THERAPIST IMMEDIACY IN BRIEF PSYCHOTHERAPY:
CASE STUDY I

LAURA B. KASPER, CLARA E. HILL, AND DENNIS M. KIVLIGHAN JR.
University of Maryland

The authors examined immediacy (i.e., discussions about the here-and-now therapeutic relationship) in a 12-session case of individual interpersonal psychotherapy. Therapist immediacy during immediacy events most often focused on parallels between external relationships and the therapy relationship, encouraging expression of immediate feelings, processing termination, therapist expressing disappointment/sadness/hurt and inquiring about the client’s reactions. Client involvement was slightly higher before and after than during immediacy events. On the positive side, therapist immediacy seemed to help the client express her immediate feelings about the therapist more openly, feel closer to the therapist, and become less defended. On the negative side, the client felt somewhat awkward and pressured when the therapist used immediacy. Limitations and implications for practice and research are discussed.

Keywords: immediacy, therapeutic relationship, psychotherapy process

Therapist immediacy, which we defined as disclosures within the therapy session of how the therapist is feeling about the client, him- or herself in relation to the client, or about the therapy relationship (Hill, 2004), involves discussing and processing what occurs in the here-and-now client–therapist relationship. Terms that other interpersonal theorists have used for this therapist intervention are metacommunication (Kiesler, 1988) and talking in the here-and-now about the here-and-now (Yalom, 1995, 2002). Interpersonal theorists (e.g., Cashdan, 1988; Kiesler, 1988, 1996; Safran & Muran, 2000; Teyber, 2006; Yalom, 1995, 2002) have suggested that clients reenact with their therapists the interpersonal conflicts that brought them into therapy. If therapists can use immediacy with clients to openly discuss these conflicts in the therapeutic relationship, clients can become aware of and change these interpersonal patterns. Thus, working immediately with the therapeutic relationship can help clients have a corrective emotional experience and change both internally and interpersonally.

Psychoanalytic therapists also work with the therapeutic relationship, particularly by interpreting and resolving the client (patient) transference. To describe the therapist (analyst) behavior, they use terms such as transference interpretation (Hoglund, Johnsson, Marble, Bogwald, & Amlo, 2007; Malan, 1976; Strupp & Binder, 1984), interpretation of the here-and-now transference (Gill, 1984), working in the moment (Greenson, 1967), and countertransference disclosures (i.e., a form of “clinical honesty that focuses on the
therapist’s experience of the patient in the here-and-now of the sessions,” Wilkenson & Gabbard, 1993, p. 282; or “the attempt to make explicit the analyst’s set of thoughts about the experience within the immediacy of the analytic engagement which may differ from the patient’s perception of the same moment,” Cooper, 1998, p. 379). Immediacy and transference interpretations are similar but distinct phenomena. Immediacy seeks to promote the here-and-now awareness of problematic interpersonal patterns and to create a corrective emotional experience by establishing new interpersonal patterns. By contrast, transference interpretations seek to promote the client’s awareness of the existence and insight into the origin of displaced interactional patterns by providing an explanation or reason for the behaviors.

**Empirical Studies Related to Therapist Immediacy**

A few studies have been conducted that point to the effectiveness of immediacy in therapy. Self-involving disclosures (similar to immediacy) have been found to be helpful in analogue research (e.g., viewing a videotape of therapists disclosing, Hill & Knox, 2002). Furthermore, in Hill and Knox’s (2002) review of several studies where judges coded therapist behavior in transcripts of therapy sessions, an average of 3.5% (range from 1% to 13%) of therapist interventions were self-disclosures (including both self-disclosures and immediacy).

A few studies investigated difficult events (e.g., ruptures, misunderstandings, client anger) within therapy and found that therapist immediacy was one of the therapist interventions used to resolve such events. Foreman and Marmar (1985) examined therapist actions for three clients who experienced improved alliances versus three clients who experienced unimproved alliances within therapy; all clients had adjustment disorders or posttraumatic stress disorder and initially had poor alliances with their therapists. One set of therapist action addressed the therapist-client relationship and thus seemed similar to what we are defining as immediacy. Within the set of therapist actions, the following categories were coded: defenses, problematic feelings, problematic relationship patterns, and the triangle of punishment. In the improved as compared with the unimproved cases, therapists more often addressed client defenses (e.g., “You change topics just when you begin to express feelings about me”), the triangle of punishment (i.e., the client’s expectation or believed need for punishment to assuage guilt over feelings of anger of responsibility for another person’s suffering), and problematic/negative feelings toward the therapist (e.g., “You’re feeling angry toward me” or “You seem uncomfortable with me today”). These results suggested that encouraging the client to talk about immediate, often negative feelings toward their therapists facilitates client change. A limitation of this study was the use of only one judge, which means that there were no checks on bias.

Safran, Muran, Samstag, and Stevens (2002) reviewed findings from 10 years of research on alliance ruptures. Through task analysis of a series of single sessions within cases, they found evidence for four stages of rupture repairs. The therapist first draws attention to the alliance rupture. Then, the therapist encourages the client to express negative feelings to the therapist, and the therapist responds by accepting responsibility for his or her contribution to the interaction. In the third stage, the therapist probes for any fears that may be blocking the client’s expression of negative feelings toward the therapist. In the final stage, the therapist encourages the client to express the underlying wish/need and the primary emotion associated with that wish/need. Thus, immediacy between therapist and client is central to resolving alliance ruptures. The generalizability of this model across time in a therapy case and to times within therapy when there are no ruptures need to be studied.

Rhodes, Hill, Thompson, and Elliott (1994) conducted a qualitative study of clients’ retrospective accounts of misunderstanding events in therapy. In resolved misunderstanding events, clients asserted their negative feelings toward therapists. In half of the cases, therapists responded by apologizing, accepting responsibility for the problem, or changing the offensive behavior; in the other half, clients accepted the therapist’s perceptive or decided that the therapist’s behavior was not as offensive as originally believed. In contrast, in the unresolved events, clients perceived therapists as not being open to discussing the client’s negative feelings about them. Thus, Rhodes et al. (1994) found that immediacy was one of the important factors that distinguished resolved and unresolved cases. Limitations of this study were the retrospective
nature of the qualitative interviews and the focus on only a single event within therapy.

Hill et al. (2003), in their qualitative study of the therapist’s experience of being the target of client anger, found a number of components of immediacy that were associated with resolution. Events were more likely to be resolved if therapists talked about the client anger, helped the client explore feelings about their anger toward the therapist, provided an explanation for their behavior, and apologized if their behavior was the source of the client anger. Again, however, a limitation of this study was the retrospective nature of the qualitative interviews and the use of a single event.

Although these studies provide some preliminary evidence that immediacy might be useful, immediacy has not been studied as it occurs within the course of ongoing therapy. Hence, we know very little about how much immediacy is used, what types of immediacy are used, and the effects of immediacy. Hence, the purpose of the present study was to study immediacy in a single case of brief interpersonal therapy.

Case Study Approach

A case study approach (Greenberg, 1986; Hersen & Barlow, 1981; Hilliard, 1993; Jones, 1993; Kazdin, 1981; Lueger, 2002; Yin, 1994) is well-suited to examining immediacy because it can be used to investigate how a specific therapeutic intervention (e.g., immediacy) can be used with a particular client, given a client’s presenting problems and individual characteristics. Since immediacy likely varies based on unique client, therapist, and relationship features, a case study approach seems most appropriate, especially at the early stages of investigation of this topic. The case study approach that we used in the present study was empirical in that it relied on both quantitative and qualitative analyses.

Purposes of the Present Study

Our first purpose in this study was to use a case study approach to examine how often and what types of immediacy were used by a therapist and client in one case of brief psychotherapy. We used two strategies for investigating the frequency and types of immediacy: (a) we coded whether and what type of immediacy was used in each speaking turn (defined as segments of speech in which a single person has the floor); and (b) we qualitatively examined immediacy events (beginning when one participant initiated a discussion about the immediate relationship and ending when the discussion shifted to another topic not related to the immediate relationship) for effects across a longer unit of time. These two approaches to analyzing behavior within therapy have a long history (see Hill & Williams, 2000, for review). The speaking-turn approach allows for clear identification of what is happening on a moment-by-moment basis whereas the event approach allows for more global impressions of immediacy across a larger unit of time.

Our second purpose was to examine the effects of therapist immediacy. Specifically, we wondered if therapist immediacy is associated with client immediacy, whether the client is more involved during immediacy events than before or after these events, how the client reacts to therapist immediacy, and how immediacy influences other process and outcome variables.

Method

Participants

Therapist. The therapist (“Dr. N”) was a 51-year-old White male professor of counseling psychology at a large Mid-Atlantic public university. He had 20 years of experience conducting individual and group psychotherapy. He characterized his theoretical orientation as interpersonal and indicated that he used immediacy in most psychotherapy sessions.

Client. “Lily” was a 24-year-old, female, first generation graduate student in a health services field. During the prescreening interview, she appeared anxious and eager to participate; her mood and affect were within the normal range. Her primary goal for therapy was to work on her interpersonal relationships and the patterns in her involvements with men and others. Note that details about the client’s background have been changed to preserve anonymity.

Judges. Three (1 European American, 1 Hispanic American, 1 Indian American) female undergraduate psychology students served as judges for the speaking-turn data. They ranged in age from 21 to 44, with a median age of 22, and were unaware of the purposes of the study. In addition, the first two authors (a 32 year-old female doctoral student and a 57-year-old female professor) served as judges for the immediacy events data.
Pretherapy to Posttherapy and Follow-Up
Outcome Measures

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

The Inventory of Interpersonal Problems (IIP; Barkham, Hardy, & Startup, 1996). The IIP 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. (1988) 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 (SUIP-R; Connolly et al., 1999; Connolly, Hearon, Hu, Barber, & Crits-Christoph, 2006). The SUIP-R is a 28-item self-report instrument that measures a client’s level of understanding of his or her interpersonal patterns. For each interpersonal pattern, participants identify each level of their 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). Participants also rate the importance of this interpersonal pattern in their current relationships on a 10-point Likert scale from not important (1) to very important (10). Connolly Gibbons et al. (2006) reported adequate internal consistency (.91 patients; .94 nonpatients), demonstrated that the SUIP-R was not related to self-esteem or depression, and found significant changes in clients’ self-understanding of their interpersonal patterns after interpersonal therapy compared to cognitive therapy, providing construct validity for the measure. We used the total score for this study.

Postsession Outcome Measures

The Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles & Snow, 1984). The SEQ-D is a 5-item, bipolar, adjective-anchored, self-report measure designed to evaluate the client and therapist perceptions of the quality of therapy. Stiles et al. (1994) reported significant correlations between the SEQ-D and the Understanding, Problem Solving, and Relationship subscales of the Session Impacts Scale, providing evidence of concurrent validity. Good internal consistency (.90 to .91) has been reported (Stiles et al., 1994; Stiles & Snow, 1984).

The Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is a revision of the 36-item WAI (Horvath & Greenberg, 1989) and 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 Recall Questionnaire (CRQ). The CRQ was developed for this study, based on Elliott’s (1986) brief structured recall procedure, to assess client perceptions of the session. The client rates how much, on a scale ranging from not at all (1) to the entire session (9), the immediate relationship was discussed during the session and answers open-ended questions about the content of the immediacy discussion, what this discussion was like, and what she learned about herself from this discussion. The client also indicates what the therapist did or said that was helpful or unhelpful or what she wishes the therapist had done differently.

The Therapist Process Note (TPN). The TPN was developed for the present study to assess the therapist’s perceptions of immediacy and reactions to the client. The therapist rates how much, on a scale of 1 to 9 (1 = not at all, 9 = the entire session), the immediate relationship was discussed during the session and describes how the client responded to immediacy interventions.

Judge-Rated Measures

The Speaking Turns Immediacy Measure. The Speaking Turns Immediacy Measure was developed by the first two authors to investigate
immediacy as it occurs in speaking turns. The measure was based on the theoretical and empirical literature on immediacy and revised by applying items to the data from the case. The final list of categories for therapist immediacy was (a) not immediacy; (b) feedback (therapist provides client immediate behavioral feedback based on his direct observation of something happening between them in the room); (c) inquiry about relationship; and (d) intimately self-involving statement. The final list of categories for client immediacy was: (a) not immediacy, (b) immediacy (client expresses immediate thoughts or feelings to therapist about therapist or about client-therapist relationship). Each speaking turn was assigned to one of the categories. Average kappa between pairs of raters was .72 for therapist categories and .84 for client categories.

**Client involvement.** The Client Involvement (CI) scale assessed the client's level of involvement in speaking turns during psychotherapy and was designed for the current study based on related measures (Eugster & Wampold, 1996; Wonnell & Hill, 2002). CI was defined as the amount of energy expended in therapy, as manifested by the client's expression of affect, depth of self-disclosure, focus on self versus others, and responsiveness to the therapist's direction. Ratings for this scale were made on a 5-point Likert-type scale (1 = low involvement, 5 = high involvement). Interrater reliability (alpha coefficient) for client involvement in the current study was .89.

**Procedures**

**Therapist recruitment.** Dr. N was asked by the first author to participate because of his reputation for using immediacy. Dr. N was told that we were investigating immediacy but was not informed about the specific research questions.

**Client recruitment.** A client was recruited from faculty, staff, and graduate students at local universities through email listservs. Potential clients were told that they would receive up to 15 sessions of free therapy for their participation in the research. Of the 12 people who expressed an interest in participating in the study, six were screened during a telephone interview. They were first informed about the procedures of study (up to 15 50-min sessions and a posttherapy interview; measures to be completed before therapy, before and after every session, at posttherapy, and at a four month follow-up) and then questioned to determine if they met the selection criteria (no current disordered eating; no history or current abuse of alcohol or other drugs; and no past or current suicidal ideation, gestures, or attempts) so that we would have an appropriate client for brief therapy. Those people who were not selected were provided with referrals.

The first author did a face-to-face interview with the three persons who met these requirements. After potential clients signed a consent form for the interview, the first author queried to determine if their presenting concerns were interpersonal in nature. She also used mild immediacy probes (e.g., “How are you responding to talking to me right now?”) to see how the person responded to immediacy. Lily was selected because she conceptualized her problems as predominantly interpersonal, seemed motivated to change interpersonal patterns, and responded positively to immediacy probes in the interview. Those not selected were provided with referrals.

**Judge recruitment.** Judges were recruited through announcements in upper-level psychology courses and through a departmental listserv. Of nine students who volunteered, three were selected who were interested in psychotherapy research and had a broad understanding of the constructs of interpersonal patterns and client involvement in therapy.

**Pretreatment assessment.** Lily came in one week prior to the first session to sign a consent form for the testing and therapy and complete the OQ, IIP, and SUIP-R.

**Sessions.** Prior to each session, Lily completed the OQ. Dr. N then conducted sessions in his normal style (no restrictions were placed on him). The first author observed sessions from an adjoining room and took care of all logistical details for the research (e.g., measure completion). After each session, Lily completed the SEQ–D, WAI-S, IRQ, and CRQ (she was informed that Dr. N would not see her completed measures while she was in therapy). In a separate room, Dr. N completed the SEQ–D, WAI-S, and TPN. Measures were administered in a random order.

**Post treatment.** One week after the final session, Lily completed the OQ, IIP, and SUIP-R. She then participated in a 50-min face-to-face, videotaped interview with the first author to discuss her reactions to the study, be debriefed about the purposes of the study, and indicate how she
would allow us to use the tapes of the sessions (e.g., for the research project, for professional workshops, for undergraduate or graduate education). In addition, two weeks after the final session, Dr. N participated in a 50-min face-to-face videotaped interview to discuss his reactions to the study and indicate how he would allow us to use the tapes of the sessions.

Follow-up. Four months after termination, Lily completed and returned the OQ, IIP, and SUIP-R via mail. She included a note indicating that she was studying for a major set of exams and was concerned that this might have influenced her scores.

Session transcription. All sessions were transcribed by undergraduate assistants and checked by the first author. All identifying client information was removed from the transcripts.

Training judges and coding immediacy in speaking turns. The three judges read about immediacy (Kiesler, 1996; Teyber, 2006; Yalom, 1995, 2002) and discussed the definition used for this study with the first author. Next, they practiced coding by assigning one category of the Immediacy Measures to each therapist and client speaking turn. They were instructed to base their ratings on what was actually said and not to let personal judgments or reactions to the content or participants influence their responses. They were trained about eight hours until they achieved high reliability (>.70 kappa). Judges then independently coded therapist and client immediacy in each speaking turn (sessions were coded in a random order). Immediacy was considered to have occurred in a speaking turn if at least two judges coded it. When all three judges disagreed, they discussed their decision until reaching consensus on the final coding for that turn.

Training on and rating client involvement in speaking turns. At a later time, the same judges discussed the definition of client involvement and then practiced rating client involvement from published transcripts and on one session from the current study. Training continued about eight hours until judges achieved high reliability (> .70). The three judges then independently rated client involvement in each client speaking turn of all sessions (sessions were coded in a random order), resolving disagreements through consensus.

Immediacy event identification and coding. Based on reviewing the transcripts of sessions, the first two authors identified immediacy events, which began when either participant initiated a discussion about the immediate relationship and ended when the topic shifted away from the relationship. This analysis revealed 33 immediacy events across all 12 sessions. For each event, they coded types of immediacy using categories that emerged from the therapy content (e.g., drawing parallel between external and therapy relationship), who initiated the event, whether the bid for immediacy was accepted (i.e., the other person continued the immediacy discussion), and reviewed when the events occurred to determine if there was pattern in the events. In addition, they judged whether Lily’s postsession written reactions were associated with specific immediacy events in sessions. All tasks were done via consensus.

Results

Overview of Case

Lily primarily explored concerns about her relationships with men. As she said at the beginning of Session 1, I “have everything going for me in terms of school and work and have no concerns there. It is more of the personal realm that I’m concerned about. . . I get into a lot of maladaptive relationships and dysfunctional relationships. And I’m trying to figure out why it is that I do that and how I can go about changing my patterns.” She had a tendency to be attracted to men who were not her peers in terms of education or social class, who were not very responsible, and who her parents were likely to reject. She had a pattern of getting too close to men quickly, wanting to be “doted on,” wanting to change them, having a hard time expressing her feelings toward them, and then backing off and ruminating and feeling hurt when they did not respond as she wanted. She felt insecure about being loved and reacted strongly to any indications of withdrawal or rupture in relationships.

Lily also talked a lot about her relationship (she was an only child) with her parents who had immigrated to the U.S. when Lily was very young. Her mother’s job was a source of stress for the family given her mother’s resentment about having to take a job in the U.S. that did not befit her high educational status. Her father told Lily not to “become like your mother.” Indeed, Lily had had a tumultuous relationship with her mother growing up but now was quite close to her, talking with her on the phone several times a
day. Lily described her father, who had an important career, as the center of her life growing up. But she also said that he often withdrew and would not talk to her for days if he was upset about something she did. In Session 4, Lily said, “I live my life for my parents, which is how I like to live my life. I enjoy having my goals intertwined with my parents’ goals because what makes me happy makes them happy and vice versa, and that’s my culture, and I have no problem with that.”

In terms of the relationship between the Dr. N and Lily, they started out with some initial awkwardness and hesitance about how to manage the relationship. There was also some initial flirtatiousness on both sides, which dissipated after about Session 5. Typically, Dr. N would begin the sessions by asking Lily about her reactions to the previous session. She would respond minimally to the query and then start talking about her latest “drama.” Lily related in a somewhat intellectualized manner, doing a lot of storytelling about events that had happened during the week. She would often talk uninterrupted for long periods of time. Dr. N spoke an average of only 13% of the words, ranging from 7% to 21% with no discernable trend across sessions. Dr. N listened attentively and occasionally would ask her about feelings (usually about sadness and hurt). At some point toward the end of the sessions, Dr. N would become more active and draw parallels between what was going on in the outside relationships and how that might play out in their therapeutic relationship. Starting about midway through the therapy, Dr. N started talking about termination, asking Lily if she would be “sad” when they terminated. They spent the last two sessions talking about changes Lily had made and about their relationship. They clearly had a strong bond, a good alliance, and liked each other.

Speaking Turn Analysis

Frequency and types of immediacy in speaking turns. The number of times a therapist or client immediacy action occurred in a speaking turn was divided by the number of total speaking turns for that participant in the session. Dr. N overall used immediacy in about a third of his speaking turns ($M = .34, SD = .12$). In terms of subtypes of immediacy, Dr. N most often used inquiry about the relationship ($M = .25, SD = .11$), then

intimately self-involving statements ($M = .05, SD = .04$), and least often used feedback ($M = .05, SD = .05$). Hence, Dr. N’s relative focus was primarily on asking Lily to explore the relationship, but he did not reveal much about his own immediate feelings about the relationship or give feedback. Lily used immediacy in 37% of her speaking turns ($SD = .16$).

Effects of Immediacy

Association between therapist and client immediacy. When Dr. N used immediacy, Lily was immediate in 79% of her next speaking turns. When Dr. N did not use immediacy, Lily was immediate in only 20% of her next speaking turns. The chi-square between therapist and client immediacy was significant, $\chi^2(1, 539) = 169.75$, $p < .00$. Hence, Lily was more likely to be immediate when Dr. N was immediate (recall that Dr. N initiated all of the immediacy).

The relationship between Dr. N’s and Lily’s overall use of immediacy in speaking turns across sessions was assessed using a Spearman’s correlation (because normality of data could not be assumed for the small sample of 12 sessions). The proportion of time Dr. N used any kind of immediacy in each session was significantly related to the proportion of time Lily used immediacy, $r(10) = .81, p < .01$. Furthermore, significant correlations were found between the proportion of Dr. N’s inquiry about the relationship and client immediacy, $r(10) = .63, p < .05$, and proportion of intimately self-involving statements and client immediacy, $r(10) = .58, p < .05$, although the relationship between therapist feedback and client immediacy was not significant, $r(10) = -.25, p > .05$. Thus, client immediacy occurred in response to Dr. N’s inquiries about their relationship and his use of intimately self-involving statements, but not in response to Dr. N’s feedback about Lily’s immediate in-session behavior.

Association between therapist immediacy and client involvement. Of the 33 immediacy events, 22 events had at least three client speaking turns prior to the start of the event. A paired-samples $t$ test on client involvement in the three prior speaking turns ($M = 3.36, SD = .55$) with client involvement during the events ($M = 3.17, SD = .51$) was not significant, $t(21) = 1.31, p > .05$, although the small effect size ($d = .36$) suggested that client involvement was slightly
lower during events. Of the 33 immediacy events, 17 events had at least three client speaking turns after the end of the immediacy event. A paired-samples t-test on client involvement during the events ($M = 3.26, SD = .67$) and the three subsequent speaking turns ($M = 3.54, SD = .51$) was not significant, $t(16) = -1.86, p > .05$, although the small effect size ($d = .47$) suggested that client involvement scores were slightly lower during immediacy events. Taken together, these results suggest that client involvement was slightly lower during immediacy events than before or after. Furthermore, trend analyses indicated no linear, quadratic, or cubic trends in client involvement scores across events, so client involvement during immediacy events did not change across time ($M = 3.16, SD = .55$). In sum, Lily’s involvement was slightly lower during than before or after immediacy events, and she did not become more involved as therapy progressed.

Qualitative Analyses of Events

**Frequency and types of immediacy.** In this section, we describe the 10 types of immediacy that emerged from the qualitative analysis of the 33 immediacy events (each event could involve more than one type of immediacy). Note that these types of immediacy did not correspond with the types of immediacy identified during the speaking turn analysis. Event types are presented in descending order of frequency of occurrence (see also Table 1). Dr. N initiated all 33 immediacy events. Lily responded with immediacy to all but seven of Dr. N’s bids for immediacy. We speculated that client factors (i.e., sex, culture, age, educational differences) may have played a role in her lack of initiation. Dr. N provided some support for this assertion when he noted the existence of sex role expectations for this client in Session 7, “It sounds like you do have a lot of rules about how girls are supposed to be and how guys are supposed to be.”

**Drawing parallels between external and therapy relationships.** Dr. N often (16 events in 11 sessions) drew parallels between something Lily was discussing about outside relationships and the therapy relationship (e.g., “How does that pattern happen in our relationship?”). In one example (Session 2), Lily had been talking about putting a wall up and not letting people know how she feels; she was afraid that she would get hurt even though she “yearns to connect.”

Dr. N: How that might happen in here? How might you sort of put up a wall with me?

Lily: I don’t know. I mean possibly in the sense I want to kind of remain poised and like stable or strong and secure. But I mean like it’s kind of, again that’s contradictory in itself because I’m like very willing to open up and tell you like all my weaknesses.

Lily then shifted the discussion back to relationships with friends and times that she felt hurt. Dr. N. intervened, “If I said something that hurt you, would you tell me?” Lily replied, “If you asked me. I don’t know that I would say ‘that hurt me.’” When Lily then went back to talking about difficulties in expressing her feelings in relationships with men, Dr. N said, “I wanna get back to it. It still scares me a little bit if I did something that hurt you. . . sometimes I don’t, I don’t realize and you might not even give me a signal sometimes,” Lily laughed and said, “Well you could usually tell. Like, I hold my emotions on my sleeves, so I get quiet. . . but I will definitely try to make an effort if something like that comes up.”

In Lily’s postsession comments across sessions, she often indicated that she applied what she was learning in therapy to other relationships. She did not, however, make reference to any specific immediacy comments related to parallels between outside relationships and therapy. Hence, it appears that Lily responded somewhat positively to this type of immediacy but may not have understood them entirely.

<table>
<thead>
<tr>
<th>Category</th>
<th># Events</th>
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<tbody>
<tr>
<td>1. Drew parallels between external and therapy relationships</td>
<td>16 events</td>
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<tr>
<td>2. Encouraged expression of immediate feelings</td>
<td>15 events</td>
</tr>
<tr>
<td>3. Processed termination</td>
<td>11 events</td>
</tr>
<tr>
<td>4. Felt disappointed, sad, or hurt</td>
<td>9 events</td>
</tr>
<tr>
<td>5. Inquired about reactions</td>
<td>8 events</td>
</tr>
<tr>
<td>6. Inquired about his impact on her</td>
<td>8 events</td>
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<tr>
<td>7. Expressed caring</td>
<td>7 events</td>
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<tr>
<td>8. Felt close</td>
<td>5 events</td>
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<tr>
<td>9. Wanted to connect</td>
<td>4 events</td>
</tr>
<tr>
<td>10. Felt proud</td>
<td>2 events</td>
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Note. Based on 33 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.
Encouraging expression of immediate feelings. Next most often (15 events within 10 sessions), Dr. N encouraged Lily to express immediate feelings to him. In one event (Session 6) when Lily had been ruminating about fears of her boyfriend breaking up with her, Dr. N said, “There’s a lot of sadness in some ways when you talk about that. It’s like you touch on that sadness and then you go away from it with words. Your words take, what, what’s scary about letting me see that sadness?” Lily responded, “For one, I realize like it’s silly the way I think” and then returned to talking about her lack of trust in herself and in her boyfriend. A while later, Dr. N came back again and said, “But before you tell me that, what, what’s hard about staying with that hurt? And even more, what’s hard about letting me see that?” She replied, “I think it’s less the worry about letting you see it and more the worry of allowing myself to acknowledge that about myself, that I could be a bad person cause I consider someone who cheats horrible.” Lily commented afterward, “He dove deeper into the reasons for my fears [of talking about sadness] which brought out feelings I rarely discuss but need to!”

In this instance, then, Dr. N’s immediacy helped Lily express deeper feelings and gain insight into herself, although it did not foster discussion about their relationship.

Processing termination. Beginning in Session 4 and continuing throughout the rest of treatment (11 events), Dr. N asked Lily about her reactions to termination, feelings about the termination date, reactions to the length of treatment, and any hesitations she felt discussing their upcoming ending. As an example, after a review of how Lily was feeling about changes she had made (Session 11), Dr. N asked, “I’m wondering how you’re feeling about this being our next to last session. What are you doing with that?” Lily ignored the bid for immediacy and continued talking about needing to protect herself against sadness and being hurt by her boyfriend. Dr. N intervened, “Is that happening at all in our ending? Are you letting me know, are you not telling me how sad you are?” Lily responded, “Mmm, no, because when we talk about our ending, I definitely let you know it’s a disappointment to me,” but that she did not like to think about things until they happen but then “I hurt like hell in the end.” Dr. N then said, “I don’t want that to happen with me. I want you to feel the, whatever the feelings are, whatever that sadness is. I don’t want it to happen after the fact.” Lily responded, “Yeah, it’s just that the hard part is like I don’t, I can’t predict what it will feel like... because I’m out of touch with that level of emotion.”

Lily wrote afterward, “He asked about the sadness I’ll feel when we terminate, which makes me feel a bit pressured to say I’ll feel sad while I’m not sure exactly how I’ll feel. ... I just feel a bit of a pull to say I’m sad, but admittedly I do feel sad now that I’m writing this versus before when we were discussing [termination].” In general, then, although she resisted thinking about and feeling the sadness and seemed to feel pressured to respond in a particular way, Lily seemed to appreciate the opportunity to think about termination ahead of time given that it helped her talk about feelings that she did not usually allow herself.

Feeling disappointed, sad, or hurt. Dr. N expressed feeling disappointed, sad, or hurt with respect to Lily and examined the impact of his expression of these feelings on Lily (nine events between Sessions 4 to 10). In one of these events, Dr. N addressed Lily’s lack of a strong reaction to their termination date (Session 8), “Last week when we were talking about when we’re gonna end and how long we’re gonna go... I was sort of wondering what’s going on that it doesn’t seem like it matters to you one way or the other how long we [meet].” Lily responded, “No, actually, the truth of the matter is, like I mean I think I mentioned to you that I would like to go on more than 12.” She went on to say that it would be “selfish” to tell him that she would prefer to go 16 sessions. He said, “So you didn’t in some ways wanna hurt me or upset me, put me in a bad place or make me feel guilty.” After discussing this more, Dr. N said, “For me it hurt, that it felt like it didn’t matter [to you] how long we [met].” In this event, Dr. N wanted Lily to admit that she wanted more sessions even though they could not have more than 12 sessions, thus allowing her to express her feelings about their relationship. Afterward, Lily wrote,

This was really an incredible session and I really feel much closer and more attached to Dr. N. It was knowing how disappointed he seemed at the thought of my distance (over discussing our ending) and I never would have realized this if he hadn’t brought it up... It’s amazing to know what a strong effect I can have on someone... This led to a very vulnerable discussion of how I relate to people and the negative effects of this.

Overall, Lily had positive reactions to Dr. N’s expression of sadness and hurt in these events, as
they appeared to help her feel validated and cared for, and allowed her to accept her own sadness more. Lily also appeared to feel challenged, cared for, and hurt, however, when Dr. N expressed that she had hurt him. Specifically, Lily commented that an event in Session 5 was, “Very difficult! Very effective and eye opening but painful. It hurt me to think I might have hurt him by doubting his care for me.”

**Inquiring about reactions.** Dr. N often (eight events in eight sessions) inquired about reactions to his interventions, the previous session, or to treatment in general (e.g., “Any reactions to our last session?”). The best example came in Session 4. Dr. N opened the session by saying,

Dr. N: Reactions to last time?

Lily: It was awesome. I mean I honestly left the session feeling, I felt at peace . . . When you told me that I had seemed warmer and stuff, it was just kind of inspiring to me . . . and I’ve since tried even more of the open, honest disclosure thing and it’s been awesome lately . . . I just left feeling like it was just a fabulous session for me.

Dr. N: And at least part of that was because of me talking about the softness?

Lily: About our relationship, yeah. It was kind of nice to think I could be that fragile person that I’m always so scared that I am . . .

Dr. N: That makes me feel good that you would trust me to see that piece of you . . .

Lily: Like one of the things is I get paranoid when you get silent . . . You’ll look off, and I’m like, “Is he waiting for me to say something, am I being a bad client . . . I don’t know what you’re doing, and so at those moments I generally start kind of thinking in my head of like, like, maybe you’re out of material or what you’re talking about is not getting you ready to change subjects . . .

Dr. N: Would it be okay to check that out with me where I am?

Lily: (laughs) I guess it would. Probably I’d feel like I’d be pestering.

In general, these discussions gave Lily permission to talk about what she was feeling in the relationship, open up, feel comfortable talking about her reactions, and think more deeply about her experience in therapy. Some of Dr. N’s attempts to reflect on their work together, however, felt out of place for Lily. She indicated on post-session questionnaires that she sometimes felt pressured to respond to these inquiries, particularly when Dr. N asked specific questions, such as “What was today like?”

**Inquiring about his impact on her.** Dr. N explored his impact on Lily (e.g., “Does it matter what I think about your boyfriend?”) in eight events between Sessions 3 and 6. In these events, he inquired about Lily’s concerns over his opinion of her and discussed his concerns about the influence he had on Lily. For example, in Session 4 after Lily has been talking about paying too much attention to other people’s reactions instead of her own feelings, Dr. N said, “I wanna play out a scenario for a second . . . What if you get there [making a decision], what if I say, ‘You know, I’m kind of disappointed that that’s where you ended up.’ What would you do with that?” Lily said, “I think that would be comforting to me, and I’d be disappointed in myself. I think I would be like, ‘He’s right.’” Later, Dr. N returned to this theme, “I could have a lot of power over you if you’re worried about disappointment. That scares me.” Lily responded well to this intervention, talking about how she is easily influenced by people and then she acts “cold and bitchy, but I won’t completely cut off all ties.” Dr. N then said, “Is it possible for me to be disappointed in something you did or in a decision you made and to know that I still care about you? Lily wrote afterward, “He mentioned having fear of having power over my vulnerabilities. He was very open!” Hence, this interaction, which was more of a hypothetical situation, helped Lily explore how she reacted to other people.

**Expressing caring.** In these events, Dr. N expressed that he cared about Lily, explored the extent to which she felt his caring, and discussed his reactions to her acceptance of this caring (seven events, Sessions 4 to 10). In one such event, Dr. N said (Session 5), “It does hurt that you don’t . . . see that I do care . . . I will miss you as a client. I feel . . . like I have some responsibility to you to do my best as a therapist. And there’s a human piece too, and that’s the piece that seems harder for you to feel or accept.”

Lily wrote afterward, “It was a bit strange at first because it’s hard to conceptualize a professional relationship to a human real-world one, but we had a valuable discussion . . . This was a very powerful session.” In general, Lily appeared to feel special that Dr. N viewed her so positively. Lily wrote after Session 4, “His openness and honestly was shocking! I feel tingly still about the things he said. I truly feel more satisfied with this experience. While I will always wonder if his expression of liking me is part of the experiment, a bigger part of me truly believes what he says. I
feel totally connected and warm right now.” On the negative side, Lily indicated in the post-therapy interview that she felt awkward discussing Dr. N’s caring for her.

**Feeling close.** In five events (in Sessions 3 and 10), Dr. N mentioned feeling close to Lily (e.g., “I feel closer to you when you’re softer”). For example, Dr. N said (Session 3), “What did you do with me saying about you being softer, about feeling closer to you when you were [softer]?” Lily responded, “Honestly, it was really nice to hear that.” Lily wrote afterward, “Dr. N disclosed that I seemed warmer today and knowing that he felt more connected to me sounded great,” suggesting that she liked hearing that showing vulnerability fosters closeness.

**Wanting to connect.** In four events (in Sessions 1, 2, and 10), Dr. N expressed a desire to connect with Lily (e.g., “It’s important to me to connect with you”) and asked for Lily’s reactions to his expression of this desire. At the beginning of Session 2, for example, Dr. N wondered aloud about why he had disclosed to her at the end of Session 1 that he was also an only child because “I don’t typically do that.” Lily laughed and asked, “Did you come up an answer?” Dr. N (also laughing) said, “I came up with something I said, ‘I feel closer to you when you’re softer’.” Lily wrote afterward, “Dr. N disclosed that I seemed warmer today and knowing that he felt more connected to me sounded great,” suggesting that she liked hearing that showing vulnerability fosters closeness.

**Feeling proud.** Dr. N indicated feeling proud of Lily (e.g., “I am proud of you”) in two events in the final two sessions. In Session 11, for example, Dr. N said, “You were talking earlier about being pleased with some of the changes that you see yourself having made and where you are now. And the thought that went through my head at the time that I wanted to share with you was that I’m also really proud of you. It seems like you’ve worked really hard to try to do things differently both in here and in your relationship with [boyfriend].” Lily responded, “Thank you. I mean that’s really, really nice to hear.” She then went on to say that her mom just yesterday said, “‘You haven’t changed a bit’ and that kills me.” Lily wrote afterward, “It was also incredibly refreshing to hear him say he is proud of changes I’ve made . . . This was a great session.”

**Client Reactions to Immediacy**

In the material presented above in the qualitative analysis of the events, Lily had mixed reactions to Dr. N’s immediacy. On the one hand, immediacy helped her open up, express feelings that she did not usually allow herself, feel closer to Dr. N, feel cared for, and satisfied with the session. On the other hand, immediacy sometimes made her feel pressured to respond, awkward, vulnerable, challenged, and hurt. In the final session, Dr. N asked Lily about what he did that was helpful or not helpful for her. Among other therapist interventions cited as helpful (e.g., silences once she understood them, mirroring her feelings, hearing his perspective about why things were happening, pointing out that she did not allow herself to enjoy the good moments, noting when she seemed “soft” and easy to connect with), Lily said,

> When you would ask me like what I was feeling toward, you know, what was going on in the sessions, things like that, that was also helpful because I’m not the type of person who will just volunteer information, but when kind of prompted, it’s very easy for me to let you know, so I appreciated kind of having that context, even to the point of challenging me on something, I thought that still was helpful.

In terms of unhelpful things, she said “there really wasn’t much that stood out to me as unhelpful.” In relation to immediacy, however, she went on,

Lily: I kind of was wondering if this was part of the study itself or something, you know toward the end of a session and we were talking about something, you would ask how I felt about our relationship in here was going, and a couple times I was like well, I don’t really know if that’s relevant or if that fits the situation I’m going through but I’m sure there’s a...
purpose to it but I didn’t really look at those as negatives. I just looked at those as things that maybe I didn’t understand and you kind of got something out of it.

Dr. N: So sometimes when I would ask about our relationship it felt like it was [moves hands away]?

Lily: Kind of a little unconnected, like sometimes I could see how the two were connected, but sometimes I didn’t. So it felt like maybe that, it just came across as a little bit artificialish . . . I didn’t consider it to be unhelpful, just neutral.

Dr. N: It’s interesting because in some ways, it is part of the study, but in some ways not in the ways you’re thinking. It’s more that the reason I’m in the study is because that’s what I do rather than the study asked me to do something. But that’s something I would normally do. I always think it’s important to look at our relationship.

Later in the session Lily said, “They [immediate conversations] were definitely harder for me. It was definitely much more difficult to answer questions about how we’re doing here. But I mean I did it, and I’m glad we did, but those were more challenging for me than just sitting there talking about my relationships with other people or . . . stuff that was not immediately . . . accessible in the room.” And then she said,

My . . . honest answer is I’m so used to doing what’s asked of me, which is a sad way to look at it because it’s basically I’m following directions, but it’s very hard for me to go against authority . . . but to me that was a direction and that was what you wanted of me [to use immediacy] and that was what was expected of me and that’s what I did . . . Had I maybe thought that it was okay to not provide that information without hurting your feelings or anything, [but] I don’t know that I would have been that brave, and in way I appreciate being forced into situations like that.

Hence, from these statements in the final session, Lily found immediacy helpful because it got her talking about relationship issues that she would not have otherwise discussed. On the other hand, Lily felt a little put off by the immediacy because she did not always understand the reason for it. She also indicated that immediacy was difficult and that she engaged in it mostly out of deference because it was expected of her.

Quantitative Indices of the Outcome of the Case

We compared the results for postsession and prepost outcome data to published data using an effect size analysis ($d$ for the difference between scores of this case and the mean of published data divided by the standard deviation of the published data); $d > .20$ is small, $.50$ medium, and $.80$ large. See Table 2 for the means and standard deviations for measures used in the current study and published data.

Both Lily and Dr. N ratings were higher than the published data for both the SEQ-D ($d = 1.56$, .97, respectively) and WAI-S ($d = .83$, .48, respectively). Hence, Lily and Dr. N rated the session depth and working alliance very high, indicating that they liked the process.

### TABLE 2. Scores on Process and Outcome Measures Compared to Published Data

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<tr>
<th>Average session outcome measures</th>
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<tr>
<td></td>
<td>Present study</td>
<td>Published data</td>
</tr>
<tr>
<td>Client SEQ-D</td>
<td>6.58 (0.68)</td>
<td>5.16 (0.91)</td>
</tr>
<tr>
<td>Client WAI-S</td>
<td>6.62 (0.51)</td>
<td>5.96 (0.80)</td>
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<tr>
<td>Therapist SEQ-D</td>
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<tr>
<td>Therapist WAI-S</td>
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<tr>
<th>Treatment outcome measures</th>
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<tr>
<td></td>
<td>Present study</td>
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<tr>
<td>OQ-45</td>
<td>Pre</td>
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<tr>
<td></td>
<td>58</td>
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</tr>
<tr>
<td>IIP-32</td>
<td>1.91</td>
<td>2.22</td>
</tr>
<tr>
<td>SUIP-R</td>
<td>4.07</td>
<td>4.71</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.
At pretherapy, Lily was much less distressed on the OQ ($d = 1.10$), more distressed on the IIP-32 ($d = .64$), and functioning better on the SUIP-R ($d = .76$) than clients in published data. Hence, she had few symptoms, was not functioning well interpersonally, and had high self-understanding. During treatment, her OQ score was relatively consistent ($M = 57.65$, $SD = 11.56$), suggesting that she did not vary much in terms of symptomatology (this was verified by observation of the graphed data). At posttreatment, Lily was higher than the published data for all three measures (OQ, IIP, and SUIP-R). Hence, she got worse in terms of symptomatology and interpersonal functioning but improved in terms of self-understanding. At follow-up, Lily’s scores were still higher than the published data for the OQ, IIP, and SUIP-R (post-data were used for comparison on the IIP and the SUIP-R). Essentially, she did not change much from posttreatment to follow-up.

In the final session, Dr. N asked Lily, “What are sort of the highlights of what you’re taking away?” Lily responded,

I think the biggest thing is just the self-awareness aspect. That, to me, is the hugest thing cause that’s something, like I said, I never used to engage in. I just acted upon whim and you know on emotion. Whereas now like I try to, while I still feel the emotion, I try to stop myself and think about that emotion and analyze that emotion, and figure out why am I feeling this? . . . Probably that it’s okay to be more open with people. I mean just the times that I did kind of open up to you and the way you reacted I think definitely encouraged me to look at myself in a very different perspective and see that you know like maybe other people don’t see me the way I always think they do and that maybe I have a lot more to offer than I realize.

Dr. N then said how he thought Lily had changed: “You seem softer . . . it feels like there’s more room to move toward you, there’s more space to connect.”

In sum, Lily gained in self-understanding and self-awareness, and seemed to soften or open up in her presentation style so that it was easier to connect with her. Perhaps in a related way, she got worse in terms of symptomatology and interpersonal functioning.

**Discussion**

Immediacy had mixed effects in this case. On the one hand, the client was more immediate when the therapist was immediate, so therapist immediacy helped the client open up, express feelings that she did not usually allow herself, feel closer to Dr. N, feel cared for, and feel satisfied with the session. On the other hand, immediacy sometimes made the client feel pressured to respond, awkward, vulnerable, challenged, and hurt. We conclude that therapist immediacy can be very useful but can also have some negative effects. Perhaps it is related to note that the outcome of the case was mixed.

**Speaking Turn Analysis**

Dr. N used immediacy in about a third of his speaking turns, which is high compared with therapists in other studies (in the Hill & Knox (2002) review, therapists used an average of 3.5%, with a range of 1% to 13%, of self-disclosures, which includes immediacy). His immediacy took the form of inquiring about the relationship.

Similarly, the client used immediacy in about a third of her speaking turns, always in response to Dr. N’s immediacy. She responded to his bids for immediacy in relation to inquiries about the relationship and intimate self-involving immediacy, but not to feedback. Perhaps inquiries about the relationship demanded Lily to respond with immediacy, since they were in the form of a question. In addition, because intimately self-involving statements are so personal, Lily may have also felt a demand to respond with immediacy. Because feedback alone did not require a response, Lily may not have felt the same demand to respond with immediacy. These results have made us rethink our definitions of immediacy; we would now drop feedback.

It is interesting to note that the client was less involved during the immediacy events than before or after the events. We interpret these results as reflecting the client’s discomfort with immediacy.

**Qualitative Analysis of Immediacy Events**

Because we felt that the results from the speaking turn analysis were limited in terms of their clinical richness, we reanalyzed the data from a qualitative method looking more broadly for types of immediacy. We found these results to be more clinically meaningful.

The most frequent types of therapist immedi-
acy during immediacy events involved trying to help Lily become more immediate in the moment and were thus relatively challenging of her defenses. Dr. N drew parallels between what Lily was talking about in relation to outside relationships and asked if she had similar feelings to him. He also encouraged her to talk to him about what she was feeling in the moment, and he inquired about her reaction to his interventions. In a related note, Dr. N talked about his own immediate feeling of wanting to get close to Lily, feeling disappointed and hurt when she pushed him away, and feeling close and proud of her. Given that Lily did a lot of storytelling and distanced herself from her immediate feelings, these interventions were useful as a way of challenging her to live more in the moment and deal with the therapeutic relationship, but they were also uncomfortable because Lily was not used to responding in such a direct way.

Lily had the strongest reactions on the postsession questionnaires to immediacy events in which Dr. N expressed direct feelings to her. Perhaps one reason Lily had such strong reactions to these events is because Dr. N’s openness with his feelings about her was surprising to Lily (e.g., “His openness and honesty was shocking!”). In certain theoretical approaches to psychotherapy (Beck, 1995; Watson & Tharp, 1997), therapists are not generally encouraged or expected to share personal feelings about clients directly, so it seems understandable that a client might find such statements on behalf of Dr. N surprising.

Integration of Data

Although Lily said on the postsession questionnaires that she was deeply impacted when Dr. N directly expressed feelings to her, quantitative analyses did not reveal this impact (e.g., client involvement was actually lower during immediacy events). Lily was aware of her strong reactions to these events, but did not directly express her reactions to Dr. N in sessions. Possible explanations include the fact that immediacy was difficult for her in general, her desire not to hurt Dr. N’s feelings or other fears about his reactions, and her beliefs about what was appropriate for her to discuss with Dr. N based on gender role expectations and/or cultural differences (see next paragraph for more discussion of this possibility). In addition, Yalom (2002) suggested that immediate conversations are not typical in most clients’ lives, so perhaps Lily did not know how to express her feelings to Dr. N in a productive way or perhaps she did not feel confident doing so. When reading this paper, Dr. N wrote, “The other question is why did I not notice Lily’s lack of strong reaction to my statements of feelings to her. Perhaps it was my countertransference. I got so caught up in my reactions to my own expressions of feelings toward her that I did not notice how she was responding, or not responding.”

Sex differences in this therapist-client dyad may also have played a role in how involved Lily was in sessions in response to different immediacy statements. She sometimes seemed to feel awkward having a male therapist make statements about caring and connecting. In the posttreatment interview, Lily said, “I think there was a lot of awkwardness that wouldn’t have come up with a woman . . . Had we discussed it [the sex differences], it would have put some of my thoughts about it to rest . . . The [his] wedding ring was reassuring.”

We would also note that since most of the discussion in the therapy related to problems Lily had in relationships with men, it will may be that she reenacted those interpersonal problems in her relationship with Dr. N. This hypothesis is supported by the initial flirtatiousness in the first few sessions. We wonder what the process and outcome of the therapy would have been if Lily had been paired with a female therapist.

In his posttreatment interview, Dr. N acknowledged the impact that sex differences might have and noted that he should have raised the topic with Lily. It is possible that if Dr. N had discussed their sex differences, Lily may have felt less confused about Dr. N’s intentions in using intimately self-involving statements and, therefore, been more involved in response to these in treatment. When reading the paper, Dr. N wrote, “I am more and more convinced that not talking about the sex differences was a crucial mistake on my part.”

In addition, the cultural differences between Dr. N and Lily may have been a factor in her responses to immediacy, given that she was a first-generation American whereas Dr. N was a European American. During Session 4, Lily said, “When I asked you . . . what makes me different from the other clients . . . I was like, am I allowed to ask you that question cause . . . I shouldn’t be asking you that because . . . now I’m intruding.
into your privacy, and . . . that’s not how its supposed to happen.” Lily’s cultural background may have influenced her belief that she needed to defer to authority.

**Comparison to Literature**

A comparison of the results of the present case with the past research on the resolution of difficult events within therapy (Foreman & Marmor, 1985; Hill et al., 2003; Rhodes et al., 1994; Safran et al., 2002) show minimal overlap, perhaps because this study focused on an entire case rather than just the process of difficult events (e.g., alliance ruptures, misunderstandings, anger events). The one helpful component in all studies, however, was therapist encouragement for clients to express their immediate feelings.

**Limitations**

Although the single-case design allowed us to empirically examine the process of immediacy, we cannot make causal conclusions about immediacy and its relationship to in-session and post-therapy change. Also, we cannot generalize the findings beyond the specific client and therapist (although therapists may find applications in working with similar clients). In addition, treatment was conducted in a laboratory setting using videotaping and observation, so the findings may not generalize to more natural settings. Exposure of Dr. N and Lily to the pretherapy and postsession measures may have cued them into what we were studying. Furthermore, we note that the measures of therapist and client immediacy actions, client involvement, and postsession perceptions were all developed for this project because there were no existing measures to study the phenomena of interest.

Moreover, the same judges coded therapist immediacy and client involvement in speaking turns, albeit at different times and in a different random order, which could have been a source of bias. Finally, the first two authors conducted the qualitative analyses, and thus their biases and expectancies may have impacted these results. Both judges and the therapist believed in the use of immediacy and used it themselves, so may have been biased in looking for the benefits of immediacy.

**Implications for Practice**

The results from this study suggest several implications for practice. First, more than 12 sessions may be needed when immediacy is used with a highly defended client. Perhaps 24 to 30 sessions, which is often considered to be an appropriate treatment length for brief interpersonally oriented therapy (Strupp & Binder, 1984), are required for clients to show improvement from this type of immediacy-focused treatment. If treatment had lasted longer, Lily may have had more time to resolve her interpersonal conflicts in the therapeutic relationship and, thus, have been able to achieve more symptom relief (Kiesler, 1996; Teyber, 2006; Yalom, 1995).

Second, educating clients about the role of immediacy can be useful. Although Dr. N educated Lily about immediacy in Session 2, “A lot of times things will happen in here that don’t happen outside . . . this is [why it is] all the more helpful for us to talk about our relationship and how it’s happening and then think about how does [that] apply outside,” he did not repeat this explanation later. Lily was sometimes confused about why the therapist was using immediacy, particularly when the immediacy was hypothetical asking about how she might feel under certain circumstances. For example, when Dr. N asked Lily how she might feel if he hurt her or what she might think if he were disappointed in her choices, Lily seemed to have a hard time responding perhaps because it was hard to imagine. Offering clients an explanation for immediacy might motivate them to take the emotional risks involved in discussing the therapeutic relationship (Kiesler, 1996; Teyber, 2006; Yalom, 1995).

Third, therapists might want to process client reactions after intense here-and-now events, particularly with clients who are less involved or emotionally open (Yalom, 1995). It seems important to observe how clients respond to therapists’ communication of strong emotion about them. In a related note, therapists might want to invite clients to express negative reactions and explore any hesitations in expressing such reactions. Lily did not overtly state any negative reactions, although she expressed some dissatisfaction on the postsession questionnaires, indicating that sometimes discussions about their relationship did not feel relevant to what she was interested in working on. Encouragement to discuss negative reactions is consistent with the rupture literature (Sa-
fran et al., 2002), which has found that the resolution of ruptures occurred when therapists attended to the rupture marker and explored the client’s avoidance of discussing the rupture. Fourth, therapists should also consider the impact of sex and cultural differences between client and therapist on the client’s ability to openly discuss the therapeutic relationship. Clients may get confused about therapist’s intentions with respect to certain immediacy topics, such as caring, particularly when there might be sexual attraction between client and therapist or differences in cultural norms regarding conversations about intimate relationships.

Finally, therapists who use immediacy should be aware of their countertransference reactions to clients and ensure that they are using immediacy in response to client needs rather than for their own needs. Therapists who use immediacy might want to engage in regular supervision to help manage the complex dynamics of countertransference that result from such intense immediacy-focused work.

**Implications for Research**

The key mechanism proposed by scholars for the generalization of findings using the case study method is the replication of findings across cases (Hilliard, 1993; Kazdin, 1981). Therefore, it would be important to replicate these findings with clients and therapists who are both similar to and different from those in the present study on dimensions like sex, race/ethnicity, and client involvement.

In future research, it will be important for researchers to think carefully about how they define immediacy. Although we included a category of feedback in our judgments of immediacy in the speaking turn analyses, we would now argue that feedback is more about the client (albeit the therapist’s perception of the client) and not actually about the relationship and so should be dropped from the definition and measures.

Another implication for research is that we would recommend using the qualitative approach to analyzing events rather than the more micro-process approach of coding therapist and client behaviors in speaking turns involving immediacy. The qualitative approach applied to immediacy events seemed to allow us to more richly describe the clinical phenomenon of immediacy than did the approach of coding behaviors within speaking turns.

Several findings from the present study could be tested in future studies on immediacy. Are certain clients and therapists more suited for immediacy than others? What would be the effects of immediacy if therapists and clients discussed sex and cultural differences directly? What is the best way to deal with potentially difficult immediate feelings, such as attraction? Is there a way to give feedback to therapists about things client leave unsaid? What are the effects of educating clients about immediacy? What is the role of immediacy in creating corrective emotional experiences? What are the effects of hypothetical versus real immediate interventions? Answers to these questions will provide us with a better basis for evaluating how immediacy facilitates change and for teaching trainees about when and how to use immediacy in therapy.

**References**


Case Study I of Immediacy


