrawal of her boyfriend (and father of this miscarried child); a relationship she would end a few months later.

## Clinical Applications of Immediacy

The rating team felt that Dr. M's apology to Ann for not returning her phone call stood out as the best example of a Therapist Category 16 ("Therapist acknowledges his contribution to therapeutic interaction") during the treatment. In response, Ann stated her feelings about the therapeutic relationship (Patient Category 9), especially that of feeling cared for and of being attended to. After this exchange, as noted above, Ann discussed her feelings about a recent miscarriage, a topic that she had been avoiding. The rating team was impressed by the shift that occurred during this session from Dr. M's focus on his frustration with what he perceived as Ann's lack of consistency in the therapy, to his accepting responsibility for not returning her phone call. In our minds, this provided Ann with an experience of having influence over the emotions of someone with whom she is in a relationship. Perhaps more importantly, she sees that Dr. M is willing to take responsibility for his mistakes, apologize, and focus on the repair of the relationship. This leads to Ann feeling that he pays attention to her and does not let his emotional experience crowd out her own. Ann stated previously that her mother does not take responsibility for her behavior, making Dr. M's apology a different and possibly reparative experience for Ann.

## Event 5: Termination; "They're 'Expressing Myself' Tears"

In the fourth year of treatment, after overlapping vacations led to a 4-week hiatus in therapy, Ann broached the topic of termination. First, she spoke with a good deal of self-efficacy regarding how well she had handled several potentially problematic situations and interactions during this time. She then wondered aloud what it would be like to not be in therapy any longer: did she "need" it and how well would she do without it? Dr. M approached this discussion with encouragement, support, and exploration. After agreeing to think more about the possibility of termination over the course of the week, Ann arrived at her next session having made the decision that she would like to begin the termination process and "give it a try without therapy." At that time, Ann and Dr. M contracted for a 2 ½-month period to focus on the termination process and set the date for their final session.

We found this immediacy segment near the end of her next-to-last session to be a particularly good example of how processing the therapeutic relationship is an important part of the termination process. In addition, during the final session, Ann identified this specific interaction as being particularly significant and powerful for her and her feelings about moving forward after therapy. In this segment, Ann has just finished relating several discussions she has had with friends and coworkers who have also been in psychotherapy with regard to getting her therapist a good-bye gift, and what to do in a crisis after the termination of the therapy.

T: Is that a question you want to ask me?

P: Well, no cause I'm just not that person, that's like, oh let me get gifts for somebody. And I don't think I need to because the gift would be hopefully, you know, the work that we've done . . .

T: Well, I think you're asking two questions, so let me respond to them. First, I think you've given me a very wonderful gift that's honored me every day that you've come in here . . .

P: Don't make me upset! (starts to tear up)

T: Well, it's, it's very emotional . . . and I'm not going to run from that either (tearing up)

P: No, it is.

T: I think that you've given a wonderful gift to me, but as important, to yourself. And I think that's the most important gift you could ever give, what you've given in this process over the time we've known each other. It's been a gift to me. . .it's been an honor, and it's been a gift to you to, yourself, to show yourself how worthwhile you are. As far as the future goes, I guess, this is how I look at those things and that is, once I'm your therapist, I'm always your therapist . . .

P: Mm-hmm. Mm-hmm. (crying)

T: I want you to feel that the door's always open to you.

P: That's good.

T: Sometimes I work with people and I don't hear from them for forever, and sometimes something comes up in their life and they want to give me a call and they want to come in for a few sessions, or sometimes they want to come in for more, longer than a few sessions, but that's okay. The door is always open to you. I hope that all the hopefulness you have, it all comes back to you and things work out wonderfully, and that you'll remember us in a good way and that it'll be helpful to you . . . that's what I hope . . . but bad things can happen, and circumstances can happen, and I always want you to know that you can call me. I guess, we don't know what's going to happen in the future, but I want you to know that I'll be here for you, as long as I'm here.

P: This is what I anticipated with you. One, you didn't disappoint me, and two, I didn't think you were ever going to abandon me. . .

T: How did you hear what I just said?

P: I guess that's what I expected from you . . . this has been a very emotional thing, a *very* emotional thing. I have done my random little cries here just even in the past couple weeks . . . and you know like, "Fuck, is this a good idea with Dr. M?" But you know, I'm not going to know until, I mean I'm going through this process, and I'm saying goodbye, and just even hearing you say that makes me feel good. It's like, you know, this is a chapter that doesn't have to be ongoing, but every chapter ties into the next, and I just didn't think you would abandon me. I guess hearing that . . . and I'm like, "Oh, ok good!" (with large exhale). At least I have somebody I can trust that if I, God forbid, ever needed it . . .

T: What's it like to see me tear up in here? You've seen me tear up in here before . . .

P: It's nice. It's like, "look at this emotional man". . . I mean, I've seen you tear when I'm at my most saddest . . . I've seen you tear when I'm like "Oh God!"(motions like crying hard) . . . um. . .I mean they're sad happy tears. It's a lot of good work and a lot of . . . again . . . you're very, you have a fatherly . . . I wouldn't say that you're a fatherly figure, but just you've always had that, like I know you care.

You've watched me . . . in a parent kind of way where you watch your kid struggle . . . and again, not that I think you see me as some kid, but like, you've watched a person struggle and grow and been a part of that process that's kind of like, "Huh!" (large exhale). And it's letting go for you. I'm not the only person who has to let go, I'm here every Tuesday cursing you out in one way . . . people tend to miss that. (*smiles*)

T: What are your tears saying right now?

P: Um, they're happy . . . they are just joining your tears. It's kinda like, goodbye, like sweet sadness . . . it's not sad, that's just it . . . not sad, what's the phrase that they use? Back in the day, like my Grandma . . . bittersweetnesss? Is that the word?

T: So what do you think next week's going to be like? What do you think next week's going to be like as far as when the session ends . . .

P: I don't know. . .I might be crying . . .

T: Maybe me too. We're both crying right now at the end of this session . . .

P: I know. But they're not like "wah-wah" tears. I'm expressing myself . . . they're "expressing myself" tears . . . .

T: Me too . . .

## Clinical Applications of Immediacy

In this segment, the rating group felt that it was Dr. M's expression of gratitude (Therapist Category 11) that led to Ann's deepening of her exploration of affect as a consequence of the therapeutic relationship (Patient Category 4). Previously, Ann had difficulty discussing her immediate feelings about termination and had downplayed Dr. M's attempts at focusing on the subject of loss both in and out of the therapeutic relationship. This session marked an important point in this process, where Ann discusses the impact of the loss of Dr. M and the poignant sadness that may be conceptualized as evidence of her capacity to grieve. Ann previously stated that her past relationships had not ended with an opportunity to talk about the loss and the associated feelings. Dr. M tenaciously focuses on the subject of termination and provides gentle redirection when she attempts to move away from the affect in the termination process. The rating team felt that it was Dr. M's expression of his sadness and gratitude for her vulnerability that makes Ann feel safe enough to delve into her own emotional experience; a process she describes as her tears "joining his tears."

## Posttherapy Comments Related to Immediacy

In a posttreatment interview with an independent clinician, Ann stated that talking about the therapeutic relationship (immediacy) was a vital aspect of the treatment. She noted that because her issues were mostly in relationships, discussing the therapeutic relationship enabled her to evaluate other relationships more confidently and effectively. Ann also observed that although discussion of the therapeutic relationship was initially uncomfortable, she felt safe with Dr. M, which allowed her to discuss the relationship more openly. This was evidenced by the fact that she initiated 50% of the immediacy events in these sessions. Ann identified her discussions with Dr. M about trusting men, beginning in the first session, as crucial to the therapeutic process. She stated that prior to therapy, she had "horrible boyfriends and did not trust men," and her ability to discuss her initial mistrust of Dr. M openly was a significant factor in a new experience of a trustworthy male figure in her life. Ann identified Dr. M in the posttreatment interview as "a caring, patient, nurturing, positive figure," which suggests this attention to her feelings early in the treatment paid useful dividends. Also, Ann's feelings toward her parents appear to have been affected by the therapy, as she felt at the beginning of treatment that her parents had let her down in many ways. However, in the posttreatment interview, she stated, "they are humans too and are doing the best they could with what they had." Hope was another part of the treatment that Ann valued in her sessions with Dr. M, and she felt he was especially helpful in her identification of adaptive aspects in disappointing situations. Ann also identified the expression of feelings as memorable in the treatment. She stated that she cried through several sessions, which allowed her to experience feelings she had been previously avoiding. When asked about participating in videotaping for research purposes, Ann reported that the video and research aspects of the treatment had helped her to be more accountable to herself.

## Conclusion

In this case study of 16 sessions over a 4-year psychodynamic psychotherapy, we examined the use of therapeutic immediacy and found that it was frequently initiated by both the client and therapist. In order to demonstrate the clinical utility of therapeutic immediacy, we presented examples used in the exploration of important clinical issues such as beginning treatment, identification of core relational themes, building on client strengths, increasing adaptive affective expression, resolving treatment ruptures, and processing termination. Session excerpts of therapeutic immediacy identified prominent areas of treatment focus such as (a) the building of trust, mutual respect, and recognition of deep feelings with a male figure; (b) the generation of new relational templates and skills related to in-session discussion of the therapeutic relationship; and (c) Ann's increasing ability to tolerate intense affect such as sadness and anger.

This study provides a cross-sectional view of how therapeutic immediacy may be used to work with difficult clinical issues in the here and now of the therapeutic relationship. In this study as well as in previous research by Hill et al. (2008), clients presenting with problems in interpersonal relationships seemed able to use therapy as a "relational training ground" on which immediacy interventions were observed to identify salient issues, aid in processing difficult feelings, and help develop new interpersonal skills. In addition, both patients describe participating in processes in which their expectations and possibilities in relationships were expanded. Also, in both treatments there was direct feedback from clients that the use of immediacy helped to validate their concerns and enhance their connection to the therapist. In this treatment, Ann described therapeutic immediacy as helping her better develop the ability to tolerate difficult feelings. Although it is unclear to what extent the use of immediacy was responsible for these therapeutic gains, we can surmise from these direct client reports that the use of immediacy was at least experienced as a positive and facilitative intervention during their treatment.

Recently, Shine and Westacott (2010) have used a mixed-methods quantitative-qualitative design to investigate the working alliance and session outcome in a case series of cognitive analytic therapy. The primary finding identified by the authors was the

patient theme "feeling accepted," which seemed to incorporate other themes (space to talk, feeling heard, etc.) and stood alone as helping clients to feel understood not only by their therapist but also for themselves. It is noteworthy that the themes identified in the qualitative analysis portion of the Shine and Westacott study were similar to the themes identified in the present study. For example, the experience of "feeling heard," so important to the clients in the Shine and Westacott study, echoes the sentiments of Ann, who risks sharing uncomfortable feelings with Dr. M because she feels that he will listen and be responsive. Ann's feeling heard also allowed her to feel safe enough with Dr. M to be able to discuss the therapeutic relationship more openly. When Ann had the courage to express these fears about men, Dr. M responded with acceptance, support, and even encouragement, a process captured by Shine and Westacott in the theme of "feeling accepted." The similarities in the qualitative results between these two studies indicate why more research is needed that focuses on the microprocesses of the therapist-client interaction.

Therapeutic immediacy can also be used at particular points in the treatment to facilitate the therapeutic process. Specifically, therapeutic immediacy can be helpful in the process of rupture and repair (Safran & Muran, 2000), particularly for what those authors refer to as "disembedding" in order to discuss what is going on in the here and now of the relationship, and "self-assertion," where the client states his or her feelings about the rupture. Also, therapeutic immediacy can be explicitly helpful in processing termination. As identified in Hill et al. (2008), termination is a time when discussing immediate feelings in the relationship is necessary to avoid any tendencies by either client or therapist to steer clear of difficult feelings, such as grief and loss. Also, termination gives the client an opportunity to discuss those aspects of the treatment that she found most and least helpful and to have these feelings validated by the therapist.

Although this study provides several important reliability (presence and absence of and depth/intensity of immediacy events) as well as clinical utility findings regarding the use of therapeutic immediacy, it is not without limitations. The results from this case study may not be generalizable to other cases of varying treatment length, therapeutic orientation, or client experiences (i.e., prior psychotherapy experience). It is also important to note Dr. M's involvement with Ann's case prior to becoming her therapist. In Ann's initial intake at the university training clinic, Dr. M was the faculty partner (i.e., "observer") of the graduate trainee conducting the intake and thus met Ann at that time, roughly a 1.5 years prior to beginning their work together. In the first session with Dr. M as her therapist, Ann identified this initial intake as a very positive experience, which allowed her to feel less anxious and to be more open when beginning treatment with Dr. M than she might otherwise have been. This positive previous experience may have increased her positive feelings about and willingness to engage in the treatment. In addition, part of Ann's prior treatment with a graduate therapist for 14 months was supervised by Dr. M. As such, the therapeutic focus of that previous work was quite similar to the later therapeutic interventions used by Dr. M. This similarity of therapeutic focus may have served to increase Ann's comfort with initiating and responding to the use of immediacy with Dr. M. Likewise, this familiarity may have also served to increase Dr. M's understanding of important conceptual issues regarding Ann's treatment and provide him with greater comfort in his exploration of the therapeutic relationship. It may be that other clients entering treatment for the first time would respond differently to the use of immediacy by a new therapist. However, it is important to note that Ann's entire course of treatment was completed prior to beginning this study, and thus Dr. M was completely unaware of the focus and goals of these subsequent clinical ratings. Therefore, any demand characteristics regarding therapeutic immediacy were controlled. In addition, interpersonal familiarity does not confer treatment process or outcome success, and could also contradict it within several clinical models (including psychodynamic perspectives). Given the extremely robust process and outcome data that were sustained both during treatment and at follow-up, it seems highly unlikely that these changes were due simply to such familiarity without at least some contribution from technical interventions, such as the focus on therapeutic immediacy described in this study.

## Comparison with Kasper et al. (2008) and Hill et al. (2008)

This study provides further clinical data on the immediacy construct originally developed by Hill (2004), as applied in a successful case of long-term psychodynamic psychotherapy. In Kasper et al. (2008), the authors concluded that the therapist's use of immediacy had "mixed results." Immediacy produced positive effects such as the female client feeling closer to the therapist, expressing feelings more openly, and feeling generally satisfied with the sessions. However, negative effects of therapist immediacy included the client reports of feeling awkward, pressured to respond, and overly challenged at times. Additionally, as mentioned above, her posttreatment scores were worse on measures of interpersonal functioning and symptomatology. In the second case study in which the use of therapist immediacy was examined (Hill et al., 2008), by contrast, the authors describe the client subjectively as making "dramatic changes" in the treatment. The use of therapist immediacy in this case was described as "supportive and empowering," whereas in the previous case study, therapist immediacy was determined to be more "confrontational and challenging." One element of that treatment the authors identified as important was that the *client* initiated 21% of the total immediacy events. Outcome measures indicated improvement across measures of interpersonal functioning, symptomatology and self-understanding. On the basis of these results, Hill et al. (2008) concluded that therapist immediacy served four functions in the case: (a) establishing rules and roles in the relationship; (b) the therapist's expression of real care and concern for the client; (c) encouraging the client's exploration of deeply painful (i.e., shameful) personal topics; and (d) Facilitation of a new relational experience (referred to by the authors as a "corrective relational experience") hopefully generalizing to outside relationships.

In this case study, many themes emerged that were similar to those highlighted in the previous immediacy case study research. The raters, and client herself, identified an increase in the ability to tolerate and explore deeply painful and shameful feelings as a central component of the treatment (see "Event 2" vignette). Therapist immediacy categories that pertain to the client's exploration of painful feelings occur in both our study (see Table 2, Category 17) and in the previous case study on immediacy by Hill et al. (2008; Therapist Immediacy Category 10: "Affirmed and shared

client's pain"). In addition, like the authors of the other two studies, the rating team felt that immediacy contributed to a new relational experience with Dr. M (see "Event 3" vignette). Therapist immediacy categories that relate to a new relational experience by the client ranked among the top three categories in terms of frequency in both our study (see Table 2, Immediacy Category 2) and in previous immediacy research (Hill et al., 2008; Therapist Immediacy Category 2: "Wanted to collaborate with client in working out her difficulties"). At the end of treatment, Ann reported experiencing a caring, emotionally close relationship with a man and also learned new skills with which to navigate existing relationships. Last, the previous studies' authors felt that immediacy served to allow the therapist to show care and concern for the client. In this study, we also felt immediacy was used not only for this purpose but also as a way for the client to communicate positive feelings (i.e., gratitude) for a male therapist who she initially was ambivalent about trusting (see "Event 1" vignette). Therapist immediacy categories indicating efforts to show care and concern (i.e., gratitude) for the client occurred both in our study (see Table 2, Category 11) and in previous immediacy research (Hill et al., 2008; Category 9: "Disclosed immediate feelings of closeness").

However, our study differed from the two previous case studies on immediacy in important ways. First, the treatment selected for this case study was completed before this research project was initiated. This allowed us to select a treatment with characteristics that would add to the existing literature (i.e., LTPP). Also, due to the length of the case, more process and outcome data were generated to reflect the trajectory of the therapy. Additionally, our raters provided the first interrater reliability data for both the presence/absence and the depth/intensity of immediacy, identifying it as a well-articulated construct for further research study.

In regard to future research, more studies are needed to identify when in treatment, with whom, and what types of therapeutic immediacy interventions may directly lead to positive outcomes (see Høglend, Johansson, Marble, Bøgwald, & Amlo, 2007; Kuutmann & Hilsenroth, 2011; Ryum, Stiles, Svartberg, & McCullough, 2010). In addition, large empirical studies are necessary so that results would be generalizable across different treatments. Where case studies have and will continue to provide useful examinations of immediacy in treatment at the microprocess level, larger studies would provide a view of immediacy at the "macro" level, including insight into how treatments that involve immediacy produce results relative to treatments without or with a limited focus on therapeutic immediacy (see Høglend et al., 2006).

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