ABSTRACT

Title of dissertation: THE PROCESS OF IMMEDIACY IN BRIEF

PSYCHOTHERAPY: COMPONENTS, EVENTS

AND RELATIONSHIP TO IN-SESSION CLIENT

CHANGE WITHIN A SINGLE CASE

Laura B. Kasper, Doctor of Philosophy, 2005

Dissertation directed by: Professor Clara E. Hill
Department of Psychology

This study examined the process of immediacy, defined as conversations in-session about the immediate client-therapist relationship. Therapist immediacy interventions, the relationship between immediacy and client involvement, and immediacy events within a single-case were examined. The client was a 24-year-old Middle-Eastern female and the therapist was a 51-year-old Caucasian male. The psychotherapy was interpersonal and included 12 total weekly sessions. Psychotherapy outcome was measured by the OQ 45.2 (Outcome Questionnaire 45.2), IIP-32 (Inventory of Interpersonal Problems-32), and the SUIP-R (Self-Understanding of Interpersonal Patterns – Revised). Session measures included the SEQ-D (Session Evaluation Questionnaire – Depth) and the WAI-S (Working Alliance Inventory – Short). Immediacy and Client Involvement were both judge rated measures and coded based on speaking turns. Immediacy events were identified and analyzed by two judges.

Results indicated the sessions were deep and the working alliance was strong overall. The client ended treatment with more symptoms and interpersonal problems, but with a greater understanding of her interpersonal patterns. Results also indicated the therapist used one immediacy intervention, inquiry about the client-therapist relationship, most often and the other two immediacy interventions, self-involving statements and feedback, much less frequently. The client appeared more involved in session when the therapist inquired about their relationship and appeared less involved in session when the therapist used self-involving statements.

Client involvement was slightly higher before and after immediacy events than during immediacy events. Nine types of immediacy events were found, none of which involved difficult events (i.e., misunderstandings, alliance ruptures). Events fell into two categories: process and here-and-now events. Process events included reflecting on treatment and the client-therapist-relationship, and drawing the parallel between therapy and outside relationships. Process events occurred throughout treatment. Here-and-now events included the therapist's expression of disappointment, care, and sadness in relation to the client and a desire to connect with the client. There was a changing pattern over time in the occurrence of here-and-now events. The client had the strongest reactions after sessions to here-and-now events, but did not directly express these strong reactions to the therapist in session. Limitations and implications for practice and future research are discussed.

THE PROCESS OF IMMEDIACY IN BRIEF PSYCHOTHERAPY:

COMPONENTS, EVENTS, AND

RELATIONSHIP TO IN-SESSION CLIENT CHANGE

WITHIN A SINGLE CASE

by

Laura B. Kasper

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Advisory Committee:

    Professor Clara E. Hill, Chair
    Professor Ruth Fassinger
    Professor Charles J. Gelso
    Dr. Sharon Spiegel, Independent Practice
    Professor Hedwig Teglasi

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Chapter 1: Introduction

Several theorists have proposed that immediacy, which can be defined as discussing the immediate client-therapist relationship, is a critical process within psychotherapy that facilitates client change (Kiesler, 1996; Teyber, 2000; Yalom, 1995). These theorists suggest that by reenacting with the therapist the conflicts that brought clients into therapy, and by openly discussing and resolving those experiences within the therapeutic relationship, clients have a corrective emotional experience and change both internally and interpersonally (Kiesler, 1996; Teyber, 2000; Yalom, 1995). According to interpersonal theory, repeatedly experiencing the resolution of these conflicts within the therapeutic relationship over time facilitates emotional re-learning and allows clients to recognize their role in these conflicts and to test out new behaviors within therapy and with others (Teyber, 2000; Yalom, 1995).

Unfortunately, however, there is very little research on the process of immediacy between client and therapist in individual psychotherapy to help us understand how immediacy facilitates the changes proposed by scholars (Hill & O'Brien, 1999; Kiesler, 1996). There is some work on feedback in individual psychotherapy (Claiborn, Goodyear, & Horner, 2002; Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992), but these studies addressed many different types of feedback, only one of which was immediacy. In addition, there is also some work on feedback in group psychotherapy (Claiborn et al., 2002), but this work has not been replicated in individual psychotherapy. Most of the empirical work on immediacy in individual psychotherapy has focused on difficult events in the immediate client-therapist relationship, such as alliance ruptures (Foreman & Marmar, 1985; Safran, Muran, Samstag, & Stevens, 2002),

misunderstandings (Rhodes, Hill, Thompson, & Elliott, 1994) and client anger (Hill et al., 2003).

This empirical work, however, only provides us with an understanding of the components of immediacy (i.e., therapist tasks and client actions) that occur within difficult events. In addition, this empirical work was based on single-sessions in psychotherapy and did not examine how the components of immediacy might change over time throughout a typical course of treatment (Foreman & Marmar, 1985; Hill et al., 2003; Rhodes et al., 1994, Safran et al., 2002). Furthermore, clients may have a variety of reactions to immediacy, differences that are important for both researchers and clinicians to understand. A case-study approach is one psychotherapy research method well suited to understanding such differences (Greenberg, 1986; Jones, 1993; Hilliard, 1993; Lueger, 2002). The case-study method can help researchers and clinicians learn whether specific therapeutic processes (i.e., immediacy) are appropriate for a particular client, given a client's presenting problems and individual characteristics. Such findings can improve both the field of psychotherapy research and clinical practice (Greenberg, 1986; Jones 1993; Lueger, 2002). Therefore, the first focus of this study was to examine the components of immediacy that occur across different immediacy events within a single-case over time.

Greenberg (1986) has argued that in order to understand the components within psychotherapy that contribute to client change and outcome, we need to identify relationships between detailed psychotherapy processes and in-session client changes that contribute to these outcomes over time. The previous research on immediacy does not provide any insight into how immediacy events might be related to in-session client

changes. Client involvement, in particular, seems to be an important in-session client change variable to study because it appears related to outcome (Eugster & Wampold, 1996; Gomes-Schwartz, 1978), is similar to other in-session client change variables that are also related to outcome (Klein, Mathieu-Coughlan, & Kiesler, 1986), and has been shown to predict client intention to act and implementation of therapeutic action plans (Wonnell & Hill, 2002). Therefore, the relationship between immediacy events and client involvement over time within a single-case was the second focus of this study.

Chapter 2: Review of the Literature

In this review I cover two areas of literature related to the proposed study: immediacy theories and research and single-subject research designs.

Immediacy Theories and Research

There is a significant amount of theoretical and scholarly work proposing the importance of discussing the immediate client and therapist relationship in psychotherapy to facilitate individual growth and change (Hill & O'Brien, 1999; Teyber, 2000; Yalom, 1995, 2002). In this section, I review how these scholars define immediacy, their theories about how immediacy facilitates client change, and why they propose that immediacy helps clients change.

Although there is not much empirical work on immediacy (Hill & O'Brien, 1999; Kiesler, 1996), in this section I also provide an overview of research that has generated findings about the use of immediacy in difficult therapeutic events, such as alliance ruptures (Foreman & Marmar, 1985; Safran et al., 2002) misunderstanding events (Rhodes et al., 1994) and client anger (Hill et al., 2003). I also address the research on topics related to immediacy in the psychotherapy literature, such as feedback in both individual (Claiborn et al., 2002; Kerr et al., 1992) and group psychotherapy (Yalom, 1995). Finally, based on this theoretical and empirical review, I present a definition of immediacy that includes the therapist actions and client tasks that I propose occur during immediacy events. This definition will be used as a framework for investigation in the current study.

Definitions of Immediacy

Hill and O'Brien (1999), whose work is trans-theoretical and addresses a range of interventions used by therapists, suggested that immediacy refers to therapists "disclosing immediate feelings about themselves in relation to the client, about the client directly, or about the therapeutic relationship" (p. 236). The authors also noted that immediacy differs from direct feedback to the client and suggested the difference lies in the involvement of the therapist in the communication. Direct feedback provides a client with information about him or herself, but does not include the therapist's feelings (e.g., "You did a good job when you spoke up to your mother (Hill & O'Brien, 1999, p. 236)"). They suggested immediacy provides information about the client, but also includes information about the therapist's experience (e.g., "I feel distant from you when you talk about your work").

Kiesler's (1988, 1996) approach to immediacy is based on communication and interpersonal theories (Leary, 1957; Sullivan, 1953). Kiesler used the term therapist metacommunication to refer to any instance where the therapist provides the client with verbal feedback that addresses relationship issues occurring between them in their therapy sessions. He used the term impact disclosure, a type of therapist metacommunication, to refer to feedback that includes the therapist's reactions as part of the communication. According to Kiesler (1988), impact disclosure refers to those instances where "therapists reveal to patients their inner, covert reactions (i.e., feelings, thoughts, fantasies, action tendencies) which they experience as directly evoked by the patient's recurrent behaviors during psychotherapy" (pp. 1-2).

Teyber (2000) is an interpersonal-process theorist, and his approach to immediacy is derived from interpersonal (Sullivan, 1953), object relations (Winnicott, 1965), and family systems (Bowen, 1978) theories. He proposed that immediacy includes the use of process comments by the therapist that make the interaction occurring between the therapist and the client overt, and put the topic of their immediate interaction out in the open for discussion. Teyber (2000) described immediacy as including self-involving statements, where therapists express their current reactions to what the client has just said or done (e.g., "Right now, I'm feeling angry as you're telling me about this" p. 52). He distinguished self-involving comments from self-disclosing statements. The later, according to Teyber (2000), refer to the therapist's own past or personal experiences in other relationships, and are not included in his definition of immediacy. Finally, in the context of group psychotherapy, Yalom (1995) referred to immediacy as working in the here-and-now and adopting a process focus, in which group members and the therapist use their feelings toward and experiences with one another as the major topic of discussion.

Based on the existing definitions reviewed, a preliminary definition of immediacy can be derived. For the purposes of this paper, the discussion in a psychotherapy session between the client and therapist about something happening in their immediate interaction, which includes self-involving statements by the therapist, will be called an immediacy event. Self-involving statements by the therapist can include feelings about the client, in relation to the client, or about the therapeutic relationship, as proposed by Hill & O'Brien (1999). They can also include, as Kiesler (1996) suggests, thoughts,

fantasies, and action tendencies in relation to the client, about the client, or about the therapeutic relationship.

Immediacy and interpersonal theories

Many scholars believe that clients' repetitive, maladaptive interpersonal patterns play a role in mental health symptoms (Crits-Christoph & Luborsky, 1998; Kiesler, 1996; Teyber, 2000). In fact, there is a significant body of research demonstrating that repetitive interpersonal patterns are related to psychopathology (Albani et al., 1999; Cierpka et al., 1998; Freni & Azzone, 1997). Many theorists also believe that clients could experience symptom relief if they learned to better manage or alter their repetitive, maladaptive interpersonal responses (Grenyer and Luborsky, 1996; Yalom, 1995, 2002). In order to understand how these theorists suggest that clients alter and manage these repetitive patterns, it is important to understand how scholars believe these patterns develop.

Psychodynamic and interpersonal theorists (Bowlby, 1988; Sullivan, 1953; Teyber, 2000) suggest that interpersonal relationship patterns develop as the result of repeated interactions with important others (e.g., parents, siblings, peers, society). When these interactions are consistently negative, individuals often respond to others in restricted ways that may deny their true feelings to maintain emotional ties to these important relationships. These restricted responses are believed to become part of an individual's mental representations of relationships and of themselves (Bowlby, 1988).

As a result of these mental representations, individuals may behave with others in ways that reflect these past experiences. This is often referred to as transference, which implies that there is a transfer of beliefs, attitudes, and behaviors from earlier

relationships with personally important people to later relationships with the therapist and others (Fried, Crits-Christoph, & Luborsky, 1998; Gelso & Carter, 1994; Yalom, 1995, 2002). The transfer of beliefs, attitudes, and behaviors from early relationships to current ones is thought to contribute to interpersonal problems when these transferred behaviors are inflexibly and rigidly applied to new social interactions, regardless of the circumstances.

Interpersonal theorists propose that changing maladaptive interpersonal patterns requires therapists to engage or "get hooked" in clients' interpersonal patterns, "unhook" themselves by observing and discussing the patterns occurring in the therapy relationship, and then intervene in ways that help to resolve rather than reenact clients' repetitive patterns (Kiesler, 1996; Teyber, 2000; Yalom, 1995, 2002). These scholars suggest that immediacy is a key process therapists can use to help clients openly discuss and resolve, rather than reenact, these interpersonal conflicts within the therapeutic relationship.

Teyber (2000) suggested that immediacy helps clients change because it provides clients with an opportunity to discuss their feelings and reactions to another person in a significant relationship in a way that is different than they have come to expect in their other relationships. When clients experience interactions with their therapist that are different than their maladaptive relational expectations, clients see that some relationships can be different. Teyber (2000) called these different, healing interactions corrective emotional experiences. He argued that through corrective emotional experiences clients update their working models of themselves and others and their interpersonal patterns of interacting. Teyber (2000) asserted that clients begin to change in other interpersonal relationships after having repeated corrective emotional

experiences with their therapists. Bowlby (1988) seemed to underscore the importance of immediacy in this process when he said:

> There are in fact no more important communications between one human being and another than those expressed emotionally, and no information more vital for constructing and reconstructing working models of the self and other than information about how each feels towards the other…. It is the emotional communications between a patient and his (sic) therapist that play the crucial part. (pp. 156-157)

Scholars argue that immediacy helps clients change by making them aware of their role in their problematic interpersonal patterns and the impact of their behaviors on others (Kiesler, 1996; Teyber, 2000; Yalom, 1995, 2002). These scholars noted that one of the reasons immediacy is so powerful in helping create this client self-awareness is because it is an asocial response. Specifically, immediacy provides clients with information that is not typically available to them about the impact of their behaviors on other's feelings towards them. Clients understand the role they play in their interpersonal conflicts by learning about the emotional consequences their problematic behaviors have on their relationship with the therapist. Teyber (2000) asserted that for change to occur, "clients need to become less preoccupied with the problematic behavior of others, and begin to explore their own internal and interpersonal responses" (p. 87).

Yalom (1995) provides further support for this assertion by noting that helping clients understand the following sequence over time, using immediacy, is necessary to facilitate client change: 1) here is what your behavior is like, 2) here is how your behavior makes other feel, 3) here is how your behavior influences the opinions others

have of you, and 4) here is how your behavior influences the opinion you have of

yourself. Yalom (1995) suggested that clients need to understand that their maladaptive

behavior has negative consequences for them. He believes that once clients understand

this, therapists can help clients "decide if they are satisfied with the world they have

created for themselves" (p. 166).

Components of Immediacy Events

Scholars have identified several therapist actions that seem important if

immediacy events are to be growth enhancing for clients. Kiesler (1996) proposed 15

principles of metacommunication that he believed are crucial to the usefulness of

metacommunication with clients. I have included only those principles that apply to

immediacy between client and therapist as it is defined in this study. These principles

include: 1) the therapist notes, attends to, and disengages from enacting a repetitive

pattern by making an impact disclosure (i.e., gets "hooked" and then "unhooked"), 2) the

therapist provides feedback in a manner that is confrontative as well as supportive and

protective of the client's self-esteem, 3) the therapist provides open, direct, unambiguous

communication to the client about the therapist's internal experience, 4) the therapist's

impact messages must include both positive and negative components, 5) the therapist

must be willing to explore and admit his or her own contribution to the interaction, 6) the

therapist must provide examples of the client actions that elicited those responses, 7) the

therapist must make links between what is happening between the client and therapist and

the client's relationships to significant others, 8) the therapist must be sensitive to the

sequencing and timing of feedback, varying it with the strength of the alliance,

characteristics of the client, and the client-therapist stylistic match.

Teyber (2000) believed that it is important for the therapist, at some point early in treatment, to provide a rationale to the client about the use immediacy in the relationship. He also believed that process comments need to be made tentatively, providing an opportunity for client and therapist to share their perceptions of what is happening between them. Teyber (2000) also stressed that the therapist needs to encourage the client to freely discuss his or her thoughts and feelings about, and reactions to, the therapist.

Yalom (1995) seemed to suggest that the components of immediacy events change over time. He asserted that there is a progression of process commentary that starts with simple observations of a client's behavior, and then moves to a description of the feelings evoked by that behavior (either by the therapist or other group members). He believed the therapist then moves to sharing observations about repeated behaviors in-session, to sharing speculations about repercussions of the behavior in-session, and finally to relating client in-session behavior to the outside word.

Summary of theoretical components of immediacy events

Based on the theoretical literature reviewed above, I propose that immediacy events will, over the course of therapy, include the following therapist components: 1) the therapist, at some point early in therapy, provides a rationale for the use of immediacy, 2) the therapist uses self-involving statements that are open and unambiguous, 3) the therapist provides feedback in a manner that confronts but also protects the client's self-esteem and is not shaming, 4) the therapist makes any immediate comment tentative, allowing the client room to contribute his or her perception, 5) the therapist points out the client action that elicited the therapists reaction, 6) the therapist

takes responsibility, when appropriate, for his or her part in the interaction, 7) the

therapist points out when the client's behavior is part of a repetitive pattern, 8) the

therapist makes a link between their current interaction and the client's other

interpersonal interactions outside of therapy, 9) the therapist comments on the impact of

the client's behavior on the therapist's feelings, and 10) the therapist explores the

consequences of the client's behavior on the client's feelings about him or herself.

In the next section, I review the research on immediacy, both in important

therapeutic events (e.g., alliance ruptures, misunderstandings, and client anger) and in

other forms in the psychotherapy literature (e.g., feedback in individual and group

psychotherapy). This work provides empirical support for the inclusion of some of the

therapist actions proposed above. This research also provides some insight into the client

tasks to be included in the definition of immediacy used in this study. Based on this

review the empirical literature, a final definition of immediacy event components to be

evaluated in the current study will be provided.

Immediacy in difficult psychotherapy events

In the next section, I review studies that addressed the process of immediacy in

difficult events in psychotherapy, such as ruptures, misunderstandings, and client

expression of anger.

Foreman and Marmar (1985) conducted a descriptive study to examine the

differences in therapist actions between three clients who experienced improved alliances

versus three clients who experienced unimproved alliances after treatment, all of whom

had initially poor alliance scores. Alliance was measured after the second, fifth, eighth,

and eleventh hours of treatment. Participants were six female clients drawn from a

cohort of 52 clients whose pretreatment levels of anxiety and depression were

comparable to norms for general psychiatric outpatients. All clients sought therapy after

the death of either a parent or spouse and either met the DSM-II criteria for an adjustment

disorder or post-traumatic stress disorder. The therapy conducted was dynamic and time-

limited (12 weeks).

Summaries of pre and post-therapy evaluations, process notes of therapy sessions,

and videotapes were all used in the analysis. To discover what therapist actions

differentiated the two groups, Foreman and Marmar reviewed videotapes of the therapy

hours that preceded a decline in each client's already low negative alliance scores.

Alliance was measured using the California Therapeutic Alliance Scale (Marmar,

Horowitz, Weiss, & Marziali, 1986) and was rated by independent judges. No reliability

for this scale was reported. The one dimension of the measure used to differentiate cases

was the therapist's negative contributions to the alliance score. Low negative

contributions scores (under 5) were considered positive alliance scores, and high negative

contributions (9 or greater) were considered poor alliance scores.

The list of therapist actions used to evaluate the tapes was developed from the

theoretical and empirical literature and from a review of other client cases with poor

alliance scores. The list of actions was also refined as the six cases in this study were

examined. The list used was called "factors addressed by the therapist," and included

two major categories: 1) factors addressed within the patient-therapist relationship, and 2)

factors addressed within the patient-other relationships. The actions rated within both

these categories were as follows: 1) defenses, 2) problematic feelings, 3) problematic

relationship patterns which included, 3a) problematic powerful images, and 3b) problematic vulnerable images and, 4) triangle of punishment.

During the videotape review, the researcher, who was also the lead author, rated whether any of the therapist actions were present or absent in each therapy segment. The authors did not make it clear if the rater was aware of whether the tapes were from improved or unimproved cases. The rater watched between 3 and 6 hours of therapy videotapes to rate therapist actions. The rating of the presence or absence of therapist actions was measured on a 4-point scale of degree of emphasis, from 0 (did not occur) to 3 (major emphasis). No reliability was reported for therapist action coding. Foreman and Marmar used the frequency of therapist actions to identify the differences found between improved and unimproved cases.

Results indicated that therapists addressed the defenses clients used to deal with feelings related to the therapist and others most frequently in the improved but not in the unimproved alliance cases. Examples of addressing the defenses included, "You change topics just when you begin to express feelings about me" or "When you begin to feel angry with me, you fall silent." Secondly, therapists addressed the triangle of punishment related to both the therapist and others in the improved cases. The authors describe the triangle of punishment as the client's expectation or believed need for punishment to assuage guilt over feelings of anger or responsibility for another person's suffering. They did not give examples of therapist statements reflecting this action. Finally, they found that therapists addressed the client's problematic (negative) feelings toward the therapist in the improved but not in the unimproved alliance cases. Examples included: "You are feeling angry toward me" or "You seem uncomfortable with me today." In two of the

three unimproved alliance cases, the therapists tended to ignore or avoid addressing the client's problematic feelings, even when the therapist was cognizant of the client's problematic feelings toward the therapist, as suggested by process notes in the client's file.

In summary, Foreman and Marmar (1985) found that the therapist actions that differentiated improved from unimproved cases were acknowledging the ways clients defended against negative feelings toward the therapist and addressing the client's negative feelings toward the therapist. These results suggest that encouraging the client to talk about their immediate, often negative, feelings toward the therapist was an intervention that differentiated improved from unimproved cases, providing some support for the assertion that immediacy is an intervention that facilitates client change. Additionally, these findings suggest that in immediacy events, therapists need to actively address client defenses against expressing negative feelings towards them and directly address any negative feelings the client may have towards the therapist.

A significant limitation of this study was the author's use of only one judge, who was also the first author, to rate the therapist actions that distinguished improved from unimproved alliance cases. The author's theoretical biases and awareness of the purpose of the study might have led the rater to ignore important therapist actions that may have differentiated the cases, limiting our confidence that the list of therapist actions is exhaustive. The authors did not report if the rater knew whether the tapes being rated were from improved or unimproved cases, again, possibly biasing the therapist actions found. While the authors reported that the list of therapist actions used to evaluate the tapes came from the empirical literature, they did not cite which theories were used to

generate this list. This limits our ability to evaluate whether the authors adhered to the theoretical propositions or created their own and claimed them to be based on the literature. Additionally, while the authors looked at several segments of therapy, they only looked at those hours that preceded a decline in alliance scores and did not report when in the course of therapy they examined the therapist actions. This limits our ability to know if the therapist actions are appropriate for repairing ruptures at a particular point in therapy, and how the actions therapists use might change over time. Finally, the authors only used one method, raters, to determine which actions differentiated resolved from unresolved cases, which may have led to mono-method bias in the results.

Rhodes, Hill, Thompson, and Elliott (1994) conducted a qualitative study of resolved and unresolved misunderstanding events in therapy and found similar results to Foreman and Marmar (1985). Rhodes et al. (1994) collected qualitative data about misunderstanding events in therapy from 19 clients who were also therapists or therapists-in-training, providing a different perspective than Foreman and Marmar. They used an open-ended questionnaire, asking clients to select a major misunderstanding event that had occurred in therapy. The questionnaire asked clients to describe the event in detail and how the event affected their therapy. The authors used consensual qualitative research (CQR; Hill, Thompson, & Williams, 1997) to analyze questionnaire results.

Rhodes et al. found that resolved events appeared to occur in the context of either a good or a poor relationship, where as most of the unresolved events occurred in the context of a poor therapeutic relationship. In both resolved and unresolved events, the misunderstanding seemed to begin when the therapist either did something that the client

did not like or did not do something the client wanted or needed. In response to this, the client had negative feelings toward him or herself or the therapist. In resolved events, the client either asserted his or her feelings immediately or after some period of silence, which also occurred in some, but not all, of the unresolved events. In most of the unresolved events, therapists were not perceived as being open to discussing the client's negative feelings towards them.

A significant distinction Rhodes et al. found between resolved and unresolved events was the therapist's response to the client's assertion of negative feelings. In resolved events, the therapist and client engaged in a mutual repair process. In five of the 11 resolved cases, the client perceived that the therapist accommodated the client's negative feelings, either by apologizing, accepting responsibility for the problem, or changing the offensive behavior. In another five of the 11 resolved cases, clients indicated that they accepted the therapist's perspective or had decided that the therapist's behavior was not as offensive as they had originally believed.   In contrast, in five of the eight unresolved events, clients reported no therapist response to their expression of negative feelings, and in three unresolved events clients said therapists maintained their original view without considering the client's perspective.

In resolved events, clients felt the resolution of the event improved their relationship with the therapist. In contrast, most clients (five of eight) who experienced unresolved events quit therapy (Rhodes et al., 1994). In resolved events, clients felt they were able to grow from the experience with their therapist. Clients also reported being able to see their role in the misunderstanding and how this experience with the therapist applied to other misunderstandings in their life. One client noted:

I think that in examining this event, I really learned that a part of the misunderstanding was due to my therapist and a large part was due on my own part to other issues. However, the more important piece ultimately was how I respond to being misunderstood or let down and how it occurs in other contexts. I learned a broader theme in my life through this one experience (Rhodes et al., 1994, p. 478).

In summary, Rhodes et al. (1994) found that immediacy between therapist and client about misunderstandings was one of a number of important factors that distinguished resolved from unresolved misunderstanding events. Specifically, they found that the therapist's active engagement in talking about the client's negative feelings towards them, and the therapist's acceptance of responsibility for their possible role in the conflict, was a critical difference between resolved versus unresolved events. They also found that in resolved events, clients were able to express their negative feelings directly to the therapist, see their role in the interaction with the therapist, and see the parallel between their behavior with the therapist and their behavior in other interpersonal relationships.

One limitation of this study is that it only focused on those actions that occurred in a single therapy event. While the therapist actions that differentiated resolved versus unresolved events were similar across clients, it is difficult to know whether the actions used to resolve the misunderstanding might have changed over time or whether the differences that were found between clients were related to when in the course of therapy the event occurred. Although this study provides valuable information from the client's perspective about the therapist actions that helped resolve the misunderstanding, it does

not address the therapist's perspective on those same events. Finally, clients remembered the events retrospectively so the actions they remember may have been biased by their positive memories of the therapist or their relationship.

Safran, Muran, Samstag, and Stevens (2002) reviewed the findings from their program of over 10 years of research on alliance ruptures which, like Rhodes et al., addresses the use of immediacy in rupture repair. They defined a rupture in the therapeutic alliance as a tension or breakdown in the collaborative relationship between patient and therapist. Safran et al. suggested that a breakdown can occur in any of the three dimensions proposed by Bordin (1979) as fundamental to the working alliance: agreement on the 1) tasks, 2) goals of therapy, or the 3) affective bond between client and therapist. Through their intensive program of task analysis research on alliance ruptures, they have developed a process model to describe the four stages that therapists and clients go through in resolved alliance ruptures. The four stages of their model are: 1) attending to rupture marker, 2) exploring the rupture experience, 3) exploring client avoidance, and 4) emergence of wish/need.

According to Safran et al., the first stage, attending to rupture marker, includes the presence of some marker that signals to the therapist that there is a rupture, either because the client is withdrawing from or confronting the therapist. In withdrawal ruptures, the client disengages, either completely or partially, from the therapist, his or her own emotions, or some aspect of the therapeutic process. In confrontation ruptures, the client directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy. In this stage, the therapist draws attention to the rupture, regardless of the

way it manifests, and maintains a focus on the immediate experience between therapist and client.

In the second stage of the model, exploring the rupture experience, the client is encouraged to express negative feelings directly toward the therapist, and the therapist responds with empathy or by accepting responsibility for his or her contribution to the interaction. In the third stage, exploring client avoidance, the therapist probes for any fears that may be blocking the client's expression of negative feelings towards the therapist and has the client explore these fears (e.g., fear of being abandoned if he or she expresses negative feelings). The final stage, emergence of wish/need, involves the client expressing the underlying wish/need and/or the primary emotion associated with that wish/need.

Safran et al. (2002) note that the stages of their model are not linear, and in diagrams of their model they include stage 3 (exploring client avoidance) as one that may or may not be addressed. They have also found that the transition between stage 2 (exploring the rupture experience) to stage 4 (emergence of wish/need) is different depending on whether the client signaled the rupture by withdrawing or confronting the therapist. They have found that withdrawal ruptures consist of moving through client direct expression of discontent with the therapist to self-assertion, where the primary need that emerges in stage 4 is agency. Confrontation ruptures consist of clients moving "through feelings of anger, disappointment, and hurt over having been failed by the therapist, to contacting vulnerability and the wish to be nurtured and taken care of" (p. 249). The authors also note that typical operations that emerge in stage 3 (exploring the avoidance), regardless of whether the client withdrew or confronted the therapist, include

clients expressing anxieties and fears of being too aggressive or too vulnerable and the expectation of retaliation or rejection by the therapist.

One limitation of Safran et al.'s (2002) work is that it has been collected from a series of single-session studies, which limits our ability to understand how the therapist actions and client tasks involved in repairing ruptures may change over time. While this work has provided insight into therapist actions and client tasks based on the assessment of trained raters, this work does not provide either the therapist's or the client's perspective on these same events. Similar to the other empirical work examined in this review, the authors have described immediacy in the context of studying conflict between client and therapist. It is unclear what components might occur when the client and therapist discuss their immediate relationship and there is no conflict involved.

Hill et al. (2003) examined the therapist's experience of being the target of client anger. They found that a number of immediacy components were associated with the resolution of client anger events, which provides further evidence for several therapist actions proposed for inclusion in this study. Participants included 13 therapists who provided recollections of client anger events. The authors analyzed 12 hostile anger events, where the client directly expressed anger toward the therapist, and 13 suspected-unasserted anger events, where the client did not directly express anger toward the therapist. They analyzed the therapist recollections using consensual qualitative research (CQR; Hill et al., 1997).

Hill et al. (2003) found the factors that distinguished resolved from unresolved hostile anger events included the therapist not challenging problematic client behaviors (e.g., client not showing up for random drug testing), therapists turning their negative

feelings outward (e.g., felt frustrated at the client) instead of inward (e.g., felt incompetent), and when therapists talked about the client's anger and provided an explanation of the therapist's behavior, apologizing if the therapist's behavior was the source of client anger. Some of the factors that appeared to distinguish resolved from unresolved suspected-unasserted anger events included the therapist raising the topic of anger between the client and therapist, helping the client to explore their anger towards the therapist, and relating the current interaction between them to similar problematic behaviors in other situations.

One limitation of this study is the retrospective nature and mono-method bias of the therapists' reporting. It is possible that observers rating the events from tapes might have identified different actions than the therapists reported because of possible errors in the therapists' memory. In addition, clients or trained judges might have noticed other actions that therapists were biased from acknowledging. Another limitation of the study is that each event analyzed was a single event and there was no information reported about where during the course of therapy these events occurred, again limiting our ability to know how the actions might have changed over time or how differences between resolved and unresolved events might have been related to when in therapy the event occurred.

Feedback in individual and group psychotherapy

Kerr, Goldfried, Hayes, Castonguay, and Goldsamt (1992) were interested in understanding differences in the focus of therapist feedback between cognitive-behavioral therapists and psychodynamic-interpersonal therapists, and how these differences might be related to intrapersonal and interpersonal outcomes. They believed

that cognitive-behavioral therapists would make more intrapersonal links, and psychodynamic-interpersonal therapists would make more interpersonal links.

Kerr et al. compared therapist feedback from eight sessions of therapy for 14 clients who participated in cognitive-behavioral therapy and 13 clients who participated in interpersonal-psychodynamic therapy. They used the Coding System of Therapeutic Focus (Goldfried, Newman, & Hayes, 1989*)* to code therapist's speaking turns for an intrapersonal (i.e., between different components of the client's functioning*)* or interpersonal (i.e., between the client's functioning and that of another person) focus. Clients completed self-report measures of outcome. Within-group results showed that interpersonal links in the psychodynamic-interpersonal group were marginally related to improvement in self-esteem ($r = .49, p < .10$) and social adjustment ($r = .49, p < .10$). Across treatments ($N = 26$) a focus on intrapersonal links was positively correlated with client improvement on the SCL-90 ($r = .41, p < .05$).

While tentative, Kerr et al.'s results provide some anecdotal support for the relationship between feedback and interpersonal change. Clients who received feedback that included interpersonal links between their current behavior and their behavior in other relationships showed a trend toward greater improvement in social relationships. This trend provides some additional support for including the therapist action of making interpersonal links into the definition of immediacy used in this study.

A major limitation of this study is the author's failure to operationalize the definition of feedback clearly, making generalizations to other similar types of feedback difficult. The authors also did not measure therapist adherence to either psychodynamic

or cognitive-behavioral therapy, making it difficult to draw conclusions about the relationship between the type of therapy and interventions used and outcome.

Claiborn, Goodyear, and Horner (2002) reviewed the literature on feedback in psychotherapy, which appears to be primarily based on research in group therapy, small groups, and assessments. The authors noted that basic definitions of feedback in psychology tend to suggest that feedback is "information provided to a person from an external source about the person's behavior or the effects of that behavior" (p. 217). They also suggested that in these definitions the content and form of feedback varies, depending on the situation. They cited Jacobs (1974) definition of four types of feedback content which included: 1) an observation or description of the client's behavior, 2) an emotional reaction to the client's behavior, 3) an inference about something that is not directly observable by the client, and 4) mirroring, or a presentation to the client of a sample of his or her behavior. It appears that, of the types of feedback content suggested by Jacobs (1974), the first two are included within the definition of immediacy proposed in this study. In this study, the first type, an observation or description of the client's behavior, would be considered to be part of an immediacy event only if it was made in reference to an immediate discussion of the interaction occurring between client and therapist.

Claiborn et al.'s (2002) review suggested several variables that affect the acceptance and impact of feedback on clients that seem important to address in the current study. They note that the social power of the feedback giver appears to be a key variable affecting the acceptance of feedback by the receiver (Kivlighan, 1985). Social

power, according to Claiborn et al., is likely to be the result of the therapist's credibility but also may be due to the therapist's social attractiveness and likeability as well.

The extent to which feedback is positive or negative (i.e., valence) also appears to be an important variable according to Claiborn et al. A consistent finding across the studies they reviewed was that positive feedback is more acceptable to receivers than negative feedback (Jacobs, 1974; Kivlighan, 1985). They reported research on small groups suggesting that after trust and cohesion have been established in early sessions, participants are able to view negative feedback as credible in later sessions (Morran, Robinson, & Stockton, 1985; Stockton & Moran, 1981). It also appears that, in small groups and in group therapy, negative feedback is accepted more readily when it follows positive feedback (Kivlighan, 1985; Stockton & Morran, 1981). Claiborn et al. noted that, with respect to client variables, there is research that shows that participants with high-self esteem rated negative feedback as more desirable than participants with moderate self-esteem (Morran & Stockton, 1980).

According to Claiborn et al., the results of the literature on the valence of feedback suggests that positive feedback is more likely to be seen as accurate and useful early in therapy and as the working alliance is established. In addition, clear negative feedback is more likely to be accepted as accurate and useful later in therapy and when it follows positive feedback.

Other client variables that Claiborn et al. suggested are important in the acceptance of feedback include client mood and desire for feedback. Claiborn et al. reviewed research that demonstrated that depressed participants recalled more negative than positive feedback compared to non-depressed participants (Nelson & Craighead,

1977), and that depressed participants were more negative in their interpretation of ambiguous feedback than non-depressed participants (Dykman, Horowitz, Abramson, & Usher, 1991). With regard to desire for feedback, the authors reviewed a series of studies by Snyder, Ingram, Handelsman, Wells, and Huweiler (1982) that demonstrated that participants high in desire for feedback accepted positive feedback more. Claiborn et al. suggested that therapists should consider these factors when they provide feedback to clients.

Finally, Claiborn et al. noted that while understanding the context variables that influence the acceptance of feedback is important, there is very little research in this area. They did review studies that showed that when giving assessment feedback, a collaborative relationship appeared to be an important variable in feedback acceptance (Berg, 1985; Clair & Prendergast, 1994). They noted that other context variables that might be important, but need empirical research, include setting client expectations about feedback and ensuring that feedback is clear, understandable, and relevant to the client's needs and goals.

Although Claiborn et al.'s review focused on feedback in general, and immediacy as defined in the current study can be considered one type of feedback, their review of the research provides further support for several of the therapist actions proposed for inclusion in the definition of immediacy used in the current study. Whether feedback is positive and negative seems to be an important consideration. Their review suggests that therapists should seek to provide positive feedback early in the therapeutic relationship, adding negative feedback later. This finding is suggestive of how immediacy events may need to change over time with respect to feedback valence. Their review also appears to

suggest that feedback acceptance might be influenced by a client's level of self-esteem, mood, and desire for feedback. These findings suggest that these may be important client factors to consider in recruitment, since these factors may influence the client's ability to make use of feedback, such as immediacy. Their review did not, however, address any client tasks the might occur during the feedback process.

Additionally, Claiborn et al.'s review of the feedback literature found that the therapist's social power has an impact on feedback acceptance, suggesting that a therapist's credibility, attractiveness, and trustworthiness is important if clients are to accept and make use of immediacy. Finally, while the research they reviewed was based on test assessment feedback, it seems that a strong working alliance might also be an important contextual variable to aid in client acceptance of feedback.

Summary of limitations in empirical literature on immediacy

All of the empirical work reviewed above on immediacy was done on individual events from single-sessions in psychotherapy (Foreman & Marmar, 1985; Hill et al., 2003; Rhodes et al., 1994; Safran et al., 2002) and did not look at how the therapist actions and client tasks that occur during immediacy events might change over time. In addition, all of this work examined difficult or conflictual events (Foreman & Marmar, 1985; Hill et al., 2003; Rhodes et al., 1994; Safran et al., 2002) and immediacy between client and therapist is not limited to difficult interactions, so we need to understand what components exist across all types of immediacy events. A number of the studies reviewed used retrospective recall (Hill et al., 2003; Rhodes et al., 1994), and only collected data using one method (Foreman & Marmar, 1985; Hill et al., 2003, Rhodes et al., 1994; Safran et al., 2002) limiting our confidence in the comprehensiveness of the

results found. Finally, while there is a significant amount of theoretical work about the

therapist actions that should occur within immediacy events, the research reviewed has

only provided support for some of these actions (Claiborn et al., 2002; Foreman &

Marmar, 1985; Hill et al., 2003; Kerr et al., 1992; Rhodes et al., 1994; Safran et al.,

2002).

Summary of immediacy event definition

The combination of the empirical findings and theoretical literature reviewed

above provides support for the inclusion of the following components in the definition of

immediacy events used in this study. Some components were combined in the final

definition proposed below to reduce repetitiveness. The list of components was also

refined based on the ability to operationalize the constructs for research purposes. The

components are separated into therapist actions and client tasks.

Therapist actions within immediacy events.

1. the therapist educates the client about immediacy (e.g., provides a rationale

    for the use of immediacy)

2. the therapist uses self-involving statements about his or her internal

    experience (i.e., feelings, thoughts, action tendencies) in relation to the client

3. the therapist inquires about the client's thoughts and feelings about the

    therapist or client-therapist relationship (e.g., avoidance of negative feelings,

    fears about expressing feelings, feelings or thoughts about therapist or

    therapist-client relationship)

4. the therapist takes responsibility for his or her part in a difficult interaction

    (e.g., apologizing or changing the offensive behavior)

5. the therapist makes a link between their current interaction and the client's other interpersonal interactions outside of therapy

6. the therapist inquires about the consequences of the client's behavior on the client's feelings about him or herself

Client tasks within immediacy events.

1. the client expresses thoughts or feelings about the therapist or client-therapist relationship directly to the therapist (e.g., fears about discussing feelings, direct feelings about therapist or client-therapist relationship)

2. the client acknowledges his or her role in a difficult interaction

3. the client expresses a wish or need in relation to the therapist

4. the client acknowledges how the interaction with the therapist parallels other similar interactions outside therapy

Single-Subject Research Designs

Single-subject research designs have played an important role in psychotherapy research over time (Heppner, Kivlighan, & Wampold, 1999). Several scholars have suggested that intensive case study designs are crucial to understanding the relationship between psychotherapy processes, in-session client changes, and outcomes (Greenberg, 1986; Jones 1993). However, the single-subject design has often been criticized as a weak, non-rigorous research methodology (Gelso, 1979; Hilliard, 1993). In this section, I review the literature on single-subject research designs in psychotherapy that describes the advantages and disadvantages of the methodology and some of the mechanisms proposed to address its weaknesses. I also review the literature on client involvement, the

in-session client change variable proposed for inclusion in the current study. Finally, I review a few select single-case psychotherapy studies to highlight some methodological issues in this type of research.

Single-subject designs in psychotherapy

Jones (1993) has suggested there are several reasons why the intensive study of individual cases is important to the field of psychotherapy research. The first reason he proposed is the limitation of between group designs and controlled clinical trials for helping us understand how specific therapist interventions influence client change and ultimately, psychotherapy outcomes. Greenberg (1986), a pioneer in this area of research, has argued that if we do not study the specific in-session processes involved in client change, it is not possible to determine what portion of the therapeutic outcome is the result of the process and what portion is accounted for by other factors, such as the therapeutic relationship or extraneous client variables. Chassan (1979) supports this assertion by arguing that the intensive case study, which is based on frequent observations of an individual over time, can provide more meaningful information that has more direct implications for the practice of psychotherapy than end-point only observations extended over a relatively large number of clients.

A second reason Jones (1993) proposed for the importance of intensive case research is that psychotherapy research has not been well integrated into and used by practitioners in clinical practice. It seems that experienced clinicians tend to rate the findings from traditional psychotherapy research low in terms of its influence on clinical practice (Najavits & Binder, 1990). Jones (1993) noted that since case study designs most closely reflect the dilemmas clinicians actually face, findings are more likely to be

relevant and valuable to clinicians, contributing to a better integration of research and practice. Lueger (2002) underscored this point by noting that treatment focused research using case-study methodologies can help clinicians understand whether specific treatments can work and are appropriate for the presenting problems of their clients. He asserts that psychotherapy research would be served well by attending to and providing clinicians with the type of research findings they consider helpful, such as those found using the case-study method.

Gelso (1979), in his work on research methods in counseling, noted an additional benefit of single-case research. He suggested that considering additional research methods, such as the single-case design, is important because it provides us with different ways of observing reality. He pointed out that each research method, however, has different strengths and limitations. Researchers need to evaluate the gaps in a particular field to determine which method is the most appropriate to use given what is known in an area at that point in time. Gelso (1979) acknowledged that while expanding our research methods to include additional designs, such as the single-case, will not solve our scientific problems, it is important to the advancement of any field of knowledge to look for ways to gain new perspectives on existing realities. Gelso (1979) asserted that single-subject methodologies used in the behavioristic tradition have the scientific rigor of group comparison methods with respect to causality, variability, and generalization, and that similar techniques in non-behavioral counseling research would be a significant advancement in the field.

While there appear to be important reasons to use single-case research designs in psychotherapy, historically the single-case method has not been widely accepted as a

rigorous scientific methodology (Gelso, 1979; Hersen & Barlow, 1981; Hilliard, 1993; Jones, 1993). It is criticized for both the lack of generalizability of the findings (i.e., external validity) and inability to draw conclusions about causality (i.e., internal validity) when compared to traditional experimental group designs (Hilliard, 1993).

Gelso (1979) suggested that fundamental to strong single-subject designs is the careful observation of the behaviors of one subject during periods of treatment and non-treatment. Specifically, he asserted that the basic features of a strong single-subject design include repeated measurements during a baseline (non-treatment) period, followed by repeated measurement during treatment, and continued measurement following treatment, as well as the application of new statistical procedures. Finally, he asserted that the case study might be useful in generating hypotheses, but that it has significant limitations in the process of validating hypotheses.

Hilliard (1993) argued that many of the criticisms and assumptions about single-subject designs apply only to certain types of designs, particularly descriptive, uncontrolled case studies with no formal hypotheses or research questions. He suggested that to see the value of single-case research, one must not view this method along the same lines as group research, but to view it as a type of intrasubject research. In intrasubject research, generalization is addressed through the replication of individual cases and not through the aggregation of data across individual cases. The primary focus, then, is to examine variation within a particular subject over time and also to understand this variation as a function of other variables that vary within the subject over time.

Thorngate (1986) underscored the focus of single-subject research on intrasubject variation when he argued that "before studying what people do in general, we must first

discover what each person does in particular, then determine what, if anything, these particulars have in common" (pp. 77-76). Hilliard (1993) noted then, that the generalizability of findings from single-case research is done not by aggregation of single-case data but by replication of individual cases. He noted that there are two types of replication, direct and systematic. Direct replication refers to replicating findings with participants who are similar in individual differences variables (i.e., gender, race/ethnicity) perceived to influence the phenomenon under examination. Systematic replication refers to the attempt to show that findings differ in predictable ways when participants differ along the individual-difference variables of interest. Hilliard (1993) noted that the lack of both types of replication is one of the greatest weaknesses of the use of single-subject research in psychotherapy.

Hilliard (1993), along with Greenberg (1986), asserted that studying intrasubject variation is of critical importance to the field of both psychotherapy process and outcome research. Greenberg (1986) argued that in order to really understand the components of psychotherapy that contribute to client change and outcome, we must break down global outcome into smaller, related in-session changes and discover how the interactions between client and therapist contribute to these smaller changes. Greenberg (1986) specifically suggested that it is important not just to study what is going on in therapy (process research) or to compare only two measurement points before and after therapy (efficacy research), but to "identify, describe, explain, and predict the effects of processes that bring about therapeutic change over the entire course of therapy" (p.4).

Hilliard (1993) argued that from this perspective, examining intrasubject variability within dyads over time is at the heart of psychotherapy research and that

single-case research is the only means for testing clinically important hypotheses about within-subject change and variation. He suggested single-case research that addresses psychotherapy change processes and develops theories for these processes could be used to generate more specific research questions that can be empirically tested in other cases and eventually through group research.

Despite the assertion that the single-case is an effective means of answering the question, "How does the therapist's behavior affect the client," the threats to internal validity inherent in the single-case design are a significant concern. Kazdin (1981) argued that there are several ways to address the threats to internal validity in single-case research that can lead to knowledge about treatment effects that approximates the information achieved in experimentation.

The first dimension Kazdin (1981) cited to address concerns about internal validity is the type of data collected. He noted that systematic inferences are difficult, if not impossible, to draw from anecdotal information, which might include narrative accounts by both the client and therapist about how the client has improved. Systematic, objective, quantitative data collected from a variety of means may, in contrast, allow the researcher to draw scientific inferences. Continuous assessment of the variables of interest over time, as opposed to pre-post test collection, is another factor Kazdin suggested for improving internal validity in single-case designs. He noted that continuous assessment reduces the threats to internal validity associated with testing procedures. Additionally, he noted that multiple assessments prior to treatment, particularly if it is shown that the problem is stable and has not changed for an extended period of time, allow researchers to make predictions about the likely direction of future

performance. Such predictions allow researchers to evaluate the extent to which the data after treatment are different from the predictions prior to treatment. Changes that coincide with treatment, therefore, suggest that the intervention may have played some role in change.

Kazdin (1981) also suggested that the more immediate the change after the onset of therapy or the intervention of interest being studied, the stronger the case can be made that the treatment or intervention was responsible for the change. In addition, the magnitude of the change also contributes to the extent to which the treatment can be assumed to have played some role. According to Kazdin, evaluating the magnitude of change addresses the concern of maturation, since maturational changes are unlikely to be abrupt and large. Kazdin also argued for multiple case studies. He asserted that multiple cases that show similar results helps rule out the likelihood of rival hypotheses, since an extraneous event that covaries with treatment would need to be common to all the cases, a condition that is unlikely to be met. The heterogeneity of replicated cases can also contribute to the ability to draw inferences about the cause of change, according to Kazdin. If change is demonstrated across clients who differ on important individual variables, the inferences drawn are stronger than if these differences did not exist. In summary, Kazdin argued that in order to evaluate the usefulness of single-case research for drawing valid inferences, we must shift from viewing case studies as inferior simply because they are not experiments and examine specific threats to internal validity and whether the case study design addresses those threats.

Hilliard (1993) outlined three primary types of single-case research: 1) single-case experiments, 2) single-case quantitative analysis, and 3) case studies. He asserted that the

term single-case experiments should be limited to single-case research designs where the

independent variable is directly manipulated and the data collected is quantitative.

Single-case quantitative designs, according to Hilliard (1993), involve passive

observation of a phenomenon and include an analysis of the unfolding of variables over

time. These designs involve quantitative data and may include hypothesis testing or

generation. While the confirmatory single-subject design might seem impossible,

Hilliard (1993) cited examples of this type of study from other fields and suggested that

such confirmatory case study designs do not exist in psychotherapy research because

researcher's hypotheses are not specified with enough precision to allow for the

identification of disconfirming cases. Hilliard suggested that the third type of design, the

case study, is typically based on qualitative analysis and can also involve either

hypothesis testing or generation.

Summary of Single-Subject Research Designs on Psychotherapy

Many scholars argue for the importance of using single-subject designs in

psychotherapy research (Greenberg, 1986; Jones, 1993; Hilliard, 1993). Several reasons

for this include the need to link in-session processes and changes with outcome, to

improve the consumption of psychotherapy research by practitioners, and to expand our

understanding of the unique ways that individuals respond to treatments, a uniqueness

that is often obscured by group research methods. The primary criticism of single-subject

research is the difficulty in generalizing findings (external validity) and in drawing

conclusions about causality (internal validity). Several scholars argue that to see the

value of single-subject research, one must view it as intrasubject research (Greenberg,

1986; Hilliard, 1993). Through this lens, internal validity issues can be addressed by

collecting systematic, objective, qualitative data through a variety of methods,

administering measures over a period of time, comparing post-session change to stable

pre-treatment levels, and assessing the magnitude and onset of the change that occurred.

External validity in the single-case design is addressed not through aggregation of data,

as it is likely to obscure important individual differences, but through the replication of

results across individuals that are expected to demonstrate both similarities and

differences.

Client Involvement

As noted above, Greenberg (1986) has argued that in order to understand the

components within psychotherapy that contribute to client change and outcome, we need

to identify relationships between detailed psychotherapy processes (e.g., immediacy

events) and in-session client changes (e.g., client involvement, insight, etc.) over time.

Client involvement appears to be a promising in-session client change variable to

examine in relation to immediacy because previous research has shown that client

involvement is a good predictor of both session and therapy outcome.

Gomes-Schwartz (1978) found that judge-rated client involvement was a better

predictor of outcome than other process variables examined. Participants included 35

male college students with depression and anxiety who received up to 25 sessions of

individual therapy. Client involvement was defined in this study as a client's willingness

and ability to be actively involved in treatment. It was measured by subtracting Patient

Hostility scores from Patient Participation scores on the Vanderbilt Psychotherapy

Process Scale (O'Malley, Suh, & Strupp, 1983). It was found to be a better and more

consistent predictor of therapy outcome than other process variables such as exploration

by both therapist and client, and therapist relationship variables such as warmth and friendliness.

Eugster and Wampold (1996) demonstrated that high client involvement was a significant predictor of outcome for both therapist and client. Participants included 114 therapists and 119 of their clients in long-term therapy (average length of treatment = 2.7 years). Data were collected through a survey which included nine constructs proposed by the authors to be associated with therapy outcome. Client involvement was operationalized on the survey as the amount of energy invested in therapy by the client in session, which included level of both verbal and experiential activity, expression of both positive and negative affect, degree of initiative taken within the session, and willingness to engage in an active exploration of feelings, thoughts or memories. The authors based the client involvement survey items on previous measures of similar constructs, one of which was the Experiencing Scales (Klein et al., 1986). The dependent measure of outcome in the study was global session evaluation. Results showed that of the nine constructs, client involvement emerged as a significant and positive predictor of outcome according to both therapists and clients.

As suggested in the Eugster and Wampold (1996) study, client involvement appears similar to client experiencing (Klein et al., 1986), which has also been shown to be related to outcome. Client experiencing refers to the quality of a client's participation in therapy, or more specifically, the extent to which a client's inner experience is focused on and expanded upon in a client's verbal activity during therapy sessions (Klein et al., 1986). Client experiencing has been shown to be a quality that increased over time in more successful therapy and one that was present from the beginning and continued

throughout successful therapy (Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968).
Subsequent research also showed that both the level of client experiencing across therapy and the occurrence of particular patterns are related to successful outcome (Klein et al. 1986).

In a large-scale review of process and outcome research in psychotherapy, Orlinsky, Grawe, and Parks (1994) noted that "the quality of the patient's participation in therapy stands out as the most important determination of outcome" (p. 361). Some of the process variables that the authors were referring to, and which seem to be related to or facets of client involvement, are patient cooperativeness vs. resistance, patient interactive collaboration, and patient openness vs. defensiveness.

Finally, Wonnell and Hill (2002) demonstrated that client involvement predicted client intention to act and implementation of therapeutic action plans. Participants included 30 clients who completed two sessions of dream interpretation and a follow-up interview. Client involvement was a judge-rated scale and defined, based on Eugster and Wampold (1996), as the amount of energy invested in a segment of therapy, manifested by the client's verbal and experiential activity, expression of affect, degree of initiative taken, and willingness to engage in the therapeutic process. Results showed that clients who were rated by judges as being more involved reported higher levels of intention to act and implementation of action plans than less involved clients.

This previous work suggests that client involvement is related to both session and overall outcomes and is therefore, a promising in-session client change variable to examine in relation to immediacy events.

Single-case quantitative studies in psychotherapy

In this next section, I review several single-case quantitative studies in non-behavioral psychotherapy, which is the type of design proposed for the current study. Although there are many case studies published in this area, I review only two to highlight some methodological issues to consider in this particular type of single-subject research. The studies reviewed provide helpful information regarding the case study methodology, including mechanisms for measuring and analyzing therapist and client actions and client in-session change.

Hill, Carter, and O'Farrell (1983) conducted an intensive case study of time-limited (12 sessions) counseling to describe the process and outcome of treatment and to explore some of the possible mechanisms of change within the counseling process. The participant was a 20-year-old white, female, senior at a large public university. The client was selected based on her motivation for treatment, ability to form and profit from a therapeutic relationship, willingness to change, and likeability. Her three major complaints included whether she should break off her engagement with her fiancé, anxiety and tension that resulted in migraines, and her feelings of excessive dependence on her family, particularly her mother. The therapy approach was characterized as generally insight-oriented within a supportive atmosphere.

Client and therapist statements were analyzed to describe the counseling process. Client verbal behavior was operationalized using the Client Verbal Response Category System (Hill et al., 1981), which includes 9 nominal, mutually exclusive categories for judging client verbal response modes. Client and counselor anxiety was operationalized using Mahl's (1956, 1963) Non-ah Speech Distribution Ration. Client and counselor

activity level was measured by the ratio of the number of words spoken by the client or counselor to the total number of words spoken by both the client and therapist. Counselor verbal activity was operationalized using the Counselor Verbal Response Category System (Hill et al., 1981) as well as a measure of therapist intentions. The list of 15 counselor intentions was developed specifically for this study. Session effectiveness was operationalized using the Therapy Session Report (Orlinsky & Howard, 1975), which included a numerical effectiveness score and a space for both client and therapist perceptions of the positive and negative events in the session. Outcome was measured using the Hopkins Symptom Checklist, the Target Complaints, and the Tennessee Self Concept Scale. The Hopkins Symptom Checklist and Tennessee Self Concept Scale were given one week before treatment and the Target Complaints measure was completed during the first session. These measures were also taken one week, two months, and seven months after termination.

With respect to describing the process of therapy, results indicated that there were significant differences between client and counselor verbal behavior within the first third of all sessions and the final two thirds of sessions. Specifically, it appeared that the client became more experientially involved over the course of therapy. This was measured by a decrease in the proportion of descriptive responses and an increase in the proportions of experiencing, insight, silence, and simple responses at the end of treatment. It appeared that the therapist used more minimal encouragers in the early stages of therapy, whereas interpretation was more prevalent later in therapy.

With respect to the question of what led to change, researchers examined differences in client and counselor behavior between the best and worst sessions, as

measured by the Therapy Session Report. Results indicated that in the worst sessions, clients had fewer simple responses, less silence and experiencing, and more description and activity. Also in the worst sessions, the counselor used more minimal encouragers and closed questions and fewer silences and interpretations, and was less active. In the best sessions, researchers found the client decreased her description of the problem and activity level, and increased experiencing, insight and silence.

The client and counselor both noted the effectiveness of pointing out feelings that the client had not been able to acknowledge. Specific positive events, according to the client, included a dialogue the therapist encouraged between the client and her headache, talking about suicide thoughts and fantasies, and talking about the client-counselor relationship. Negative events included not getting immediate answers about how to cope with problems and the abrupt ending of treatment. Finally, outcome measures revealed client improvement on three of the four outcome measures at termination, with no improvement on the Tennessee Self Concept Scale and one of the three problems on the Target Complaints. The client maintained her gains two months after treatment, but appeared to relapse to pre-counseling levels on three of the four measures at the seven-month follow-up.

Some limitations of the study include the appropriateness of the client for time-limited treatment. The authors noted that it seemed that the therapy was not long enough for this particular client. The client appeared to have a high baseline of storytelling behavior and low levels of experiencing and insight, and perhaps was not able to take advantage of therapist interventions because of this communication style. The client began therapy with significant physical complaints, and some (Frank, 1973) have

suggested that this type of client is not as open to interpersonal influence. Finally, as Mann (1979) suggested, brief treatment should be focused on a central theme and as the authors noted, this client might have been struggling with too many issues to be effectively dealt with in time-limited therapy. The observation, recording, and data collection after each session also limits the generalizability of the findings to counseling in real-life situations.

Despite these limitations, this study provides useful information about case study designs in psychotherapy research. The importance of selecting clients who are appropriate for time-limited treatment is highlighted, and this study provides a good example of methods and analyses that can be conducted in this type of process research. Finally, the client's report that immediate discussions between the client and therapist were a positive event gives some anecdotal support for importance of the proposed study.

Silberschatz and Curtis (1993) used a single-case quantitative design to examine the impact of specific therapist interventions on client in-session progress during brief (16 sessions) psychodynamic psychotherapy. The two clients in the study included one 34-year-old female divorced attorney and one 36-year-old male graduate student. Participants were randomly selected from a larger sample of screened clients and both were diagnosed as suffering from a dysthymic disorder. All clients were self-referred and screened to ensure suitability for brief treatment. Clients were required to meet the following minimum acceptance criteria: 1) history of positive interpersonal relationships, 2) no evidence of psychosis, organic brain syndrome or metal retardation, 3) no evidence of serious substance abuse, and 4) no evidence of suicidal potential. Therapists were experienced clinical psychologists with at least three years in private practice; they were

unaware of the study's hypotheses and had no information on clients other than their acceptability for brief treatment.

Researchers were interested in seeing whether a therapist's disconfirmation of a client's pathogenic beliefs in the context of testing those central beliefs would lead to immediate client in-session productivity. Therapist disconfirmation of client pathogenic beliefs was operationalized using judge's ratings, on a scale of 1-7 (7 = high), of the degree to which the therapist passed or failed the client's test. Client testing was operationalized using judge's ratings of the degree to which, on a 1-6 scale, excerpts of therapy sessions represented a key test. A 6 on the scale indicated a clear-cut example of a client testing his or her central pathogenic beliefs, and a 1 on the scale did not suggest the client testing his or her pathogenic beliefs. Immediate client in-session productivity was measured on three minutes of client verbalizations immediately before the test and immediately after, and was operationalized using the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986), the Boldness Scale (Caston, Goldman & McClure, 1986) and the Relaxation Scale (Curtis, Ransohoff, Sampson, Brumer, & Bronstein, 1986). All measures had adequate reliability except two: the Boldness scale for the male patient was low (alpha = .62) as was patient testing for the female client (alpha = .50). The authors noted this latter low reliability was attributable to the restricted range of scores, since most of the tests used in the study were key tests.

Immediate client changes on the three process measures (Experiencing, Boldness, and Relaxation) were calculated using residual gain scores (Cohen & Cohen, 1975), which measures the variance in the postscore not predicted by the prescore. Semipartial correlations were conducted between residual gain scores and therapist behaviors (passed

or not passed client test). Results indicated that when the therapist passed a key test (disconfirmed a central pathogenic belief) the patient's level of experiencing increased and when the therapist failed a key test, the patient's level of experiencing decreased. Similar results were found for the other two process measures for the female but not the male client.

One limitation of the Silberschatz and Curtis (1993) study is the appropriateness of the three process measures for each client. It appeared that perhaps, given the male client's interpersonal dynamics, he was unlikely to show much change on the Boldness and Relaxation measures. The authors suggest that determining which process measures to use in a case requires a case formulation that identifies which changes would be expected for a particular client and how these changes are likely to manifest. This study does provide some additional insight into the types of criteria that might be important to consider when selecting a client for time-limited therapy, such as having no evidence of psychosis, substance abuse, or suicidal potential.

In summary, it appears that client selection is an important consideration when conducting single-case research. It seems that selecting clients who appear able to make use of the length of treatment under investigation (i.e., short or long-term) and who are in the normal range of functioning (i.e., not suicidal, no addictions, no psychosis) is important for this type of research. Selecting in-session client change measures based on informed hypotheses about the ways in which a particular client may change also seems to be an important consideration highlighted in the single-subject quantitative studies reviewed.

Summary of literature on single-subject research designs

Based on the review of the literature above, it appears that single-subject research in psychotherapy is important to consider given the need to understand the specific in-session client processes that contribute to outcome, to understand the unique ways in which individuals change that is often obscured by large between group designs, and to produce more research that is consumed by clinicians (Greenberg, 1986; Hilliard, 1993; Jones, 1993; Kazdin, 1981). The life stage of a particular area of research is also an important consideration in deciding which design to select for a study, with single-case studies often useful in the initial stages of discovery and hypothesis generation (Gelso, 1979; Greenberg, 1986). Client selection also appears to be an important consideration when conducting single-case research (Hill et al., 1983; Silberschatz & Curtis, 1993). Specifically, these studies seem to suggest that clients who are in the normal range of functioning (i.e., not suicidal, no addictions, no organic brain damage) are better candidates for single-case research using a short-term model.

As noted earlier, there is a significant amount of theoretical work that suggests immediacy is a therapeutic process that facilitates client change (Kiesler, 1996; Teyber, 2000; Yalom, 1995, 2002). There is, however, very little empirical research that has directly examined the process of immediacy (Hill & O'Brien, 1999; Kiesler, 1996) and none that has linked immediacy to in-session client changes, an empirical process proposed to help us better understand how immediacy might contribute to psychotherapy outcomes (Greenberg, 1986). It appears that in order to answer important questions regarding the impact of immediacy on psychotherapy outcomes, it is necessary to start by describing and measuring the task itself (i.e., immediacy) through a discovery-oriented

process and relating immediacy to important in-session client changes. Client

involvement seems to be an important in-session change variable to consider because it

appears related to outcome (Eugster & Wampold, 1996; Gomes-Schwartz, 1978) and to

similar constructs that are also related to outcome (Klein et al., 1986), and has been

shown to predict client intention to act and implementation of therapeutic actions plans

(Wonnell & Hill, 2002). Given the need for a detailed in-session description of the

process of immediacy in psychotherapy, the infancy of the research in this area, and the

importance of conducting research that contributes to the integration of psychotherapy

research and practice, a single-case study seems to be the most appropriate method for

understanding immediacy at this point in time.

Chapter 3: Statement of the Problem

Greenberg (1986) has argued that in order to understand the components within psychotherapy that contribute to client change and outcome, we need to break down global outcomes into smaller, related in-session changes and discover how the interactions between client and therapist contribute to these changes. He argues that to do this, we need more intense, single-case analysis that allows researchers to describe detailed psychotherapy processes (e.g., immediacy events) and in-session client changes (e.g., client involvement, insight, etc.) over time, and identify relationships between them.

Although many theorists argue that discussing the immediate client-therapist relationship is a therapeutic process that facilitates client change (Kiesler, 1996; Teyber, 2000; Yalom, 1995, 2002), there is not much research on what occurs during immediacy events between client and therapist in individual therapy. Some research has examined the components (i.e., therapist actions and client tasks) that occur during difficult immediacy events (i.e., misunderstanding, alliance ruptures, and client anger) in individual psychotherapy (Foreman & Marmar, 1985; Hill et al., 2003; Rhodes et al., 1994; Safran et al., 2002). Other research has examined feedback, a related concept, in both individual and group psychotherapy (Claiborn et al., 2002; Kerr et al., 1992). There is no research, however, examining whether the components proposed by theorists occur during different immediacy events in individual psychotherapy. In addition, all the previous empirical work on immediacy events was based on single psychotherapy sessions and did not examine how the components of immediacy events might change

over time throughout a typical course of treatment. Hence, the first set of research

questions examines what therapist actions and client tasks occur during immediacy

events and how these change over time during a single-case of psychotherapy.

Research Question 1: What therapist actions and client tasks occur during immediacy

events?

Research Question 2: How do the therapist actions and client tasks in immediacy events

change over time?

As noted above, Greenberg (1986) has argued that in order to understand the

components within psychotherapy that contribute to client change and outcome, we need

to identify relationships between detailed psychotherapy processes (e.g., immediacy

events) and in-session client changes (e.g., client involvement, insight, etc.) over time.

Client involvement is an important in-session client change variable to study for several

reasons. Client involvement appears related to both session and therapy outcome

(Eugster & Wampold, 1996; Gomes-Schwartz, 1978) and similar to client experiencing,

an in-session client change variable also shown to be related to outcome (Klein et al.,

1986). In addition, client involvement has been shown to predict client intention to act

and implementation of therapeutic action plans (Wonnell & Hill, 2002), suggesting this

in-session change variable is related to overall outcomes.

While historically single-subject research has not been considered a rigorous

scientific methodology because it lacks the internal and external validity of experimental

group designs (Gelso, 1979; Hersen & Barlow, 1981; Hilliard, 1993; Jones, 1993), some

scholars argue that single-case research is crucial to advancing theories that inform

psychotherapy process and outcome research (Greenberg, 1986; Hilliard, 1993; Jones, 1993). Kazdin (1981) acknowledges that although the threats to internal validity in single-case research cannot be ruled out in the same ways as they can in experimental group designs, he noted several ways to address the threats to internal validity in single-case research. First, systematic quantitative data collected over time from a variety of perspectives (e.g., therapist, client, and observer) and using a variety of methods (e.g., self-report, judge-rated, qualitative) in a single-case allows researchers to draw more valid inferences (Kazdin, 1981; Yin, 1994) about the relationship between variables. In addition, Kazdin (1981) suggests that in single-case research, the more immediate an in-session change occurs after the intervention being studied, the stronger the case can be made that the intervention might be responsible for the change.

Hence, the second set of research questions examines what changes occur in client in-session behavior (i.e., involvement) before, during, and after immediacy events.

Research Question 3: How does client involvement change before, during, and after immediacy events?

Research Question 4: How does overall client involvement during immediacy events change over time?

Chapter 4: Method

Design

The project used a naturalistic, single-subject design of individual psychotherapy. The psychotherapy was interpersonally-oriented and consisted of a total of 12 weekly sessions. The therapist was asked to use immediacy as he normally would, whenever he felt it was clinically appropriate. The data were analyzed using the following methods: 1) standard outcome and session measures, 2) judge-rated process measures created specifically for this study, and 3) a qualitatively-informed analysis of immediacy events conducted by the primary investigator and her advisor.

Participants

Therapist. The therapist who participated in this study was a 51-year-old Caucasian male professor of counseling psychology at a large public university in the Mid-Atlantic. He had 20 years of experience conducting both individual and group psychotherapy and characterized his theoretical orientation as predominantly interpersonal. He reported using immediacy in most psychotherapy sessions, and this was the key reason he was invited to participate in this study.

Client. A 24-year-old female, Middle-Eastern graduate student in a mental health field was chosen to participate in the study. The client reported having a history of interpersonal problems and was open to conceptualizing her problems as predominantly interpersonal. She had an appropriate level of distress for short-term therapy and showed an ability to make use of immediacy in a pre-screening interview with the primary investigator. The client also reported no current disordered eating, no history or current

abuse of alcohol or other drugs, and had no past or current suicidal ideation, gestures, or attempts.

The client was of average height, and was thin and attractive. During the pre-screening interview, the client appeared anxious and eager to participate. The client's mood and affect were within the normal range. She was highly articulate and indicated during the pre-screening interview that her primary goal for therapy was to work on her interpersonal relationships and the patterns in her involvements with men and others in her life.

Judges/Transcriber. Three female judges and one female transcriber participated in the current study. One judge was Caucasian, one was Hispanic, and one was Indian-American. The transcriber was Black. The judges and transcriber ranged in age from 21 to 44, with a median age of 22. The judges and the transcriber were all psychology majors. One of the judges was double majoring in criminology and one received a certificate in women's studies. The judges and the transcriber committed to working nine hours a week for the semester and were given 3 credits in a 400-level Psychology course for their participation in this project. The three judges coded Immediacy Components first and then coded Client Involvement. Judges were blind to the purposes of the study overall. Judges were told that the project involved the analysis of a case study of one therapist and one client over the course of 12-15 sessions of psychotherapy.

Outcome Measures

Symptom change. The Outcome Questionnaire 45.2 (OQ 45.2; Lambert et al., 1996) was used to assess symptomotology before, during, and after treatment. The OQ 45.2 is a 45-item self-report outcome instrument designed for repeated measurement of

client progress throughout the course of therapy and at termination. Items on the OQ

45.2 are scored on a 5-point Likert-type scale from never (0) to almost always (4). The

alpha coefficient reported for the total OQ 45.2 was .93 and the test-retest reliability was

.84 (Burlingame, Lambert, Reisinger, Neff, & Mosier, 1995). The OQ 45.2 was

correlated .61 with the SCL-90, .63 with the Beck Depression Inventory, and .81 with the

Zung Self-Rating Anxiety Scale, providing criterion validity for the measure (Burlingame

et al., 1995). There is also evidence to suggest that the OQ 45.2 is sensitive to change in

clinical settings within one-week of treatment (Vermeersch, Lambert, & Burlingame,

2000). Since there is some evidence to suggest that there is not adequate construct

validity for the use of the three subscales of the OQ 45.2 (i.e., symptomatic distress,

interpersonal relationships, and social role functioning; Mueller, Lambert, & Burlingame,

1998; Umphress, Lambert, Smart, Barlow, & Clouse, 1997) the overall scale was used in

the current study. Sample items from the measure include, "I feel lonely" and "I have

trouble getting along with friends and close acquaintances." The alpha coefficient for the

OQ 45.2 in the present study was .88. See Appendix A for a copy of the Outcome

Questionnaire 45.2.

The Inventory of Interpersonal Problems – 32. The Inventory of Interpersonal

Problems – 32 (IIP-32; Barkham, Hardy, & Startup, 1996) is a 32-item self-report

instrument designed to help clients and therapists identify interpersonal sources of

distress. The IIP-32 was shortened from the 127-item IIP (Horowitz, Rosenberg, Baer,

Ureno, & Villasenor, 1988) to allow for easier repeated measurement of psychotherapy

progress and outcome in clinical settings. Items on the IIP-32 are scored on a 5-point

Likert-type scale from not at all (0) to extremely (4). Sample items include, "It is hard

for me to trust people" and "I am too dependent on other people." The alpha coefficient reported for the IIP-32 was .87 and the test-retest reliability was .70 (Barkham et al., 1996). The IIP-32 was able to distinguish between asymptomatic, community, and outpatient samples, demonstrating the discriminant validity of the measure (Barkham et al., 1996). Since the measure was administered three times in the current case, reliability data are not available. See Appendix B for a copy of the Inventory of Interpersonal Problems - 32.

The Self-Understanding of Interpersonal Patterns - Revised scale. The Self-Understanding of Interpersonal Patterns - Revised scale (SUIP-R; Gibbons, Schamberger, Narducci, & Crits-Christoph, 2003) is a 28-item self-report instrument that measures a client's level of understanding of his or her own interpersonal patterns. For each interpersonal pattern, participants are asked to 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 are also asked to rate the importance of this interpersonal pattern in their current relationships on a Likert-type scale from 1 to 10 where 1 = not important and 10 = very important. Gibbons et al. (2003) reported adequate internal consistency for the SUIP-R (.91 patients; .94 non-patients), but did not report test-retest reliability for the measure. Gibbons et al. (2003) also demonstrated that the SUIP-R scale was not related to self-esteem (Beck Self Esteem, -.09) or depression (Beck Depression Inventory, -.05), providing discriminant validity. In addition, the authors found significant changes in clients' self-understanding of their interpersonal patterns after interpersonal therapy compared to cognitive therapy,

providing construct validity for the measure. Since the measure was administered three times in the current case, reliability data are not available. See Appendix C for a copy of the Self-Understanding of Interpersonal Patterns – Revised.

Post-Session Measures

Depth Scale. The Depth Scale of the Session Evaluation Questionnaire (SEQ-D; Stiles & Snow, 1984) was used. The SEQ-D is a 5-item, bipolar, adjective-anchored, self-report measure designed to evaluate the quality of therapy. Both therapist and client versions were used in this study. Respondents were asked to "circle the appropriate number to show how you feel about this session." An example of an adjective set from the measure is "shallow" versus "deep." Stiles et al. (1994) reported correlations between the SEQ-D and the Understanding, Problem Solving, and Relationship subscales of the Session Impacts Scale (Elliot & Wexler, 1994), providing evidence of the concurrent validity of these measures of session impact. The scale has good internal consistency (.91, Stiles & Snow, 1984; .90, Stiles et al., 1994). The alpha coefficient for the SEQ-D in the current study was .77 for the client and .93 for the therapist. See Appendix D for a copy of the SEQ-D.

Working Alliance Inventory – Short Form. The Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989) is a 12-item self-report measure designed to assess the working alliance between client and therapist, as proposed by Bordin (1979). The working alliance is proposed to assess agreement between client and therapist on the tasks and goals of therapy, and the emotional bond between the client and therapist (Bordin, 1979). The WAI-S was shortened from the 36-item WAI (Horvath & Greenberg, 1989) to allow for easier repeated measurement in clinical settings.

Respondents on the WAI-S, which include both client and therapist, are asked whether a statement describes the way they feel or think about the therapist-client relationship, on a 7-point Likert type scale from never (1) to always (7). Sample items from the client version include, "I believe _____ likes me" and "_____ and I have different ideas about what my problems are." Sample items from the therapist version include, "I believe _____ likes me" and "_____ and I have different ideas about what his/her real problems are." Busseri and Tyler (2003) demonstrated that the WAI-S and the WAI are statistically interchangeable by showing that the subscale and total scores on the 12-item WAI-S corresponded highly to the scores on the 36-item full scale of the WAI. Tracey and Kokotovic (1989) demonstrated high internal consistency of the WAI-S with alpha coefficients ranging from .83 to .98. The alpha coefficient for the WAI-S in the present study was .84 for the client form and .76 for the therapist form. See Appendix E for a copy of the Working Alliance Inventory – Short Form, Therapist and Client.

　　　　Immediacy Recall Questionnaire. The Immediacy Recall Questionnaire (IRQ) was developed for this study to assess client perceptions of immediacy, based on Elliott's (1986) brief structured recall procedure and materials. The client was asked to rate how much during a session, on a scale of 1 to 9 (1 = not at all, 9 = the entire session), she and her therapist talked about their immediate relationship with each other. The client was also asked to answer open-ended questions about the content of the discussion with the therapist about their relationship, what this discussion was like for her, and what she learned about herself from this discussion. Sample questions from this measure include, "When you and your therapist talked about your relationship today, what was the content of your discussion?" and "When you and your therapist talked about your relationship

today, what was that like for you?" See Appendix F for a copy of the Immediacy Recall Questionnaire.

Therapist Process Note. The Therapist Process Note (TPN) was developed for the present study to assess the therapist's perceptions of immediacy and his reactions to the client. Similar to the Immediacy Recall Questionnaire (IRQ) completed by the client, this measure asked the therapist to rate how much during a session, on a scale of 1 to 9 (1 = not at all, 9 = the entire session), the client and therapist talked about their immediate relationship with each other. In addition, the therapist was asked to conceptualize the client's concerns and to describe his thoughts and perceptions of how the client responded to his use of immediacy. Finally, the therapist was asked to discuss his personal reactions to the client. See Appendix G for a copy of the Therapist Process Note (TPN).

Client Post-Session Measure - Helpfulness. The Client Post-Session Measure – Helpfulness (CPSM – Helpfulness) was developed for this study to provide an additional measure to distract the client from guessing the main purpose of the study, given the face-obvious nature of the other post-measures she completed, and to provide further information about the client's reactions to immediacy. The client was asked to answer an open-ended question about what the therapist did or said in a specific session that was helpful. The client was also asked to answer an open-ended question about what the therapist did or said in a specific session that was unhelpful or what the client wished the therapist had done differently in the session. See Appendix H for a copy of the Client Post-Session Measure – Helpfulness.

Judge-rated measures

Immediacy Components. The Immediacy Components (IC) measure was created

for this study based on the theoretical and empirical literature. The primary investigator

and her advisor further refined the measure based on a review of several pilot sessions

with the therapist and a volunteer client, and discussions with judges based on the coding

of an initial session. The final measure included eight therapist actions and four client

tasks proposed to occur while client and therapist are discussing their immediate

relationship.

Judges reviewed the videotape of one therapist and one client speaking turn at a

time, read the corresponding session transcript for those turns, and then rated components

that occurred in each therapist and client speaking turn. Judges could choose as many

components from the list as they felt occurred in a particular speaking turn. A sample

therapist action on the measure is, "TH provides client immediate behavioral *feedback*

(i.e., direct observation of something happening in the room)." An example of a client

task on the measure is, "CL expresses immediate thoughts or feelings to TH about TH or

CL/TH relationship." Inter-rater reliability for the Immediacy Components measure in

the current study, using average kappas between pairs of raters, was as follows: therapist

speaking turns, .72; client speaking turns, .84. See Appendix I for a copy of the

Immediacy Components Measure – Therapist and Client versions.

Client Involvement. The Client Involvement (CI) scale assessed the client's level

of involvement in psychotherapy and was designed for the current study based on other

related measures (Eugster & Wampold, 1996; Wonnell & Hill, 2002). Client

involvement 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). Inter-rater reliability for client involvement in the current study, assessed using alpha coefficients, was .89. A correlational analysis was conducted at the speaking turn level to determine whether client immediacy and client involvement were independent constructs. Results indicated that there was no relationship between client involvement scores and client immediacy, r (538) = .06, p > .05, suggesting these two variables were measuring independent constructs. See Appendix J for a copy of the Client Involvement Scale.

Procedures

Measures. An overview of the measures completed over the entire course of the study is provided in Table 1.

Table 1
Measures Completed by Client and Therapist Over Time

	Pre Treatment[1]	Pre Session[2]	Post Session[2]	One-Week Follow-Up[1]	Four-Month Follow-Up[1]
Client					
	OQ 45.2	OQ 45.2	SEQ-D	OQ 45.2	OQ 45.2
	IIP-32		WAI-S	IIP-32	IIPI-32
	SUIP-R		IRQ	SUIP-R	SUIP-R
			CPSM-Helpfulness		
Therapist		SEQ-D			
			WAI-S		
			TPN		

[1] Measures administered once at interval; [2] Measures administered for each of 12 sessions.

Therapist recruitment. The therapist was asked to participate in the current study because he was known to the primary investigator to use immediacy frequently in client sessions. In return for his participation, the therapist was offered the option of receiving third authorship on the published manuscript, should it be accepted, and the use of therapy tapes in practicum coursework, pending client approval.

Pilot. Prior to data collection and analysis there was a pilot test of three participant completed measures: IRQ, CPSM – Helpfulness, and TPN, and one judge-rated measure: Immediacy Components. Three pilot sessions were conducted to evaluate the usefulness and adequacy of these measures and make any changes necessary prior to data collection. The pilot participant was recruited from an outpatient psychotherapy group that was being conducted at the time by the therapist in the current study. The pilot participant completed the IRQ, CPSM – Helpfulness and the therapist completed the TPN after each of the three sessions. The primary investigator spoke with the participant and therapist after each session to discuss their reactions to the measures. Feedback from these discussions was collected, discussed with the primary investigator's advisor, and changes to these measures were made after each session and finalized prior to the start of data collection.

To evaluate the Immediacy Components measure, the primary investigator observed each pilot session live from a television monitor located in another room. While observing each session, the primary investigator attempted to code the therapist tasks and client actions using the Immediacy Components measure and noted any proposed changes. After each session, the primary investigator discussed the proposed changes to the measure with her advisor. Once agreement was reached on the changes,

the measure was revised. The primary investigator used this revised measure during the next session, and this review-edit-revise process was repeated after the other two pilot sessions until the measure was finalized. Eight therapist actions and four client tasks were identified on the final Immediacy Components measure.

In addition to the changes identified in the Immediacy Component measure, the live observation of each pilot session also revealed a limitation in the strategy proposed for using this measure. It was originally proposed that immediacy events would be identified and components would be coded based on these events. The therapist in the current study used immediacy so frequently in the three pilot sessions that the primary investigator and her advisor were concerned it would not be possible to delineate immediacy events and have raters code speaking turns within those events. As a result, it was decided that raters would code immediacy components for every therapist and client speaking turn.

Client recruitment. Clients were recruited from faculty, staff, and graduate students at a large, public university in the Mid-Atlantic through an email sent to several listserves. In addition, clients were recruited from graduate students in mental health fields at surrounding universities through an email sent to the training directors of individual programs. See Appendix K for a copy of the Recruitment Email. Potential clients were told that they would receive up to 15 sessions of free therapy for their participation. Approximately 12 respondents expressed an interest in participating in the study, of which six potential clients were available and scheduled for a pre-screening interview over the telephone. See Appendix L for the Telephone Screening Interview Form.

During the pre-screening telephone interview, the six potential clients were told that they would not, under any circumstances, have the option of continuing to work with this particular therapist once the study was complete. The potential clients were also told that they would be required to participate in a 30-minute follow-up three months after the study was finished to complete a set of self-report measures. The selection criteria included the client not reporting any current disordered eating, having no history or current abuse of alcohol or other drugs, and having no past or current suicidal ideation, gestures, or attempts. Of the six potential clients, three individuals met these requirements and were invited to participate in a 30-minute in-person interview with the primary investigator to determine their final eligibility. Potential clients signed a consent form, prior to their participation in the in-person interview. All in-person interviews were audio-taped. See Appendix M for a copy of the In-Person Screening Interview Consent Form.

The final client was selected because she was open to conceptualizing her problems as predominantly interpersonal, had an appropriate level of distress for short-term therapy, and showed an ability to make use of immediacy in the pre-screening interview with the primary investigator. In addition, the chosen client had not recently been in treatment, so her distress was more pronounced than one of the other two potential clients who was in therapy at the time but was terminating with her current therapist.

Judge recruitment. Judges were recruited from a large, public university in the Mid-Atlantic through announcements made during upper-level psychology courses and through a notice posted on an email listserve for students in the Psychology Department.

Each potential judge participated in a 30-minute in-person selection interview. Of the nine total applicants, three judges were selected on the basis of their interest in psychotherapy research and their broad understanding of the constructs of interpersonal patterns and client involvement in therapy.

Pre-session. After the client verbally consented to participate in the study over the telephone, she came in to complete a set of pre-session measures. She completed the following measures the week prior to the first session: Consent Form (Appendix N), OQ 45.2, IIP-32, and SUIP-R.

Each session. Prior to each session, the client completed the OQ 45.2. The use of the OQ 45.2 before sessions to assess symptomotology is standard for this instrument (Lambert, Hansen et al., 2002). The primary investigator attended each session to start and stop the videotape, administer the measures, observe the session from a separate room over a television monitor for transcription purposes, and to answer any client or therapist questions regarding the study.

Post-session. After each session, the client and therapist completed a set of self-report measures in separate rooms. The client completed the SEQ–D, WAI-S, IRQ, and CPSM – Helpfulness. The client was told that the therapist would not see her responses to these measures while they were in treatment together. The therapist completed the SEQ–D, WAI-S, and TPN. All measures were completed on paper except the TPN, which was completed by the therapist directly on a computer. All paper measures were randomly ordered across sessions.

Post Treatment. One week after the final session, the client completed the following measures: the OQ 45.2, IIP-32, and SUIP-R. After completing these

measures, the client participated in a 50-minute in-person, videotaped interview with the primary investigator to discuss her reactions to the study and to receive a debriefing on the purposes of the study. At the end of this discussion, the client was given the Debriefing Form (See Appendix O). The client was also asked at the end of the debriefing interview to consider providing permission for the videotapes from the study to be used for training purposes. The client agreed to allow the primary investigator, her advisor, and the therapist in the study to use the tapes for teaching purposes, but only on the condition that her face be entirely unrecognizable on the videotapes. The client signed the Client Release of Information form to document this agreement (See Appendix P).

Two weeks after the final session, the therapist participated in a 50-minute in-person videotaped interview to discuss his reactions to the study and to receive a debriefing on the purposes of the study. During this interview, the therapist was also asked to provide his permission for the videotapes from the study to be used for training purposes. The therapist agreed without reservation, and signed the Therapist Release of Information form to document this agreement (See Appendix Q).

Follow-up. Four months after termination the client was mailed the following measures: the OQ 45.2, IIP-32, and SUIP-R. She mailed the completed measures back to the primary investigator within one week of receiving them. In the returned packet, the client sent a note indicating that she was studying for a set of very difficult exams during the week she took the measures, and was concerned that this might impact her scores. The client provided her demographic information through an email to the primary investigator after the follow-up measures had been collected.

Session transcription. The transcriber and three judges transcribed all of the psychotherapy sessions. Each transcript was checked once by a judge who had not previously transcribed the session, and then by the primary investigator. All identifying client information was removed from the transcripts.

Data entry. The judges typed the free form responses from the IRQ and the CPSM – Helpfulness measures and entered the data from the post-session client measures directly into SPSS. The judges also entered data into SPSS from the Immediacy Components and Client Involvement rating forms.

Training of judges on Immediacy Components coding. Three judges were trained on the Immediacy Components measure by the primary investigator. Prior to training, judges were given a collection of readings on the concept of immediacy from some of the major interpersonal theorists (Kiesler, 1996; Teyber, 2000; Yalom, 1995, 2002). In training, judges discussed the concept of immediacy in the therapeutic relationship and were trained on the definition of immediacy used in this study. After reviewing the definition, the researcher asked each judge to discuss her understanding of immediacy. The researcher facilitated a discussion until it appeared that all judges conceptualized the construct in a similar fashion and were able to provide examples of immediate discussions.

Next, the researcher discussed the therapist actions and client tasks from the Immediacy Components measure that were proposed to occur during immediacy between client and therapist. The researcher reviewed examples of session transcripts from textbooks (Hill & O'Brien, 1999; Teyber, 2000) that illustrated some of the proposed therapist actions and client tasks from the measure. The researcher then explained that,

based on their review of session videotapes and transcripts, judges would need to rate whether or not each therapist action or client task was present in a particular speaking turn. Judges were trained to identify additional therapist actions and client tasks and to evaluate the adequacy and accuracy of the existing components to revise the measure for final use. Raters independently identified the immediacy components represented in a specific therapist and client speaking turn. Judges then would discuss their independent ratings and their reasons for choosing a particular immediacy component to improve reliability. Training was considered complete when raters achieved .70 inter-rater reliability. See Appendix R for a copy of the Immediacy Rating Form.

Coding of Immediacy Components. Judges rated whether or not each of the therapist actions and client tasks occurred in each speaking turn. On the rating form, judges placed the number corresponding to the immediacy component(s) (i.e., therapist action or client task) that they believed occurred in a speaking turn. As judges coded the first session, they and the primary investigator added components to the measure that were observed to occur but that were not on the original measure. The judges and the primary investigator discussed these additions and consolidated the components in the measure based on their additions. The judges and the primary investigator, in consultation with the primary investigator's advisor, agreed on a finalized measure prior to coding the remaining 11 sessions that contained eight therapist actions and four client tasks.

Judges worked independently on codings and discussed any disagreements afterwards to continually improve their reliability. An immediacy component was considered to have occurred in a speaking turn if at least two judges identified the same

immediacy component. When at least two judges did not agree on the presence of a component in a particular speaking turn, judges discussed which component(s) they believed had occurred and came to consensus on the final component(s) for that turn. Judges coded psychotherapy sessions using the Immediacy Components measure in three stages. Specifically, the sessions one through four were coded first, sessions five through eight were coded second, and sessions nine through 12 were coded third. Within each group, sessions were randomized. After coding all 12 sessions, judges recoded the session used to finalize the measure. Judges generally conducted the ratings in 1.5-hour coding sessions and completed an average of four sessions each week.

Training of judges on Client Involvement coding. At a later time, the same judges that were trained on the Immediacy Components measure were also trained on the Client Involvement scale by the primary investigator. Judges were given a definition of client involvement and after reviewing the definition, judges were asked to discuss their understanding of the construct with one another. The primary investigator facilitated this discussion with the judges until it appeared that all judges conceptualized the construct similarly and were able to provide examples of client involvement. Judges then discussed the criteria that were used to assess the client's involvement in a session, providing judges with some basis for making a decision on the 1 to 5 Likert-type scale. Judges practiced rating client involvement using transcripts from psychotherapy sessions found in textbooks and using both the videotape and transcript from one of the twelve sessions conducted in the current study. Training was considered complete when raters achieved .70 inter-rater reliability. See Appendix S for a copy of the Client Involvement Rating Form.

Coding of Client Involvement. Client involvement scores were coded after Immediacy Component ratings were completed. The same three judges rated the level of client involvement in each client speaking turn on a scale of 1 to 5. Judges were asked to rate only what the client said verbally, based on their review of the session videotape and transcript. Judges were also asked not to infer what the client might have meant in a speaking turn. Judges were asked not to base their ratings on what the therapist said and not to let their personal judgments or reactions to the content or participants influence their responses in any way. Judges worked independently on ratings, and discussed any disagreements after the final ratings had been recorded. Transcripts from all 12 psychotherapy sessions were randomized prior to coding client involvement. Judges generally conducted the ratings in 1.5-hour coding sessions and completed an average of four sessions each week.

Preliminary Analyses of Immediacy Components

Therapist Actions. Prior to data collection, eight therapist immediacy actions had been proposed for coding purposes: 1) Not Immediacy, 2) Feedback, 3) Inquiry about the Relationship, 4) Moderately Self-Involving Statement, 5) Intimately Self-Involving Statement, 6) Behavior Change, 7) Linking Client Behavior In Session to Other Relationships, and 8) Education About Immediacy. Preliminary analyses on the data collected revealed that the category of "Behavior Change" was not coded at all throughout the course of therapy, and so was dropped. Two other categories, "Linking Client Behavior In Session to Other Relationships" and "Education about Immediacy," were coded less than 1% of the time by judges, so were recoded as "Other Immediacy."

This category was not included in the final analysis, however, because it did not occur frequently enough to result in any data to report.

A qualitative audit of the judgments in the category of "Moderately Self-Involving Statements," conducted by the author and her advisor, revealed that many of these statements were of the therapist's thoughts and feelings that did not involve the client-therapist relationship (e.g., I feel sad hearing you say that about your father.) Thus, they did not fit the definition of immediacy identified in the current study. In order to have a more valid analysis of immediacy in the present study, it was decided to recode the category "Moderately Self-Involving" as "Not Immediacy." As a result of this preliminary analysis, the final list of therapist immediacy categories analyzed was as follows: 1) Not Immediacy, 2) Feedback, 3) Inquiry About Relationship, 4) Intimately Self-Involving Statement.

Client Actions. Prior to data collection there were four client immediacy actions proposed for coding purposes: 1) Not Immediacy, 2) Immediacy (i.e., Immediate Thoughts or Feelings about TH or TH/CL Relationship), 3) Immediate Wish or Want of TH, 4) Linking Client Behavior In Session to Other Relationships. Preliminary analysis revealed that, "Immediate Wish or Want of TH" and "Linking Client Behavior in Session to Other Relationships" were coded by judges less than 1% of the time. All three types of immediacy were then collapsed into the category "Immediacy." The final list of client immediacy categories analyzed was as follows: 1) Not Immediacy, 2) Immediacy.

Changes to Data Analyses

Research questions one and two had to be modified because the initial data did not fit the questions. Specifically, as noted earlier, the therapist used immediacy so

frequently in the three pilot sessions that it was decided judges would rate immediacy at the speaking turn and not the event level. Hence, research questions one and two were modified and an additional question was added to account for this change. It was determined that the remaining two research questions, however, were not answerable through any means other than identifying immediacy events. As the author and her advisor became familiar with the data and were able to observe the therapist's use of immediacy across all 12 sessions, it seemed possible to identify immediacy events and use these events as the basis for answering the remaining two research questions.

Immediacy Event Identification. The author and her advisor generated a preliminary list of immediacy events through a qualitative review of each session, based on session transcripts. An immediacy event was defined as any discussion between the client and therapist about their immediate relationship. An immediacy event was considered to have begun when either the client or therapist initiated a discussion about their immediate relationship. An immediacy event was considered to have ended when neither the therapist nor the client returned to the discussion.

First, the author read the transcripts of each session and, using clinical judgment, identified the beginning and the end of each immediacy event. Second, the author's advisor, who served as the auditor, reviewed the proposed events using session transcripts and either agreed or disagreed with the proposed beginning and ending of each immediacy event. If there was agreement, the event was considered ready for analysis and if not, the event was reviewed by both the author and the auditor until consensus was reached. This analysis revealed a final list of 33 immediacy events.

Additional Data Analyses

Once immediacy events were identified, an additional qualitatively-informed analysis of the immediacy events was conducted to provide more insight into the phenomenon of immediacy. These additional analyses included the identification of the types of immediacy events that occurred, initiation and reciprocation of immediacy events, changes in events over time, and the client's post-session reactions to immediacy events.

Types of Immediacy Events. A content analysis of the immediacy events was completed to identify types of events. For this analysis, the author reviewed each immediacy event and identified the main topic(s) of each event (i.e., what they talked about). From this list of event topic(s), the author went through and generated categories and assigned each event to one or more categories. Once the preliminary list of event categories and assignments was identified, the auditor went through and either agreed or disagreed with both the event categories and the assignment of events to categories. If there was disagreement, the author and the auditor discussed the event type and/or assignment until there was agreement on both. The assignment of immediacy events to categories was conducted two times, after which a final list of event categories and assignments was generated.

Initiation and Reciprocation of Immediacy Events. After identifying the types of immediacy events that occurred, both the author and her advisor reviewed each event and identified which participant (therapist or client) initiated the event and whether the initiation attempt was reciprocated by the other person. An initiation was considered not to have been reciprocated when either the client or therapist began a discussion of the

immediate client-therapist relationship but the other person changed the subject to another topic and neither person returned to the original topic for three speaking turns.

Changes in Immediacy Events Over Time. As part of the immediacy event type analysis, the session in which each immediacy event occurred was also identified. The author reviewed a visual chart of when the events occurred over time and determined a pattern of event occurrence over time. The author's advisor reviewed this pattern, disagreements were discussed, and agreement was reached on the final pattern of immediacy events across the 12 sessions.

Client Reactions to Immediacy Events. A summary of the client's post-session reactions to immediacy was generated by the author and reviewed by the auditor. To generate these summaries, first the author reviewed the client's comments and assigned them to both an event type and a specific immediacy event. The auditor reviewed the assignment of client comments to both event type and specific immediacy events, and the author and auditor discussed these assignments until consensus was reached. Next, a summary of the client's reactions to each event type was generated and an example of each event type from the session transcripts was chosen for review. The auditor reviewed the summary of the client's reactions and either agreed or disagreed with the characterization of the client's reactions. When there was disagreement, the author and the auditor reviewed the client's comments until agreement was reached.

Chapter 5: Results

In this section, first I briefly provide a clinical overview of the current case. Next, I discuss the preliminary analyses of both the session and outcome measures. These analyses were conducted to understand how the client in the current case compared to norms and changed throughout treatment with respect to the depth of sessions, the working alliance, and on interpersonal and general symptomotology. Next, I discuss the results of the research questions. These analyses were conducted on therapist and client speaking turns and session level data, and illustrate both the patterns of immediacy use by therapist and client and the relationship between immediacy use and client involvement. Finally, I discuss the additional data analyses completed. These analyses were conducted at the immediacy event level. This level of analysis allowed us to examine the content of and the client's reactions to immediate conversations between client and therapist throughout treatment.

<div align="center">Clinical Overview of Case</div>

As noted earlier, the client in the current study was interested in working on interpersonal problems. The client had begun a romantic relationship around the same time that therapy had started. She spent the majority of her time in treatment exploring the patterns she engaged in with her boyfriend that caused conflict between them and discomfort for her. The client also spent time in treatment discussing some of the difficulties she was experiencing in her relationship with her parents. The client explored her feelings associated with these relationship patterns and discussed ways to cope with and manage them.

The client related in a somewhat intellectualized manner and appeared to sometimes use storytelling to manage the anxiety she was experiencing in session. Some of the primary relationship patterns she discussed included difficulty openly expressing her feelings towards her boyfriend and initiating discussions with him when she was angry with or hurt by him. The client also had difficulty feeling confident that others (i.e., boyfriend, parents) cared for her and occasionally felt insecure in response to any indications of withdrawal or signs of a rupture in a relationship. Finally, the client was also coping with feelings of loss associated with the separation-individuation process with her parents, both due to her new romantic relationship and her parents' possible geographic move.

<div align="center">Preliminary Analyses of Session and Outcome Measures</div>

Comparison to Norms

Mean scores were calculated for the client and therapist on the two session measures (SEQ-D and WAI-S). Pre and post-treatment scores (1 week and 4 months after treatment) on the three outcome measures (OQ 45.2, IIP-32, SUIP-R) for the client were also identified. Scores on each of these five measures were compared to norms to provide a context for the results found in the current case.

We used effect sizes to evaluate whether differences existed between the current case and norms on these five measures and how the client changed over the course of treatment on the three outcome measures. Cohen (1988) defines an effect size (ES) as "the degree to which the phenomenon is present in the population…The larger the effect size, the greater the degree to which the phenomenon under study is manifested" (p. 9-

10).   The definition of effect sizes used in the current case were as follows: small ES =

.20-.49, medium ES = .50-.79, and large ES = .80 and above (Cohen, 1988).

To compare the current case to norms, effect sizes were calculated using the

following procedure: 1) the difference was found between the mean of the previous

sample and the current case, 2) the result from the calculation in step one was divided by

the standard deviation of the previous sample, resulting in an effect size. To understand

how the client changed on the three outcome measures over the course of treatment,

effect sizes were calculated using the following procedure: 1) the difference was found

between the client's mean score at Time 2 and Time 1, 2) the result from the calculation

in step one was divided by the standard deviation of the norm group during Time 1

because the client only had one score at each time and we had to use the best available

standard deviation estimate.

SEQ-D. The client and therapist completed the SEQ-D after each of the 12

sessions. See Table 2 for results. Effect size calculations showed there was a large effect

for both the client (1.56) and therapist (.97), based on their average scores across all 12

sessions, compared to norm SEQ-D scores. These results suggest that in this case, both

client and therapist perceived the sessions to have greater depth than was found in the

normative sample. See Figure 1 for both client and therapist SEQ-D scores over time.

Table 2

Means and Standard Deviations on Session Evaluation Questionnaire-Depth (SEQ-D) for Client and Therapist Compared to Norms

| | Current Case[1] | | Norms[2] | |
	M	SD	M	SD
Client SEQ-D	6.58	.68	5.16	.91
Therapist SEQ-D	5.67	1.28	4.62	1.08

[1]$N = 12$; [2]Client norms (Stiles et al., 1994), Therapist norms (Stiles & Snow, 1984).

Figure 1

Client and Therapist Session Evaluation Questionnaire-Depth (SEQ-D) Scores Across Treatment
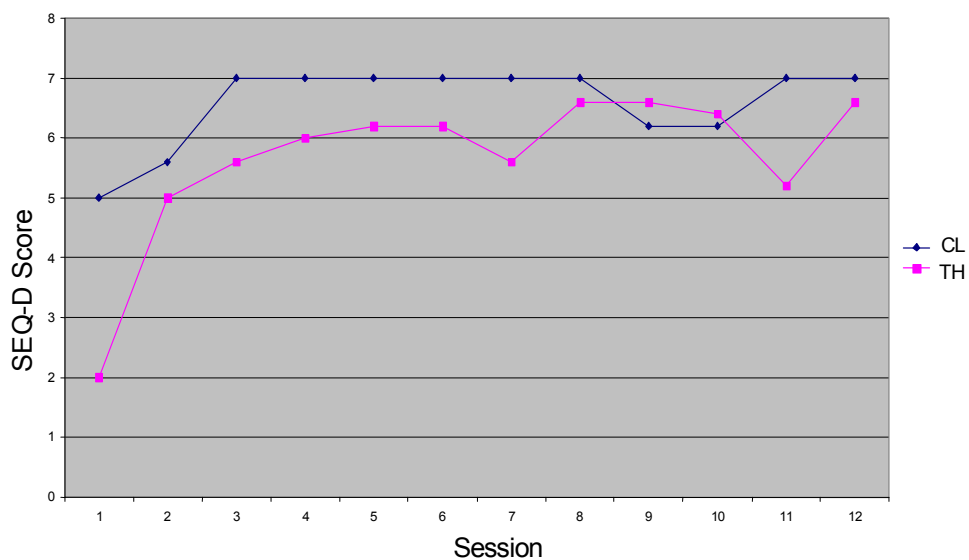
WAI-S. The client and therapist completed the WAI-S after each of the 12 sessions. See Table 3 for results. Effect size calculations showed that there was a large effect for the client (.83) and a small effect for the therapist (.48), based on their average

scores across all 12 sessions, compared to norms on the WAI-S. These results suggest

that both client and therapist perceived their working alliance to be better than did those

in the normative sample. See Figure 2 for both client and therapist WAI-S scores over

time.

Table 3
Means and Standard Deviations on Working Alliance Inventory-Short (WAI-S) for Client
and Therapist Compared to Norms

| | Current Case[1] | | Norms[2] | |
	M	SD	M	SD
Client WAI-S	6.62	.51	5.96	.80
Therapist WAI-S	5.92	.84	5.50	.88

[1]$N = 12,$ [2]Scores reported are final session ratings of total WAI-S (Bosseri & Tyler, 2003).

Figure 2
Client and Therapist Working Alliance Inventory-Short (WAI-S) Scores Across
Treatment

.
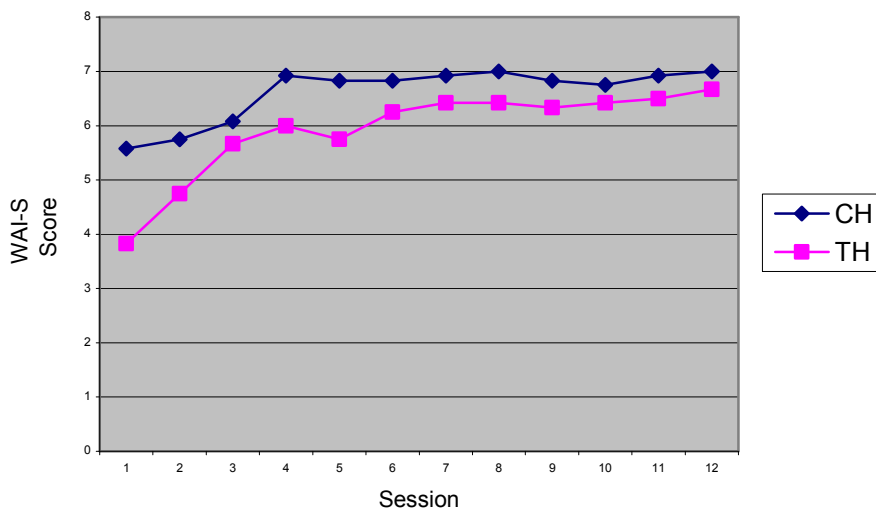
OQ 45.2. The client completed the OQ one week prior to treatment, prior to each session, as well as one week and four months after treatment was completed. Client scores on the OQ were compared to norms using two methods: 1) effect size calculations as described above, and 2) the cutoff score and Reliable Change Index (RCI) identified in the OQ 45.2 manual (Lambert, Hansen, et al., 2002). See Table 4 for pre and post-treatment OQ scores.

Table 4
Pre and Post-Treatment Outcome Questionnaire (OQ) 45.2 Scores Compared to Norms

	Current Case[1]	Norms[2]	
		M	SD
Pre-Treatment OQ	58	84.65	24.14
One-Week Post-Treatment OQ	79	67.18	27.12
Four-Months Post-Treatment OQ	79	67.18	27.12

[1]$N = 1$; [2]Norm scores based on 7-weeks of treatment (Lambert, Hansen, et al., 2002).

Comparing the current case to norms using effect size calculations, results showed there was a large effect for the client (1.10) on the pre-treatment OQ scores, suggesting that this client began treatment with fewer symptoms than the normative sample. Results also showed that there was a small effect on both post-treatment scores (.44; .44), suggesting that the client ended treatment with slightly more symptoms than the normative sample.

Comparing the client's own pre and post-treatment OQ scores using effect size calculations, results showed there was a large effect for the client (.86) from pre to one-week post-treatment, no effect (0) from one-week to four-months post-treatment, and a

large effect (.86) from pre to four-months post-treatment. These results suggest that the client ended treatment with more symptoms than when she began.

According to the OQ manual, "in order for an individual's score to be considered clinically significantly changed, it must cross the cutoff score (63),…and must change by at least 14 points (RCI)" (Lambert, Hansen, et al., p. 5, 2002). Using this method to evaluate change, the client's OQ score decreased by 14 points between sessions 2 and 4, suggesting she experienced a clinically significant improvement in her symptoms. The client's symptoms increased before session 10, decreased before session 11, and increased before the one-week follow-up. These changes suggest the client's symptoms increased and decreased over time, but that the client ended treatment (session 12, one-week post-treatment, four-months post-treatment) with more symptoms than when treatment began (79 vs. 58). See Table 5 for OQ scores across treatment.

Taken together, these results suggest that the client began treatment with fewer symptoms than the norm group and experienced an improvement in her symptoms during treatment. However, it appears the client ended treatment with more symptoms than both the norm group and than she had experienced when treatment began.

Table 5
Client Outcome Questionnaire (OQ) 45.2 Scores Pre, During, and Post-Treatment

							Session Number										
	Pre	1	2	3	4	5	6	7	8	9	10	11	12	1W[1]	4M[2]	Mean	SD
OQ	58	60	63	56	41	45	44	54	50	50	67	53	65	79	79	57.65	11.56

[1] Follow-up completed one-week after treatment. [2] Follow-up completed 4 months after treatment.

IIP-32. The client completed the IIP-32 one-week prior to treatment, as well as one week and four months after treatment was completed. These scores were compared to norms on the IIP-32. See Table 6 for results.

Table 6
Pre and Post-Treatment Inventory of Interpersonal Problems (IIP) 32 Scores Compared to Norms

	Current Case[1]	Norms[2]	
		M	SD
Pre-Treatment IIP-32	1.91	1.62	.45
One-Week Post-Treatment IIP-32	2.47	1.21	.56
Four-Months Post-Treatment IIP-32	2.22	1.21	.56

[1]*N = 1;* [2](Barkham, Hardy & Startup, 1996)

Comparing the current case to norms using effect size calculations, results showed that there was a medium effect for the client (.64) on the pre-treatment IIP-32 scores, suggesting that this client had more interpersonal problems at the beginning of treatment than the normative sample. Results also showed that there was a large effect on both post-treatment IIP-32 scores (2.25; 1.80), suggesting that the client's interpersonal problems were also higher than the norm sample after treatment.

Comparing the client's own pre and post-treatment IIP-32 scores using effect size calculations, results showed there was a large effect for the client (1.24) from pre to one-week post treatment, a medium effect (.55) from one-week to four-months post-treatment, and a medium effect (.69) from pre to four-months post-treatment. These results suggest that although the client's interpersonal problems improved from the

period between one-week and four months post-treatment, the client still ended treatment with more interpersonal problems than when she began.

Taken together, these results suggest that the client began treatment with more interpersonal problems than the normative sample, and ended treatment with more interpersonal problems than both the norm group and than she had experienced when treatment began.

SUIP-R. The client completed the SUIP-R one-week prior to treatment, as well as one week and four months after treatment was completed. These scores were compared to norms on the SUIP-R. See Table 7 for results.

Table 7
Pre and Post-Treatment Self-Understanding of Interpersonal Patterns – Revised (SUIP-R)
Scores Compared to Norms

	Current Case[1]	Norms[2]
		M SD
Pre-Treatment SUIP-R	4.07	2.97 (1.44)
One-Week Post-Treatment SUIP-R	4.75	3.54 (1.66)
Four-Months Post-Treatment SUIP-R	4.71	3.54 (1.66)

[1]$N = 1;$ [2]Norms reported were based on interpersonal therapy (Gibbons et al., 2003).

Comparing the current case to norms using effect size calculations, results showed that there was a medium effect for the client (.76) on pre-treatment SUIP-R scores, suggesting this client began treatment with a greater understanding of her interpersonal patterns than those in the normative sample. Results also showed that there was a medium effect on both post-treatment scores (.73, .70), suggesting that the client ended

treatment with a greater understanding of her interpersonal patterns than the normative sample.

Comparing the client's own pre and post-treatment SUIP-R scores using effect size calculations, results showed there was a small effect for the client (.47) from pre to one-week post-treatment, no effect (.03) from one-week to four-months post-treatment, and a small effect (.44) from pre to four-months post-treatment. These results suggest that the client ended treatment with a greater understanding of her interpersonal patterns than when she began treatment.

Taken together, these results suggest that the client began treatment with a greater understanding of her interpersonal patterns than the normative sample, and that she ended treatment with a greater understanding of these patterns than both the normative sample and than she had when treatment began.

Summary of Preliminary Analyses of Session and Outcome Measures

In terms of session measures, results showed that both the client and therapist perceived the sessions to have greater depth than did those in the normative sample, suggesting that the sessions in the current case were deep overall. Results also showed that both client and therapist perceived their working alliance to be stronger than did those in the normative sample, suggesting the working alliance in the current case was also strong overall.

In terms of outcome measures, it appears that the client ended treatment with more symptoms and interpersonal problems than when treatment began, suggesting the client's symptoms and interpersonal problems got worse as a result of treatment. However, the client did end treatment with a greater understanding of her interpersonal

patterns than when treatment began. These results suggest that on one dimension, knowledge of interpersonal patterns, the client improved as a result of treatment.

Test of Research Questions

This section addresses the four proposed research questions. These analyses were conducted on therapist and client speaking turns and session level data. These analyses illustrate both patterns of immediacy use by therapist and client across treatment and the relationship between immediacy and client involvement.

Research Question 1: What immediacy-related therapist and client actions occurred during each session?

This analysis was conducted by dividing the number of times a therapist or client immediacy action occurred in a session by the number of speaking turns in the session. This analysis revealed (See Table 8) the proportion of times the therapist and client used immediacy overall and during each session, and what proportion of time the therapist used each of the three types of immediacy actions overall and during each session. Results indicated that the therapist used some form of immediacy an average of .34 ($SD =$ .12) and that the client used immediacy an average of .37 ($SD = $.16). With respect to specific therapist immediacy actions, "Inquiry about the Relationship" was used most often ($M = $.25, $SD = $.11). The other two therapist immediacy actions, "Intimately Self-Involving Statements" ($M = $.05, $SD = $.04) and "Feedback" ($M = $.05, $SD = $.05) were used much less frequently.

Thus, it appears that the client and therapist used immediacy, on average, about a third of the time throughout therapy. The therapist ranged in immediacy use from a low of .15 to a high of .59 across sessions. The client ranged in immediacy use from a low of .13 to a high of .64 across sessions. The majority of therapist immediacy use involved the therapist asking the client questions about their immediate relationship. The therapist made statements that included his thoughts or feelings about the immediate client-therapist relationship and about the client's immediate behavior in session much less frequently, an average of five percent of the time for each.

Table 8

Therapist and Client Percentage Use of Immediacy by Session

| | Session Number | | | | | | | | | | | | | |
	1	2	3	4	5	6	7	8	9	10	11	12	Mean	SD
TH Immediacy	.15	.33	.26	.59	.20	.35	.45	.36	.21	.39	.38	.40	.34	.12
FDBK	.05	.00	.06	.03	.00	.04	.00	.02	.12	.08	.12	.02	.05	.05
IAR	.10	.29	.16	.41	.17	.27	.42	.24	.09	.31	.19	.26	.25	.11
ISI	.00	.04	.03	.12	.02	.04	.04	.07	.00	.00	.08	.12	.05	.04
CL Immediacy	.13	.35	.26	.41	.24	.31	.47	.56	.15	.53	.42	.64	.37	.16

Note: Percentage calculation = # times action occurred/# speaking turns in session; **FDBK** = Feedback; **IAR** = Inquiry About TH/CL Relationship; **ISI** = Intimately Self-Involving Statement.

Research Question 2a: How are the therapist and client's use of immediacy related to one another?

A chi-square test used to determine whether therapist immediacy was associated with client immediacy at the speaking turn level (e.g., was therapist immediacy followed by client immediacy in the subsequent speaking turn) was significant, $X^2 (1, 539) =$ 169.75, $p < .00$. Specifically, therapist immediacy was followed by client immediacy in 126 speaking turns and was not followed by immediacy in 33 speaking turns. In contrast, when the therapist did not use immediacy, the client followed with immediacy in 75 speaking turns and did not follow with immediacy in 305 speaking turns. Hence, these results show that therapist and client immediacy were strongly related to one another at the speaking turn level, more often than would be expected by chance.

The overall proportion of time the therapist and client used immediacy in each session was also correlated to see how their use was related to one another. Since this correlation was conducted on an N of 12 (session number), which is a small sample, normality of the data could not be assumed. Therefore, a Spearman's correlation was used for this analysis because it accounts for such a lack of normality. Results showed that the proportion of time the therapist used immediacy in each session was significantly related to the proportion of time the client used immediacy in each session, $r (10) = .81, p < .01$.

The overall proportion of time the therapist used specific immediacy actions in each session also was correlated with the proportion of time the client used immediacy in each session. Spearman correlations were again used because normality could not be assumed given the small sample size. Significant correlations were found between the

therapist's inquiry about the therapist-client relationship and client immediacy, r (10) = .63, $p < .05$, as well as between the therapist's use of intimately self-involving statements and client immediacy, r (10) = .58, $p < .05$. No relationship was found between the therapist's use of feedback about the client and the client's use of immediacy, r (10) = -.25, $p > .05$. See Table 9 for the correlation results.

Table 9
Intercorrelations Between Therapist and Client Percentage Use of Immediacy Per Session

Immediacy Actions	1	2	3	4	5
1. TIM	--				
2. CIM	.81**	-			
3. TFDBK	-.17	-.25	--		
4. TIAR	.82**	.63*	-.47	--	
5. TISI	.66*	.58*	-.29	.44	--

*p < .05; **p < .01; N = 12; **TIM:** Therapist Immediacy; **CIM:** Client Immediacy; **TFDBK:** Therapist Feedback; **TIAR:** Therapist Inquiry About Relationship; **TISI:** Therapist Intimately Self-Involving Statement.

These results suggest that in general, therapist and client immediacy use were related to one another. Two therapist immediacy actions appeared related to client immediacy use. Specifically, the client appeared to use immediacy when the therapist inquired about their relationship or made an intimately self-involving statement. Results also suggest that when the therapist provided the client feedback about her immediate in-session behavior, the client did not respond to such feedback with immediacy.

Research Question 2b: How does the therapist and client's use of immediacy change over time?

Curve estimation regression analyses were conducted to understand the relationship between therapist and client immediacy use and time. Results showed that the cubic model, F $(584) = 3.99$, $p < .05$, $R^2 = .02$, accounted for the most variance in the relationship between therapist immediacy use and time. Results also showed that the cubic model, F $(535) = 10.85$, $p < .00$, $R^2 = .06$, accounted for the most variance in the relationship between client immediacy use and time. Although other tests were also significant, only the model that fit the data best is reported. The cubic relationships found for both client and therapist immediacy use over time suggests their immediacy use followed an increasing and decreasing pattern over time (See Figure 3).

Figure 3
Therapist and Client Percentage Immediacy Use Over Time
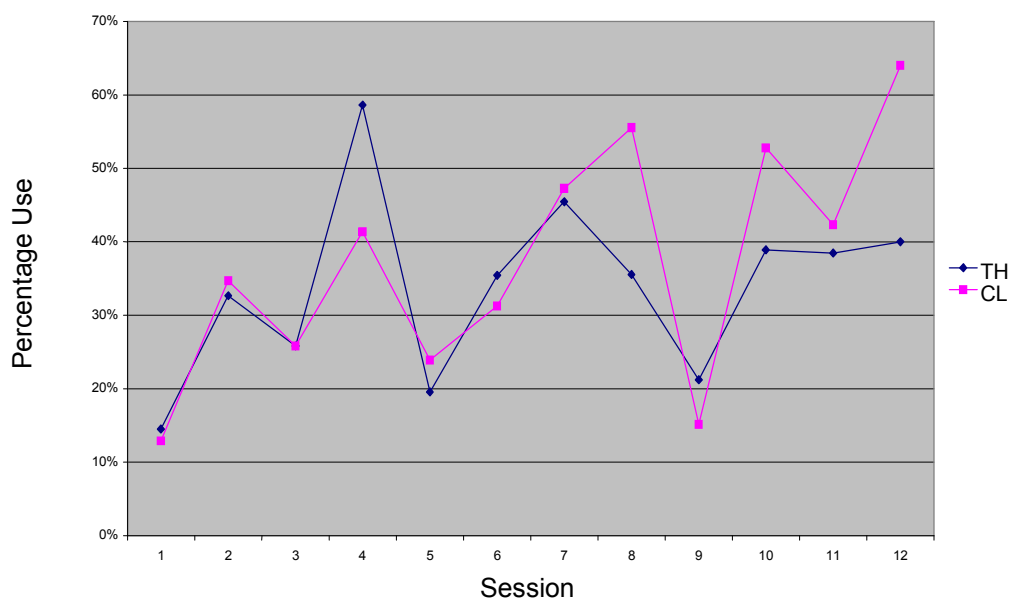
Next, curve estimation regression analyses were conducted to understand the

relationship between the use of specific therapist immediacy actions and time. Results

showed the cubic model accounted for the most variance in the relationship between both

the therapist's use of inquiry about the relationship, F $(584) = 3.03$, $p < .05$, $R^2 = .02$, and

intimately self-involving statements, F $(584) = 3.95$, $p < .00$, $R^2 = .02$, and time. All

other analyses were non-significant. These results suggest that the therapist's use of both

inquiry about the relationship and intimately self-involving statements followed an

increasing and decreasing pattern over time (See Figure 4).

Figure 4
Therapist Percentage Use of Immediacy Actions Across Treatment
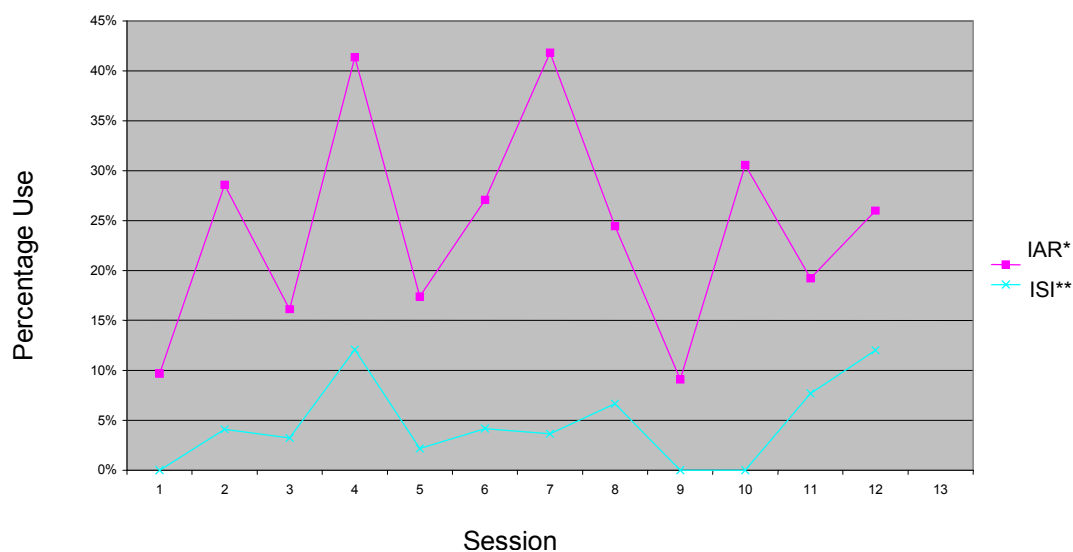
*IAR = Inquiry about Relationship; **ISI = Intimately Self-Involving Statement

These results suggest that both client and therapist immediacy use followed an

increasing and decreasing pattern over time. It appears that the therapist's use of two

immediacy actions, inquiry about the relationship and intimately self-involving

statements, also followed an increasing and decreasing pattern over time.

Research Question 3: How is client involvement related to therapist immediacy use?

Preliminary analyses were conducted on client involvement before answering this research question to understand what, if any, changes occurred in client involvement.

Curve estimation regression analyses were conducted to determine the relationship between client involvement (rated on a scale from 1 to 5, where 5 = high involvement) and time. Results indicated that there was a linear, F $(536) = 4.87$, $p < .05$, $R^2 = .01$ relationship between client involvement scores and time, suggesting that client involvement increased over time (See Figure 5). All other tests were non-significant.

The client's mean involvement score across therapy was $M = 3.16$, $SD = .83$. See Table 10 for a list of average client involvement scores throughout the course of treatment. The highest mean involvement score the client reached across the 12 sessions was $M = 3.49$, $SD = .84$ and the lowest mean involvement score the client reached across the twelve sessions was $M = 2.92$, $SD = .74$. Given that the client's mean involvement score could have gone as high as a 5 and as low as a 1, it appears the client in the current study did not vary a great deal on average involvement over the course of treatment. This lack of variability may have implications for any subsequent tests conducted using client involvement as a variable.

Figure 5
Average Client Involvement Scores Across Treatment
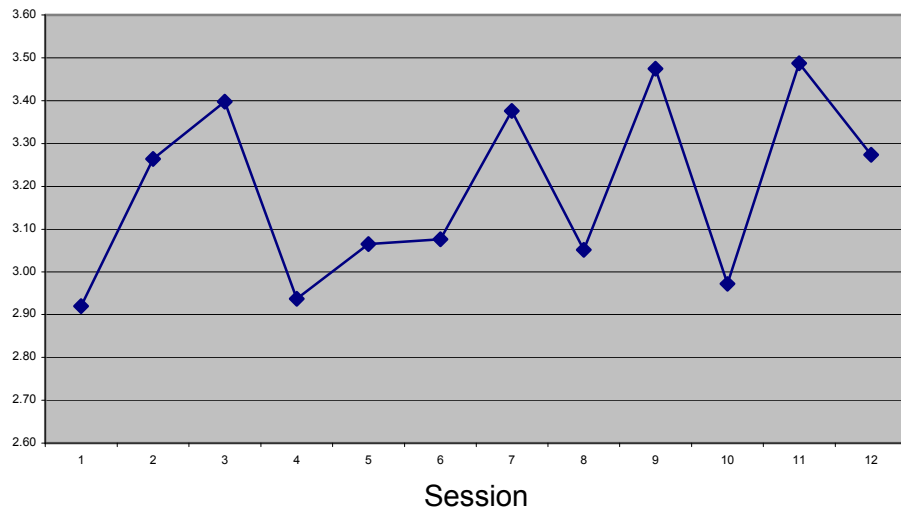
Table 10

Means and Standard Deviations of Client Involvement Scores by Session

| | Session Number | | | | | | | | | | | | |
	1	2	3	4	5	6	7	8	9	10	11	12	Overall
CL Involvement													
Mean	2.92	3.26	3.40	2.94	3.07	3.08	3.38	3.05	3.47	2.97	3.49	3.27	3.16
SD	.74	.62	.56	1.03	.76	.95	.48	.64	1.16	.93	.84	.84	.83

Primary Analyses

To understand the relationship between client involvement and therapist immediacy use overall, a hierarchical regression analysis was conducted at the speaking turn level. Client involvement was the dependent variable and the independent variables entered into each step of the model were as follows: 1) time (i.e., session number and session speaking turn), and 2) therapist immediacy use (i.e., dummy coded Immediacy with Not Immediacy as the referent group). All speaking turns from each of the twelve sessions were included in the analysis to account for any changes in client involvement while controlling for time. Session number and session speaking turn were both centered prior to the analyses to account for collinearity. Results indicated that there was no relationship between when the therapist used immediacy versus when the therapist did not use immediacy and client involvement, $t (3, 534) = 1.86$, $p = .06$. Unadjusted mean client involvement scores for the two groups were as follows: Immediacy $M = 3.26$, $SE = .08$, Not Immediacy $M = 3.12$, $SE = .04$.

To understand how client involvement was related to the therapist's use of specific immediacy actions, analyses were again conducted at the speaking turn level. A hierarchical regression analysis was conducted where the dependent variable was client involvement and the independent variables entered into each step of the model were as follows: 1) time (i.e., session number and session speaking turn), 2) therapist immediacy actions (i.e., Dummy coded for Feedback, Inquiry About Relationship, Intimately Self-Involving Statement with Not Immediacy as the referent group), and 3) the interactions between time and immediacy actions. This analysis again was used to account for any

changes in client involvement while controlling for time, and session number and session speaking turn were again both centered to account for collinearity.

Results indicated that there was a significant relationship between client involvement and session speaking turn, t (5, 532) = -3.65, $p < .00$, B = -.010, SE = .01, suggesting the client was more involved earlier in sessions than later in sessions. Results also showed that, compared to when the therapist did not use immediacy, there was a significant relationship between the therapist's use of both inquiry about the relationship, t (5, 532) = 2.76, $p < .05$, B = .239, SE = .09, and intimately self-involving statements, t (5, 532) = -2.65, $p < .05$, B = -.50, SE = .19, and subsequent client involvement. All other tests were not significant.

These results suggest that subsequent client involvement scores were higher when the therapist inquired about the immediate therapist-client relationship (M = 3.36, SE = .09) and lower when the therapist made an intimately self-involving statement (M = 2.62, SE = .19) than when the therapist did not use immediacy (M = 3.12, SE = .04). In summary, it appears that the client was more involved when the therapist inquired about the immediate client/therapist relationship and less involved when the therapist made an intimately self-involving statement than when he did not use immediacy at all. See Table 11 for results.

These results suggest there were no differences in client involvement scores when the therapist used immediacy overall compared to when the therapist did not use immediacy. However, when specific immediacy actions were examined, results suggest the client was more involved when the therapist inquired about their relationship and less involved when he used an intimately self-involving statement compared to when he did

not use immediacy at all. In addition, it appears that the client was more involved earlier in sessions than later in sessions.

Table 11

Means and Standard Errors for Client Involvement Scores by Therapist Immediacy Action

Therapist Immediacy Action	M	SE
Not Immediacy	3.12	.04
Feedback	2.84	.31
Inquiry About Relationship	3.36**	.08
Intimately Self-Involving Statement	2.62**	.19

Note. Mean scores based on comparison to Not Immediacy
** $p < .01$

Research Question 4: How does client involvement change before, during, and after immediacy events?

The analysis for this research question was based on data from the 33 immediacy events identified by the author and her advisor, as described in Chapter 4 (Methods). Since the original research question was written broadly, three sub-research questions have been identified to better answer Research Question 4.

Research Question 4a: How does client involvement change from before to during immediacy events?

Of the 33 total immediacy events identified, 22 events were included in the analysis of this research question because these events had at least three client speaking turns prior to the start of the event, which was considered enough to calculate an average

client involvement score before the event. A paired-samples t-test was conducted on this final list of 22 immediacy events to assess how client involvement changed from before to during these immediacy events.

The average pre-event involvement score for these 22 immediacy events was 3.36 (SD = .55) and the average during-event involvement score was 3.17 (SD = .51). Results showed that there were no significant differences between client involvement scores before and during immediacy events, t (21) = 1.31, p > .05. An effect size analysis of client involvement from before to during these events showed there was a small effect (.36), suggesting that client involvement scores decreased slightly from before to during these immediacy events.   See Table 12 for results.

Research Question 4b: How does client involvement change from during to after immediacy events?

Of the 33 total immediacy events identified, 17 events were included in the analysis of this research question because these events had at least three client speaking turns after each immediacy event, which was considered enough to calculate an average client involvement score. A paired-samples t-test was conducted on this final list of 17 immediacy events to assess how average client involvement changed from during to after these immediacy events. It is important to note that some, but not all, of the events included in the analysis of this research question were also included in the analysis of the previous research question (4a).

The average during-event involvement score for the immediacy events included in this analysis was 3.26 (SD = .67) and the average post-event involvement score for these immediacy events was 3.54 (SD = .51). Results showed there were no significant

differences between client involvement scores from during to after these immediacy events, t (16) = -1.86, p > .05. An effect size analysis of client involvement from during to after these events showed there was a small effect (.47), suggesting that client involvement scores increased slightly from during to after these immediacy events. See Table 12 for results.

Research Question 4c: How does client involvement change during immediacy events over time?

All 33 immediacy events were included in the analysis of this research question. Curve estimation regression analyses were conducted to see what changes there were in client involvement during immediacy events over time. The average involvement score during immediacy events was 3.16 (*SD* = .55). Results indicated that there was no linear, F (31) = .02, p > .05, R^2 = .00, quadratic, F (30) = .08, p > .05, R^2 = .01, or cubic, F (29) = .15, p > .05, R^2 = .02, relationship between client involvement and time. These results suggest that client involvement did not increase or decrease over time during the 33 immediacy events. See Table 12 for results.

To summarize the results of these three sub-research questions, it appears that, based on effect size analyses, client involvement was slightly higher before and after immediacy events than during immediacy events. In addition, there does not appear to have been any overall increase in client involvement during immediacy events over the course of therapy.

Table 12

Means, Standard Deviations and Effect Sizes for Client Involvement Pre, During and Post-Immediacy Events

	Pre		During		Post		Effect Size
	M	SD	M	SD	M	SD	
Pre-During Events[1]	3.36	.55	3.17	.51			.36
During-Post Events[2]			3.26	.67	3.54	.51	.47
During Events[3]			3.16	.55			

[1]22 events; [2]17 events; [3]33 events

Summary of Research Question Results

Results suggest that the client and therapist used immediacy, on average, about a third of the time throughout therapy. The majority of therapist immediacy use involved the therapist asking the client questions about their immediate relationship. The therapist made intimately self-involving statements and gave the client feedback about her immediate behavior in session much less frequently. Therapist and client immediacy use were related to one another. The client's immediacy use was related to the therapist's inquiry about their relationship and his use of intimately self-involving statements but not his use of in session feedback about the client. Both client and therapist immediacy use followed an increasing and decreasing pattern over time. Specifically, it appears that the therapist's use of two immediacy actions, inquiry about the client-therapist relationship and intimately self-involving statements, followed this pattern.

There appeared to be no differences in client involvement scores when the therapist used immediacy overall compared to when the therapist did not use immediacy. However, the client did appear to be more involved when the therapist inquired about their relationship and less involved when the therapist used an intimately self-involving statement than when he did not use immediacy at all. When examining client involvement before, during, and after immediacy events, it appears that client involvement was slightly higher before and after immediacy events than during these events. In addition, there does not appear to have been any overall increase in client involvement during immediacy events over the course of therapy.

Additional Data Analyses

In addition to the quantitative analyses of immediacy events conducted in Research Question 4, we also completed a qualitatively informed analysis of these same events. This analysis helped us understand the phenomenon of immediacy better by allowing us to see patterns and changes in immediacy that could only be understood by examining the immediacy events themselves. The author and her advisor (i.e., auditor) conducted this additional analysis by reviewing the content of these immediacy events (i.e., what both the therapist and client said in each event) and the client's self-reported responses on the post-session questionnaires. This analysis provided data about the client's personal reactions to immediacy events which were not included in any previous analyses.

Types of Immediacy Events

The final list of immediacy event types identified is as follows: 1) Therapist explores his impact on client (e.g., Does it matter what I think about him [your boyfriend]?), 2) Therapist inquires about client reactions to sessions/treatment (e.g. Any reactions to our last session?), 3) Therapist wants to connect with client (e.g., It's important to me to connect with you.), 4) Therapist feels closer to client (e.g., I feel closer to you when you're softer.), 5) Therapist expresses disappointment, sadness, and/or hurt in relation to client (e.g., It hurts me that you don't see that I care about you.), 6) Therapist encourages client to express immediate feelings to therapist (e.g., Would you tell me if I hurt you?), 7) Therapist expresses care for client (e.g., Do you know that I care about you?), 8) Therapist discusses termination (e.g., How are you feeling about ending?) 9) Therapist draws parallel between outside relationships and therapy relationship (e.g., How does that pattern happen in our relationship?), 10) Therapist feels proud of client (e.g., I am proud of you.). See Table 13 for the list of events and event type assignments.

Table 13

Immediacy Events and Event Topic Categories Across Treatment

Sn[1] #	Event #	Event Topic	Event Category Assignment[2]
1	1	What do think I'm thinking about you?	1, 9
1	2	You've told me a lot. I'm an only child too.	3
1	3	What was today like?	2
2	4	Reactions to our last time together? I was wanting to make a connection with you.	2, 3
2	5	How might you put up a wall with me? Reactions to my saying it's important to me to connect with you?	3, 6, 9
2	6	Would you tell me if I hurt you? It scares me that I might hurt you and never know it.	6, 9
2	7	Would you tell me if I hurt you?	6
3	8	Reactions to last time we were here?	2
3	9	I'm stuck and I don't want to impose my values on you.	1, 9
3	10	I feel closer to you when you're softer/slower.	4
3	11	Is it important to know what I think of him (your boyfriend)?	1, 9
3	12	Reactions to my saying I feel closer to you?	4, 6
4	13	Reactions to last session? I'll feel sad when we say good-bye. What if I were disappointed in you?	1, 2, 5, 6, 8, 9
4	14	What if I were disappointed in you? I don't want to have that much power over you.	1, 5, 7, 9
4	15	I am disappointed you don't let me enjoy your positive feelings with you.	5
5	16	Reactions to last session?	2
5	17	It scares me that I influence you.	1
5	18	Do you know that I care about you? I'm sad you don't know that I care about you.	5, 6, 7, 8, 9
6	19	What's scary about letting me see your sadness?	6
6	20	Do we have a real relationship? It hurts me that you don't see that I care about you.	1, 5, 7, 8, 9
6	21	Do you hesitate to ask me for reassurance too?	6, 9
7	22	Let's agree on when we're ending.	8
7	23	How come you give me the benefit of the doubt?	6, 9
7	24	You know I care by having the power to hurt me. You already have hurt me.	5, 6, 7, 9
8	25	I am hurt that it didn't seem to matter (to you) how long (we continued treatment). What's scary about telling me what you want? I feel connected to you when you're softer/vulnerable.	3, 4, 5, 6, 8, 9
9	26	I wonder if you're not thinking about our ending?	8, 9
9	27	What are you taking from treatment? It matters to me that you're in pain right now.	2, 7, 8
10	28	Reactions to last week?	2

Table 13 (cont.)
Immediacy Events and Event Topic Categories Across Treatment

Sn[1] #	Event #	Event Topic	Event Category Assignment[2]
10	29	Are you going to regret having been open with me? Do you know how much I care about you? I feel closer to you when you let me see your happiness and sadness. How do you think I see you? I want to know if I've hurt you.	1, 4, 5, 6, 7, 8, 9
11	30	Are you letting me know how you're feeling about our ending? Things are moving fast again. I'm really proud of you.	6, 8, 9, 10
12	31	How are you feeling about ending?	6, 8
12	32	I'm proud of you.	10
12	33	What are you taking away from treatment? What was helpful? What could I have done better? You were brave for talking about our relationship. I'm sad this is ending.	2, 4, 5, 6, 7, 8

[1]Sn = Session. [2]**1** = TH explores his impact on CL; **2** = TH inquires about CL reactions to sessions/treatment; **3** = TH wants to connect with CL; **4** = TH feels closer to CL; **5** = TH expresses disappointment, sadness and/or hurt in relation to CL; **6** = TH encourages CL to express immediate feelings to TH; **7** = TH expresses care for CL; **8** = TH discusses termination; **9** = TH draws parallel between outside relationships and therapy relationship; **10** = TH feels proud of CL.

Initiation and Reciprocation of Immediacy Events

It was determined that the therapist initiated all 33 immediacy events. Of these 33 immediacy events, there were seven that the therapist introduced but the client did not respond to with immediacy (i.e., she ignored the therapist's bid to talk about their relationship). Three of these events involved the therapist asking about the client's reactions to the previous session, two events related to the therapist wanting to discuss termination, one involved the therapist expressing feeling closer to the client, and one involved the therapist exploring his impact on the client (i.e., "It scares me that I influence you.").

On the post-session questionnaires, the client expressed three reactions to the therapist that she did not initiate discussions about in session. First, the client expressed

discomfort with the silences that occurred when the therapist was thinking during sessions. Specifically, the client expressed worry about what the therapist was thinking of her during silences and felt responsible for saying or doing something during those silent moments. The client eventually shared this discomfort during an immediacy event initiated by the therapist. Second, the client commented after session nine that their goodbye at the end of the session was awkward. Finally, after session 10 the client commented she was sad thinking that treatment was ending.

Frequency of Immediacy Events Across Treatment

A frequency analysis was conducted to see how often each type of immediacy event occurred. See Table 14 for results. The therapist drew a parallel between outside relationships and the therapy relationship and encouraged the client to express immediate feelings to the therapist most often. The therapist discussed termination, feelings of disappointment, sadness, and/or hurt in relation to the client, and inquired about the client's reactions to sessions and/or treatment the next most frequently. The therapist explored his impact on the client, expressed care for and that he felt closer to the client with similar frequency. The two types of immediacy events that occurred least frequently were the therapist's expression of a desire to connect with the client and feeling proud of the client.

Table 14

Number of Immediacy Event Types and Number of Sessions During Which Events Occurred

Event Type	Number of Events[1]	Number of Sessions[2]
1. TH draws parallel b/w outside relationship and therapy relationship	16	11
2. TH encourages CL to express immediate feelings to TH	15	10
3. TH discusses termination	11	9
4. TH expresses disappointment/sadness/hurt in relation to CL	9	7
5. TH inquires about CL reactions to sessions and/or treatment	8	8
6. TH explores his impact on CL	8	5
7. TH expresses care for CL	7	7
8. TH feels closer to CL	5	4
9. TH wants to connect with CL	4	3
10. TH feels proud of CL	2	2

Note. TH = Therapist; CL = Client; b/w = between
[1]$N = 33$ events; [2]$N = 12$ sessions

In addition, the frequency of client post-session comments for each type of immediacy event was analyzed. This analysis was based on questionnaires completed by the client at the end of each session. The questionnaires asked the client to answer the following: 1)"When you and your therapist talked about your relationship today, what was the content of your discussion(s)?," 2) "When you and your therapist talked about your relationship today, what was that like for you?," 3) "What did you learn about

yourself from these discussions?," 4) "What did your therapist do or say in today's session that was helpful?," and 5) "What did your therapist do or say in today's session that was less helpful or what do you wish your therapist had done or said today that he did not?" It was decided that this frequency analysis would count only whether the client commented on an event type or not after a session, irrespective of how many times the client commented about a type of immediacy event in a given session. For example, if after a session the client made four comments about an event where the therapist expressed care for the client, the client was considered to have commented on this type of event one time for the whole session. See Table 15 for results.

The client commented most frequently on events where the therapist expressed disappointment, sadness, and/or hurt in relation to the client. The client commented on those events in which the therapist discussed termination and inquired about the client's reactions to sessions and/or treatment the next most frequently. The client commented on those events where the therapist expressed care for, a desire to connect with, and feeling closer to the client the next most frequently. The client commented the least frequently on those events in which the therapist felt proud of the client, encouraged the client to express immediate feelings to the therapist, and explored his impact on the client. The client did not comment at all on the parallel the therapist made between outside relationships and the therapy relationship.

Table 15

Number of Sessions in which the Client Commented on Different Types of Immediacy Events[1]

Event Type	Number of Sessions
1. TH expresses disappointment, sadness, and/or hurt in relation to CL	7
2. TH discusses termination	6
3. TH inquires about CL reactions to sessions/TX	6
4. TH expresses care for CL	4
5. TH wants to connect with CL	3
6. TH feels closer to CL	2
7. TH encourages CL to express immediate feelings to TH	2
8. TH explores his impact on CL	2
9. TH feels proud of CL	1
10. TH draws parallel between outside relationships and therapy relationship	0

[1] Based on client comments from post-session questionnaires, $N = 12$

An analysis was conducted to see what differences and similarities there were in the immediacy event types that occurred most frequently and those the client commented on most frequently. See Table 16 for results.

Results showed that the two event types that occurred most often (the therapist draws a parallel between outside relationships and the therapy relationship and therapist encourages client to express immediate feelings to the therapist) were two types of immediacy events the client commented on infrequently. The client commented most often on immediacy events in which the therapist expressed disappointment, sadness,

and/or hurt in relation to the client. This type of event occurred fourth most frequently.

The client commented on other events in which the therapist expressed strong, direct

feelings toward the client (i.e., TH expresses care for CL, TH wants to connect with CL,

TH feels closer to CL) with greater frequency than those event types occurred. These

results suggest that this client responded frequently to immediacy events in which the

therapist expressed direct, strong feelings about the client, but these events did not occur

as frequently. Finally, two event types (therapist discusses termination and therapist

explores client reactions to sessions and/or treatment) both occurred frequently and were

commented on frequently by the client.

Table 16

Comparison of Rank Order of Immediacy Event Type Frequency to Frequency of Client

Comments About Immediacy Events in Post-Session Questionnaires

Event Type	Frequency Ranking[1]	CL Ranking[2]
1. TH explores impact on CL	6	8
2. TH inquires about CL reactions to sessions/TX	5	3
3. TH wants to connect with CL	9	5
4. TH feels closer to CL	8	6
5. TH expresses disappointment/sadness/hurt in relation to CL	4	1
6. TH encourages CL to express immediate feelings to TH	2	7
7. TH expresses care for CL	7	4
8. TH discusses termination	3	2
9. TH draws parallel between outside relationships and TH relationship	1	10
10. TH feels proud of CL	10	9

[1]Results from Table 14; [2]Results from Table 15.

Changes in Immediacy Event Types Over Time

Next, we examined what changes occurred in immediacy events over time. First,

changes in the length of immediacy events themselves were examined. Length of

immediacy events was measured by the number of speaking turns per event. We

examined changes in immediacy events over time by correlating the number of speaking

turns in each event by event number. Results showed there was a significant positive

relationship between the number of speaking turns in each event and event number, r (31)

= .37, p < .05, suggesting that immediacy events increased in length as therapy progressed.

Next, we examined how the occurrence of specific event types changed over time. See Table 13 for results. The therapist drew a parallel between outside relationships and the therapy relationship in all but one session. The therapist encouraged the client to express immediate feelings about the therapist in all but two sessions, and the therapist asked about the client's reactions to the previous session and/or treatment in all but four sessions.

Two immediacy event types were addressed early and returned to later in treatment. The therapist expressed a desire to connect with the client (session 1 to 2) and expressed feeling closer to the client (session 3) early in treatment, with one of each of these events also occurring later in treatment (session 10).

There were several immediacy event types that occurred only in the middle of treatment. These events included those in which the therapist explored his impact on the client, (session 3 to 6), and expressed strong emotions in relation to the client, such as caring (session 4 – 10), disappointment, sadness, and/or hurt (sessions 4-10).

The therapist began discussing termination during the middle of treatment and continued discussing this topic until treatment ended (session 4 to 12). Finally, the therapist expressed pride in the client only at the end of treatment (session 11-12).

These results suggest that some immediacy event types, drawing a parallel between the therapy relationship and outside relationships, encouraging the client to express direct feelings towards the therapist, and encouraging the client to explore reactions to the sessions and treatment, occurred regularly throughout treatment. There

was also a changing pattern in the occurrence of some immediacy event types across treatment. Specifically, early in treatment, the therapist engaged in events to connect with the client and acknowledge that connection (i.e., he felt closer to the client). During the middle of treatment, the therapist began expressing strong emotions in relation to the client, such as sadness, disappointment, hurt and feelings of care, and also began discussing termination. At the end of treatment the therapist directly expressed pride in the client.

Description of and Client Reactions to Immediacy Event Types

In this section, each immediacy event type is described and an example of each event type is provided. A summary of the client's post-session reactions (e.g., positive, negative, challenged, hurt) to different immediacy event types is also described.

Therapist explores his impact on the client. In these events, the therapist inquired about the client's concerns over his opinion of her and discussed his concerns about the influence he had on the client. These events tended to occur towards the middle of treatment. Although this type of immediacy event occurred fairly frequently, the client did not comment on these events frequently. In an example of this type of event, the therapist said (Session 4), "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?…I want you to care about me. That feels good. I like that. And, I don't want to have that much power…It feels too dangerous." The client commented afterwards, "He mentioned having fear of having power over my vulnerabilities. He was very open!" Overall, the client appeared to feel more positively towards the therapist and to reflect on her own reactions in response to these types of events.

Therapist inquires about client reactions to sessions and/or treatment. In these events, the therapist asked the client to reflect on the previous session or treatment in general. The therapist usually engaged in this type of event at the beginning of a session. These events occurred fairly frequently across treatment and the client commented on them frequently. In an example of this type of event, which began with the client struggling with and reflecting on her relationship with her family, the therapist said (Session 9), "You certainly are reflecting a lot, which makes me wonder in some ways what are you going to take from here? Are you going to take the negatives from here? When you look back, how are you going to filter us?" The client commented afterwards, "(I felt) a bit awkward (talking about our immediate relationship) because I felt so pulled and at odds about my family situation. Just seemed a bit out of place today but it was interesting to note good experiences I take from here."

The client had both positive and negative reactions to this type of immediacy event. On the positive side, these discussions helped the client open up and feel comfortable talking about her reactions and thinking more deeply about her experience in therapy. On the negative side, occasionally the therapist's attempts to reflect on their work together felt out of place for the client, as in the example given above. The client also sometimes felt pressured to respond to these inquiries, particularly when the therapist asked more specific questions, such as "What was today like?" and "What are you taking from this experience? What are the highlights that you're sort of taking away?" rather than a more general intervention from this type of event such as, "Reactions to last session?"

Therapist wants to connect with client. In these events, the therapist expressed a desire to connect with the client and asked for the client's reactions to his expression of this desire. These events typically occurred early in treatment. While these events did not occur that frequently, the client commented on them fairly frequently. In an example of this type of event, the therapist said (Session 2), "…we talked a little bit about half of my reaction…the other half though that I haven't said much about, is that it was important to me to connect with you, that I felt I needed to…I couldn't read if we were connected and I needed to do something….I'm curious, what's that like to hear that it's important to me to connect with you?" The client commented afterwards, "I thought this (his comment on connectedness) was brave…Today was very valuable! I sensed some vulnerability in him which was strange yet nice to think because it shows he doesn't consider himself superior to me…I do feel more connected now that he brought up his feelings." Overall, the client appeared to have a strong positive reaction to these types of events. Specifically, these positive reactions included the client feeling more of a connection to the therapist and understanding how she protects herself from connecting with others.

Therapist feels closer to client. In these events, the therapist directly expressed that there was something about the client's way of interacting that led the therapist to feel closer to the client. These events occurred during the middle to the end of treatment. These events did not occur that frequently and the client did not comment on them frequently. In an example of this type of event, the therapist said (Session 3), "What did you do with me saying about you being softer, about feeling closer to you when you were (softer)?" The client commented afterwards, "(The therapist) disclosed that I seemed

warmer today and knowing that he felt more connected to me sounded great." The client had a strong positive reaction to these types of events. Specifically, the client appeared to appreciate learning that showing more vulnerability fosters connections with others.

Therapist expresses disappointment, sadness, and/or hurt in relation to client. In these events, the therapist expressed direct feelings of hurt and/or sadness with respect to the client and examined the impact of his expression of disappointment on the client. These events tended to occur during the middle of treatment. These events occurred fairly frequently and they were the event type the client commented on most frequently.

In one of these events, the therapist was addressing the client's lack of a strong reaction to their termination date. The therapist said (Session 8), "at first 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)…it was actually worse not hearing it…so I'm sort of going down this track of well, the relationship probably wasn't as important to her as I thought it was…for me it hurt, that it felt like it didn't matter (to you) how long (we met)." Afterwards, the client commented, "This was really an incredible session and I really feel much closer and more attached to (the therapist). 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… This was an amazing session and really opened my eyes to missed opportunities."

Overall, the client had positive reactions to the therapist's expression of sadness in these events, as they appeared to help her feel validated and cared for, and allowed her

to accept her own sadness more. The client also appeared to feel challenged, cared for, and hurt when the therapist expressed that she had hurt him. Specifically, the client commented that one of these events was, (Session 5) "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." In response to the therapist's expression of disappointment at losing out on sharing positive moments with her, the client commented (Session 4), "I learned that I don't let myself enjoy happy things in life – far too often! I always bask in disappointments and linger in sad feelings but I never do so with happy feelings. It felt great and bold that he pointed this out to me and expressed a desire to want to experience joys with me!...Such a valuable session."

Therapist encourages client to express immediate feelings to therapist. In these events, the therapist encouraged the client to express feelings about the therapy relationship or the therapist himself. These events occurred throughout treatment, and although they occurred frequently, the client rarely commented on this type of event. In one of these events, the therapist said (Session 6), "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. What's scary about letting me see that sadness?" The client commented afterwards, "He dove deeper into the reasons for my fears (of talking about sadness) which brought out feelings I rarely discuss but need to!" Overall, the client appeared to feel positively about these types of events.

Therapist expresses care for client. In these events, the therapist expressed care for the client, explored the extent to which the client felt the therapist's care, and the therapist's reactions to her acceptance of this care. These events occurred during the

middle of treatment. The client commented on these events more often than they occurred. In one of these events, the therapist said (Session 5), "…it does hurt that you don't…see that I do care…I will miss you as a person… I'll 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." The client commented afterwards, "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."

The client had strong reactions to this event type, both positive and negative. Specifically, the client appeared to feel special that the therapist viewed her so positively. The client commented (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." As noted earlier, the client also felt challenged by the therapist's reactions to her doubting his care for her. On the negative side, the client felt awkward discussing the therapist's care for her, particularly as it related to confusion about his feelings for her beyond their professional relationship.

Therapist discusses termination. In these events, the therapist raised the issue of the termination date, and explored the client's reactions to the length of treatment as well as any hesitations the client felt discussing feelings about their upcoming ending. These events started to occur in the middle of treatment and continued until treatment ended. The client commented on these events frequently. In an example of one of these events,

the therapist asked (Session 11), "I have to ask, is that happening at all in our ending? Are you letting me know, are you not telling me how sad you are?" The client responded afterwards saying, "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)."

The client seemed to have both positive and negative reactions to the discussion of termination. Specifically, on the positive side, the client seemed to like the opportunity to be clear about the ending date and to have the time to give the therapist feedback. On the negative side, it appears that the client again felt pressured to respond in a certain way to these inquiries.

Therapist draws parallel between outside relationships and therapy relationship. These events involved the therapist drawing a parallel between the therapy relationship and something the client was already discussing in the session about another relationship. These events occurred consistently throughout treatment, with the exception of one session. While they occurred frequently, the client never commented specifically on these events. Examples of therapist interventions for this event type include (Session 2) , "it sounds like it's hard to do, to tell them that they've hurt you, to tell them that they pissed you off…it seems hard…If I said something that hurt you, would you tell me, would you let me know?" and "how might that happen in here, how might you sort of put up a wall with me?" In the client's post-session comments, she often drew the parallel between what she was learning in therapy and her other relationships, but the client's

comments never addressed the specific links the therapist made during sessions between the therapy relationship and other relationships.

Therapist feels proud of client. These events involved the therapist's direct expression of pride in the client and only occurred during the end of treatment. These events did not occur frequently and the client did not comment on them frequently. In an example of this type of event, the therapist said (Session 11), "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…" The client commented afterwards, "It was also incredibly refreshing to hear him say he is proud of changes I've made…I've got to say this was a great session." The client had a strong positive reaction to these events. Specifically, the client appeared to enjoy that the therapist disclosed that he felt proud of her.

Summary of Client Reactions to Immediacy Event Types

The client seemed to have the strongest reactions to immediacy events in which the therapist expressed strong, direct feelings towards her. These events included those in which the therapist expressed disappointment, sadness, hurt and care for the client as well as feeling closer to, a desire to connect with, and pride in the client. The client felt validated, cared for, and challenged by these events. The client also felt hurt knowing that she may have hurt the therapist. In addition, the client was confused by the therapist's expressions of care for her, specifically not knowing how to understand his care in the context of their professional relationship. Furthermore, the client felt more connected to the therapist when he discussed his desire to connect with her. The client

also learned about the ways she protects herself from connecting with others through these interactions. Finally, the client felt happy after the therapist told her he was proud of her.

The client's reactions did not seem as strong to events in which the therapist inquired about her reactions to sessions and treatment, discussed termination, and explored his impact on her. The client occasionally felt pulled to respond in a certain way to the therapist's inquiry about her reactions to both sessions and termination, and these discussions also occasionally felt out of place to the client. The client did, however, appreciate the opportunity to express her reactions and thoughts about both the sessions and termination. The client also appeared to feel more positively towards the therapist when he acknowledged during these discussions that he did not want to influence her in a negative way.

Summary of Additional Data Analyses

These additional analyses revealed nine types of immediacy events. The two event types that occurred most often (the therapist draws a parallel between outside relationships and the therapy relationship and therapist encourages client to express immediate feelings to the therapist) were two types of immediacy events the client commented on infrequently. The client responded frequently to immediacy events in which the therapist expressed direct, strong feelings about the client (i.e., TH expresses disappointment, sadness, and/or hurt in relation to CL; TH expresses care for CL; TH wants to connect with CL; TH feels closer to CL), but these events did not occur as frequently. Two event types (therapist discusses termination and therapist explores client

reactions to sessions and/or treatment) both occurred frequently and were commented on frequently by the client.

In terms of changes in immediacy events over time, it appears that events increased in length as therapy progressed. Results also suggest that some immediacy event types occurred regularly throughout treatment, such as drawing a parallel between the therapy relationship and outside relationships, encouraging the client to express direct feelings towards the therapist, and encouraging the client to explore reactions to the sessions and treatment. There also appeared to be a changing pattern in the occurrence of some immediacy event types across treatment. Specifically, early in treatment, the therapist engaged in events to connect with the client and acknowledge that connection (i.e., he felt closer to the client). During the middle of treatment, the therapist began expressing strong emotions in relation to the client, such as sadness, disappointment, hurt and feelings of care, and also began discussing termination. Only at the end of treatment did the therapist directly express pride in the client.

The client seemed to have the strongest reactions to immediacy events in which the therapist expressed strong, direct feelings towards her. The client felt validated, cared for, and challenged by these events, felt hurt knowing that she may have hurt the therapist, felt more connected to the therapist when he discussed his desire to connect with her. In addition, the client was sometimes confused by the therapist's expressions of care for her and felt happy when the therapist said he was proud of her. The client did not react as strongly, though, to events in which the therapist inquired about her reactions to sessions and treatment, discussed termination, and explored his impact on her. The client appreciated the opportunity to express her reactions to treatment, but sometimes

felt pulled to respond in a certain way to these events and these discussions occasionally felt out of place to her. In addition, six of the seven immediacy events the therapist introduced but the client did not respond to fell into these same immediacy event categories (i.e., reactions to sessions/treatment, discussing termination, and exploring his impact on the client).

Chapter 6: Discussion

In this section, first I discuss the results of the session and outcome measures. Second, I discuss the therapist tasks and client actions found during immediacy and how these changed over time. Third, I discuss the relationship found between immediacy and client involvement, an important in-session change variable. Fourth, I describe the immediacy events found in this particular case. Specifically, I describe what immediacy event types occurred, the initiation and reciprocation of immediacy events, the patterns of event types over time, and the client's post-session reactions to events. Finally, the client's reactions to immediacy events after sessions are compared to the client's in-session level of involvement.

<div align="center">Session and Outcome Measure Analyses</div>

Prior to the start of treatment, the client was experiencing fewer interpersonal and general symptoms, and had a greater understanding of her interpersonal patterns than did those in normative samples. Throughout treatment, both the therapist and client considered the psychotherapy sessions themselves to be deep and the working alliance to be strong. The client's general symptoms declined significantly during the middle of treatment, but began to increase again towards the end of treatment and stayed high through the four-month follow-up. The client's interpersonal functioning also declined at the end of treatment and remained lower at the four-month follow-up. However, the client reported gaining a significant amount of insight from treatment, specifically with respect to understanding her interpersonal patterns. Hence, the outcome picture for this client was mixed.

The therapeutic alliance may have been a factor in both the client's symptom improvement during treatment and symptom increase towards the end of treatment. Perhaps because the client experienced the support of a strong therapeutic alliance during treatment to help manage her anxiety, she reported experiencing fewer symptoms during treatment. As the loss of the therapeutic alliance approached, however, the client began to report increased symptoms. This assertion is consistent with the termination literature that suggests clients' symptoms get worse as termination approaches (Mann, 1979).

Theorists propose that clients learn to manage and change their interpersonal conflicts, and thus experience symptom relief, by openly discussing and resolving these conflicts within the therapeutic relationship (Kiesler, 1996, Teyber, 2000; Yalom, 1995). Results showed this client did become more aware of and reenacted some her interpersonal conflicts with the therapist. Results also showed, however, that the client was not able to openly discuss all her reactions to the therapist and perhaps, did not fully resolve these experiences within the therapeutic relationship. Perhaps the client continued to experience symptoms after treatment ended because she did not have the resolution within the therapeutic relationship proposed to facilitate change.

In addition, it may be that the client's apparent healthy functioning prior to treatment was illusory. Shedler (1993) found that client's often rate themselves higher on symptom measures prior to treatment in order to appear healthier. Since the client in the current case was a graduate student in a mental health field, she may have felt a need to make a good impression on others in the field by appearing healthier at the beginning of treatment than she actually was. As treatment went on, the client became more self-aware and her higher symptom ratings at the end of treatment may reflect this greater

self-awareness. Since a goal of any psychotherapy is to increase clients' self-awareness, it seems possible that differences found between the client's pre and post-treatment symptom scores were the result of her increased self-awareness. The client's higher score than the normative sample on the IIP-32 at the start of treatment, however, suggests that she was aware of her interpersonal problems. She may have been more open about reporting interpersonal problems than general symptoms at the beginning of treatment because she was aware that to be selected to participate she needed to be experiencing interpersonal problems.

The client's greater understanding of her interpersonal patterns at the end of treatment provides some evidence for the assertion that treatment increased her self-awareness. In addition, during the last session, the client reported increased self-awareness as an outcome of treatment. Specifically, she said, "I think the biggest thing (I am taking from treatment) is…self-awareness…to me that's just the hugest thing cause that's something….I never used to engage in, I just acted upon (a) whim and… on emotion, whereas now…I try to stop myself and think about the emotion and analyze (it), and figure out, why am I feeling this? And… if I decide to act on it in this way, how is that (going to) affect me versus if I react to it in this way." Perhaps this greater self-awareness generalized to a more realistic assessment at the end of treatment of both her general symptoms and interpersonal problems, resulting in the appearance of an increase in symptoms.

Finally, situational factors may have also played a role in the client's continued symptoms four months after treatment ended. When the client returned the fourth-month post-treatment measures in the mail, she included a note explaining that she had been

studying for a major set of exams at the same time that she completed the measures. The client expressed concern that perhaps her symptom measures might reflect the anxiety associated with studying for the exams and not her true level of symptoms. Perhaps this stressful life event explains the client's continued symptoms four-months after treatment ended.

<div align="center">Research Questions</div>

Research Question 1: What immediacy-related therapist and client actions occurred during each session?

In the current case, the client and therapist used immediacy, on average, about a third of the time. In some sessions, the client and therapist each used immediacy for approximately two thirds of the entire session, whereas in other sessions they each used immediacy rarely. These results suggest the client and therapist in the current study spent a considerable amount of time in therapy having discussions about their immediate relationship. To understand how these results relate to the frequency of immediacy used in psychotherapy in general, we compared our results to a study conducted by Hill et al. (1988). In this study, most of the therapists characterized their orientation as psychodynamic and therapist immediacy was coded in the same category as therapist self-disclosure. Results showed that across brief therapy (12-20 sessions), immediacy and self-disclosure combined occurred less than 1% of the time. This comparison suggests the amount of time spent in the current study on immediacy is not typical for psychotherapy in general and also seems to reflect the therapist's interpersonal orientation. Although interpersonal theories are psychodynamically based, there is a

greater emphasis in interpersonal theories on the use of immediacy (Kiesler, 1996; Teyber, 2000; Yalom, 1995), which was reflected in the current case.

The constructs of transference and countertransference might also help explain the amount of immediacy found in the current case (Fried, Crits-Christoph, & Luborsky, 1998; Gelso & Carter, 1994). Some of the immediacy was likely to have been the result of the client's transference and the therapist's subsequent countertransference in response to the client. As noted earlier, interpersonal relationship patterns are developed with significant others and often transferred to and applied in other important relationships, such as the one with the therapist. Change is proposed to occur for clients through reenacting and openly discussing these patterns with the therapist (Kiesler, 1996; Teyber, 2000; Yalom, 1995). Some of the immediacy found may have been related to the client's maladaptive interpersonal patterns that the therapist wanted to help her resolve. In addition, some of the immediacy found may have been due to the therapist's own countertransference that needed to be managed.

The client and therapist in the current study used immediacy on average approximately the same amount of time, which as noted earlier was more than occurs generally in therapy. Since the client in the current study was a graduate student in a mental health profession, it is possible that she was better able to use immediacy than a client with less knowledge of the field would have been able to do. This client was also chosen, as noted in Chapter 4, because she was able to make use of immediacy in a pre-screening interview with the author. It is possible that short-term treatment of this nature may not have contained as much immediacy if the participant was not as able to use immediacy upon entering treatment as the client in the current study was. It is also

possible that the therapist adjusted the amount of time he spent using immediacy to what he assessed the client could handle, which for this client appeared to be a significant amount.

The frequency of immediate discussions may have had an impact on the client, however, since she reported that these discussions were very difficult for her. In the final session the client said, "They were definitely harder for me (immediate conversations). 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…(about) stuff that was not immediately… accessible in the room."

Since these conversations were more challenging for this client and they occurred frequently, therapy was likely to have been an intense experience for this client. This intensity may have contributed to the client's increased symptoms at the end of treatment, as noted earlier. The frequency of these immediate discussions may have helped the client realize the extent of her interpersonal patterns, improving her self-awareness. How challenging these conversations were for this client, combined with how frequently they occurred, may have fostered a strong attachment to the therapist, the loss of which as suggested earlier, may have contributed to the client's symptom increase.

The majority of therapist immediacy use involved the therapist asking the client questions about their immediate relationship. An example of this type of intervention from the current study is, "What's scary about telling me what you want in therapy?" The therapist used intimately self-involving statements, however, much less frequently. An example of this type of intervention from the current study is, "I want you to want

more (sessions), even though…that will make it harder on me, I still want you to want more." The therapist also gave the client feedback about her immediate in-session behavior infrequently. An example of this type of intervention from the current study is, "One of the things that is striking to me today, particularly when you talked about your weekend, with (your boyfriend)…you're softer. …A friend of mine used to always talk about being hard or soft. I mean sometimes you're hard, but today you're softer when you talk about (him)."

Research Question 2a: How are the therapist and client's use of immediacy related to one another?

Results showed that therapist and client immediacy use was related to one another. Specifically, the client frequently used immediacy in response to the therapist's use of immediacy (both the speaking turn and session level analysis showed this). The client reported using immediacy in response to the therapist out of deference and not wanting to hurt the therapist's feelings by not providing the information he wanted, "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, so…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."

Client immediacy occurred in response to the therapist's inquiries about their relationship and his use of intimately self-involving statements, but not in response to the

therapist's feedback about the client's immediate in-session behavior. Perhaps inquiries about the relationship demanded the client to respond with immediacy, since they were in the form of a question. In addition, because intimately self-involving statements are so personal, the client may have also felt a demand to respond with immediacy. Because feedback alone did not require a response, the client may not have felt the same demand to respond with immediacy.

Hill and O'Brien (1999) distinguished immediacy from direct feedback about the client. They suggested that feedback about the client only involves the client (e.g., You are smiling a lot and seem more open to making changes) and immediacy is about the interaction between the client and therapist in the therapeutic relationship (e.g., "we" or "you and I"). It seems that the therapist in the current study often followed or combined feedback about the client with an intervention tying the feedback to the client-therapist relationship. The combination of feedback with either a question about the relationship or an intimately self-involving statement made the feedback immediate. These findings suggest feedback about the client's immediate in-session behavior should not be considered immediacy unless the feedback is combined with immediate questions or statements.

Research Question 2b: How does the therapist and client's use of immediacy change over time?

Both client and therapist immediacy use followed an increasing and decreasing pattern over time. Since immediate discussions were so intense for this client, as noted earlier, the increasing and decreasing pattern may have been a way for the client and therapist to manage this intensity. Although the therapist initiated all immediacy events

and therefore, was more in control of when immediacy occurred than the client, perhaps the therapist did not want to initiate as much immediacy in a session after there had been a great deal of immediacy during the previous one. There is anecdotal clinical evidence to support the assertion that rough sessions are often followed by smooth sessions.

These findings of an increasing and decreasing pattern of immediacy can also be explained by the assertion that therapists must engage with clients' maladaptive relational patterns first (i.e., become hooked) and then disengage, observe, and discuss the interpersonal pattern with the client in their immediate relationship (Cashdan, 1988; Hill & O'Brien 1999; Kiesler, 1996). We observed that the therapist seemed to get hooked and needed time to step back and figure out what was going on before he could come back to process the event between he and the client.

In terms of specific immediacy interventions, the therapist's use of inquiry about the relationship and intimately self-involving statements followed the increasing and decreasing pattern over time, although feedback about the client did not follow this pattern. The therapist may not have felt he needed to moderate his use of feedback because the client did not respond as strongly to these interventions. This finding also provides further support for the assertion that feedback should only be considered immediacy if it is specifically tied to the client-therapist relationship.

Research Question 3: How is client involvement related to therapist immediacy use?

There were no differences in client involvement scores when the therapist used immediacy overall compared to when he did not use immediacy. As noted earlier, the client in the current study did not vary a great deal on average client involvement scores per session. Specifically, on the 5 point scale (5 = high), the highest mean involvement

score the client reached overall across the 12 sessions was $M = 3.49$, $SD = .84$ and the lowest mean involvement score reached was $M = 2.92$, $SD = .74$. This limited variability in average client involvement scores may have been a factor in the lack of differences found between when the therapist used immediacy versus when he did not use immediacy. In addition, perhaps when all immediacy actions were combined, any mean differences across the three immediacy actions (i.e., inquiry about the relationship, intimately self-involving statements, feedback) cancelled one another out.

The client was more involved, however, when the therapist inquired about their relationship and less involved when the therapist used an intimately self-involving statement compared to when he did not use immediacy at all. These findings suggest that the type of immediacy made a big difference in client involvement. Perhaps the client felt more of a demand to respond to the therapist's questions about the therapeutic relationship than when the therapist used an intimately self-involving statement. Since the client was not being asked anything directly when the therapist made such a statement, the client may have been less clear about how to respond to these statements and therefore, appeared less involved. It is also possible that this client was not as comfortable volunteering information in response to the therapist's statements, but was more comfortable when probed to talk. The client's comments in that last session support this assertion. She said, "often times when you would ask me…what I was feeling towards (you), you know what was going on the sessions…that was also helpful because I'm not the type of person who will just volunteer information but when…prompted it's very easy for me to let you know..."

Sex differences in this therapist-client dyad may also have played a role in how involved the client was in session in response to different immediacy actions. This female client sometimes seemed to feel awkward having a male therapist make such intimate statements to her and as a result, was more hesitant to be open in response to such statements. In a post-treatment interview, the client reported, "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 wedding ring was reassuring."

In a post-treatment interview, the therapist acknowledged the impact sex differences might have had on their immediate discussions and noted that he should have raised the topic between them. It is possible that if the therapist had discussed their sex differences, the client may have felt less confused about the therapist's intentions in using intimately self-involving statements and therefore, been more involved in response to these in treatment.

Cultural differences between the client and therapist may also have been a factor in how involved the client was in session in response to different immediacy actions. The client was a first-generation American of Middle-Eastern decent and the therapist was Caucasian. Perhaps the cultural differences between the therapist and client were a factor in the client's different responses to immediacy. In particular, it is possible that the client's cultural background is what influenced her gender role beliefs and expectations, which, as noted above, seemed to play a role in the discomfort she felt during immediate conversations with this male therapist.

Perhaps this client would have been comfortable responding to the therapist's intimately self-involving statements had the treatment continued longer. As noted earlier, it was difficult for this client to go against authority and it might have required more time to work on this issue. If treatment had gone on longer, the client might have felt more comfortable asserting her reactions to the therapist's statements.

Research Question 4a: How does client involvement change from before to during immediacy events?

Research Question 4b: How does client involvement change from during to after immediacy events?

Client involvement was slightly higher before and after immediacy events than during these events. As noted earlier, immediate conversations were particularly challenging for this client, which may explain why this client was not as involved during events as she was before or after events. The sex and cultural differences between the client and therapist might also have contributed to the client's lower involvement during events compared to before or after events. In addition, the therapist may have used immediacy when the client seemed particularly involved already in treatment. Specifically, the therapist may have observed that the client was emotionally open and took the opportunity to discuss something immediate because he felt she was engaged enough in treatment to handle immediacy. As noted earlier, immediacy was particularly challenging for this client and may explain her decrease in involvement from before to during these events. The client's higher involvement after events might be because she gained insight from these events, felt closer to the therapist because of these

conversations, and became more involved in treatment after immediacy events because of these two factors.

Research Question 4c: How does client involvement change during immediacy events over time?

There was no increase in the level of client involvement during immediacy events over the entire course of therapy, yet the length of immediacy events themselves increased over time. This suggests the client was able to engage in these events for a longer period of time at the end of treatment compared to the beginning. Perhaps tolerating longer immediacy events was a first step in the progression for this client to respond more to immediacy. Client involvement did increase over the course of treatment, however, but it did not increase specifically during immediacy events.

Treatment or therapist factors may also have played a role in the lack of change in client involvement during immediacy events across therapy. The therapist may have noticed how difficult it was for this client to engage in immediacy and knew that just to tolerate the conversations was significant therapeutic progress for this client, so did not push her to be more involved. The therapist did not specifically initiate a conversation to discuss what it was like for the client to talk about their relationship, nor did he point out that the client seemed emotionally guarded during those conversations. The therapist also did not educate the client about the connection between being more emotionally open (as measured in the current study by involvement) in their relationship and improvement on her interpersonal concerns in general, which also could have been a factor in the lack of change in involvement during events.

Additional Data Analyses

Types of Immediacy Events and Tasks Found

Two types of immediacy events were found in the current study: here-and-now-events (i.e., an emotional experience immediately occurring in the client-therapist relationship) and process events (i.e., reflecting on what is occurring in the client-therapist relationship). Yalom (1995) asserts that for change to occur, therapists need to both create an emotional experience in the immediate moment (i.e., here-and-now events) and reflect on and process the client's reactions to that experience (i.e., process events). If the therapist only creates a here-and-now experience, Yalom (1995) suggests that clients will feel deeply involved in therapy but will have no cognitive framework for generalizing the experience and transferring their learning to outside relationships. He also notes that if therapists focus only on process, therapy lacks the meaning generated by here-and-now experiences and becomes an intellectual exercise. It appears that the current case included both types of immediacy events proposed by Yalom (1995) to be important in facilitating client change.

There also appears to be some overlap between therapist immediacy interventions, identified in the speaking-turn analysis, and immediacy event types. Process events (e.g., therapist explores his impact on client, therapist inquires about client reactions to sessions/treatment, therapist encourages client to express immediate feelings to the therapist, therapist discusses termination, and therapist draws parallel between outside relationships and therapy relationship) seem to be similar to the intervention, "inquiry about the relationship." Here-and-now events (e.g., therapist wants to connect with the client, therapist feels closer to client, therapist feels pride in client, therapist

expresses disappointment, sadness, and/or hurt in relation to client, and therapist expresses care for client) seem to be similar to the intervention, "intimately self-involving statements." Thus, these event types provide more detail for the earlier speaking-turn level interventions identified.

Most of the empirical work reviewed for the current study examined difficult immediacy events between client and therapist, such as misunderstanding (Rhodes et al., 1994), ruptures (Safran et al., 2002) and client anger directed towards the therapist (Hill et al., 2003). The findings from the current study provide support for the assertion that immediacy between client and therapist is not limited to difficult interactions but also includes positive interactions. In addition, the previous research addressed immediacy events that focused on the client's feelings towards the therapist (Hill et al., 2003; Rhodes et al., 1994; Safran et al., 2002). The results from the current study suggests that immediacy events may also focus on the therapist's feelings towards the client (i.e., desire to connect, feel closer to, sadness, hurt, disappointment, care and pride in the client).

None of the immediacy events in the current study related to the client's expression of negative feelings towards the therapist. It is possible that, as suggested earlier, the treatment was not long enough for the client to have been comfortable expressing anger towards the therapist. In addition, perhaps treatment had not gone on long enough for the client to allow herself to become aware of any negative feelings she may have had towards the therapist. It is possible that the sex differences between client and therapist also played a role in the client's lack of expression of anger. Perhaps as a woman, this client felt less comfortable expressing anger towards a male therapist

because of gender-role expectations. In addition, age, level of education, and cultural factors may also have played a role in the client's discomfort expressing anger or negative feelings towards the therapist.

The previous empirical work on negative immediacy events focused on the resolution of these events and how this resolution relates to the therapeutic relationship and the client's continued treatment and outcome. For example, Rhodes et al. (1994) found that most clients (five of eight) who experienced unresolved misunderstanding events quit therapy, whereas the clients who experienced resolved events reported an improved relationship with their therapist. It seems this previous body of research has tried to understand what therapists can do to help clients stay in treatment when there is a misunderstanding or a rupture in the therapeutic alliance. Given how strong the therapeutic alliance was in the current case, and how strong it remained throughout treatment, perhaps the types of immediacy events found in the current study can help us understand how therapists build and maintain a strong therapeutic alliance. Specifically, the therapist's expression of a desire to connect with the client, which occurred early in treatment, may have played a role in the development of the initial working alliance. The therapist's expression of care for and closeness to the client later in treatment may have played a role in the deepening of the therapeutic alliance.

Initiation of Immediacy Events

Although the client did not initiate any of the 33 immediacy events, she indicated several reactions to the therapist on the post-session questionnaires. In other words, she could have initiated immediate discussions in sessions but did not. Several client factors mentioned earlier (i.e., sex, culture, age, educational differences) may have played a role

in her lack of initiation. The therapist provided some support for this assertion when he noted the existence of sex-role expectations for this client in session seven, "it sounds like you do have a lot of rules about how girls are supposed to be and how guys are supposed to be…"

Treatment and therapist factors may also have played a role in the client not initiating immediacy. Yalom (2002) suggested that clients need to be taught how to participate in therapy. He asserted that therapy is a new, ambiguous social experience and that clients enter treatment not knowing the "rules." Perhaps the client did not initiate immediacy because she did not know this was something she was allowed to do. During session four, the client commented on this issue, "…when I asked you…what makes me different from the other clients…I was like, am I allowed to ask you that question cause what am I…the therapist now…I felt…I shouldn't be asking you that because…now I'm intruding into your privacy, and…that's not how its supposed to happen…"

Reciprocation of Immediacy Events

There were seven events that the therapist introduced but the client did not reciprocate with immediacy. These events occurred at different points throughout treatment. The client may not have known how to respond to the therapist's attempts at immediacy early in treatment because she was learning how to have immediate conversations. This does not, however, explain the client's failure to respond to immediacy events attempted later in treatment.

Six of these seven events involved the therapist asking about the client's reactions to sessions, treatment and termination, and exploring his impact on the client (i.e.,

process events). As noted earlier, these events are all similar to the category of therapist immediacy interventions called "inquiry about the relationship." The client commented, both in the last session and on the post-session questionnaires, that occasionally these inquiries about the relationship did not feel relevant to what she was discussing at the time or wanting to discuss with the therapist. Perhaps the client expressed her desire not to discuss their relationship by ignoring the therapist's bid to talk about their relationship. The client expressed her feelings about these events in the last session, "once in awhile…towards the end of a session…(while) we were talking about something, you would ask how I felt our relationship in here was going…(and) a couple of times I was like well, I don't really know if that's relevant or if that fits the situation I'm going through…"

Changes in Immediacy Events Over Time

Events in which the therapist inquired about treatment, the client's reaction to sessions, or made a parallel to outside relationships (i.e., process events) occurred regularly throughout treatment, perhaps because these events were not as difficult for this client to respond to in session. These events are also not very intimate, so perhaps the therapist was not concerned about bringing them up early in treatment when their relationship was not yet established.

The timing of some immediacy events, however, varied across treatment. During the first few sessions, the therapist initiated events to discuss the client-therapist bond and his desire to get close to the client, which may be related to the therapist's attempts to establish a working alliance. These events rarely occurred later in treatment, however,

since once their relationship was established, there would not be as much of a need for the therapist and client to discuss their developing bond.

Events in which the therapist expressed strong, direct emotions towards the client, such as disappointment, sadness, hurt, and care did not begin occurring until the middle of treatment, specifically not until session four. Since their relationship was still forming, the therapist may not have developed these feelings towards the client yet, so he may not have had them to share earlier in treatment. Perhaps the therapist did not discuss his feelings sooner because he did not think the client would have believed him, given how briefly they had been working together. The therapist may also have sensed that the client was less involved when he used intimately self-involving statements, so he may have hesitated to share his feelings as a result of her reactions.

The therapist did not express pride until the end of treatment. As noted earlier, perhaps there was no reason for the therapist to express pride in relation to the client sooner than the end of treatment. There might also be something about the therapist's desire to let the client feel pride herself before he expressed it about her that led to the timing of this particular type of event.

The therapist began discussing termination in session four and continued to do so until treatment ended. This approach is consistent with the literature on short-term treatment suggesting that it is important to raise the issue of termination throughout treatment (Mann, 1979).

Frequency and Intensity of Client Reactions to Immediacy Events

The client had the strongest reactions on the post-session questionnaires to immediacy events in which the therapist expressed direct feelings to her (i.e., here-and-

now events), which, as noted earlier, are similar to the therapist immediacy intervention, "intimately self-involving statements." In addition to having the strongest reactions to these events, the client also commented on these events the most frequently.

Perhaps one reason the client had such strong reactions to these events is because the therapist's openness with his feelings about her was surprising to the client (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 the therapist surprising.

Although the client said on the post-session questionnaires that she was deeply impacted when the therapist directly expressed feelings to her, the quantitative analyses did not reveal this impact. For some reason, the client did not express the intensity of her responses to these events in session, as suggested by her lower involvement scores in response to similar interventions (i.e., intimately self-involving statements). She was obviously aware of her strong reactions to these events, but something stopped her from directly expressing them to the therapist in session. Possible explanations include the fact that immediacy was difficult for this client in general, the client's desire not to hurt the therapist's feelings or other fears about his reactions, and the client's beliefs about what was appropriate for her to discuss with the therapist based on gender-role expectations and/or cultural differences. Additionally, Yalom (2002) suggested that immediate conversations are not typical in most clients' lives, so perhaps the client did not know

how to express her feelings to the therapist in a productive way or perhaps she did not feel confident doing so.

Treatment or therapist factors may have also contributed to the client not discussing the intensity of her reactions to these events in session. The client may not have known how important discussing her reactions directly with the therapist was for her progress in therapy, so she might not have been as motivated to overcome her hesitation. In addition, treatment might not have been long enough for the client to feel comfortable discussing her intense reactions directly with the therapist. Although the therapist inquired about the client's reactions to sessions and treatment, perhaps the therapist did not probe enough specifically into the client's reactions to his expression of strong emotions about her.

In contrast, the client did not react as strongly on the post-session questionnaires to events in which the therapist inquired about her reactions to sessions and treatment, discussed termination, and explored his impact on her (i.e., process events). The quantitative analyses suggested, however, that she was more involved in session in response to similar interventions (i.e., inquiry about the relationship). The client may have had less to share on the post-session questionnaires about these events because she had already discussed her reactions in session and therefore, appeared not to react strongly. The client may have felt more comfortable responding to these events in session because they were questions about the treatment, as opposed to feelings the therapist had about her and their immediate relationship, and perhaps they felt less threatening for this client to discuss.

The two event types that occurred most often (the therapist draws a parallel between outside relationships and the therapy relationship and therapist encourages client to express immediate feelings to the therapist) were also event types the client commented on infrequently in her post-session questionnaires. Although the client did not comment directly on the link the therapist made between other relationships and the therapy relationship, she often made comments suggesting that she could see how what was happening with the therapist was related to her other relationships. The lack of client comments on the therapist's encouragement to express her immediate feelings to the therapist could be related to how uncomfortable the client was with expressing her feelings directly to him. Again, she clearly had strong feelings about things the therapist said that she did not express to the therapist directly in session, despite his invitations.

<div style="text-align:center">Limitations</div>

Although the single-case design allowed us to examine the process of immediacy, our ability to draw causal conclusions about immediacy and its relationship to both in-session (client involvement) and post-session (OQ, IIP-32, SUIP-R) change is limited. The variety of methods we used to measure the constructs of interest (e.g., client self-report and open-ended questionnaires, observer ratings), the different methods we used to analyze the data (i.e., speaking turn and events), and the measurement of dependent variables (i.e., client involvement) as closely after the occurrence of immediacy in session gives us more information to support the possibility of causal connections, but we are still limited by the descriptive nature of the design.

Another limitation of the single-case design is the lack of generalizability of the findings. Generalizability is not possible given the idiosyncratic dynamics of this single-case, including the characteristics of this client, the style of this therapist, and the particular interpersonal dynamics of this dyad. This client was in a mental health profession, came to treatment motivated, was in the normal range of functioning (i.e., no eating disorders, substance abuse problems, current or past suicidal ideation or behaviors), was willing to identify her problems as interpersonal in nature, and was able to have an immediate conversation prior to the start of treatment. It was important to select a high functioning client to ensure the therapist could engage the client in immediacy quickly upon entering treatment and not be compelled to address pressing clinical issues like disordered eating or suicidality. We also chose a client who could engage in immediacy so we were confident the phenomenon would occur with some frequency over the brief course of treatment, and therefore be observed and analyzed. These "ideal" client characteristics, however, do limit the generalizability of the results. The results also might not generalize to immediacy-focused therapy practiced by other clinicians.

Although this study used an experienced therapist as opposed to counselor trainees, treatment was conducted in a laboratory setting using videotaping and simultaneous observation, so the findings may not generalize to more natural settings. In addition, the client was recruited so results may not generalize to clients who seek treatment out on their own.

Exposure of the therapist and client to the measures collected before treatment and after each session may have cued participants into what we were studying. These

measures were face valid, so the therapist or client may have speculated about the purpose of the study and changed their behavior as a result. Additionally, although the therapist had not read any versions of the proposal for this project, he was initially intended to be a dissertation committee member, so he had some awareness of the overall intent and objectives of the study, which may have influenced his behavior with this client.

The measures used to evaluate therapist and client immediacy actions, client involvement, and the post-session questionnaires were all developed for this project and revised in a discovery-oriented way based on the emerging data. This was done because there were no existing measures to study the phenomenon of interest. Hence, these measures may not work with another case. The immediacy action and client involvement measures had good inter-rater reliability, but no tests of construct validity were conducted for either of these measures or the client post-session questionnaires, limiting our confidence that these variables represent the constructs they were intended to measure.

The differences in the immediacy components found between the two types of analyses (i.e., speaking-turn and event) highlights a limitation in the speaking-turn level analysis. Specifically, according to the speaking-turn analysis, the therapist rarely drew a parallel between their relationship and the client's other relationships, but the event analysis revealed many of these parallels. It appears that the speaking-turn analysis did not allow for a description of the nuances that occur between client and therapist during immediacy events.

Although one of the benefits of single-case designs is the repeated measurement of the phenomenon of interest to allow for the observation of changes over time, this

method impacts our confidence that the relationships found between variables actually exists. All the measures collected were repeatedly measured, which means the data lack independence. This lack of independence may have played a role in the results found, particularly with respect to client involvement. Specifically, changes found may not be the result of treatment or immediacy, but a function of the repeated measurement of this variable over time. We attempted to address this by accounting for the impact of time in the analysis of client involvement wherever possible. The statistical tests used, however, assume independence of the data so results need to be viewed with some caution given that this assumption was violated.

The author and her advisor conducted the additional analyses and their biases and expectancies may have impacted the results found. Their views about immediacy events may have played a role in the results found in that section, including which events were discovered and the assessment of client reactions to these events.

It is important to note that not all of the events included in the analysis of changes from before to during immediacy events were included in the analysis of changes in involvement from during to after events. As a result, comparisons of pre to post-event scores need to be viewed with some caution.   In addition, the minimum number of speaking turns used to calculate client involvement before and after an event was three, whereas client involvement during events was based on the average of many more speaking turns ($n = 24$). As a result, differences in client involvement before and after events might not reflect the client's level of involvement in general when she was not engaged in immediacy, but only how involved she was for a few speaking turns.

Despite these limitations, this study provides important insights for practitioners and researchers. Practitioners can use the findings from this study and begin to explore their application with clients for whom immediacy is a relevant intervention and researchers can begin to test the hypotheses generated to further expand our understanding of this important clinical phenomenon.

Implications for Practice

A 12-session therapy model might not be long enough to achieve change when using the type of intense, immediacy-focused therapy found in the current case, as suggested by the increase in the client's symptoms both towards the end of treatment and at the four-month follow-up. Perhaps 24 to 30 sessions are required for clients to show improvement from this type of immediacy-focused treatment. Some scholars suggest 24 to 30 sessions is an appropriate treatment length for brief interpersonally-oriented therapy (Strupp & Binder, 1984). If treatment had lasted longer, the client may have had more time to openly discuss and resolve her interpersonal conflicts in the therapeutic relationship, thus having the resolution proposed to facilitate change and achieve symptom relief (Kiesler, 1996; Teyber, 2000; Yalom, 1995).

Client characteristics may also need to be considered when using such an intense amount of immediacy in short-term therapy. There may have been factors specific to this client that made it difficult for her to openly discuss her reactions with the therapist in the 12-session timeframe. Specifically, the client was fairly restricted on her level of emotional openness and engagement in therapy, as suggested by her average rating on client involvement (M = 3.19 on scale of 1 to 5). Perhaps a client who was more able to

express her emotions and deepen the clinical material upon entering treatment would have shown more improvement using immediacy-focused therapy in a 12-session model.

Perhaps if the therapist was given feedback about the client's reactions to immediacy or her increased symptoms, the therapist could have done something to help the client discuss and resolve her interpersonal conflicts in the therapeutic relationship within the 12-session timeframe. Lambert et al. (2001) has found that providing therapists' feedback about clients' progress in treatment helps facilitate change (Lambert, Whipple, et al., 2002). The therapist in the current study had no feedback at all about the client's reactions to immediacy, other than what the client directly shared, which as results showed was only a portion of what she was experiencing. If the therapist was provided with information regarding the client's increasing symptoms and post-session reactions, he might have asked more about what was not being discussed between them. This may have created an opportunity for the client to discuss these feelings within the therapeutic relationship and perhaps to have had more of the open discussion and resolution proposed to facilitate change (Kiesler, 1996; Teyber, 2000; Yalom, 1995). Therapists who use immediacy might consider collecting written post-session feedback about clients' reactions to immediacy. However, this might not work because one of the reasons the client in the current study may have shared her reactions so honestly on these post-session questionnaires was that she had been told the therapist would not see her responses while they were in treatment together.

Therapists who use immediacy might want to consider educating clients about immediacy at the beginning of therapy and during treatment, particularly when clients are less involved in response to immediacy. The therapist in the current study did educate

the client in session 2 when he said, "…a lot of times things will happen in here that happen outside…this is (why it is) all the more helpful for us to talk about our relationship and how it's happening (with us) and then think about how does (that) apply outside. It's a good model." Although the therapist did some of this, more education might have helped the client in the current study be more open and involved during immediacy events. This education might include a rationale for immediacy, as the current therapist provided and theorists propose (Teyber 2000), but could also include explaining to clients the link between openly discussing their reactions in the immediate client-therapist relationship and improvement in their other interpersonal relationships. Offering clients this type of explanation might provide them with the motivation needed to take the emotional risks with the therapist proposed to facilitate change (Kiesler, 1996; Teyber, 2000; Yalom, 1995).

Therapists who use immediacy might want to be sure to engage in process events after intense here-and-now events, particularly with clients who are less involved or emotionally open. Yalom (1995) asserts that the therapeutic power of immediacy depends on the use of both event types together. It seems important to observe how clients respond to the therapist's communication of strong emotion about them, discuss clients' reactions to hearing these from the therapist, give clients' permission for it to be difficult to discuss those reactions with the therapist, and explore what some of the difficulties might be for them. Such a coupling of here-and-now and process events might help clients who are less involved in session become more involved.

Therapists might want to specifically invite clients to express negative reactions and explore any hesitations clients might have in expressing these reactions. As noted

earlier, there were no anger-related events found in the current case, even though the client expressed dissatisfaction on the post-session questionnaires that sometimes discussions about their relationship did not feel relevant to what she was interested in working on. Such encouragement by the therapist to discuss negative reactions is consistent with the rupture literature (Safran et al., 2002), which found that the resolution of ruptures occurred when therapists attended to the rupture marker and explored the client's avoidance of discussing the rupture.

Therapists who use immediacy should 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 the therapist's intentions with respect to certain immediacy topics, such as caring for the client, particularly when there might be sexual attraction between client and therapist or differences in cultural norms regarding conversations about intimate relationships. It is possible that if the therapist had discussed the sex differences between the client and himself, the client may have felt less confused about the therapist's intentions and therefore, have been more involved and open in treatment. It is also possible that the therapist may have discovered that cultural differences played a role in the client's reactions to immediacy and if discussed, might also have been resolved and contributed to greater client involvement during immediacy.

Therapists might also want to consider the timing of certain here-and-now immediacy events. Specifically, it seems that communicating a desire to get closer to the client early in treatment could be useful in helping foster a working alliance. Once the therapeutic relationship has been established, immediacy events could be used to create

strong, emotional here-and-now interpersonal experiences, such as discussing sadness, disappointment, and hurt in relation to one another.

Finally, therapists who use immediacy as a primary intervention might want to be extra careful with respect to their countertransference reactions. Specifically, it seems important for therapists to assess clients' interpersonal patterns and to focus their immediacy use on the client's specific maladaptive patterns. Therapists should be aware of their countertransference reactions to clients and assess when they use immediacy in response to their own issues and not the client's patterns. Therapists who use immediacy frequently 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 Future 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 is important to see if these findings would replicate with clients who are both similar to and different from the client in the current case on dimensions such as sex, race/ethnicity, and client involvement at the start of therapy. It is also important to examine whether the findings would replicate using different therapists, particularly those who use immediacy in a way that is both similar to and different from the therapist in the current study, and who are both similar to and different from the client with respect to both sex and race/ethnicity.

Once the types of immediacy events found have been replicated, future research could use task analysis methods (Greenberg, 1986, Safran et al., 2002) to understand

what occurs during immediacy events and how these different tasks relate to client in-session change and outcome. Although an original intention of the current study was to understand the therapist tasks and client actions that occur during immediacy events, it was discovered that the speaking-turn level analysis did not allow for a description of the nuances that occur between client and therapist during these events. Task analysis methods appear to provide such clinical nuance (Greenberg, 1986; Safran et al, 2002).

Scholars suggest that to understand the components within psychotherapy that contribute to client change and outcome, we need to break down global outcomes into smaller, related in-session changes and discover how interactions between client and therapist over time contribute to these changes (Greenberg, 1986). Client involvement was proposed as an important in-session change variable to examine in relation to immediacy because it appears related to both session and therapy outcomes (Eugster & Wampold, 1996; Gomes-Schwartz, 1978) and has been shown to predict client intention to act and implementation of therapeutic action plans (Wonnell and Hill, 2002). The findings from the current study do not allow us to draw any conclusions as to whether client involvement is an important in-session change variable to measure to understand the relationship between immediacy and client outcome, so further replication is necessary. Future research could continue to examine this variable, measured similarly or using different methods.

There were several hypotheses generated from the findings of the current study for why the client was not as involved during immediacy events that could be tested in future research. It seems important to examine if there are differences in client involvement when here-and-now events are always followed by process events, as

suggested by Yalom (1995). This could be done using an experimental design, with these event components manipulated as the independent variable. The current findings also suggest it might be important to examine if there are differences in client involvement when client and therapist discuss sex differences between them (if such differences exist), and when therapists encourage clients to initiate immediacy events and express negative emotions about the therapist in session. It might also be important to study the impact of education about immediacy on client involvement. Future research could specifically examine differences in involvement when therapists educate clients about the importance of emotional involvement during immediacy to outcome and when clients reach some level of understanding that discussing the relationship is important to their improvement.

The differences found between the client's reactions to immediacy events after sessions compared to her reactions during sessions suggests future research should examine the impact of providing therapists with feedback about clients' post-session reactions to immediacy. There is a body of work that suggests providing therapists' feedback about client progress improves outcome (Lambert et al., 2001; Lambert, Whipple, et al., 2002). It would be interesting to know if a therapist is provided with information about a client's hidden post-session reactions, would it make a difference in the way the therapist intervenes during immediacy events and whether these interventions have any impact on client involvement and outcome.

The existing literature on immediacy has looked at the impact of ruptures and misunderstandings on the therapeutic alliance (Rhodes et al., 1994; Safran et al., 2002). Given the strength of the therapeutic alliance in the current case, the types of immediacy events found and their patterns over time in treatment might help us understand how

immediacy contributes to the establishment of a therapeutic alliance early in treatment. Specifically, future research could compare when therapists use immediacy events focused on wanting to connect with the client early in treatment (first two sessions) versus therapists who do not use these types of immediacy events and see what, if any, differences there are in the working alliance.

Another area of future research might examine whether short-term immediacy focused therapy that addresses one core-interpersonal conflict could result in a better outcome than was found in the current case. This type of research could examine the proposed connection between changes within the therapeutic relationship and changes in other relationships, as well as the proposed link between such changes and client outcome. The CCRT (Core Conflictual Relationship Theme; Luborsky & Crits-Christoph, 1998) method, which was originally proposed for inclusion in the current study, could be used in such an analysis.

Finally, the findings from the current study also suggest that it might be important to examine the relationship between immediacy and client involvement over a longer period of time, perhaps 24 to 30 sessions. This might help us understand whether client change in involvement within immediacy events occurs after a longer period of time and whether length of treatment is an important factor in the achievement of client symptom relief in immediacy-focused therapy.

Conclusion

In conclusion, it appears that immediacy is a difficult therapeutic process, even for a client who is motivated, interested in working on interpersonal issues, and trained in

a mental health profession. It seems important for therapists who use immediacy to consider creating both emotional experiences for clients (i.e., here-and-now events) and exploring clients' reactions to such experiences (i.e., process events). It appears that therapists should consider exploring whether clients are sharing all of their reactions to immediacy in session and if clients are holding back, therapists might want to explore the client's avoidance. It also seems that therapists might want to address how sex, cultural, age, and educational differences between client and therapist play a role in a client's difficulty with immediate discussions. Therapists might also want to carefully evaluate their own countertransference reactions when using immediacy to be clear what is related to the client's transference and what needs to be managed. Educating clients about immediacy might help to reduce client confusion about the use of immediacy. Finally, it appears that therapists might want to consider the length of treatment when choosing to engage clients in the types of here-and-now emotional experiences found in the current study. Specifically, therapists might want to reserve such intense events for longer term therapy when there is more time for a client to integrate and possibly translate the emotional learning from such events to outside relationships.

Appendix A

Outcome Questionnaire 45.2

The Outcome Questionnaire 45.2 is protected by copyright. Several sample items are included below. For more information about obtaining a copy of the OQ 45.2, please go to www.OQMeasures.com.

Sample Items:

1. I feel lonely.

2. I have trouble getting along with friends and close acquaintances.

3. I have trouble falling asleep or staying asleep.

4. I feel that I am not doing well at work/school.

Appendix B

Inventory of Interpersonal Problems – 32

Name: _____

Date: _____

People have reported having the following problems in relating to other people. Please read the list below, and for each item, consider whether it has been a problem for you with respect to any significant person in your life. Then fill in the numbered circle that describes how distressing that problem has been.

The following are things you find hard to do with other people.

	Not A Lot	A Little Bit	Moderately	Quite a Lot	Extremely
It is hard for me to:					
1. Say "no" to other people.	1	2	3	4	5
2. Join in on groups.	1	2	3	4	5
3. Keep things private from other people.	1	2	3	4	5
4. Tell a person to stop bothering me.	1	2	3	4	5
5. Introduce myself to new people.	1	2	3	4	5
6. Confront people with problems that come up.	1	2	3	4	5
7. Be assertive with another person.	1	2	3	4	5
8. Let other people know when I am angry.	1	2	3	4	5
9. Socialize with other people.	1	2	3	4	5
10. Show affection to people.	1	2	3	4	5
11. Get along with people.	1	2	3	4	5
12. Be firm when I need to be.	1	2	3	4	5
13. Experience a feeling of love for another person.	1	2	3	4	5
14. Be supportive of another person's goals in life.	1	2	3	4	5
15. Feel close to other people.	1	2	3	4	5
16. Really care about other people's problems.	1	2	3	4	5
17. Put some else's needs before my own.	1	2	3	4	5
18. Feel good about another person's happiness.	1	2	3	4	5
19. Ask other people to get together socially with me.	1	2	3	4	5
20. Be assertive without worrying about hurting other people's feelings.	1	2	3	4	5

	Not A Lot	A Little Bit	Moderately	Quite a Lot	Extremely

The following are things that you do too much.

21. I open up to people too much.	1	2	3	4	5
22. I am too aggressive toward other people.	1	2	3	4	5
23. I try to please other people too much.	1	2	3	4	5
24. I want to be noticed too much.	1	2	3	4	5
25. I try to control other people too much.	1	2	3	4	5
26. I put other people's needs before my own too much.	1	2	3	4	5
27. I am overly generous to other people.	1	2	3	4	5
28. I manipulate other people too much to get what want.	1	2	3	4	5
29. I tell personal things to other people too much.	1	2	3	4	5
30. I argue with other people too much.	1	2	3	4	5
31. I let other people take advantage of me too much.	1	2	3	4	5
32. I am affected by another person's misery too much.	1	2	3	4	5

Appendix C

Self-Understanding of Interpersonal Patterns - Revised

SUIP-R SCALE (Time 2)* Revision 3
The following items present experiences that people sometimes have in their relationships. For each item, please circle all the letters ("a" through "g") that represent how you have understood these experiences since you began treatment. There may be more than one item that represents your experience. Next rate how important each experience is in your current relationships by circling a number on the 10 point scale labeled "H".

1) **I feel the need to "save" others when I see them having a tough time and therefore try to solve their problems for them:**
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.
    H. **How important is this experience in your current relationships?**
        1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
        not   **somewhat**   **very**
        important   **important**   **important**

2) **I feel the need to guide others when I see them about to make a mistake and wind up telling them what to do:**
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.
    H. **How important is this experience in your current relationships?**
        1------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
        not   **somewhat**   **very**
        important   **important**   **important**

3) I need someone to truly understand me, and feel hurt when he/she cannot relate to my feelings:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H**. How important is this experience in your current relationships?**
    1------------2------------3------------4---------5---------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

4) I feel the need to keep someone close, and do whatever is necessary to keep him/her with me even when they need to leave me:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.
    H**. How important is this experience in your current relationships?**
    1------------2------------3------------4---------5---------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

5) I feel the need to change someone, and wind up helping him/her to think more like me even when he/she has beliefs or values different from mine:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H**. How important is this experience in your current relationships?**
    1------------2------------3------------4---------5---------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

6) I feel the need to be understood by others, and get defensive or angry when others are not able to see things like I see them:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H. **How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

7) I feel the need to be close to someone and have difficulty letting them have the space they need:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.
.

    H. **How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

8) I need to be trusted by someone, and feel rejected when they do not trust me:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H. **How important is this experience in your current relationships?**
    1------------2------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   mportant

9) I need to trust someone, yet I distance myself from that person when they act in a dishonest way:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
   1------------2------------3------------4---------5---------6-----------7----------8--------9-----------10
   not   somewhat   very
   important   important   important

10) I feel the need to be accepted by someone, and feel bad about myself when he/she doesn't like me:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
   1------------2------------3------------4---------5---------6-----------7----------8--------9-----------10
   not   somewhat   very
   important   important   important

11) I need someone to take care of me, and I feel abandoned when he/she is not helpful:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
   1------------2------------3------------4---------5---------6-----------7----------8--------9-----------10
   not   somewhat   very
   important   important   important

12) I need someone to be reliable, and I feel disappointed when he/she lets me down:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H**. How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

13) I need to feel free of responsibility, and I distance myself from someone I care about because they are too dependent on me:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H**. How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

14) I need to be respected by someone, and I feel hurt when he/she does not approve of me:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H**. How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

15) I want to accept someone else, but I am forced to distance myself when they do not live up to my expectations:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
     1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
     not   **somewhat**   **very**
     important   **important**   **important**

16) I would like to feel free to do my own thing, so I separate myself completely from another when I feel he/she is trying to butt in and take over:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
     1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
     not   **somewhat**   **very**
     important   **important**   **important**

17) I want someone to look after me and I feel angry when he/she doesn't notice me or pay any attention to me:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
     1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
     not   **somewhat**   **very**
     important   **important**   **important**

18) I want to be able to count on someone else, but when he/she neglects my needs I shut myself off from him/her and
  feel sad:
- a) I do not feel and act this way in my current relationships.
- b) I feel and act this way with at least one person in my life.
- c) I feel and act this way with multiple people in my life.
- d) I feel and act this way with multiple people because of my past relationship experiences.
- e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
- f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
- g) 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.

H**. How important is this experience in your current relationships?**
1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
not   somewhat   very
important   important   important

19) I want another person to accept me as I am, but I bottle up my feelings and do whatever the other wants when I feel like he/she is putting me down:
- a) I do not feel and act this way in my current relationships.
- b) I feel and act this way with at least one person in my life.
- c) I feel and act this way with multiple people in my life.
- d) I feel and act this way with multiple people because of my past relationship experiences.
- e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
- f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
- g) 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.

H**. How important is this experience in your current relationships?**
1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
not   somewhat   very
important   important   important

20) I want to be close to someone, so I try to do things the other person's way in order to please him/her when I see that the other person is too busy with his/her own thing to notice me:
- a) I do not feel and act this way in my current relationships.
- b) I feel and act this way with at least one person in my life.
- c) I feel and act this way with multiple people in my life.
- d) I feel and act this way with multiple people because of my past relationship experiences.
- e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
- f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
- g) 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.
.

H**. How important is this experience in your current relationships?**
1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
not   somewhat   very
important   important   important
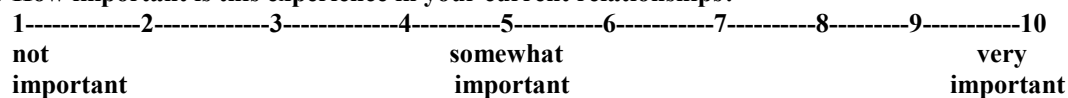
21) I want to stay and take care of another person, but I go my own separate way when he/she tries to tell me what to do:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H. **How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   **somewhat**   **very**
    important   **important**   **important**

22) I need for someone to take care of me, so when I see him/her abandoning me I feel angry but try to do whatever he/she wants:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H. **How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   **somewhat**   **very**
    important   **important**   **important**

23) I want someone to pay close attention to me, but I shut myself off from him/her and feel angry when he/she puts me down:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.
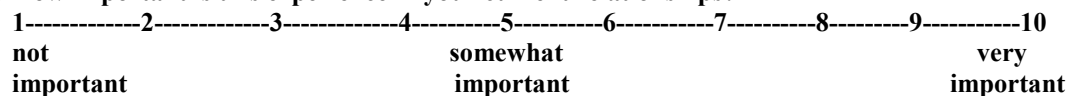
    H. **How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   **somewhat**   **very**
    important   **important**   **important**

24) I want another to go his/her separate way, but he/she checks in with me about every little thing just because I have a clear opinion about things:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.
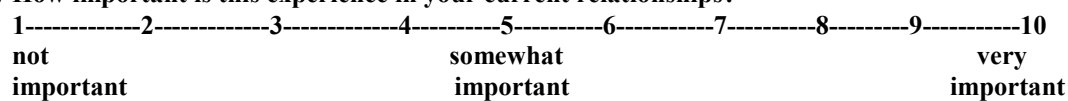
.

   H. **How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

25) I want to be able to tell someone my innermost thoughts, but I close myself off from him/her when he/she neglects my needs:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

26) I want someone to feel free to express to me the way he/she feels, but he/she just goes along with what I want when I clearly state my own opinion:
   a) I do not feel and act this way in my current relationships.
   b) I feel and act this way with at least one person in my life.
   c) I feel and act this way with multiple people in my life.
   d) I feel and act this way with multiple people because of my past relationship experiences.
   e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
   f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
   g) 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.

   H. **How important is this experience in your current relationships?**
   1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
   not   somewhat   very
   important   important   important

27) I want someone to invite me to be close to him/her, but I close myself off when I see that the other person is unaware of my needs:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H**. How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

28) I want to leave someone free to be whatever he/she thinks is best, but in order to make sure that things turn out right I wind up telling him/her exactly what to do even when he/she resists me:
    a) I do not feel and act this way in my current relationships.
    b) I feel and act this way with at least one person in my life.
    c) I feel and act this way with multiple people in my life.
    d) I feel and act this way with multiple people because of my past relationship experiences.
    e) I am in part responsible for continuing to feel and act this way with multiple people (i.e. I go into situations expecting to feel and act this way or I chose to put myself into these kinds of situations).
    f) I recognize that I am feeling and acting this way in the moment it is happening or shortly thereafter.
    g) 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.

    H**. How important is this experience in your current relationships?**
    1-------------2-------------3-------------4----------5----------6-----------7----------8---------9-----------10
    not   somewhat   very
    important   important   important

Appendix D

Session Evaluation Questionnaire – Depth Scale

Therapist/Client # _____

SEQ-D

Directions: Please circle the appropriate number to show how you **feel about this session**.

This session was:

Valuable	1	2	3	4	5	6	7	**Worthless**
Shallow	1	2	3	4	5	6	7	**Deep**
Full	1	2	3	4	5	6	7	**Empty**
Weak	1	2	3	4	5	6	7	**Powerful**
Special	1	2	3	4	5	6	7	**Ordinary**

Appendix E

Working Alliance Inventory – Short Form: Therapist

As you read the sentences, mentally insert the name of your client in place of _____ in the text. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. _____ and I agree about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

2. My client and I both feel confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

4. I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

5. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

8. We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

10. _____ and I have different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

_____

12. _____ believes the way we are working with his/her problems is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Working Alliance Inventory – Short Form: Client

As you read the sentences, mentally insert the name of your therapist in place of _____ in the text. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. _____ and I agree about the things I will need to do in therapy to improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in therapy gives me knew ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas about what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kinds of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problems is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix F

Immediacy Recall Questionnaire

IRQ

Client Code: _____

Please be as **HONEST** as you can when answering the following questions. Your responses will not be shared with your therapist, so please be as candid and open as you can be about your experiences today.

1. How much did you and your therapist talk about **your relationship** today (i.e., by relationship I mean any of the following: how you feel about each other, what you think of each others, how you get along, how you interact with each other)?

      Not   The entire

        At All   session

           1   2   3   4   5   6   7   8   9

If you answered **Not at all (1)** to the above question, please stop here and give this form to the researcher. Otherwise, please continue.

2. When you and your therapist talked about your relationship today, what was the content of your discussion (s)?

3. When you and your therapist talked about your relationship today, what was that like for you?

Client Code: _____

4. What did you learn about yourself from these discussions?

Appendix G

Therapist Process Note

1. How would you **conceptualize** this client based on your session today?

2. How much did you and your client talk about **your relationship** today (i.e., by relationship I mean any of the following: how you feel about each other, what you think of each other, how you get along, how you interact with each)?

| Not | | | | | | | | The entire |
| At all | | | | | | | | session |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

3. Tell me your **thoughts** about your use of immediacy in this session.

4. Tell me your **reasons** for using immediacy in this session.

5. How do you think the **client responded** to your use of immediacy in this session?

6. What were some of your **personal reactions** (i.e. feelings, thoughts, pulls) towards the client today?

7. What part of your reactions today do you feel typify the **reactions of others toward** this client and what part might you consider your own **countertransference** issues?

Appendix H

Client Post-Session Measure – Helpfulness

Client Code: _____

CPSM – Helpfulness

Please be as **HONEST** as you can when answering the following questions. Your responses will not be shared with your therapist, so please be as candid and open as you can be about your experiences today.

1. What did your therapist do or say in today's session that was **helpful?**

2. What did your therapist do or say in today's session that was **less helpful** or what do you **wish your therapist had done or said today** that he did not?

Appendix I

Immediacy Components Measure – Therapist

	Therapist Actions	Examples
1	No immediacy related actions	
2	TH provides client immediate *behavioral feedback* (i.e., direct observation of something happening in the room)	"You seem softer today."
3	TH inquires about or encourages client to directly express thoughts or feelings about something **immediate between CL and TH or in TH/CL relationship**	"I wonder how that is happening in here between you and me?" "What's scary about sharing that with me?" "What's it like for you to not know what I'm thinking when I'm being quiet?"
4	TH uses MODERATELY self-involving statement about his internal immediate experience – feelings, thoughts, and action tendencies	"I am confused about what you're telling me" "I'm concerned about your silence"
5	TH uses INTIMATE/INTENSE self-involving statement about his internal immediate experience – feelings, thoughts, action tendencies	"I feel closer to you when you share your feelings with me that way." "I think that you're special" "It's very important to me that you know I care for you."
6	TH says he will change a behavior the client found offensive/hurtful (i.e., TH points out what he could have done differently in their interaction)	"In the future, I will try to be more cautious of your feelings."
7	TH makes a link between their current interaction and the client's other interpersonal interactions outside of therapy	"The struggle we just got into sounds like how you described what happens with your father."
8	TH provides education around process of immediacy (i.e., rationale, therapist provides explanation of corrective emotional response)	"I'm going to talk about what happens between us because it will help us understand what happens for you in other relationships."

Immediacy Components Measure – Client

	Client Tasks	**Example**
1	Nothing related to immediacy	
2	CL expresses immediate **thoughts or feelings** to TH about TH or TH/CL relationship	"I feel scared right now telling you this stuff."
3	CL expresses immediate wish, want or need in relation to the TH (i.e., about the therapist)	"I wish you understood me."
4	CL acknowledges that s/he perceives the CL/TH interaction to parallel other similar interactions outside therapy	"Hmm…that's interesting that you say that. My mother has always tried to control me as well."

Appendix J

Client Involvement Scale

1	Uninvolved	• No mention of feelings at all • Does not respond or provides material that is tangential to the topic at hand • Actively blocking therapist's direction, doesn't follow in direction that the therapist is suggesting to go • Client actively opposes self-understanding in response to the material brought up by counselor ("I don't even want to think about that")
2	Slightly Involved	• Intellectualizing – translates emotions into cognitions ("although I may have had angry feelings they were because of X"), also could be informational or closed responses (yes/no) • Client laughs to cover affect • Client material is other focused ("they feel X") and very vague • Client acknowledges therapist's direction but goes in a different direction • Client doesn't report any self-understanding in material, may report material in a matter of fact way
3	Moderately Involved	• Indirect indications of emotional experience (discusses being down without saying was hurt; uses profanity instead of saying was angry; lists worries but doesn't say is worried) • Client talks about self in a removed way and focuses somewhat on other people (i.e., storytelling) • Client follows therapist's direction somewhat or follows direction but does not elaborate • Client expresses a willingness to understand self or motives ("I just don't understand why I do that")
4	Involved	• Client reports experiencing feelings using emotional words (may tear up, raise voice, anxiety might be present) and I statements ("I feel X") • Client is focused on self and describes material in some detail but is still somewhat vague • Client follows therapist's direction and elaborates on material, but does not deepen • Client agrees with counselor's insights and/or may add new material but does not add new connections
5	Completely Involved	• Client reports experiencing feelings (current or past) using emotional words with tears, direct expression or anger, fear or other feelings present • Client clearly focused on self, reporting real life events in specific detail with identifiable people, specific actions and specific events • Client follows therapist's direction and deepens material • Client verbalizes self-understanding and makes connections between feelings, thoughts and behaviors, and provides historical references and/or examples

Appendix K

Recruitment Email

Dr. XXXX -

My name is Laura Kasper and I am one of Clara Hill's advisees in the Counseling Psychology Doctoral Program at the University of Maryland. Clara suggested I contact you to see if you would be willing to send the advertisement listed below to your Family Studies Graduate Program's listserve. The research is for my dissertation and the therapist in the study is a faculty member in our program. I appreciate you considering my request. Please let me know if you are willing to send this along, and if you have any questions feel free to contact me via email or at the number listed below. Thank you for your time and consideration.

Sincerely,

Laura B. Kasper

FREE psychotherapy: Research participants needed

We are looking for adults between the ages of 25 and 50 who are interested in being research participants in a psychotherapy study. The selected participant would receive between 12 to 15 sessions of free individual psychotherapy from a psychologist (Ph.D.) with 20 years of clinical experience in exchange for his or her participation in the research project. We are interested in individuals who want to work on interpersonal problems. All participant information will be kept completely confidential. The Institutional Review Board of the University of Maryland has approved this study. If you are interested, please contact Laura B. Kasper, M.A., Doctoral Candidate in Counseling Psychology at the University of Maryland at either lbkasper@wam.umd.edu or 202-487-6340.

Laura B. Kasper, M.A.
Doctoral Candidate
Counseling Psychology
University of Maryland
CAPS Department
3214 Benjamen Building
College Park, MD 20742
p: 202.487.6340
f: 301.405.9995

Appendix L

Telephone Screening Interview Form

Telephone Screening Interview Form

"Hello. My name is Laura Kasper and I am a Doctoral Candidate from the Counseling Psychology program at the University of Maryland. Before we begin the telephone interview today, I would like you to formally give me your consent to participate in this interview. Before we can do that, I need to give you some more information about the study, your rights as a research participant, and give you a chance to ask any questions you might have to help you make an informed decision about your participation.

As I stated in my email, I will be asking you some personal questions today, including demographic, mental health history, and schedule availability information. All of the information you have provided to me thus far and that you provide to me today will be kept completely confidential. However, I need you to be aware of certain limits to your confidentiality. I need you to be aware that if, during this interview today, you communicate any imminent intent to harm yourself or others, or if you report any current or past child abuse, that I am required by Maryland state law to break your confidentiality. I will discuss these issues with me before breaking your confidentiality, and will give you the option of addressing the issues yourself with my assistance. If these steps need to be taken, I will need to involve Dr. Clara Hill, the faculty advisor on this project. I also want to advise you that you are free to choose not to answer any of the questions I ask you today or to stop this interview at anytime.

We are looking for individuals who can participate in up to 15 weekly individual psychotherapy sessions, provided free of charge by a clinician with 20-years of experience. If selected, your time commitment would be about one and a half hours per week for up to 15 weeks. If selected we will ask you to fill out a few questionnaires before treatment, before and after every session, and one week after treatment is over. We will also ask you to fill out some additional measures three months after the treatment is over. All of the sessions will be videotaped and I will observe the sessions. My research assistants and myself, who are all bound by confidentiality, will view the tapes and the measures you complete. I will ensure that no one involved in the project knows you personally and anonymous identification codes will be used on all the tapes and measures you complete. I also need you to be aware that under no circumstances will you be able to continue seeing the therapist in the study privately, even if you are willing and able to pay for his or her services.

I want to remind you that if you are initially eligible for the study based on this telephone conversation, you will need to participate in a 30-minute in-person interview to determine your final eligibility. All the answers to the questions you provide during that interview will also be kept completely confidential, with the same limits I explained earlier. If at any point you are not selected to participate in this study, it doesn't mean you aren't a

suitable candidate for psychotherapy, but only that you do not meet the inclusion criteria for this particular study.

Do you have any questions for me about the project at this point?

Based on everything I have just reviewed with you, are you willing to give your verbal consent to participate in this telephone interview today?

Now we will begin."

Date _____

<u>Identifying and Demographic Information</u>

Name _____

Female ___   Male ___   Age_____   Race/ethnicity _____

Occupation: _____

<u>Phone number</u>:
Home _____   Work _____

1) Where did you hear about this study? _____

2) Why are you interested in participating?

    _____

    _____

3) Tell me what your primary goal is for counseling?

    _____

    -

    _____

    _____

    (If did not identify interpersonal problems in either #2 or 3, Refer)

4) Are you currently in any type of counseling or psychotherapy? Yes____ No ____ (If

Yes, refer)

5) Have you ever consulted a psychologist, therapist, social worker, counselor, or

psychiatrist for any problem? If YES, tell me about that a bit?

6) Have you ever been hospitalized for mental or emotional problems? Yes __ No __

If Yes, when and for what reason? (If within last 5 years, refer)

7) Have you ever had suicidal thoughts or ideation? Yes __ No __

If Yes, when? (If within last 5 years, refer)

8) Are you currently taking any medication for emotional problems? Yes ___ No ___

If Yes, what and how long?

_____

(If Yes and less than two months, refer)

9) How many times a week do you drink alcohol? _____

10) How much do you drink each time? _____ (If > or = 3 drinks, refer)

11) Do you use any other drugs? Yes ___ No ___ (If Yes, refer)

12) Are you at all concerned about your drug or alcohol use? Yes ___ No ___ (If Yes,

refer)

13) Have you ever binged or purged? Yes ___ No ___

If Yes, when was the last time (If within last 2 years, refer)

14) Have you ever restricted your food intake? Yes ___ No ___

If Yes, when was the last time (If within last 2 years, refer)

15) Are you comfortable talking with your therapist about your relationship? Yes _____

No _____ (If Yes, refer).

16) Do you have reliable transportation to the College Park campus once a week between now and May 31, 2004?   Yes ___ No ___ (If <u>No</u>, refer)

17) Do you plan to be out of town for more than one week between now and the end of

_____, or can you think of anything else that might interfere with your

participating in this study for up to 15 weeks, with an end date no later than May 31,

2004? _____

19) How would you rate your motivation for participating in the study on a 1-10 scale,

where 1 = not at all and 10 = extremely motivated? ___ (If < 6, refer)

20) Are you willing to be videotaped? Yes ___ No ___ (If <u>No</u>, refer)

<u>Checklist</u>:

___ passes criteria for talking with therapist about relationship

___ passes criteria for primarily interpersonal problems

___ not in current therapy

___ not hospitalized recently for mental or emotional problems

___ no alcohol or drug abuse

___ not on psychotropic medication, or stabilized for 2 months on medication

___ no eating disorder

___ no suicidal potential

___ available with transportation over duration of study

___ motivated

___ willing to be videotaped

<u>Script for referral</u>: "I'm sorry, but you are ineligible to participate in this study. For

research purposes, we are looking for a specific type of person. However, you seem

like you'd be an appropriate candidate for psychotherapy. I have some referral

information for you."

If participant is faculty/staff: EAP unit of Health Center 301.314.8184

All others: Maryland Psychological Association referral service, 410.992.4258

Script for initial acceptance: "You meet the initial eligibility criteria and I'd like to

schedule you for a 30-minute in-person interview with me. Can we do that now?"

Interviewer Impressions:

Appendix M

In-Person Screening Interview Consent Form

In-Person Screening Interview Consent Form

I understand that the interviewer will be asking me some personal questions today about the types of things I would like to work on in psychotherapy.

I understand that all of the information that I provide during this interview today will be kept completely confidential. I am also aware, however, that there are certain limits to the protection of my confidentiality. I am aware that if, during this interview today, the interviewer determines that I pose an imminent threat to myself or others, or if I report any current or past child abuse, that the interviewer is required by Maryland state law to break my confidentiality. I understand that the interviewer will discuss these issues with me before breaking my confidentiality, and that I will have the option to address the issue myself with the interviewer's assistance. I am aware that if these steps need to be taken, the interviewer will need to involve Dr. Clara Hill, the faculty advisor on this project.

I am aware that I am free to choose not to answer any of the questions I am asked today or to stop this interview at anytime.

I have had a chance to ask any questions I have about this interview. I understand that by signing this form, I am acknowledging that I have read and understand the above material.

_____   _____
Printed Name of Participant   Signature of Participant and Date

_____
Signature of Project Director and Date
Laura B. Kasper, M.A.

Approval period of project: January 1, 2004 through December 31, 2004

Appendix N

Participant Consent Form

Participant Consent Form

Project Title: Events in Psychotherapy

Project Directors: Clara E. Hill, Ph.D., Department of Psychology, University of Maryland, 301-405-5791, hill@psyc.umd.edu; Laura B. Kasper, M. A., Department of Counseling and Personnel Services, University of Maryland, 202-237-5463, lbkasper@wam.umd.edu

Purpose of research: The purpose of this project is to understand the therapist actions and client tasks involved in events in psychotherapy, to examine the relationship between these events, involvement, and interpersonal patterns.

Procedures: If I agree to participate in this study, I am aware that I will be participating in between 12 to 15, 50-minute sessions of individual psychotherapy. Before the first session, I will be asked to complete the Outcome Questionnaire 45.2, the Inventory of Interpersonal Problems, and the Self-Understanding of Interpersonal Patterns-Revised. Before each session, I will be asked to complete the Outcome Questionnaire 45.2. After each session, I will be asked to complete the Session Evaluation Questionnaire – Depth, the Event Recall Questionnaire, and the Working Alliance Inventory. One week after my last session I am aware that I need to come in to complete the Outcome Questionnaire 45.2, the Inventory of Interpersonal Problems, and the Self-Understanding of Interpersonal Patterns-Revised. Three months after my last session, I am aware that I need to come in to complete the Outcome Questionnaire 45.2, the Inventory of Interpersonal Problems, and the Self-Understanding of Interpersonal Patterns-Revised.

I acknowledge that by agreeing to participate in this study, I understand that this study involves as few as 12 and at most 15, 50-minute individual psychotherapy sessions, and the completion of a set of follow-up measures three months after termination. I understand that I am free to withdraw my participation at any time and that I will receive free psychotherapy in exchange for my participation in this project. I understand that all information will be kept completely confidential at all times and that I will be assigned a code number to protect my identity. I also understand there are circumstances under which my therapist is legally obligated to break my confidentiality, such as if I am in imminent danger of harming myself or others, or there is discussion of past or current child abuse. Only those people approved by the research team will have access to the data, which will be kept in a filing cabinet in a locked room under the responsibility of Dr. Clara Hill. I am aware that the research team will be viewing the videotapes of my sessions and analyzing the measures I have completed, and that the researchers will ensure that no one involved in the project knows me personally. I also understand that these materials will be used for publication of the research, but that my identity will be protected.

I am aware that this study is not designed to help me personally or for treatment purposes, but the investigator seeks to learn more about events in psychotherapy. Although I might experience personal growth from these sessions, I am also aware that there is a small possibility for deterioration in any psychological intervention (estimates in the research are about 5%). I am aware of this slight possibility and realize that at any time I am free to withdraw participation with no prejudice or penalty. I also realize that if the therapist or researcher judges that the study is having a harmful effect, it will be stopped and I will be referred to Dr. Clara Hill, who will determine the best course of action. If Dr. Hill is not immediately available, I will be referred to either the Counseling Center or the EAP Unit of the Health Service.

Certification: I am willing to participate in this research project being conducted by Dr. Clara E. Hill and Laura B. Kasper at the Graduate School, University of Maryland College Park, Department of Psychology.

I am over 18 years of age and in good physical health. I understand the procedures of the activity in which I am being asked to participate. I have had an adequate chance to ask questions and understand that I may ask additional questions at any time. I am aware that the results of the study can be made available to a counselor who is qualified to interpret them to me after the research project. I am participating in this project of my own free will. I will receive from 12 to 15, 50-minute psychotherapy sessions free for my participation. I am free to withdraw my consent and discontinue my participation at any time with no prejudice or penalty. I am aware that I can contact Dr. Harold Sigall, 301-405-5920, Chair of the Human Subjects Committee of the Department of Psychology, University of Maryland, about any questions regarding my rights as a research participant.

_____   _____
Printed Name of Participant   Signature of Participant and Date

_____   _____
Signature of Faculty Director and Date   Signature of Project Director and Date
Clara E. Hill, Ph.D.   Laura B. Kasper, M.A.

Appendix O

Debriefing Form

Debriefing Form

This study you have just participated in is an investigation of a particular therapist intervention called immediacy. Immediacy, according to Hill and O'Brien (1999) in their book *Helping Skills,* refers to therapists "disclosing immediate feelings about themselves in relation to the client, about the client directly, or about the therapeutic relationship" (p.32). This study is concerned with what therapists and clients specifically do during immediate discussions with one another, how these discussions impact a client's involvement in therapy, and how these discussions relate to changes in a client's interpersonal patterns.

Many theorists believe strongly that discussing the immediate experience occurring between client and therapist is valuable and beneficial to clients. However, there has been little empirical research done on whether these immediate discussions occur the way that scholars say or on what clients do during these interactions. Hence, we know very little about the process of immediacy in psychotherapy. Additionally, many scholars believe that by reenacting with the therapist the conflicts that brought clients into therapy, and by openly discussing and resolving those experiences within the therapeutic relationship, clients have a corrective emotional experience and change both internally and interpersonally. According to interpersonal theory, repeatedly experiencing the resolution of these conflicts within the therapeutic relationship facilitates emotional re-learning and allows clients to test out new behaviors within therapy and with others. There is no research, however, which examines this proposed relationship.

We hope that completing the measures and participating in the psychotherapy sessions helped you to understand yourself better. We hope that you will be able to use what you learned about yourself to improve some aspect of your life.

We realize that given the nature of short-term therapy, there might still be things you wish to talk about with someone. If you wish to continue to work on what you have learned about yourself over this study, we strongly urge you to seek out therapy. Counseling services are provided to graduate students at the Counseling Center free of charge for up to 12 visits in a calendar year. Records kept are confidential and are not part of the educational records kept by the university. The Counseling Center is located in the Shoemaker Building and can be reached at 301-314-7651. If you are a faculty or staff member, EAP Services is located in the University Health Center, can be reached at 301-314-8184, and they typically have a 3 to 4 session limit. For information about obtaining a referral to a private therapist for more extended therapy, depending on your insurance coverage and ability to pay, please contact the Maryland Psychological

Association at 410.992.4258, or contact your health insurance company for a list of participating mental health providers.

If you would like a copy of the published article (expected in about two to three years) or if you have any questions or comments regarding the study, please feel free to contact Laura B. Kasper at (202) 237-5463 lbkasper@hotmail.com or contact Dr. Clara Hill, 301-405-5791, hill@psyc.umd.edu.

If you would like more information about immediacy in psychotherapy, we recommend Teyber, E. (2000). *Interpersonal process in psychotherapy: A relational approach.* (4th ed.). Belmont, CA: Wadsworth Publishing.

Appendix P

Client Release of Information

CLIENT RELEASE OF INFORMATION

Project Title: Events in Psychotherapy
Project Directors: Laura B. Kasper, M.A. and Clara Hill, Ph.D., Department of
                         Psychology, University of Maryland, College Park

Below is a situation in which we would like to use your data if you give us permission to do so. No names or identifying information will be included. Additionally, we will make sure that no one who sees any of your materials knows you personally. Write your initials next to the statement if you give us permission to use your information for this purpose.

_____ I am willing to allow the videotapes of my sessions to be watched by advanced graduate students for training purposes, under the supervision of the therapist or the investigators from this study.

_____ I am willing to allow the videotapes to be watched by professional colleagues in psychology as long as my identity is protected.

_____ I am willing for other research teams who have been cleared by the project directors to use the data for research purposes.

I understand that by placing my initials beside the above items, I have given my permission to use the videotapes from my sessions in the manner described. I further understand that any uses beyond that indicated above require my approval in advance.

_____
Name of Participant

_____   _____
Signature of Participant   Date

Appendix Q

Therapist Release of Information

THERAPIST RELEASE OF INFORMATION

Project Title: Events in Psychotherapy
Project Directors: Laura B. Kasper, M.A. and Clara Hill, Ph.D., Department of
                             Psychology, University of Maryland, College Park

Below is a situation in which we would like to use your data if you give us permission to do so. No names or identifying information will be included. Additionally, we will make sure that no one who sees any of your materials knows you personally. Write your initials next to the statement if you give us permission to use your information for this purpose.

____ I am willing to allow the videotapes of my sessions to be watched and transcripts to be read by advanced graduate students for training purposes, under the supervision of the therapist or the investigators from this study.

____ I am willing for other research teams who have been cleared by the project directors to use the data for research purposes.

I understand that by placing my initials beside the above items, I have given my permission to use the videotapes from my sessions in the manner described. I further understand that any uses beyond that indicated above require my approval in advance.

_____

Name of Participant

_____   _____

Signature of Participant   Date

Appendix R

Immediacy Rating Form

Immediacy Rating Form (sample)

Speaking Turn	TH/CL rating
T1	
C1	
T2	
C2	
T3	
C3	
T4	
C4	
T5	
C5	
T6	
C6	
T7	
C7	
T8	
C8	
T9	
C9	
T10	
C10	
T11	
C11	
T12	
C12	
T13	
C13	
T14	
C14	
T15	
C15	

Appendix S

Client Involvement Rating Form

Speaking Turn	TH/CL rating
C1	
C2	
C3	
C4	
C5	
C6	
C7	
C8	
C9	
C10	
C11	
C12	
C13	
C14	
C15	
C16	
C17	
C18	
C19	
C20	
C21	
C22	
C23	
C24	
C25	
C26	
C27	
C28	
C29	
C30	

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