Immediacy was examined in a 17-session case of brief therapy with a bright, articulate, inner-city, African American female client seeing an interpersonally oriented, White, male therapist. The main types of therapist immediacy were reinforcing the client for in-session behavior, inviting the client to collaborate, inquiring about client reactions to therapy, and reminding the client that it was okay to disagree with him. An in-depth qualitative examination of the seven most extensive/salient immediacy events revealed that therapist immediacy enabled the therapist and client to negotiate the relationship, helped the client express her immediate feelings to the therapist, helped the client open up to deeper exploration of concerns, and provided the client with a corrective relational experience. Implications for practice and research are discussed.

Keywords: immediacy, therapeutic relationship, psychotherapy process

Kasper, Hill, and Kivlighan (2008) studied therapist immediacy (defined as disclosures within therapy sessions of how the therapist is feeling about the client, about him/herself in relation to the client, or about the therapeutic relationship; Hill, 2004) within a 12-session case of brief therapy. The male therapist was interpersonally oriented, and the articulate, volunteer, female client’s primary goal for therapy was to work on interpersonal relationships. The therapist used a lot of immediacy (33% of his interventions involved immediacy, in contrast to the average of 3.5, range of 1% to 13%, of therapist interventions coded as self-disclosures/immediacy in the review by Hill & Knox, 2002). In addition, the therapist initiated all of the immediacy events. Immediacy events involved parallels between external relationships and the therapy relationship, encouraging expression of immediate feelings, processing termination, therapist expressing disappointment/sadness/hurt, inquiring about the client’s reactions to therapy, inquiring about his impact on her, expressing caring, feeling close, wanting to connect, and feeling proud of the client. Kasper et al. concluded that immediacy was an intense and mostly positive experience for this client, given that it facilitated negotiation of the therapeutic relationship, provided a corrective relational experience by opening her up to a new kind of relationship that differed from the problematic patterns she had discussed in treatment, and helped lower her defenses. Immediacy also had a few negative effects, though, in that the client sometimes
felt puzzled by it and felt pressured to respond (e.g., when the therapist indicated that he cared for her, the client felt awkward and confused by the possible implications of his caring for her beyond the professional relationship, although this was not his intention).

Clearly, findings based on a single case, no matter how well developed and intriguing, raise concerns about generalizability, including how immediacy would operate in a different case. Would, for example, immediacy serve the same functions in another relationship? Would another dyad engage in immediacy more or less frequently? What types of immediacy might another therapist use? How would a different type of client react to immediacy? How would presenting issues or cultural factors affect a client’s reactions to immediacy?

The purpose of this study, then, was to conduct a second case study and compare the results to those of Kasper et al. (2008). Conducting a second case study allowed us to investigate both similarities and differences in immediacy and its effects across cases, and it allowed us to begin to speculate about when it might or might not be therapeutic to use immediacy in therapy.

In this effort, we purposefully started with broad research questions to allow the clinical material in the case to inform our investigation. These broad questions were: (a) What types of immediacy did the therapist use? (b) When and why did the therapist use immediacy? (c) How did the client respond to immediacy? and (d) What were the effects of immediacy?

In planning for the second case, we defined immediacy (based on the results of Kasper et al., 2008) as disclosures involving both therapist and client, and thus excluded feedback related just to the client. As did Kasper et al., we also excluded minimal social pleasantries (e.g., “Nice to see you”) that often occur at the beginnings of sessions. Thus, immediacy had to be about both therapist and client in the immediate moment and be at least moderately involving.

We also carefully considered what methodology to use to investigate immediacy. Kasper et al. (2008) used two different methods: having judges code therapist and client immediacy within speaking turns and a qualitative method of examining the process and outcome of immediacy events (defined as occurring across longer periods of time within sessions based on when the discussion about the relationship started and stopped). The findings for the second analysis of events seemed more clinically relevant but still seemed limited because events were just classified into various types and effects were not studied intensively for the antecedents and consequences. Therefore, for the present study, we used a modified consensual qualitative research method (CQR; Hill, Thompson, & Williams, 1997; Hill et al., 2005) method, as did Hill et al. (2007) and Knox, Hill, Hess, and Crook-Lyon (2008) because CQR provided a systematic method for examining each event to determine type of immediacy, intensity of the event, and the antecedents and consequences of immediacy.

Method

Design

We conducted a naturalistic, mixed quantitative/qualitative, case study of brief individual psychotherapy. The quantitative process and outcome data provide a context for the case and allowed us to compare the results to normative data. The heart of the study, however, is the clinical qualitative description of the case. For the qualitative portion, we used a modified consensual qualitative research (CQR; Hill et al., 1997, 2005) method.

Participants

Therapist. Dr. W, a White heterosexual 55-year-old clinical psychologist with 30 years of clinical experience, was the therapist in this study. In appearance, he was tall, slender, attractive, casual, and gentle looking. He identified himself as an interpersonally oriented therapist who draws on family systems theory and uses an attachment-informed perspective. Using 5-point scales (5 = high), he rated himself as a 5 in psychoanalytic/psychodynamic, 4 in humanistic/person-centered, and 3 in cognitive/behavioral orientations.

Client. Jo, an articulate, bright, African American, lesbian, 29-year-old woman with long-standing symptoms of significant depression and anxiety, was the client in the study. She was attractive and usually dressed casually in dark clothes or active gear. Jo came from a low socioeconomic background and grew up in a racially tense, high-crime community. Jo reported that throughout her childhood, her mother had been a drug addict (now recover-
ing) who required that Jo meet her physical and emotional needs, manage money for her drug use, reassure her when she was afraid or in a drug-induced state, and negotiate the predatory men who trafficked in and out of the home. Jo coped by retreating into her room and fantasizing about female rock stars and movie celebrities. Jo’s biological father molested her and beat her younger brother so badly that he later died from the injuries. Subsequently, Jo was molested by her stepfather, which was a deep betrayal for Jo because she had trusted him and felt that he cared about her. Child Protective Services placed Jo in the foster care system from ages 13 through 18 because of her mother’s neglect. At this point, Jo established some long-term friendships, but she also reported that she suffered intensely from anxiety-arousing ridicule and taunting from peers. Upon emancipation from the foster care system, Jo lived at times with her mother or nearby with girlfriends/partners.

Jo reported that since childhood she had always found school to be a haven where she felt physically safe, could find responsive adults and, once in college, could obtain needed income through school-related grants and financial aid. Primarily for these reasons, she was currently taking classes for a master’s degree in communications, although she regularly missed classes and was earning marginally passing grades. In addition, she was working part-time as a clerk, which she found “boring and meaningless.” Jo had significant financial stress and realistically worried if her telephone, gas, and electricity bills could be paid at the end of each month or if these basic services would be cut off, as they had at times in the past. Jo had been in therapy previously at the same university-based clinic but with a different therapist. Researchers. The research team was composed of a 58-year-old White female professor, and four advanced female doctoral students (3 White, 1 Asian) in counseling psychology, ranging in age from 25 to 46. In terms of biases, all five researchers reported before the study that they liked immediacy and found it to be a powerful intervention in therapy, although they ranged in how comfortable they felt using it themselves as therapists. All had read Dr. W’s book but had not met him personally before the study.

Pre- and Posttreatment Outcome Measures

The Outcome Questionnaire 45.2 (OQ; Lambert et al., 2002) is a 45-item self-report instrument designed for repeated measurement of client progress (in terms of symptomatology, interpersonal functioning, and social role performance) throughout therapy and at termination. Items are scored on a 5-point Likert scale from never (4) to almost always (0). Internal consistency was .93 and test–retest reliability was .84, positive correlations were reported with other symptomatology measures, and it was sensitive to change in clinical settings. We used the total score for this study.

The Inventory of Interpersonal Problems–32 (IIP; Barkham, Hardy, & Startup, 1996) is a 32-item self-report instrument of interpersonal distress (shortened from Horowitz, Rosenberg, Baer, Ureno, & Villasenor’s, 1988, 127-item measure). Items are scored on a 5-point Likert scale from not at all (0) to extremely (4). Horowitz et al. reported an internal consistency of .87, test–retest reliability of .98, discrimination from a measure of symptomatology, and sensitivity to change in clinical settings. We used the total score for this study.

The Self-Understanding of Interpersonal Patterns–Revised scale (SUIP-R; Connolly et al., 1999; Connolly, Hearon, Hu, Barber, & Crits-Christoph, 2006) is a 28-item self-report instrument of a client’s level of understanding of his or her own interpersonal patterns. For each interpersonal pattern, participants identify all their levels of understanding of that pattern from, “I do not feel and act this way in my current relationships” (1) to “When I recognize that I am feeling and acting this way, I am able to consider other ways of viewing the situation in the moment” (7). Connolly, Gibbons et al. (2006) reported adequate internal consistency (.91 patients; .94 non-patients), discriminant validity (not related to self-reported self-esteem or depression), and construct validity (more changes in self-understanding after interpersonal therapy than cognitive therapy). We used the total score for this study.

Postsession Measures

Session outcome. The Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles & Snow, 1984) is a 5-item, bipolar, adjective-
anchored, self-report measure designed to evaluate client and therapist perceptions of the quality of sessions. 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 (.91, Stiles & Snow, 1984; .90, Stiles et al., 1994).

The Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989), a revision of the 36-item WAI (Horvath & Greenburg, 1989), is a 12-item self-report measure designed to assess perceptions of the working alliance. Clients and therapists use a 7-point Likert scale from never (1) to always (7) to describe how they feel or think about the therapeutic relationship. Tracey and Kokotovic (1989) reported high internal consistency of the WAI-S (alpha coefficients ranging from .83 to .98).

The Client Immediacy Recall Questionnaire (CIRQ) was developed for the Kasper et al. (2008) study. The client is asked open-ended questions about the content of discussions of the relationship with the therapist, what these discussions were like, and what was learned from the discussions. The client was also asked open-ended questions about what the therapist did or said that was helpful and unhelpful in therapy as a whole.

The Therapist Immediacy Recall Questionnaire (TIRQ) was created for the Kasper et al. (2008) study. The therapist is asked to describe her or his thoughts and perceptions about the use of immediacy, reasons for using immediacy, and how the client responded to the immediacy.

Procedures

Recruiting. Dr. W was asked to participate in the current study because of his reputation as an expert in interpersonal therapy. He had written extensively about processing the therapeutic relationship in a widely used book on interpersonal therapy.

During regular intake sessions at a psychology department community clinic, Dr. W screened clients to choose one who fit the criteria used in the Kasper et al. (2008) study (i.e., female, at least 10 years younger than the therapist, appeared able to establish a relationship and willing to discuss interpersonal concerns, no obvious personality disorders or psychosis, no eating disorders, no history or current abuse of alcohol or other drugs, no past or current suicidal ideation or attempts, and not currently in any therapy). After seeing Jo for an intake, Dr. W consulted with the first author and together they determined that Jo was appropriate for the study because she met the above criteria and seemed articulate, insightful, and resilient despite being depressed, anxious, and having a significant abuse and neglect history. When Dr. W called Jo to invite her to participate in the research, Jo reported that she had found the initial intake useful, strongly wished to continue in treatment, and was comfortable participating in the research program in a weekly time-limited format (up to 30 sessions) for a minimal fee.

Sessions. Before the first session, the client signed a consent form and completed the OQ, IIP, SUIP–R, and a demographic form.

The therapist audiotaped and videotaped each session. He conducted sessions as he normally would, with no interference from the research team. He knew that we were interested in studying immediacy, but we asked that he use it only as he normally would. After each session, the client completed the SEQ–D, WAI-S, and CIRQ; in a separate room the therapist completed the SEQ–D, WAI-S, and TIRQ. The measures and videotapes were mailed to the first author after every other session (Dr. W did not see Jo’s completed measures).

After the final session, Jo completed the OQ, IIP, and SUIP-R, and participated in a 60-min telephone interview with the first author to discuss reactions to the treatment and study and be debriefed. The therapist later participated in two 90-min telephone interviews with the first author to discuss his reactions to the case and study. Both gave written permission for the tapes and transcripts to be used for research and training purposes.

Four months after termination, Jo was sent the OQ, IIP, the SUIP–R, and a $20 check as token compensation for completing the measures. She returned the completed measures to the first author using a self-addressed stamped envelope.

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

Qualitative analyses. About 3 weeks after each session, the research team watched the videotape while reading the transcript. We stopped the tape whenever we agreed that an immediacy
event had occurred (broadly defined at this point as any talk about the relationship) and reached consensus about our responses to four questions: (a) Who initiated the immediacy? (b) What type of immediacy was it? (c) What were the effects of immediacy? and (d) Why was immediacy used? We also stopped the tape whenever we had strong reactions to anything that occurred and discussed these reactions. We purposely kept our questions and responses broad at this stage, so that we could observe and record whatever emerged from the case.

After observing all the sessions, we reviewed all the transcripts to determine if each identified immediacy event fit the criteria for such events (e.g., specific focus on the therapy relationship or disclosure of feelings about the other person; more than social pleasantries at the beginning of sessions, e.g., “I’m glad to see you”) and checked whether we had missed any immediacy events. The research team then categorized therapist and client behaviors within each event (each therapist or client behavior could last from 1 to several speaking turns), using a list of categories that emerged from reviewing the case (see Tables 1 and 2). We also rated the overall depth/intensity of each immediacy event on a 5-point scale (1 = mundane, one-sided; 2 = minimal two-person exchange; 3 = longer two-person exchange lacking depth; 4 = prolonged two-person exchange; 5 = prolonged exchange with both participants actively expressing genuine immediate feelings). We then matched postsession comments on the CIRQ and TIRQ with the related immediacy events. We also gave each event a title to capture its salient aspects.

Next, the team reevaluated the client/therapist behavior categories, collapsing those that occurred infrequently into broader categories. We also reexamined all codings of therapist and client behaviors to ensure consistency across events, resulting in 12 categories of therapist behaviors (see Table 1) and 9 categories of client behaviors (see Table 2). Team members discussed each decision until reaching consensus.

We then conducted in-depth qualitative analyses on the seven events rated 3.5 or higher (the remaining events were brief and seemed to have less impact, although none were negative). In analyses of these seven events, we identified the context, the effects of the events, and conceptualized how immediacy functioned in this event, again using consensus for all judgments.

Finally, we sent drafts of the manuscript to the therapist for review. He had many comments that helped us refine our understanding of the case.

Results

In this section, we first provide background about the case (the logistics, the therapeutic relationship, the therapy process) to set the context for the results. We then provide an overview of all the immediacy events and describe in detail the seven most salient immediacy events. Finally, we present results related to the outcome of the case.

Context of Case

Logistics of the case. In total, Dr. W and Jo had 17 sessions over 8 months. The first 13

<table>
<thead>
<tr>
<th>Category</th>
<th># Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reinforced client for something she did in the session</td>
<td>24 events</td>
</tr>
<tr>
<td>2. Wanted to collaborate with client in working out her difficulties</td>
<td>13 events</td>
</tr>
<tr>
<td>3. Inquired about client’s reactions to therapy</td>
<td>11 events</td>
</tr>
<tr>
<td>4. Reminded client that it was okay to disagree with him</td>
<td>9 events</td>
</tr>
<tr>
<td>5. Said he was glad to see client</td>
<td>8 events</td>
</tr>
<tr>
<td>6. Talked about a boundary related to fees or meeting times</td>
<td>8 events</td>
</tr>
<tr>
<td>7. Inquired about possible problems in relationship</td>
<td>7 events</td>
</tr>
<tr>
<td>8. Drew parallel between external and therapy relationship</td>
<td>7 events</td>
</tr>
<tr>
<td>9. Disclosed immediate feelings of closeness</td>
<td>7 events</td>
</tr>
<tr>
<td>10. Affirmed and shared client’s pain</td>
<td>6 events</td>
</tr>
<tr>
<td>11. Reinforced client for disagreeing with him</td>
<td>4 events</td>
</tr>
<tr>
<td>12. Gave client a gift</td>
<td>4 events</td>
</tr>
</tbody>
</table>

Note. Based on 56 immediacy events; categories were not mutually exclusive given that several types of immediacy could occur in each immediacy event; each category was counted only once per event.
sessions were held over 16 weeks, and the final four sessions were held sporadically over the next 3 months. During the weeks without sessions, Dr. W and Jo typically had a 20-min untaped phone conversation.

They initially negotiated a fee of $5 per session, but after several times when Jo asked to delay or lower the payment, Dr. W proposed that they be “done with paying.” The policy of the clinic was that clients paid whatever they could afford, so it was not unusual for clients to pay nothing or a token fee of $1. For the final face-to-face session, when Jo asked to borrow bus money ($6), Dr. W gave her the money as a gift.

The therapeutic relationship. From the very beginning, Dr. W and Jo seemed to be attuned to each other. For example, Dr. W seemed to genuinely care for Jo. In addition, Jo asked about Dr. W’s health when he had problems with his eyes and back, and expressed concern after he disclosed his grief reactions to his own parents’ deaths during a session when Jo was processing her grief over her aunt’s death.

Both also clearly valued the relationship (based on what they said during sessions as well as postsession ratings and comments). Their intense connection began during the intake interview (not taped) and continued despite missed sessions and perceived ruptures. In the posttherapy interview, in response to a question about what the therapy was like with Dr. W, Jo said,

It was wonderful because I felt like Dr. W really took out the time to understand me [and]...the issues that I was going through. It was really helpful because I had a different therapist before and you could just tell that they weren’t interested in what I was dealing with. So he wanted to get to the core of the issue. So, that’s what made it special to me.

In response to the query in his posttherapy interview about the relationship, Dr. W Said,

[It was] extremely intense and engaging ... Being in the room with Jo, her eye contact and her emotional presence with me was compelling and I was riveted after session ... I really liked Jo a lot, and I think Jo really liked me a lot. There was a lot of warmth and a sort of easy friendliness and I think a genuine sense of looking forward and excited when we saw each other, and I think a mutual respect.

The therapy process. Jo disclosed deeply during the therapy. For example, toward the end of therapy, she told the heartbreaking story about how her father had beaten her brother so badly that he was totally paralyzed and then died several years later. Also heartbreaking, Jo talked about how her mother would overtly express that she loved her brother more than her. When she was born, her mother turned away from her and said she did not want her because she was too dark-skinned. These events indicate that Jo had been wounded deeply in her life, but her motivation to understand herself and to change were reflected in her eagerness for therapy and involvement in the sessions. She frequently took notes during session on what Dr. W said and went out and implemented most of his suggestions, indicating that she absorbed everything that he gave her.

On his part, Dr. W was active and direct as Jo requested, using many more problem-solving, educational interventions with her than he said he typically used with clients (e.g., he suggested that Jo move to an apartment in a safer neighborhood, get a new and more satisfying job that provided some financial stability/independence, devise a little doll called Little Jo whom Jo could nurture when she felt anxious, and stop mediating disputes between her mother and her mother’s boyfriend). Dr. W had strong convictions about what Jo should do and challenged her accordingly because he felt that Jo was in crisis, treatment was
going to be brief, and she had requested and seemed to benefit from this active, problem-solving approach.

The first 10 sessions of the therapy were characterized by a sense of warmth and understanding. In contrast, progress stalled in Sessions 11 to 13 when Dr. W seemed less empathically attuned with Jo and often redirected the session to his own treatment goals (e.g., Jo seeking employment) in an ineffective, repetitive manner that kept their work on the surface. On her part, Jo became more passive and did not disclose as much. In hindsight, Dr. W acknowledged that he became overly anxious when Jo’s aunt died unexpectedly because he worried that Jo would abandon the gains she had made and return home as her mother requested. Dr. W recovered his focus, however, in Session 14 and reestablished the collaborative spirit that had characterized their previous interactions. In the final four sessions, Jo brought up important new topics (e.g., a date rape and gynecological/health problems), explored deeply about issues (e.g., her childhood molestation), and made changes (e.g., got a new job).

Process Data

Overall, Dr. W was quite active, averaging about 44% of the words spoken in the case. In the 17 sessions, we identified 56 events that fit our criteria for immediacy; 44 of the events were initiated by Dr. W and 12 by Jo. About 5% of the client’s words and 12% of the therapist’s words used immediacy.

Categories of therapist immediacy during immediacy events are shown in Table 1 and categories of client behavior during immediacy events are shown in Table 2 in descending order of frequency (recall that behaviors were coded for all 56 immediacy events; each category was counted only once per event, but each event could be coded into more than one category). A chi-square analysis of therapist immediacy and subsequent client behavior (beginning with any time the therapist had an immediacy statement in a speaking turn), was significant, $\chi^2(88) = 123.68$, $p < .001$, indicating that the two sets of behaviors were related. More examination (cell chi-square analyses) revealed seven significant associations: (a) when Dr. W said that he wanted to collaborate, Jo was mildly defensive, $\chi^2(1) = 3.87$, $p < .05$, (b) when Dr. W inquired about her reaction, Jo indicated that what he did was okay, $\chi^2(1) = 7.39$, $p < .01$, (c) when Dr. W said that he was glad to see her, Jo indicated commitment to therapy, $\chi^2(1) = 6.17$, $p < .05$, (d) when Dr. W inquired about problems in their relationship, Jo indicated that what he did was okay, $\chi^2(1) = 10.00$, $p < .01$, (e) when Dr. W affirmed her pain, Jo was mildly defensive, $\chi^2(1) = 6.67$, $p < .01$, (f) when Dr. W reinforced her for disagreeing, Jo expressed immediate feelings about the relationship, $\chi^2(1) = 4.61$, $p < .05$, and (g) when Dr. W gave her a gift, Jo expressed gratitude, $\chi^2(1) = 10.26$, $p < .01$.

The judges rated the 56 immediacy events an average of 2.18 ($SD = .87$) on the 5-point depth/intensity scale (1 = mundane, 5 = prolonged exchange with both participants actively expressing genuine immediate feelings), with the deepest events occurring more toward the end of therapy. Many of the events were brief check-ins by Dr. W and were responded to minimally (but not negatively) by Jo, and thus seemed to have minimal impact on therapy other than to let Jo know that Dr. W cared about her and was there for her. Here we present excerpts and our in-depth analyses of the seven most intense/deepest (rated 3.5 or higher) events during the therapy to illustrate the role and impact of immediacy. For each immediacy event, we present the context of what was occurring in the session/therapy before the event, the verbatim transcript of the event (with ellipses . . . to show where words were deleted to shorten the presentation; minimal encouragers, e.g., Mm-hmm, were dropped unless they had specific communication value), quotes from related postsession comments (unless otherwise noted, Jo did not write anything about the immediacy events), the observable effects of the immediacy, and our conceptualization of the event.

Event 1: Middle of Session 3; “Am I Being Too Active?”

Context and excerpt. In this session, Jo was talking about not knowing how to behave as an adult. She said that girlfriends had labeled her as “dingie” because she did not know the basics of such things as driving, maps, ironing, and interpersonal behaviors. Dr. W suggested several things to help Jo become more adult and independent. She took notes and then said,

C: I want to thank you because I’ve never really felt comfortable talking to someone about that, you know, because it
bothered me, made me feel like, “Oh there’s really something wrong with me.” But in a lot of ways either I was in certain situations that required me to really be an adult, like you said I’d withdraw, that’s exactly what I’d do.

T: . . . I really appreciate you just saying, “Thank you.” . . . because you know what I was thinking right before you said that? “Boy, [I’m] talking so much.”

C: That’s a good thing.

T: Is it?

C: Mm-hmm. Because I talk to myself all the time, but it might not be what I need to be saying . . . you generate new ideas and stuff like that, which is what I need to grow.

T: Okay. So [I’m] not arguing with you or being like a teacher or telling you too much?

C: No.

T: ‘Cause you know what happens for me? You talk, and I feel really compelled by what you’ve talked about and touched by it and . . . I almost get too active to help you with it.

C: No, remember when I talked to you the first time I said I wanted somebody who was going to be active . . .

T: I remember you saying you wanted it. I guess I just wanted to get the right level. What are your tears there as we share this moment?

C: I don’t know really, I guess I have so many different emotions, you know, hurt, disappointment. Because you know, when you actually have to admit, I mean actually speak these things like, “This is where I am,” it’s kind of scary.

**Postsession comments.** Dr. W wrote: “I was touched when she thanked me. I thought I was filling way too much space, but she told me to remember that she had requested an “active” therapist . . . Jo responds extremely well whenever I take us to the moment of our relationship. She also initiates immediacy herself—by thanking me, telling me how I should continue being so active, and by sharing her vulnerable feelings so clearly.”

**Effects of immediacy.** When Dr. W asked directly how she felt about his activity level, Jo told him that she wanted him to be active. In addition, after the immediacy, Jo started to tear up and expressed deeper emotions (feeling hurt, disappointed, and scared).

**Conceptualization of the effects of immediacy.** We viewed this as a corrective relational experience. In her outside relationships, Jo usually took care of everyone else (e.g., her drug-addicted mother) and did not often get her own needs met. In this situation, Dr. W was taking care of her. He also asked her for feedback, indicating that he was not perfect and that her input was valuable and necessary to make the relationship work. Dr. W genuinely prized Jo and acted like a parent who was delighted in his child speaking up. Jo’s tears at the end of the event might be viewed as an indication of the importance of this reinforcement from Dr. W.

**Event 2: End of Session 4; “It’s Okay to Disagree”**

**Context and excerpt.** Jo was talking about how she was like her mother. Dr. W said that the part of Jo that was like her mother was holding her back. Jo disagreed with him, saying that her mother was her biggest fan and had always supported her. Dr. W said,

T: You’re saying “No, it’s not like that, you’re missing that one.” I feel I kind of see your independent, strong, healthy lovely self (client chuckled) right now.

C: It’s hard for me. I don’t want you to think, “Oh, I’m saying you’re just wrong.” I don’t like that.

T: No, you were very polite. No, no, this is being an adult. This is, of course, I can be wrong sometimes. Of course, we’re gonna disagree sometimes . . . It’s like two separate people, got their own mind, got their own identity, got their own self. Some will be similar, and some will be different . . . I like that you go, “No, that’s not quite right.”

C: Yeah. Thank you for teaching me a lot. (tears up and wipes her eyes).

T: I really like our time together very much. I really look forward to it.

C: Me too, “cause I felt like I’m kind of growing, I’m not stagnating, which is real good thing . . . Thank you for being real, and I mean, honest.

T: And, you can disagree with everything I say. and we’ll have an authentic relationship.

**Postsession comments.** Jo wrote: “We learned that I must be more direct and learn how to deal with disapproval.” Dr. W wrote, “I thought it was very significant that Jo disagreed with me about something (her mother feeling threatened by Jo’s successful presentation in class). She thanked me twice for giving her permission to disagree with me, that I can be wrong. I thought it was a corrective experience for her because we didn’t have to be fused together and could still be close; talking together about what had just transpired seemed very important to me. I will go back to it next session. She can’t get better if she is complying with me.”

**Effects of immediacy.** Jo again teared up during this event, which suggests that she was deeply.
touched. In addition, Jo thanked Dr. W for teaching her and said that she felt that she was growing. At the beginning of the next session (Event 3), Jo further reflected that this event allowed her to express her feelings and disagree with him.

**Conceptualization of the effects of immediacy.** Jo had been worried that Dr. W would become angry and their relationship would be ruined if she disagreed with him. Rather than being angry, Dr. W was excited and overtly supported and encouraged Jo’s disagreeing with him. This experience was new and surprising to Jo, and seemed to allow her to become more genuine and free in the relationship. This event also seemed to provide new interpersonal learning for Jo; Dr. W highlighted and Jo seemed to understand the importance of healthy disagreement in relationships, as reflected in her comment, “Thank you for teaching me a lot.”

**Event 3: Beginning of Session 5; “What Was Beneficial?”**

**Context and excerpt.** Jo was late for the session and initiated this event.

C: I thank you for switching days. I really do. I was like, “Oh gosh! I don’t want to miss my appointment “cause it’s very beneficial to me.”

T: I don’t want you to miss either, Jo, so I’m glad we were able to reschedule. I’m glad to hear that it’s feeling beneficial. You can kind of start there, just for a minute or two. What’s beneficial? . . . What might we need to change?

C: There’s one recommendation, but as far as what I find that’s beneficial, I think you allow me to really express my feelings and allow me to feel comfortable about that, and you also give me very good ideas. You’re not just making a comment or two, you’re actually engaging in real conversation about the issues. We’re not going around the issues, we’re actually confronting them. I think that’s important.

T: I like hearing that ‘cause I really want us to get close to what’s most important and what really matters . . . If you feel like I’m missing the boat sometimes . . . just tell me and we’ll try and get closer to it.

C: Okay.

T: Remember last week . . . at one point I said something, and you said, “No, that’s not quite right. That’s not how it is.” You disagreed with me. I loved it.

C: Yeah, you told me, and I feel kind of . . . bad, in a way. That’s how I am though . . . I don’t like to rock the boat and stuff like that, which is something I’m going to have to get out of eventually. I mean if it’s something that I don’t agree with, it’s not just because you’re wrong and I’m right. If there’s an actual strong feeling that I have about something, I should be able to express it. That’s been something that’s kind of difficult for me to do.

T: Let’s make the start of changing that right in here between you and me . . . maybe I see it differently or think differently or don’t like it or something, and I don’t speak up, I’m going along. I think that’s really bad for all people, and I think it’s especially bad for you.

C: I just don’t like confrontation, and I think it goes right along with that just being out there and feeling like I’m attacked and not knowing how to defend myself . . . I don’t like to feel confronted, and so I usually just say, “Oh, yeah, okay,” but I’m really thinking, “No, that’s not quite right.” Not with you, though. When you said in the last session basically, “You don’t feel like you can defend yourself,” and I said, “Yes.” And that’s one thing that’s very true for me, that holds very true.

**Postsession comments.** Dr. W Wrote,

I want Jo to have the real-life experience that she can disagree with me, or have her own independent mind with me, and I am pleased with that, unambiguously not hurt or angry. Also, I am trying hard to demonstrate, in our moment-to-moment interactions, that I want to respond to her emotional needs or personal concerns. She expects to have to respond to others, and to be alone in her own needs. I want our interaction to show her that I can be another way, that I, and some others, want to attend to what she wants and needs, and take pleasure in her success and independence.

**Effects of immediacy.** During this event, Jo began exploring her anxieties about confrontation in greater depth. After the event, Jo and Dr. W began to focus on the ways in which Jo’s relationship with her mother undercut her ability to grow and individuate. Thus, the event led to further insights about where Jo’s difficulty disagreeing with others originates, that she does not have to be so worried about disagreeing with others, and that she can defend herself. Later in therapy, Jo revealed that she had joined an African American lesbian support group, so perhaps the encouragement and validation she received in this event helped increase her self-confidence to begin expanding her social support network.

**Conceptualization of the effects of immediacy.** Dr. W’s use of immediacy in this event allowed Jo to learn about interpersonal relationships. Specifically, Dr. W reminded Jo that it is okay to disagree with others and that he was committed to helping Jo grow (in contrast from her other relationships, especially with her mother). Thus, the event was a form of reparenting for Jo and thereby contributed to the overall corrective experience of their relationship; she learned that she could disagree without being hostile or angry and without being attacked. The one “miss” in this event was that Dr. W did not follow-up on Jo’s allusion to a recommendation she had about their work together.
Event 4: End of Session 14;
"Are You Withdrawing From Me?"

Context and excerpt. As noted above, treatment stalled in Sessions 11 through 13 after Jo moved and her aunt died; Dr. W. was less collaborative and empathic than before, did not hear or follow Jo’s concerns/agenda closely, and became very active. Jo generally complied with Dr. W’s interventions, but seemed more depressed, passive, and missed sessions. Dr. W felt that Jo was distancing herself and was less committed to treatment (although he was unaware of his contribution to the problem). In his notes after Session 13, Dr. W wrote that he wanted to identify the rupture or resistance and resolve it. Jo then canceled the next two sessions. In the middle of the 14th session, when Jo was exploring the conflict between her desire for closeness and tendency to withdraw from others when her mood or self-esteem were low (a defense she had used since childhood when she sought escape from her dysfunctional family), Dr. W drew a parallel to their relationship.

C: I’ll get depressed and I’ll totally withdraw . . .

T: Jo, let me use that word, “withdraw.” Last two Mondays it was raining. It was hard to get here. You’re workin’, you’re makin’ money, you’re doing exactly what we’re talking about. It’s so cool. But I also had wondered, “Is there a withdrawal from me?”

C: [emphatically] No.

T: No . . . There’s nothing here? . . . You’d tell me right?

C: Of course. I would say, you know, “This just isn’t working.”

T: Okay.

C: No, seriously, everything’s fine. Mm-hmm. I wouldn’t have been here . . .

T: You called, you cancelled, you did all the responsible things . . . But . . . my job is [to ask] “Is something here not sitting right?” . . . I kept pushing this education thing, and you were gonna dream [about possible careers in the entertainment world].

C: . . . I know that you’re here to help me, you’re not here to [say], “Oh, don’t do that . . . just focus on it.” And I know the reason why you said that . . .

T: And you know that when you don’t like my ideas, don’t use it.

C: But like I said, I still keep them in the back of my mind . . .

T: . . . Well, I did need, for myself, to check in. Was there a bump in our road?

C: No.

T: Did the depression kick you away from me?

C: No . . .

T: You and I work together well, and I have a heart for you, and I wanna do this.

C: Me too. If I didn’t . . . I would really sit down with you . . . I would just tell you, “Well, these are the things I’m concerned about, and what can we do there?” . . . I wouldn’t just cut you off completely though, either. I would try to say . . . maybe there’s something I’m not saying or doing, you know? . . . But no, as far as [I’m] concerned, we’re fine . . .

T: I’m fine too, but I needed to ask. Anytime that happens, I will always want to ask.

C: Okay.

T: . . . I like talking about something I’ll call, “You and me.” What’s going on between us, how is this working? What’s right and what isn’t? . . .

C: I really respect that, because a lot of therapists are like, “Pshh, whatever.” But you really put that in the forefront, and I respect that and appreciate that because that means that you care about how I feel, or how I’m progressing.

Postsession comments. Dr. W wrote, “We had a very powerful session . . . However, we did not identify rupture/resistance. I tried repeatedly to explore bumps in our relationship . . . But Jo kept saying “no problems.” I think something doesn’t feel right to her and Jo may not yet know what it is.” However, Dr. W also wrote, “We powerfully reaffirmed the importance of our relationship . . . I was using immediacy to set us back on track and reengage Jo in the treatment process. I was also using it to give her the experience that I was reliably present and still connected to her even though she was succeeding in work—a message I think Jo needs to get from me—especially as she is facing current, competing messages from her mother.”

Effects of immediacy. After this event, Dr. W and Jo seemed more comfortable with each other. They both were able to express how much the relationship meant to them, and Jo let Dr. W know that she valued and was committed to therapy. Jo began working again, seemed more open, and asked for Dr. W’s help in dealing with gynecological problems later in the session. In the next session, Jo again raised her medical issues and talked frankly about being molested as a child, a disclosure that seemed to reflect her increased comfort with Dr. W.

Conceptualization of the effects of immediacy. In this event, Dr. W’s tenacity in both expressing his own feelings about their relationship and asking for a response invited Jo to engage with him. It also provided a forum for her to articulate and
defend her feelings about their relationship. Jo emphatically denied that there was a rupture and provided detailed feedback to Dr. W. This session was a turning point in their relationship.

Although Dr. W said during the event that he was “fine too,” he wrote afterward that he was uncomfortable and still thought there might be a rupture (as did we who watched the session, particularly noting Jo’s polite sing-song voice as opposed to her voice when she was deeply engaged). Therefore, although the immediacy event was productive, Dr. W was unable to help Jo discuss the relationship in depth. Perhaps Jo never really felt any rupture, but it could also be that she worked out any feelings about a rupture between sessions concluding that she was getting a lot out of the sessions and that it was not worth it to be angry, or it could be that she could not admit to anger because of her difficulty with confrontation (see Event 3). It could also be that the word “withdrawal” was too strong for her, and she might have responded better to another approach, such as Dr. W asking about what was going on with her in missing sessions.

Event 5: Middle of Session 15; “Dr. W Is a Gift From God”

Context and excerpt. At the beginning of this session, Jo reported feeling good because she had sought medical help from a low-fee clinic as Dr. W had advised, and she was hugged in public by a female African American movie star. She said that God was helping her change,

C: It’s gonna happen. I really do believe that it is because . . . the way how everything is . . . God wants to give me that chance because I’ve asked Him . . . for a good therapist, and I mean, he gave me you, and I truly do believe that.
T: Well, thank you.
C: I believe that sincerely. He knew exactly who to send and who would work the best.
T: Well, he set up a good match here because I think we are a very good match.
C: I think so too. And I don’t think anything like that happens by chance, so I’m just going with it.

Postsession comments. Dr. W wrote: “Different immediacy interventions made us feel closer to each other, and that genuine affection and respect in the real relationship between us might be giving her the safety or support she needs to look more clearly at the trauma in her life, and better come to terms with it.” He described using immediacy “to engage her directly and strongly and let her know, experientially, that I “hear” her and am affected by what she says. It has been especially important for me to do this the last two sessions because I have felt a rupture between us.” His perception of her response to immediacy was: “Jo has responded very well to every immediacy bid I have given in this session and in others. She responds very well to forthright, direct, person-to-person dialogue. We are a good match in that I like to talk with the client about our interaction/relationship, and Jo seems to actively enjoy and benefit from it.”

Effects of immediacy. Jo opened up and explored deep issues immediately after this event. She talked about beginning to face the pain and resolve her grief over her aunt’s recent death rather than running away from it. She then revealed her pain over how terrible and cruel her father had been and how her mother had rejected her because she looked like her father.

Conceptualization of the effects of immediacy. Jo gave feedback to Dr. W about how helpful he was, which reassured him that the relationship was back on track. This event also marked a shift in that Dr. W acknowledged Jo’s religious beliefs rather than ignoring them as he had in the past. In addition, Jo seemed to feel accepted on a deep level, which allowed her to admit and accept parts of herself about which she felt shame. Finally, their relationship and mutual admiration were affirmed.

Event 6: Middle of Last (17th) Session; “Mutual Respect”

Context and excerpt. This immediacy event took place in the middle of the final session. Jo had been deeply exploring her self-esteem, anxiety in relationships, and need to be loved.

T: Jo, I respect you so much.
C: Do you?
T: I respect you so much. The way you go at these huge issues and face them with such courage . . . the work you’ve done with me since November has been so hard and so challenging and you have been so strong and capable and successful. I respect your integrity, I respect your courage.

C: Thank you, but I’m glad I met with you because there’s no telling if I met with someone else. Not to say that it would have been . . . it’s probably more of a feeling you know, with you than let’s say somebody else who is just kind of like “so how do you feel about that” . . . you really do talk about the issues and . . . It matters what we talk about in here. I always
reflect back and say “oh that makes sense” or then I’ll jot it down . . .

T: You surprised me right from the get-go, Jo, you got in the
driver’s seat and you put your foot on that gas pedal and you went to work. You initiated and you led me and us to such profound conversations at times. It’s been a deep sharing.

C: Oh yeah. It really has.

Postsession comments. On her postsession form, Jo said that they had “dealt with how we discussed my issues and how our meetings were helpful to these issues.” Dr. W wrote that they “talked extensively about how we worked together in treatment, as partners, and how we cared for, respected, and will miss each other.” In addition, he said that he used immediacy to “punctuate/demonstrate by expressing my compassion and respect for her in a way that she could not dismiss, as she was telling me about what happened with father/step-father, mother’s boyfriend, and assaulting woman.” Dr. W indicated that Jo “felt” the ending with me in a realistic and progressive way that will help her internalize me and increasingly transmute my affirming/respecting voice into her own good feeling about herself.” Finally, Dr. W said, “I felt so admiring of Jo—her capacity to learn and change, her commitment to approach her anxieties and not ‘run.’ I felt very respectful of her courage, and thought that anybody who understood anything ought to feel the same, although I realize that many in society would see her as young, immature, weak (e.g., “avoidant” attachment style).”

Effects of immediacy. Although Dr. W’s direct expression to Jo about his respect for her and her willingness to do the hard work of therapy initially surprised her, Jo was able to take in this feedback, as evidenced by her thanking him and acknowledging the impact of their relationship on her. Furthermore, immediacy seemed to help Jo open up, given that she began to discuss her experience of having been molested and raped, and how these sexual assaults affected her. She acknowledged that this was the first time that she had really discussed these assaults with anyone and went on to state that she wanted to stop ignoring them.

Conceptualization of the effects of immediacy. Dr. W’s validation of her strength and ability to confront her problems gave Jo the courage to talk about very difficult topics. In addition, Dr. W’s expression of his faith in Jo’s capacity for self-healing was a way of reparenting her and sug- gesting how she could come to parent herself (see next event). His acceptance of her also seemed to allow her to accept herself and not blame herself quite so much for the terrible things she had experienced (e.g., sexual assault, abandonment).

Event 7: End of Last (17th) Session;
“Dishes and Guidance”

Context and excerpt. Right before this event, Jo and Dr. W had been talking about how poorly her mother dealt with Jo’s traumatic childhood experiences, and Jo had been exploring her relationship with her mother. Jo said that she tried to be her own mother now. Dr. W said,

T: Jo, I have this present for you . . . it’s dishes and plates. I don’t know if you need them or want them or whatever, but it’s dishes and plates and like a place setting thing.

C: Thank you.

T: And what’s the present about? It’s kind of what we’re talking about right here . . . my wish for you with this present is that in a week or a month or a year, at your house, your apartment, you’re sitting around at your table . . . having dinner with people who care about you, respect you . . . That’s the intention, that’s the meaning of the present.

C: Well, thank you, very much. I actually need plates, too.

T: Oh, good, good.

C: I actually do . . .

T: I, I wish, makes me sad [crying] I wish I could, uh, continue with you on that and it’s a loss for me that I’m not really going to be able to share all that journey, but I’m so happy to see you successfully launched on it . . .

C: But thanks to you! . . . I’m happy about that ‘cause, like I said, I really believe that God put you in my life for a reason [hands him a tissue] . . .

T: You don’t need very much help. You’re doing awfully well on your own. And just a little bit of help is enough to get you around any block you [want to] get around.

C: Thank you for I guess taking out that time to I guess listen to what I have to say and kind of understand the things I had to deal with. And not just say, “Oh, it’s okay, you’re fine,” but kind of like, “Oh, well, we can work on that.”

T: Yeah . . . I’ve felt the things you’ve talked about are profound and very important. And again you’ve just been so courageous in your ability to face or look at these things that most people just want to run away from. And you’ve sat here and you’ve done it again and you come back the next week and do it again and you come back, you’ve stayed with it, Jo. You’ve shown up here in a way that’s been so strong.

C: I’m gonna continue to show up in my life.

T: That’s right . . . maybe that’s our ending point.

C: Well, I always know where you are so if anything big happens or anything, I’ll let you know . . . Thank you, Dr. W,
for not only being my doctor, my therapist, but my friend. Because not a lot of people can say that, “Oh, my therapist is my friend,” meaning it’s not just a job and, okay, next. It’s more like we’ve developed a real friendship, a mutual kind of friendship.

T: It’s been a real relationship, right. You didn’t do this on your own, and I didn’t cure you or fix you, um, but working together we’ve had a terrific partnership.

C: I think so.

Postsession comments. The postsession comments described above for Event 6 also apply to Event 7 (about how they talked about collaborating, caring for each other, and that they were going to miss each other). In addition, Dr. W wrote, “I had a strong [countertransference] reaction as I started to cry in the session as we were saying goodbye . . . I think she took it as caring and not binding because I really do want her to move on successfully and not be seeing me in treatment, but out there living more independently and happily.”

Effects of immediacy. Dr. W and Jo were able to say good-bye and express their mutual caring. Jo seemed touched that Dr. W gave her a gift. She expressed her gratitude to Dr W, and asserted that she was going to continue to “show up” in her life.

Conceptualization of the effects of immediacy. This event seemed to us to be an example of a corrective relational experience given that it involved interpersonal learning (i.e., Jo learned how to say good-bye in a healthy way). Jo had not previously experienced a positive “good-bye” experience: Her relationships with her brother, aunt, and father had ended suddenly and painfully, preventing Jo from wrapping up the relationships or processing her feelings. Dr. W, in contrast, shared his feelings toward her and the ending of their relationship and expressed his concern and care for her future with his words and gifts (i.e., dishes and bus fare). The dishes were a tangible object by which Jo could remember Dr. W and the therapy. Being able to say good-bye well was probably associated with Jo’s positive evaluation of the session and the therapy. A critique is that Dr. W did not encourage Jo to express any possible negative feelings about the therapy.

Excerpts From the Posttherapy Interviews Related to Immediacy

In response to the interviewer’s query about how he defined immediacy and how it operated in his work with Jo, Dr. W said, This didn’t play out at all like I thought it would, the immediacy, just not at all. I thought I’d be seeing a client and saying, “Well, how does that play between you and I [sic]?” Those bread-and-butter immediacy comments really are second nature to me and I think pervade my work with most clients. And in that way it was different with Jo . . . I just didn’t need it. We were there. What was going on was almost always what I wanted to be going on or what I thought was highly therapeutic or highly useful, and I didn’t want to be anywhere else than where we were. We’d start off so many sessions in kind of this problem-solving mode, and 10 minutes into it, she’s into powerful material that was complex and affect-laden and exactly where I wanted us to be, and I just didn’t need to do that [immediacy] . . . Throughout most of the sessions we were in immediacy in the sense that we were talking very forthrightly, very directly, with great feeling, very personal . . . with Jo, there’s an emotional presence and immediacy that I don’t have with most clients or most people . . . I was compelled by her, I felt in her story, I felt she was taking in and filtering and processing and agreeing with or disagreeing with what I was saying or suggesting, and that we were very attuned and very collaborative, and that I didn’t need to alter that with the use of immediacy.

From our perspective as researchers, we agreed that Jo was very open. However, we felt that Dr. W could have used more immediacy to help Jo deal with some unexplored aspects of the relationship (e.g., the cancelled sessions, his activity level).

The interviewer also asked Jo about her reactions to immediacy in the therapy, providing examples of immediacy events from the sessions to illustrate the intervention. Her only response to queries about immediacy focused on the potential rupture in the therapy relationship:

I would actually feel sad that he would even think that I’m just missing [sessions] because I’m just not interested anymore in having these sessions or that something’s wrong with us personally because it really wasn’t. It was just if I called, if I’m sick or just anything, it was really because I was really sick. But, I never wanted him to feel that way because I knew I owed it to myself to continue.

Outcome Data

We compared the results for the postsession and prepost outcome data to data from other studies using an effect-size analysis (i.e., $d =$ difference between means divided by the standard deviation from the previous study; $d > .20$ is small, $> .50$ is medium, and $> .80$ is large). See Table 3 for means and standard deviations for the present study compared to the Kasper et al. case and the published data on the measures.

Ratings for both Jo and Dr. W were much higher than the published data for the SEQ-D ($d =$ 2.02, 1.49, respectively) and WAI-S ($d =$
Hence, both Jo and Dr. W rated the depth and working alliance very positively.

Compared to the normative data of clinical samples for the beginning of therapy, Jo was about the same on the OQ ($d = .15$), considerably more distressed on the IIP ($d = 2.98$), and had less self-understanding on the SUIP-R ($d = .44$). After therapy, Jo improved on all three measures. At follow-up, Jo stayed about the same on the OQ, continued to improve on the IIP, and declined slightly on the SUIP-R.

In terms of changes during therapy, Jo shifted in appearance (from wearing dark clothes to wearing brighter clothes) and tone of voice (from depressed and hopeless to optimistic). She also made notable gains in autonomy, moving from a bad living situation with a former partner to a better apartment by herself in a safer location. Despite being terrified, she quit her dead-end, low-paying, part-time job and got a higher-paying job; at follow-up, she had gotten an even better job that matched her academic credentials. She stood up to her mother (e.g., did not rush over to her mother’s apartment each time she called) and was able to resist some of her mother’s negative comments (e.g., asking why Jo was a homosexual). One goal that she did not meet was getting her driver’s license, although she took the test again during therapy, which required considerable effort on her part (saving money for the test, borrowing a car, and finding someone to go with her). In sum, Jo liked therapy and made dramatic changes during therapy.

**Discussion**

In this 17-session case of successful brief psychotherapy with a bright, articulate, African American, lesbian, 29-year-old woman and a verbally active, White, heterosexual, 55-year-old interpersonal male therapist, therapist immediacy had mostly positive effects. The most frequent types of therapist immediacy were reinforcing the client for in-session behavior, encouraging the client to collaborate, inquiring about the client’s reactions to therapy, reminding the client that it was okay to disagree, and indicating pleasure at seeing the client. All of the immediacy interventions were supportive in nature.

Immediacy seemed to serve four functions in this case. First, immediacy allowed Dr. W and Jo to negotiate their relationship and establish the rules for their interactions. For example, in Event 1, Session 3, when Dr. W asked whether he was talking too much, Jo assured him that she wanted him to be active. This interaction clarified that Dr. W was being responsive to Jo’s needs. Similarly, they discussed that it was okay to disagree (Event 2, Session 4), what was beneficial in therapy (Event 3, Session 5), whether there had been a rupture (Event 4, Session 14), logistics of times

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**TABLE 3. Scores on Measures for the Present Study as Compared With Kasper et al. and Published Data**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Present study</th>
<th>Kasper et al.</th>
<th>Published data</th>
</tr>
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<tbody>
<tr>
<td><strong>Average session outcome measures</strong></td>
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<tr>
<td>Client SEQ-D</td>
<td>7.00 (.00)</td>
<td>6.58 (0.68)</td>
<td>5.16 (0.91)</td>
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<tr>
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<td>5.96 (0.80)</td>
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<td>5.67 (1.28)</td>
<td>4.62 (1.08)</td>
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<td>5.92 (0.84)</td>
<td>5.50 (0.88)</td>
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<td><strong>Treatment outcome measures</strong></td>
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<tr>
<td>OQ-45</td>
<td>Pre- 84</td>
<td>Post- 65</td>
<td>F-up 64</td>
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<tr>
<td></td>
<td>Pre- 58</td>
<td>Post- 79</td>
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<td>IIP-32</td>
<td>Pre- 2.96</td>
<td>Post- 2.55</td>
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<tr>
<td></td>
<td>Pre- 1.91</td>
<td>Post- 2.47</td>
<td></td>
</tr>
<tr>
<td>SUIP-R</td>
<td>Pre- 2.33</td>
<td>Post- 5.50</td>
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<tr>
<td></td>
<td>Pre- 4.07</td>
<td>Post- 4.75</td>
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Note. F-up = follow-up; SEQ-D = Session Evaluation Questionnaire—Depth Subscale (published data from Stiles et al., 1994); WAI-S = Working Alliance Inventory-Short Form (published data from Brosseri & Tyler, 2003); OQ-45 = Outcome Questionnaire 45.2 (published data from Lambert et al. 2002); IIP –32 = Inventory of Interpersonal Problems–32 (published data from Barkham et al., 1996); SUIP -R = Self Understanding of Interpersonal Patterns–Revised (published data from Connolly Gibbons et al., 2006). Higher scores on all measures reflect higher levels of the construct; reductions in IIP –32 and OQ-45 and increases in SUIP -R reflect positive treatment outcome.
and fees (throughout), and saying goodbye (Session 17). Thus, immediacy seemed to allow them to have a better relationship and help Jo learn about how to negotiate relationships, which seems very similar to the task function of the working alliance (Bordin, 1979).

Second, Dr. W’s expression of real caring for Jo and concern for their relationship (e.g., in Event 6 he said “I respect you so much”) enabled Jo to express her immediate genuine positive feelings about Dr. W to him directly. For example, she thanked him for teaching her a lot, said that he was a gift from God, and said that she was glad to have met with him. Recall in the final session that she said “It’s more like we’ve developed a real friendship, a mutual kind of friendship,” which seemed descriptive of the real relationship (see Gelso et al., 2005). She was not able, unfortunately, to express negative feelings toward Dr. W (see Event 3), probably because of reality-based fears of abandonment from her childhood.

Third, immediacy encouraged Jo to open up and explore deeply about shame-based personal topics. Examples are in Event 1 when she started crying, in Event 4 when she talked about needing help with gynecological problems, and Event 5 when she disclosed her parents’ cruelty toward her. Such disclosures in a safe setting served a healing function, in that Dr. W’s caring seemed to help Jo begin to care about herself and activated Jo’s self-healing. Similarly, humanistic theorists (e.g., Bohart & Tallman, 1999; Rogers, 1957) postulate that the therapist’s caring about the client allows the client to care for her or himself.

Fourth, immediacy provided Jo with a corrective relational experience (defined as coming to understand or experience relationships in a different and unexpected way). Dr. W genuinely wanted Jo to find her own voice; he explicitly said several times (e.g., Event 2) that it was okay for Jo to disagree with him, and he told her he was worried that he had been too active and asked if that had caused her to withdraw from him (Event 4). Jo learned that she could be herself with Dr. W and that she did not need to be as defended as she had been with her mother and others. Being able to express herself more openly with Dr. W encouraged Jo to be genuine and trust herself in other interpersonal relationships (e.g., talking more openly with her mother and partners). Given Jo’s history of abandonment and abuse, it might have been especially important for her to have someone genuinely and nonpossessively care for her. Interestingly, Dr. W’s countertransference (i.e., overprotectiveness and high activity level) and the client’s idealization of the therapist might have actually facilitated the corrective relational experience, given that the client had experienced such impoverished interpersonal relationships previously.

These functions seem similar to those postulated for immediacy in the theoretical literature (e.g., Carkhuff, 1969; Cashdan, 1988; Ivey, 1994; Kiesler, 1988, 1996; Safran & Muran, 2000; Teyber, 2006; Yalom, 1995, 2002). Thus, this study provides some empirical support for the theorized functions of immediacy.

Although there was evidence that immediacy was helpful, there were also other factors that probably led to the success of the case (e.g., Jo was motivated to change, involved in the process, and able to form a relationship with the therapist; Dr. W was actively engaged in the process, supportive, and problem-solving; strong therapeutic alliance). Of course, there were also some imperfections in the case (Dr. W may have been too active, invested, and giving in the relationship), but the imperfections were far outweighed by the positive components.

**Comparison of Results With Kasper et al. Case**

Immediacy was expressed and experienced in very different ways in this case (in which the outcome was very successful) than in the Kasper et al. (2008) case (in which the outcome was mixed). First, immediacy occurred proportionally less often in this case than in the Kasper et al. case (12% vs. 34%) in the context of this therapist being much more active and problem-solving than the therapist in the Kasper et al. case (using 44% vs. 13% of the total words in the sessions). Second, Jo initiated several immediacy events (about being late, not being able to pay the fee, and expressing gratitude), whereas the Kasper et al. client never initiated immediacy. Third, whereas Dr. N’s (in Kasper et al.) most frequent types of immediacy were confronting and challenging (e.g., drawing a parallel from outside relationships to the therapy relationship and encouraging the client to express immediate feelings to the therapist), Dr. W’s most frequent types of immediacy were supportive and empowering (i.e., reinforcing Jo for something she did,
indicating that he wanted to partner/collaborate with her, inquiring about Jo’s reactions to therapy, or reinforcing that it was okay to disagree with him).

There were some superficial similarities between the two cases (bright, articulate, non-White female clients with older, gentle, White, male, interpersonal therapists), but the two cases were distinct on a number of crucial variables that might have affected the use and impact of immediacy. Jo had survived a traumatic abuse history, presented for therapy with severe symptoms and distressing personal issues, and showed marked vulnerability in her current functioning. In contrast, Lily (in Kasper et al.) was a well-functioning, well-defended graduate student in a mental health field, and had volunteered to participate in a research project involving therapy for problems in interpersonal relationships. Hence, it is not surprising that the immediacy interventions in the present case were more encouraging and supportive to help stabilize the client, whereas they were more challenging in the Kasper et al. case to help reduce the client’s defenses. Furthermore, Dr. N (in Kasper et al.) put high priority on processing the therapeutic relationship as an end goal, whereas Dr. W (current case) used immediacy only when needed.

Given the differences in types of immediacy across cases, it is interesting then that therapist immediacy had very similar positive effects across the two cases in that it led to both clients being immediate, helped the dyads negotiate the rules of their relationships, helped the clients express immediate feelings, and enabled the clients to have corrective relational experiences. In contrast, however, we did not find any overt negative effects of immediacy in the present case, whereas some negative effects (the client felt awkward, pressured, and uneasy with some of the therapist’s immediacy) were observed in the Kasper et al. case. Likewise, the outcome in the present case was successful in every dimension assessed, whereas the outcome in the Kasper et al. case was mixed. Although causal inferences cannot be drawn between the immediacy and outcome using a nonexperimental method, it could be that the successful use of immediacy in the current case played a role in the successful outcome.

From the data in these two studies, we conclude that immediacy can be a powerful way to bring relationship issues to the foreground and address them productively. As immediacy brings intensity to the therapeutic interaction, therapists can use conversations about what is going on between them to help clients understand more about how interpersonal relationships operate. Thus, immediacy may facilitate the development of the working alliance and real relationship and also help to resolve transference distortions.

Comparison of Results With Previous Literature on Immediacy

We conclude, as did Kasper et al. that the main similarity in types of immediacy used in this case and previous studies (Foreman & Marmar, 1985; Hill et al., 2003; Rhodes, Hill, Thompson, & Elliott, 1994; Safran, Muran, Samstag, & Stevens, 2002) was therapist encouragement for the client to express immediate feelings (e.g., Dr. W inquired about client’s reactions to therapy and inquired about possible problems in the relationship). Thus, it appears that types of immediacy depend on the therapist and client as well as what is going on in therapy (e.g., repair of a rupture vs. processing a positive event such as feeling close).

Limitations

This study provided a rich description of how immediacy operated in a single case, but we cannot generalize these findings to other cases. Indeed, we know the immediacy functioned somewhat differently in the present case as compared with in the Kasper et al. (2008) case. Further replication with other similar and different clients is necessary before we can draw firm conclusions about when and how to use immediacy.

A second limitation is that participating in the research may have changed the therapy somewhat, making it difficult to generalize to regular therapy. During the posttherapy interview, Dr. W mentioned that he was self-conscious about the research and tried to use immediacy more often than he might have otherwise, although this pressure dissipated after the first couple of sessions. He also noted that he spent at least an hour a week writing notes about the case for the research, which probably made him think more about the case than therapists typically do. In contrast, when asked how the research affected her, Jo said, “It really didn’t have any affect on me because I didn’t even think about that. I thought about okay, I’m here for a purpose, so I didn’t think about, okay, they’re taping me, so I need to...
act like this, or say this or that, or be appropriate. I was just myself. I didn’t even think about it.” Thus, participation in the research may have heightened Dr. W’s performance anxiety but did not seem to affect Jo overtly.

Furthermore, because the intake and phone calls during therapy were not recorded (and thus not included in analyses), we do not know what role they played in the outcome of the therapy. We also analyzed in depth only the most salient immediacy events, so we cannot say much about less salient events other than that they seemed at least minimally effective.

Finally, possible bias on the part of the judges must be considered. Because all judges liked immediacy and interpersonal therapy, they may have been biased to find it to be effective in therapy. We would also note that the case stimulated many feelings for the judges, which needed to be discussed to make sure that we were responding to the case rather than to our own feelings. We had a large team of judges and relied on specific data from the sessions to draw conclusions, but there was clearly an interpretive element in analyzing the data particularly in our conceptualizations of the effects of immediacy. Another research team might have come to slightly different conclusions about the functions and effects of immediacy.

**Implications for Practice and Research**

The results from this study and the Kasper et al. (2008) study indicate that immediacy can be a powerful and helpful intervention if used at the right time with the right client for therapeutic reasons in a way that fits the client’s needs. For example, it appears that it is useful for therapists to use immediacy to check in with clients about their reactions to therapy. Because clients often do not know that it is appropriate to talk about negative feelings, they might have to be encouraged to reveal such feelings, especially negative feelings about the therapist.

Another salient time to use immediacy is when there is a rupture in the relationship, as suggested by Safran and Muran (2000). Unless ruptures are brought out into the open, it is difficult to resolve them. By dealing with these immediate feelings and allowing the client to state feelings openly, changes can be made and the client can learn that it is possible to disagree and work through problems. However, the results from the current case also remind us that clients are not always willing to talk about ruptures. Thus, therapists need to be aware that clients may not be able to be immediate, especially with regard to negative reactions. They may have to assess client readiness for working immediately and determine if immediacy is appropriate. If so, they then may need to educate clients about immediacy so that they understand why it is being used.

Immediacy can also be useful at termination. Therapists can use immediacy to help clients look back, look forward, and say goodbye (Ward, 1984). Being personal at the end of therapy may help to build the real relationship (e.g., Gelso et al., 2005) and make it easier for the client to leave therapy with the therapist internalized as a good object.

In terms of future research, more case studies are needed so that we can determine characteristics of therapists, clients, and situations that call for immediacy. Researchers could also use larger sample sizes to examine the effects of immediacy more generally (e.g., interview therapists and clients about their reactions to specific moments of immediacy in sessions, manipulate the amount of therapist immediacy in sessions). In addition, research is needed about how clients with different types of defenses react to challenging versus supportive types of immediacy. Training students to use immediacy is another direction for future research, given that many beginning therapists are nervous about being immediate with clients. It would also be interesting to use the qualitative method developed for these two cases to assess the effects of other therapist interventions (e.g., interpretations, self-disclosures).

**References**


