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Therapeutic Immediacy in Psychodynamic Psychotherapy for Depression: A Mixed-Method Study

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This exploratory study assesses the use and quality of therapeutic immediacy in short-term psychodynamic psychotherapy for depression. We aimed to identify what constitutes effective here-and-now discussions of the therapeutic relationship by examining a sample of four treatment cases drawn from a previous randomized clinical trial for depression. Transcripts of 16 treatment sessions (four time points per treatment) were analyzed using the consensual qualitative research for case study method. The therapists' contributions to therapeutic immediacy were assessed qualitatively by independent judges and then quantitatively analyzed in relation to immediate session outcome as well as overall treatment outcome (reduction in depressive symptoms). A total of 41 immediacy events were identified across 16 sessions, of which 35 were therapist-initiated and subsequently organized into 18 discrete categories. High-quality immediacy events (as assessed by the judges) were associated with higher patient involvement. Two immediacy categories were significantly different between good and poor outcome cases. Therapists "acknowledged their patient's progress in therapy" more often in good outcome cases, whereas they "assessed patients' feelings about the overall progress of therapy" more often in poor outcome cases. No significant relationship was found between frequency, rated quality of immediacy events, and treatment outcome. Four immediacy events rated by the judges as high- and low-quality are presented as clinical examples illustrating positive and negative therapists' contributions to therapeutic immediacy. Therapist behaviors that may improve the effectiveness of therapeutic immediacy are discussed.

Clinical Impact Statement

Question: What characterizes successful therapeutic immediacy in psychodynamic therapy for depression? ***Findings:*** Effective immediacy interventions are characterized by keeping the patients highly involved by encouraging them to express feelings about the treatment and the therapist. No relationship was found between frequency, rated quality of immediacy events, and treatment outcome. ***Meaning:*** The results illustrate what constitutes a successful immediacy intervention in the context of a session and identifies different types of immediacy interventions associated with good and poor treatment outcomes. ***Next Steps:*** Our results suggest several hypotheses about possible effective and ineffective therapist behaviors within therapeutic immediacy that may be tested in larger scale research and could potentially lead to clinical implications for psychodynamic treatments for depression.

Keywords: immediacy, consensual qualitative research, depression, interpersonal, psychodynamic

Supplemental materials: https://doi.org/10.1037/pst0000452.supp

According to psychoanalytic, and more recently, interpersonal theory, patients bring their relational patterns and interpersonal problems into their therapy sessions (Freud, 1993; Safran & Muran, 2000). In psychodynamic treatments, the therapist often aims to make these interpersonal processes explicit (Crits-Christoph & Gibbons, 2001) to enhance treatment effectiveness. Often, the therapist will work to illuminate patients' patterns of relational struggles by facilitating a discussion about the patient–therapist relationship in the here-and-now of a session, an intervention known as "therapeutic immediacy."

The origins of therapeutic immediacy can be identified within the principles of "therapeutic metacommunication" (Kiesler, 1988), a

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therapy intervention which involves the therapist inciting an open and direct discussion with their patient about the nature of their interactions. This intervention operates under the framework of interpersonal psychotherapy, wherein the therapist self-discloses their experience of the patient in hopes to bring the patients' relational dynamics into conscious awareness (Kiesler, 2001). This intervention aims to bring attention to the patients' "maladaptive transaction cycle," which unfolds in four stages wherein the therapist notices (a) their covert experience of the patient, (b) their overt reaction to the patient, (c) the patients' overt reaction to the therapist, and finally (d), the patient's covert experience of the therapist (Kiesler, 1996).

Hill (2004) later introduced the concept of "therapist immediacy" as defined by therapists' disclosures in the here-and-now of the session, most often consisting of their feelings toward the patient or about the therapeutic relationship. While therapist immediacy aligns with the intervention of therapeutic metacommunication by working to promote awareness about the patients' problematic interpersonal patterns, therapist immediacy also aims to provide a corrective emotional experience for the patient.

More recently, the term "therapist immediacy" has evolved into the more general conceptualization of "therapeutic immediacy," described as a dyadic and interactive process that includes any disclosures about the here-and-now relationship by either the therapist or the patient (Hill et al., 2014, 2018; Kuutmann & Hilsenroth, 2012; Mayotte-Blum et al., 2012). In theory, therapeutic immediacy is a therapist-facilitated process wherein the therapist encourages the patient to openly explore their concerns or perspectives about the therapeutic relationship in hopes to ultimately revise, repair, or otherwise examine facets of the dyad, potentially providing them with a model for interpersonal conflict resolution and effectiveness outside of the therapy (Hill et al., 2014).

Focusing on maladaptive interpersonal patterns within the therapy process may be particularly relevant for treating symptoms of depression. Poor intimate relationships are characteristic of major depressive disorder (Zlotnick et al., 2000). Highly depressed individuals tend to report various interpersonal problems, such as finding social interactions less enjoyable, finding it difficult to be sociable, assertive, or intimate, all of which has been found to cause significant distress (Triscoli et al., 2019). The interpersonal theory of depression suggests that people with depression potentially reinforce their symptoms by engaging in unhelpful interpersonal behaviors or perpetuating dysfunctional relational patterns, that is, "the depression vicious cycle" (Blatt, 2004; Hames et al., 2013; Joiner & Timmons, 2002; Kuprian et al., 2017). Clinical research offers some support for this theory, in that the negative quality of interpersonal relationships can significantly predict depression (Majd Ara et al., 2017), and the severity of depression can predict the degree of interpersonal problems (Triscoli et al., 2019). While there is a body of research on depressed patients and their interpersonal problems outside the therapeutic setting (Barrett & Barber, 2007; Blatt, 2004; Hames et al., 2013; Joiner & Timmons, 2002), how maladaptive interpersonal patterns of these patients could be effectively addressed by the therapist via the intervention of therapeutic immediacy in psychotherapy treatment sessions remains unclear.

Empirical Studies on Therapeutic Immediacy

The empirical study of therapeutic immediacy in psychodynamic treatments is still in its early stages, and to the best of the authors' knowledge, no studies to date have specifically focused on patients diagnosed with major depressive disorder. Five empirical studies have examined the clinical utility of therapeutic immediacy in psychodynamic interpersonal psychotherapy at university-based clinics. Three of these were qualitative case studies (Hill et al., 2008; Kasper et al., 2008; Mayotte-Blum et al., 2012). The fourth study used a mixed-method design in 16 adults receiving psychotherapy in an outpatient community mental health clinic to investigate the use and perceived effects of therapeutic immediacy (Hill et al., 2014). Based on follow-up interviews with patients, Hill et al. (2014) found that immediacy was generally positively correlated with session processes and outcomes, and patients indicated that they remembered and benefited from immediacy interventions. The fifth study (Shafran et al., 2016) was a quantitative follow-up study on the same sample of 16 patients, which reported a positive effect of immediacy on patient-reported session outcomes. They reported that higher frequencies of immediacy events in the beginning of the treatment were associated with a lower patient-rated therapeutic alliance, while higher frequencies of immediacy events late in the treatment were associated with a higher patient-rated therapeutic alliance.

Prior research has found therapeutic immediacy to result in patient reactions that are both positive and negative. Overall, these five empirical studies reported that therapeutic immediacy is a useful therapeutic intervention that provides several therapeutic benefits, such as facilitating the patients' ability to experience and express painful feelings, providing a corrective emotional experience, allowing therapists to validate their patients' feelings, addressing alliance ruptures, and helping to establish boundaries (Hill et al., 2008; Kasper et al., 2008; Mayotte-Blum et al., 2012). In a recent qualitative meta-analysis, Hill et al. (2018) identified the most frequently occurring processes following therapeutic immediacy: an enhanced therapy relationship, patients opening up, and overall helpfulness. Kasper et al. (2008) assessed patient involvement in the context of immediacy speaking turns and found that patient involvement was slightly higher before and after immediacy, compared to during immediacy. However, they concluded that analyzing speaking turns lacked clinical richness, leaving the role of patient involvement in therapeutic immediacy unclear. Some of the findings from these studies indicated that in certain cases, therapeutic immediacy may not have a positive impact as it may bring up negative feelings in patients about the session or the therapist. One case study of therapeutic immediacy in a brief psychotherapy treatment reported that in a posttreatment interview, the patient revealed they felt discomfort when pressured to respond to therapists' immediacy interventions (Kasper et al., 2008). Hill et al. (2014) also identified neutral or negative effects of therapeutic immediacy during the session up to 30% of the time, and in these instances, patients reported feeling worse, blamed, attacked, confused, or pressured.

Given these mixed findings, the question of what constitutes successful and unsuccessful immediacy events arises. Therapeutic immediacy appears to be a nuanced intervention which warrants appropriate clinical judgment and expertise, including careful consideration of the content, timing, appropriateness, relevance, and ability to engage the patient in an evocative and therapeutically productive conversation.

The Aim of the Present Study

To ascertain what constitutes an effective therapeutic immediacy intervention in psychodynamic psychotherapy for depression, we aimed to address the following exploratory research questions: (a) What is the frequency of therapist-initiated therapeutic immediacy in this psychodynamic treatment of depression? (b) Which categories of therapist-initiated therapeutic immediacy can be identified in this psychodynamic treatment of depression? (c) What characterizes a "high-quality" therapeutic immediacy in the context of a session? Specifically, which categories of therapist-initiated therapeutic immediacy correlate with higher or lower quality ratings? (d) How do the categories, frequencies, patient involvement, and quality of therapeutic immediacy in-session differ between good versus poor treatment outcomes? (e) What do higher and lower quality therapeutic immediacy events look like in good and poor outcome cases?

To address these research questions, we aimed to conduct a systematic qualitative analysis to evaluate the use and quality of therapeutic immediacy events in a previous randomized clinical trial (RCT) of a brief psychodynamic treatment for depression (Barber et al., 2012). By first identifying various categories of therapeutic immediacy, we will be able to conduct a quantitative analysis to assess the association of various types of therapeutic immediacy with its rated quality. Additionally, we will be able to compare instances of therapeutic immediacy in treatments that were assessed as having good and poor treatment outcomes (i.e., reduction in depression symptoms).

In line with previous immediacy research, we aimed to assess the frequency of therapeutic immediacy, as well as the emerging types or categories of therapeutic immediacy. For this study, we were most interested in therapist-initiated immediacy to identify potential therapist skills, and because the majority of therapeutic immediacy events are therapist-initiated (Hill et al., 2014). However, because immediacy is defined as a dyadic process, and oftentimes therapist immediacy pulls for patient-initiated immediacy, we included patient-initiated immediacy events in the Supplemental Material for descriptive purposes. The skillfulness of interventions was assessed through measures of the quality of therapeutic immediacy that were based on scales used in previous studies (Hill et al., 2008, 2014; Kasper et al., 2008) and of patient involvement (Kasper et al., 2008).

Method

Patients

The sample of four cases presented here was drawn from an RCT for patients diagnosed with major depressive disorder (Structural Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, fourth edition [DSM-IV]*; First et al., 1995) conducted at the University of Pennsylvania (treatments for depression; Barber et al., 2012). In this RCT, depressed patients were randomly assigned to receive one of three treatments: an active medication (selective serotonin reuptake inhibitors [SSRI]), a placebo pill, or supportive–expressive therapy (SET; Luborsky, 1984; Luborsky et al., 1995).

This post hoc analysis[1] is based on the SET arm of the clinical trial; 51 patients participated in a brief 16-session psychodynamic psychotherapy for depression, 33 of whom completed the treatment. Of the 33 completed treatments, seven patients could not be considered for this post hoc study due to unusable video recording of sessions, and four could not be included because they did not have a main outcome score (Hamilton Rating Scale of Depression [HRSD]; Hamilton, 1960) at Week 32 that was used to define treatment outcome, resulting in a usable sample of 22. Compared to dropouts, treatment completers had lower baseline depression severity on the HRSD (Hamilton, 1960; completers: $M = 18.97$, $SD = 3.63$; dropouts: $M = 21.39$, $SD = 4.01$); $t(49) = -2.19$, $p = .03$, $d = 0.63$. Among patients who completed treatment, included and excluded patients did not differ in baseline depression severity (included: $M = 18.50$, $SD = 3.97$; excluded: $M = 19.91$, $SD = 2.77$); $t(31) = -1.05$, $p = .30$. Out of the 22 treatment completers with usable session recordings, four cases from two therapists were selected based on their treatment outcome. The choice of four cases is more than required for consensual qualitative research for case study (CQR-C; e.g., Jackson et al., 2012) but in line with other psychotherapy studies in which process was compared across multiple treatments (e.g., Hill et al., 2020). Specifically, from the sample of 22 patients who had available video and outcome data, we selected the two patients with the best treatment outcomes to resemble a "good outcome" and the two patients with the poorest treatment outcomes to resemble a "poor outcome." The two "good outcome" cases had a superior outcome on the HRSD (Hamilton, 1960) in terms of achieving remission at the end of active treatment (Week 16) and sustaining at follow-up (Week 32). The two "poor outcome" cases did not achieve remission and demonstrated the least change in depression symptoms from baseline to the end of active treatment and at follow-up. Table 1 illustrates each patient's demographic characteristics and their treatment outcomes. Of these four patients, three were men and one was a woman, two were Caucasian, one African American, and one Hispanic, and their ages ranged from 23 to 56 years.

Therapists

For this qualitative study, we examined recorded treatment sessions from two (Therapists A and B) of the four therapists who conducted SET in the RCT. In contrast to the other two therapists, these two therapists had a poor outcome case, as well as a good outcome case within the available sample of 22 treatment completers. Both therapists were female, Caucasian, between the ages of 40 and 50 years old, were doctoral-level clinical psychologists, each with over 15 years of experience providing psychodynamic psychotherapy, with at least 10 years of experience providing SET.

Main Outcome Measures

The HRSD (Hamilton, 1960), an observer-rated 17-item measure of depression severity, was used as the primary outcome measure in the RCT (Barber et al., 2012). The HRSD was administered at intake and throughout the course of therapy (Weeks 2, 4, 6, 8, 12, 15, 16, and at booster sessions). The raters were six master's or doctoral-level diagnosticians. Interrater reliability in the trial was good (intraclass correlation [ICC] of .92). In the RCT, remission was defined as the absence of a diagnosis for major depressive disorder according to the Structured Clinical Interview for *DSM-IV* (First et al., 1995) *and*

[1] The present study and analyses were not preregistered. The original RCT was registered (NCT00043550).

Table 1
Patient Demographics and Treatment Outcomes

Therapist	Patient	Demographic profile	HRSD pre	HRSD post (Week 16)	HRSD follow-up (Week 32)	Outcome
Therapist A	Patient 1	White male, 23, college student	19	8	7	Good
	Patient 2	White male, 49, unemployed	16	13	13	Poor
Therapist B	Patient 3	Hispanic male, 39, driver	20	0	0	Good
	Patient 4	African American female, 56, unemployed	15	15	14	Poor

Note. HRSD = Hamilton Rating Scale of Depression (Hamilton, 1960).

HRSD score < 8 at the end of the 16-week treatment (Barber et al., 2012).

Treatment

SET (Luborsky, 1984) is a manualized 16-week psychodynamic treatment that focuses on the exploration of patients' interpersonal difficulties, by increasing awareness of repetitive patterns in their relationships (core conflictual relationship themes). The therapist attends to the patient's past and current relationships with others, including the therapist, and identifies common themes across these relationships that may be associated with psychological symptoms. SET was chosen for this research study due to its interpersonal focus, as well as its opportunity to organically incorporate the intervention of therapeutic immediacy. For this study, a modified version of the manual was used: SET for depression (Luborsky et al., 1995). Each SET session was 45–50 min in length, provided twice a week in the first 4 weeks, and then weekly for the following 12 weeks of treatment. After the end of treatment (Week 16), four follow-up "booster" sessions occurred between Weeks 16 and 32.

Judges

Following other publications using CQR (Hill, 2012) and guidelines on CQR-C, five judges as well as an auditor participated in the qualitative process analyses of the transcripts. All judges were females, four were Caucasian, and one was African American. Two judges were senior undergraduate psychology students and three were clinical psychology graduate students (two masters' level and one doctoral level). Their ages ranged from 22 to 35 years old. All judges were informed of the focus of this study but were unaware of the study's hypotheses as well as the treatment outcome of the cases.

In addition to the team of judges, we also included an auditor (as per CQR methodology). The auditor was a female, Caucasian, clinical psychologist who was 35 years old. The auditor became familiar with the cases through reading transcripts of the sessions analyzed in this study but did not familiarize themself with the full treatment data. Their role was to ensure adherence to the CQR-C method, as well as provide an additional perspective to reduce the impact of group-level bias (Hill, 2012). The auditor did not participate in the consensus meetings but reviewed transcripts and consensus ratings afterward to provide feedback.

Procedure

From the treatments of each of the four selected cases, four transcribed sessions were analyzed: Sessions 2, 4, 8, and the second-to-last session, resulting in a total of 16 sessions. These sessions were specifically chosen to reflect ongoing SET therapy. The first and last sessions were not chosen because these sessions would likely focus on treatment orientation or termination rather than reflect an ongoing therapy process. The inclusion of four treatment sessions per patient was intended to provide sufficient depth of qualitative exploration in the context of each patient case while providing enough therapeutic differences to identify variations in therapeutic encounters.

Patients were de-identified in the original RCT. Each patient was assigned a four-letter combination to label each session tape and subsequent transcripts. Any identifiable information was removed during the transcription process in accordance with the guidelines described by Mergenthaler and Stinson (1992). The 16 treatment sessions were transcribed verbatim by undergraduate research assistants and double-checked for confidentiality and accuracy by doctoral students from the same research lab.

Given the case study nature of our data, we applied the CQR method modified for case studies to examine individual occurrences of therapeutic immediacy (CQR-C; Hill et al., 2011, 2020; Jackson et al., 2012). CQR is a systematic qualitative methodology used in psychotherapy research (Hill, 2012). This method emphasizes discussion and multiple viewpoints to achieve more trustworthy judgments than if the judges were to rate and code therapeutic immediacy independently (Hill et al., 2014). CQR-C is a method that offers rigor and depth in the examination and description of complex science phenomena (Jackson et al., 2012). In contrast to CQR, the CQR-C method does not rely on calculating reliability statistics and averaging independent judges' scores on existing rating systems. Instead, CQR-C invites an in-depth discussion among team members to reach consensus judgment on a domain of interest. Each member's experience is thus incorporated into a constructive understanding of a particular phenomenon. When CQR-C is applied to several cases, data from events can be summarized within and between cases. To date, precursors of the CQR-C have been reported in several case studies (e.g., Hill et al., 2011; Kasper et al., 2008). As described by Jackson et al. (2012), our CQR-C procedures involved the following four steps: (a) selecting a team of five judges, gaining familiarity with the case, defining events of interest, and developing domains; (b) data collection: reading of psychotherapy session transcripts, identifying immediacy events (segment in a therapy session during which the phenomenon transpires), code events according to each predetermined domain, repeating this process until all events have been identified and coded. Noting frequency counts for each category to help indicate the frequency of occurrence of the immediacy event relative to other categories, labeled as general, typical, or variant; (c) cross

analysis: creating a summary table; developing categories of domains, triangulating event data with other case data (e.g., quantitative outcomes); (d) developing a narrative that answers our research questions; a joint final conceptualization based on separate individual conceptualizations of the data.

All judges attended a 1-day training in identifying therapeutic immediacy while adhering to the generalized principles of the CQR method. Prior to the 1-day immediacy training, judges were given a definition of therapeutic immediacy as described in the literature (Hill et al., 2014; Kuutmann & Hilsenroth, 2012) and were asked about their preexisting biases and perspectives regarding immediacy and its effectiveness in treatment.[2]

Each of the judges received training materials on CQR in the form of book chapters, published articles (Hill, 2012; Hill et al., 2005), PowerPoint slides from CQR workshops, and training videos. They were then given a training transcript (not used as part of the analysis) to independently identify immediacy events and rate their quality independently using the five 5-point Likert scales used in this study. The judges discussed the identified events in their training and compared their quality ratings until all disagreements had been resolved and consensus was achieved.

Post Hoc Process Measures

Identification of Immediacy Event

For this post hoc exploration of the therapy process, we attempted to remain as close as possible to the observable dyadic process without committing to specific theoretical assumptions as to why and by whom these moments of therapeutic immediacy were initiated. Hill advocates that the judges should be provided with as much context about the treatment cases as possible (Hill et al., 2005 and from personal correspondence); resulting in each judge watching a tape of the first session for each of the four cases, prior to rating the selected four sessions of those treatments (i.e., Sessions 2, 4, 8, and second-to-last). Prior to consensus meetings, each judge was asked to watch a tape of a session while reading the transcript of this session, identifying, and rating all immediacy events.

To reflect the interactive nature of the process and yield the most clinically meaningful results (Hill et al., 2008), we chose to use "immediacy event" as our analysis unit as opposed to participants' speaking turns as done by Kasper et al. (2008). In line with previous research, we operationalized "a therapeutic immediacy event" as "discussions and disclosures of feelings regarding the therapist–patient relationship in the here-and-now of the session," starting when these discussions began and ending when the conversation shifted to another topic (Hill et al., 2014; Mayotte-Blum et al., 2012).

In-Session Quality of Immediacy

After identifying a therapeutic immediacy event, the judges examined its effectiveness in-session. Based on previous studies on therapeutic immediacy, the quality of immediacy events was rated across five aspects (Hill et al., 2008; Kasper et al., 2008). Each immediacy event was rated on "depth,"[3] defined as how intensely participants express immediate feelings (Hill et al., 2008, 2014), "appropriateness,"[4] defined as appropriateness in the context of the case (Hill et al., 2014), "helpfulness,"[5] renamed from "resolution" as in Hill et al. (2014), defined as helpfulness for the outcome of the session, "relevance"[6] to the session, and "timeliness"[7] in the context of the treatment. These five aspects of quality were rated on a 5-point Likert scale.

Patient Involvement

An additional process scale, "patient involvement,"[8] was added to the assessment of immediacy events. This scale is defined as "the amount of energy expended in therapy, as manifested by the patient's expression of affect, depth of self-disclosure, focus on self versus others, and responsiveness to the therapist's direction," as in Kasper et al. (2008).

Observer Codings

Identification and ratings on the quality of immediacy events within the transcribed treatment sessions followed the sequence of procedures outlined in the CQR-C manual (Jackson et al., 2012). Prior to consensus meetings, each judge independently watched a videotape of a session while reading the corresponding transcript, identifying immediacy events, then rating each identified event on observer measures described above. For each immediacy event, judges answered the following questions: (a) What is the core idea of the immediacy event? (as described in Hill, 2012); (b) Who is the initiator of the immediacy event?; (c) What is the reason the immediacy event was thought to have been initiated?, that is, role (open-ended); (d) What are the consequences of the immediacy event for the session?, that is, impact/effect (open-ended).

Consensus meetings took place once a week for a period of 8 weeks and lasted 2–4 hr each. During each meeting, two transcribed sessions were covered on average. The judges discussed whether an event could be considered therapeutic immediacy until consensus was reached. Judges then discussed their quality and involvement ratings until consensus was reached. As in Hill et al. (2008), the judges then reached consensus on the role (i.e., why immediacy was initiated) and impact (consequences of immediacy for the relationship and the session) of each immediacy event to provide context for the event. This step was intended to provide an in-depth clinical understanding of high-quality versus poor-quality rated immediacy events. In situations where consensus could not be achieved, the team deferred to the auditor, who would double-check all identified events within the transcripts and subsequently offer their perspective. This process was repeated for each of the 16 total sessions.

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[2] Judges were asked to reflect on and document their responses to the following prompts: (a) What are your thoughts about the use of therapeutic immediacy in psychotherapy?; (b) Please list some advantages and disadvantages of immediacy interventions in psychotherapy; (c) How could immediacy interventions affect the outcome of psychotherapy for depression?

[3] Ranging from 1 = *mundane, one-sided*; 2 = *minimal two-person exchange*; 3 = *longer two-person exchange lacking depth*; 4 = *prolonged two-person exchange*; to 5 = *prolonged exchange with both participants actively expressing genuine immediate feelings.*

[4] Ranging from 1 = *not appropriate at all* to 5 = *very appropriate.*

[5] Ranging from 1 = *not helpful at all* to 5 = *very helpful.*

[6] Ranging from 1 = *not relevant at all* to 5 = *very relevant.*

[7] Ranging from 1= *not timely at all* to 5 = *very timely.*

[8] Ranging from 1 = *not at all* to 5 = *very much.*

Cross Analysis

After identification and rating of the immediacy events across the 16 sessions, each judge individually reviewed all immediacy events and listed categories of therapeutic immediacy that emerged. The judges then met again to categorize all identified immediacy events through consensus and code each event according to the final list of categories that emerged from the analysis. The goal of this iterative process was to keep the categories specific enough to understand what was said without having to go back to the transcript, yet general enough to maintain categories as opposed to listing isolated events.[9] This completed the coding process of the data, resulting in a tally of therapist-initiated immediacy events and patient-initiated immediacy events, organized into categories, per case and session. Lastly, a quantitative analysis was conducted of the immediacy events' quality, involvement, and frequency, according to outcome (good vs. poor) of each case.

Results

Research Question 1: Frequency of Immediacy Events

A total of 41 immediacy events were identified across 16 sessions. Therapists initiated 35 (85.4%) events, whereas patients initiated six (14.6%) events. There was no significant difference in frequency of immediacy events between the two therapists ($p = .34$). Table 2 illustrates the distribution of immediacy events across the four cases.

Research Question 2: Categories of Immediacy Events

The judges categorized the 35 therapist-initiated immediacy events into 18 categories.[10] No category reflected every immediacy event (i.e., no general categories), and no category was coded in over half of all immediacy events (i.e., no typical categories). Thus, all individual categories were variant, in that they occurred in more than two events. The most frequently coded categories were "drawing parallels between patient's outside relationships or relational pattern and the patient–therapist relationship or interaction in the here-and-now" (10 events), "assessing patient feelings about the therapist's specific behavior/intervention" (8 events), "assessing patient's feelings about the overall progress/outcome of the treatment" (7 events), and "validating patient's feelings" (7 events).

To conceptually organize the 18 individual categories of therapist-initiated immediacy events for this article, we later qualitatively examined the overall focus of each category and identified five overarching categories for therapist-initiated immediacy events: "drawing parallels" (typical), "making space for patient's feelings" (typical), "exploring treatment progress" (variant), "exploring patients' thoughts and feelings about the therapist" (variant), and "therapist disclosing own feelings" (variant). Table 3 lists the individual categories of therapist-initiated immediacy events identified by the judges, their frequency across all four cases, as well as the five overarching categories the authors identified post hoc. Categories were not mutually exclusive given that several types of immediacy could occur within each immediacy event.

Research Question 3: Quality, Category, and Patient Involvement of Immediacy Events

As the five scales assessing in-session quality of immediacy events ("depth," "timeliness," "appropriateness," "relevance," and "helpfulness") were all highly intercorrelated (correlation coefficients ranging from .61 to .80), with a high consistency overall (Cronbach's $\alpha = .92$), these five scales were combined in an overall "mean quality" rating. The mean quality rating across all cases was high: 4.0 ($SD = .67$) and ranged from 2.4 to 5.

The two events with the highest quality ratings (5) were in category "disclosing therapist's feelings about/experience of the patient (therapist disclosing own feelings)" and category "pointing out that the patient is changing or avoiding a topic (making space for patient's feeling)." The two events with the lowest quality ratings (2.4 and 2.6, respectively) were in the categories "drawing parallels between patient's outside relationships or relational pattern and the patient–therapist relationship or interaction in the here-and-now (drawing interpersonal parallels)" and "assessing patient's feelings about the overall progress/outcome of the treatment (exploring treatment progress of patient)." The most frequently used category was "drawing parallels between patient's outside relationships or relational pattern and the patient–therapist relationship or interaction in the here-and-now (drawing interpersonal parallels)." The mean patient involvement was 3.46 ($SD = 9.5$), ranging from 1 to 5. There was a significant positive correlation between the assessed quality of immediacy events and patient involvement in immediacy events ($r = .715$, $p < .001$), indicating that more patient involvement was related with higher quality immediacy events.

Research Question 4: Treatment Outcome Versus Frequency, Quality, Category, and Patient Involvement of Immediacy Events

There was no significant difference between the frequency of immediacy events across good versus poor outcome cases, $\chi^2(40) = 41.00$, $p = .426$. There were no significant differences in the mean in-session quality scores of the 41 immediacy events between good versus poor outcome cases, $t(39) = .093$, $p = .92$. No significant difference in patient involvement was found in immediacy events across good versus poor outcomes, $t(39) = -.412$, $p = .68$.

However, the immediacy categories were significantly different in the good and poor outcome cases. Therapists "acknowledged their patient's progress in therapy" more often in good outcome cases than in poor outcome cases, $\chi^2(1) = 4.02$, $p = .04$. Out of the four times this category occurred, three took place in the first half of the treatment, and one in the second half of the treatment. Therapists assessed patients' feelings about the overall progress of therapy significantly more often in poor outcome cases, $\chi^2(1) = 4.65$, $p = .03$, than in good outcome cases. This category of immediacy occurred seven times, all of them in the second half of the treatment.

[9] For example, "assessing patient feelings about therapy" was split into more specific categories: "assessing patient feelings about a particular session," "assessing patient feelings about a therapist's intervention/behavior," "assessing patient feelings about the overall progress of the treatment," and "assessing patient feelings about termination."

[10] An additional 10 patient-initiated immediacy events were identified, see Supplemental Material.

Table 2
Frequency of Immediacy Events Across Patient Cases

Therapist	Patient	Frequency of immediacy events	
		Total	Initiated by therapist
Therapist A	Patient 1 (good outcome)	10	10
	Patient 2 (poor outcome)	11	9
Therapist B	Patient 3 (good outcome)	10	6
	Patient 4 (poor outcome)	10	10

Research Question 5: Clinical Examples of Good- and Poor-Quality Immediacy Events

To clinically illustrate good-quality and poor-quality immediacy events and further develop hypotheses for future research about positive and negative therapists' contributions to therapeutic immediacy, four immediacy events are presented below, across both good and poor outcome cases. Consensus narratives (i.e., judges' responses to questions about the role and impact/consequences of each immediacy event) were used to understand the context of each event, as well as to develop clinical interpretations of good or poor quality of therapeutic immediacy based on these and similar immediacy events from the four treatment cases.

A High-Quality Immediacy Event in a Good Outcome Case (Therapist B, Time Point 2)

This event represents therapist-initiated therapeutic immediacy categories "assessing patient feelings about/after a specific session" and "assessing patient's feelings about the overall progress/outcome of the treatment." Consensus narratives about the role and impact of these immediacy events in the context of the session consistently mention good alliance as well as sustaining hope and motivation in the patient.

P: *I'm opening up to you because we've been seeing each other (T: Right) for four weeks now.*

T: *And- and what, how do you feel about bringing it up to me?*

P: *I don't think you're gonna hurt me (T: Yeah) I- I'm starting to trust you more and more (T: Good) and (T: It's a gradual process) (laughs) and uh you're helping me feel better about myself (T: Mm-hm) so if you could do that then I think I can trust you (T: Mm-hm, okay) and um—it- it's hardest thing for me to do is trust people (T: Yeah that's what you've told me) I was telling my wife I was able to trust you from the beginning (T: Mmm) cause uh*

T: *Well in the beginning you told me you weren't sure you could, which I thought was being very honest (T: Yeah) why should you, you know. I mean you've been open to it and you want this to work, I can't help you unless I know everything (P: Right) about you (P: And I know that) yeah*

P: *So I'm- I'm opening up*

T: *Yeah. So when you went home from that session what'd you feel?*

P: *Um—I was, you know what compared to the other sessions where I would go home and I would cry several days (T: Mm-hm) I didn't do that (T: Mm-hm) um actually I felt good—um this week has been a lot better for me (T: Yeah?) um things have happened—that I- I- I see a glimpse of hope.*

Even though this patient did not easily engage in immediacy-related conversations earlier in the treatment, the therapist continued to pursue the topic until the therapist received a response which subsequently led to a new and meaningful conversation about how the patient feels about the developing therapeutic alliance. The patient mentioned a shift toward trusting their therapist more as the treatment progressed, and they were able to talk about it explicitly. Consensus-based narratives among the judges about the role and impact of this and other highly rated immediacy events in this treatment case suggest that the therapist actively encouraged the patient to express their experience about the therapist and the therapy. The therapist also utilized Kiesler (1988) model of self-disclosures of their overt reactions to the patient in hopes to challenge the patient's fantasy about how the therapist might be feeling about him and his general belief about how people may see him.

A High-Quality Immediacy Event in a Poor Outcome Case (Therapist A, Time Point 3)

This event represents the therapist-initiated therapeutic immediacy categories "assessing patient feelings about the therapist's specific behavior/intervention" and "exploring patient's concerns, fears, or doubts about therapy."[11] In this case, the therapist was able to engage the patient in expressing their honest feelings about therapy, and it became evident that the patient had been feeling disappointed with the therapy and with the therapist for a while. This patient had been in a silent disagreement with their therapists' suggestions/interventions and did not seem to regard the treatment as a valuable experience.

T: *You know there was something that's going on that I wanted to check with you on, that you did not feel perhaps that coming telling me how horrible that weekend was for you um would help you in any way. That maybe you know um it wasn't really that safe or helpful to bring all that to me. Did you feel that way?*

[11] This immediacy event was also coded on the following patient-initiated immediacy categories: "comparing current therapist to previous therapist," "clarifying intentions and motivation," and "expressing feelings about a specific aspect of therapy/therapist's behavior/intervention."

Table 3
Categories of Therapist-Initiated Behaviors in Immediacy Events

Overarching category	Individual category	Frequency of events					
		Total	Patient 1	Patient 2	Patient 3	Patient 4	*M* (*SD*)
Drawing interpersonal parallels	Drawing parallels between patient's outside relationships or relational pattern and the patient–therapist relationship or interaction in the here-and-now Example: *Based on what you've told me, your dad was very critical of you. I was wondering if at times you felt that I sounded critical in what I was telling you?*	10	3	6	1	0	2.50 (2.65)
Making space for patient's feelings	Assessing patient feelings about the therapist's specific behavior/intervention Example: *How did you feel about me cutting you off?*	8	2	3	2	1	2.00 (0.82)
	Validating patient's feelings Example: *There is a part of you that resents it when people are telling you what to do?*	7	2	2	0	3	1.75 (1.26)
	Assessing patient feelings about termination Example: *Any thoughts or feelings about this being the end of our weekly sessions?*	6	1	0	5	0	1.50 (2.38)
	Pointing out that the patient is changing or avoiding a topic Example: *I'm going to stop you for a second. Let's stay in the present. I'm just trying to help you deal with where you are now.*	2	1	0	1	0	0.50 (0.58)
	Clarifying patient's intentions and motivation Example: *what things would you try to do differently given some of the things we've talked about?*	2	0	1	1	0	0.50 (0.58)
	Encouraging the patient to open up to the therapist Example: *You had gotten a good start with telling me some things, but I am wondering if you would be interested in going further.*	2	0	0	1	1	0.50 (0.58)
	Exploring patient's concerns, fears, or doubts about therapy Example: *I know how bad that weekend was for you. Do you think that maybe it didn't really feel that safe or helpful to bring all that to me?*	1	0	1	0	0	0.25 (0.50)
Exploring treatment progress of patient	Assessing patient's feelings about the overall progress/outcome of the treatment Example: *Do you have feelings about how we've worked here, how it's gone?*	7	1	2	4	0	1.75 (1.71)
	Assessing patient feelings about/after a specific session Example: *We had kind of a heavy session on Tuesday. How did you feel about it?*	5	2	0	1	2	1.25 (0.96)
	Acknowledging patient's progress/good work in therapy Example: *I'm glad you can tell me that you have those feelings anyway; I know it's not easy.*	4	0	0	0	4	1.00 (2.00)
	Discussing/aligning on treatment goals Example: *What would you say your goals would be from these sessions? What would you like to focus on?*	2	0	2	0	0	0.50 (1.00)
Exploring patient's thoughts and feelings about the therapist	Exploring patient's immediate affect in relation to the therapist	6	2	1	2	1	1.50 (0.58)

(*table continues*)

Table 3 (*continued*)

Overarching category	Individual category	Frequency of events					
		Total	Patient 1	Patient 2	Patient 3	Patient 4	*M* (*SD*)
	Example: *How do you feel about bringing it up to me?*						
	Exploring patient's fantasies about what the therapist might be thinking or feeling	3	2	1	0	0	0.75 (0.96)
	Example: *Did I sound angry to you?*						
Therapist disclosing own feelings	Disclosing therapist's feelings about/experience of the patient	3	1	1	1	0	0.75 (0.50)
	Example: *You make a good impression, you come across as very thoughtful, very knowledgeable.*						
	Providing a rationale for therapist's behavior/intervention	2	1	0	1	0	0.50 (0.58)
	Example: *But, you're trying to get a job today, so I want to keep you focused on the present.*						
	Acknowledging therapist's mistake or lack of sensitivity	2	1	1	0	0	0.50 (0.58)
	Example: *I did push you; I realize it actually falls on something you experience a lot in your life.*						
	Expressing positive feelings about therapy and the patient appreciating/praising/the patient	2	0	0	0	2	0.50 (1.00)
	Example: *It makes me feel so good that I've been part of your improvement.*						

Note. Based on 41 total immediacy events across all four cases, categories are not mutually exclusive given that several types of immediacy occurred within each immediacy event. Each category was counted only once per event.

P: *Well no, no, and um I- I don't you know- I just- yeah it's not that I wanted to hold back—I'm telling you about this now. (T: mm-hm) But I guess- I don't know what I'm calling into question too—I mean I knew when I was- when I was getting into the program uh I mean I knew it was going to be intense more than- than- than what I'm- what I'm being used to. And I- I know*

T: *You mean from your previous therapy?*

P: *From my previous therapy, and you know and I'm just wondering, well, I guess the time- the time, the demands that are being made (T: mm-hm) upon me uh- it's been a lot of like running- running around and you know the idea of coming here is- is for me to- to get better and I- and I- I don't like being miserable (T: no doubt) I'm not you know- but uh, but the other- the evaluation session, when I- I- I mentioned that like over-over the past 3 months, you know at this- these feelings that I have I (incomprehensible) I mean if you diagnose it as depression, you can diagnose it as whatever you want but- the feelings still exist. And I don't know if these feelings would still exist you know whether- irregardless of whether I came here or not because like- like the issues do not go away. Like the joblessness, the- uh- the- the lack of communication with my father, the inability to forge like any kind of a meaningful relationship, the feeling- the ability to experience any sort of intimacy with- with that one special person. I mean it's- these feelings- these feelings are not going- away you know like whether like we can talk about these things like all we want but I don't you know no matter how many times I- I- I- I- and I have to . . .*

T: *You feel that nothing (?could leave) us?*

P: *And- and I have to- to admit that maybe I'm making comparisons to my previous therapist (T: mm-hm) and maybe in a sense I felt more comfortable with- with her like maybe- I- I don't know like maybe I guess maybe you have a different approach. You have more of a- I don't know like maybe you wanna like challenge me to like you know I uh you know I guess to want me to be able to like go out- go outside- go outside the box and I- I know you make suggestions and maybe uh some of the suggestions I don't- I don't feel are- are the most practical for me to do.*

This and other highly rated immediacy events in poor outcome cases showed that even though patients expressed negative feelings about therapy, the therapists worked to validate those feelings. The therapist checked in with the patient about possible discomfort with the therapist and encouraged the expression of uncomfortable feelings. The therapist attempted to explore these feelings further, according to the judges, left a positive impact on the session in which these events occurred. This follows Kiesler's model of "maladaptive transaction cycles" in which the therapist notices covert and overt reactions in the patient.

A Low-Quality Immediacy Event in a Poor Outcome Case (Therapist B, Time Point 2)

This event represents a therapist-initiated therapeutic immediacy category "encouraging the patient to open up to the therapist,"

"assessing patient feelings about/after a specific session," and "assessing patient feelings about the therapist's specific behavior/intervention." Despite the therapist offering the patient an invitation to express their experience of a past session, as well as relating that experience to relational patterns, the patient was reluctant or unwilling to offer a response.

T: *I wanna shift gears a little bit. I know you told me last week that your focus is on (?work). But, I wanna ask you, how did it feel to be talking about the personal end of relationship stuff. I had asked you some questions. When you walked out, any emotions, reactions, thoughtfulness about it? Was it sorta like —next. (P: mm-hm) You did it for me, that-that was the sense (P: mm-hm). Cause I had, I had a couple of questions (P: okay), um,—um, you know, I told you that I thought that you had gotten a good start with telling me some things, but you know, and I thought there'd probably be more to it and I wondered if you would be interested in going further, but you got right back to work today, so I-I'm fine there, but I did have another question myself, which was—what do you think it was about that relationship that um—that um—with that ended so tragically? That afterwards, you didn't want to pursue something, I mean, it turns out you were pursued (P: mm-hm) um, but what was it about that affected you or somehow coincided with you not wanting to pursue a relationship afterwards?*

P: *(no response)*

This and other poorly rated immediacy events in this case were brief and one-sided (i.e., low patient involvement) and were deemed by the consensus team as unimpactful and not helpful. In the judges' opinion, some of these were poorly executed interventions that were either confusing to the patient, did not leave room for the patient to respond, or both. In some instances, Therapist B asked a question about the patient's feelings about therapy, but then quickly pivoted the topic toward something more concrete and practical. Both therapist and the patient were then engaged in external problem-solving, moving away from feelings and immediacy.

Other potentially problematic aspects of poorly rated events in poor outcome cases occurred when therapists' interventions were taken by the patients as criticisms. This was not as apparent early in the treatment, but as the treatment progressed, patients became more defensive or disengaged in their responses to therapists' interpretations. In some ways, this immediacy event captures the elements of a declarative observation as described in a "therapeutic metacommunication," (Kiesler, 1988) while forgoing the aspect of a corrective experience in "therapeutic immediacy" (Hill, 2004).

A Low-Quality Immediacy Event in a Good Outcome Case (Therapist A, Time Point 1)

This event represents a therapist-initiated therapeutic immediacy category "assessing patient feelings about/after a specific session." In this case, the therapist asks the patient if a previous session made a lasting positive impact, which the patient denies held any influence.

T: *Anything you're feeling about how things are going? About maybe a session we had on Monday, anything that kind of made you feel a bit less [depressed]?*

P: *No, I don't think so. I don't think it's related, maybe I just slept much more.*

T: *Did you have any feelings about the last session we had or anything that stayed with you?*

P: *Any feelings, no. It's difficult for things to stay with me [patient complains about his memory problems and therapist engages in this new topic].*

This and similar low-quality immediacy events seemed to have failed to accomplish what they were intended to, in this case because of the patients' resistance (therapist's questions and comments fell flat, did not engage the patient/did not result in any meaningful discussion). In some cases, the therapists did not pursue the topic when the patients avoided talking about their feelings about the treatment, the therapist, or the therapeutic relationship. This "incomplete" immediacy event leaves the opportunity for the patient to make their own interpretations about the inquiry, possibly inciting feelings of discomfort (Kasper et al., 2008).

Discussion

This mixed-method study examined the use and quality of therapeutic immediacy in a brief psychodynamic treatment for depression. Transcripts of 16 therapy sessions of SET treatments were examined across four patients, two of which were good outcome cases and two of which were poor outcome cases (as evaluated by reduction of depressive symptoms). We assessed the use (frequency and categories) and quality of immediacy events (based on 5-point scales assessing various aspects of quality), as well as levels of patient involvement.

Frequency and Identified Categories of Therapeutic Immediacy

Out of the 41 identified immediacy events across the four treatments, 35 (85.4%) were initiated by therapists, even when both sides of the dyad were engaged in an immediacy event. The large number of 18 identified granular categories of immediacy events reflects the exploratory nature of this clinical study (i.e., there were no predetermined categories because as this study was based on a specific population with a diagnosis of a major depressive disorder) and is in line with the previous studies that developed a taxonomy of therapist-initiated immediacy categories (12 categories in Kasper et al., 2008[12]; 17 categories in Mayotte-Blum et al., 2012[13]). Identifying categories of therapeutic immediacy was aimed at illuminating various content areas, which together with quality

[12] Similar categories included "Reinforced client for something she did in the session"; "Wanted to collaborate with client in working out her difficulties"; "Inquired about client's reaction to therapy"; "Reminded client that it was okay to disagree"; "Said he was glad to see client"; "Inquired about possible problems in the relationship"; "Drew parallel between external and therapy relationship."

[13] Similar categories included "Exploration of client's fears and concerns about the therapy relationship"; "Affirming/validating/supporting client's feelings about the relationship"; "Exploration of client's fantasies about the therapist"; "Comparison of therapist/client relationships to outside relationships"; "Therapist comments on his experience of the client"; "Therapist directing client toward her immediate affective experience."

and patient involvement measures may help us understand what constitutes a positive or successful therapeutic immediacy intervention in a psychodynamic treatment for depression. The most frequent categories of therapist-initiated immediacy were drawing parallels between outside relationships or relational patterns and patient–therapist relationship or interaction, exploring patient feelings about various aspects of the treatment, validating patient's feelings, and exploring immediate affect in relation to the therapist (e.g., "I see you are having a strong feeling in response to what I said, what are you feeling?"). Similar to results by Kasper et al. (2008) and Hill et al. (2008), immediacy events often covered more than one category of immediacy. Therapist-initiated immediacy events often facilitated new patient-initiated immediacy events. In one example, the therapist asked the patient about her reactions to the therapist's earlier question (therapist-initiated category: "assessing patient feelings about the therapist's specific behavior/intervention"); the patient responded by saying that question made him feel uncomfortable, and then added that his previous therapist had a very different style and never made him feel uncomfortable. Subsequently, the patient recalled something from the previous session that he admitted was concerning to him.

Quality of Immediacy Events and Patient Involvement

A significant positive relationship was found between the rated quality of immediacy events and the assessed level of patient involvement. This infers that high patient involvement is an important element of effective therapeutic immediacy. A well-executed immediacy event appears to constitute interventions that require personal involvement, reflecting their immediate emotional experience of each other in the room as indicated by the categories that received the highest quality ratings about the therapist self-disclosing their own feelings and making space for patients' feelings. This contrasts the low-quality immediacy events, that appear somewhat more interpretative, and emotionally distant regarding interpersonal patterns and treatment progress. Notably, the most frequently occurring immediacy event (drawing interpersonal parallels) was also the event that had the lowest quality ratings. Highlighting interpersonal patterns is the main focus in SET, but might not be generating emotionally involved discussion about the immediate experience in the room per se.

Immediacy in Good Versus Poor Outcome Cases

No relationship was found between judges' in-session quality scores of immediacy events and whether these events occurred in a good or poor outcome case. As many factors contribute to treatment outcome, this study was unable to confirm if the intervention of therapeutic immediacy is one of these factors. Additional quantitative research assessing the relationship between therapeutic immediacy and various aspects of treatment outcome is needed to further explore if therapeutic immediacy could be identified as a separate mechanism of change.

As to be expected in this very small sample, no relationship was found between the overall frequency of immediacy events in the assessed four time points and the outcome of the cases, and so any conclusions in regard to the frequency of immediacy events hold inherent limitations. Therapists acknowledged their patients' positive progress in therapy significantly more often in good outcome cases than in poor outcome cases. Out of the four identified occurrences of this category of immediacy event, three of them took place in the first half of the treatment, which may reflect an effort to build a therapeutic alliance and/or motivate the patient to remain engaged in the treatment. Therapists assessed patients' feelings about the overall progress/outcome of therapy significantly more often in poor outcome cases than in good outcome cases. All seven occurrences of these therapists' behaviors took place in the second half of the treatment. This may infer that these immediacy events were either related to processing termination or were reactive to the poor progress of the treatment.

Strengths and Limitations

This exploratory study, conducted as post hoc analysis of archival data from an existing RCT, has several methodological advantages over previous CQR studies on immediacy that increase the validity of the results. First, by utilizing CQR-C, we allowed for the categories to emerge from the data (idiographic method of a bottom-up analysis), avoiding possible presumptions of predetermined types of immediacy categories. The observation-based, discovery-oriented approach of CQR-C views the depth and uniqueness of the data as paramount. Second, in contrast to the immediacy analyses in other studies (Hill et al., 2008, 2014; Kasper et al., 2008), the therapies were already conducted as part of the original RCT, meaning that the content of the sessions was less likely to be confounded by the demand characteristics of the present study. Third, the validity of the process and session outcome measurements were further strengthened by judges' ratings of the treatment sessions, the availability of standardized symptom outcome measurements, and the lack of any preexisting relationship between the therapist and the judges (in contrast to the previous studies; Hill et al., 2014; Mayotte-Blum et al., 2012). In all previous qualitative and mixed-method studies of immediacy, therapists were either involved in the analysis or served as supervisors for the student judges, which could have potentially affected the judges' willingness to openly criticize therapists' clinical skills and in-session behaviors.

Although this exploratory study has several methodological strengths compared to previous studies, the results of this small-scale illustrative case study need to be considered in the context of its inherent limitations. First, the examination of immediacy in relation to outcome was limited by the use of a distal outcome measurement (outcome at the end of treatment) rather than more proximal outcomes closer to the moment of immediacy, such as the level of affect experiencing or reflective functioning in the minutes after the intervention or the following session. In addition to the clinical relevance of immediate patient responses, proximal outcomes may have provided additional contextualizing and nested data points. Second, therapists' and patients' subjective experiences were not assessed in follow-up interviews (Hill et al., 2008; Mayotte-Blum et al., 2012), meaning therapists could not provide their reasoning behind their use of therapeutic immediacy in these four cases. Third, we cannot assume causality between the identified process variables (i.e., categories of the quality of immediacy events) and the treatment outcome. Fourth, because of the small number of therapists (two), it is impossible to conclude if the identified effective in-session behaviors are generalizable to more therapists or constitute a so-called "therapist effect"

(Baldwin & Imel, 2013). Fifth, due to the exploratory nature of the analyses, there may have been an undetected inflation of the results. Lastly, this study focused on a subsample of patients who completed treatments, and the sample of patients who dropped out of the original RCT may have shown different immediacy patterns over treatment.

Furthermore, there are intersecting patient and therapist characteristics that could have influenced the results, as this study did not explore the cultural context of psychotherapy and the fact that the patients were of diverse backgrounds. While the relative patient diversity in this study could make this study more generalizable than previous single-case studies (Hill et al., 2008; Kasper et al., 2008), it is unclear how much the patients' and the therapists' ethnic backgrounds could have played a role in the outcome of these cases. It is likely that race, age, gender, ethnicity, and power differences between patient and therapist impact the use and usefulness of immediacy events. We did not identify any immediacy events related to these patients' and therapists' personal characteristics in this study, and because only four sessions per treatment were analyzed, we cannot say for sure that these events did not occur in the treatments. In other words, this study was underpowered to examine the cultural and demographic variability between patients and therapists.

Moreover, there are several methodological limitations in how the data were analyzed. First, the observer ratings of immediacy events were not validated or standardized, may have been inadvertently biased, as the personal backgrounds of the judges may have played a part in their ratings of the quality of the immediacy events. Second, it might have been beneficial to use a standardized measure of client involvement, as used in health care settings (e.g., Martin et al., 2001). Third, the "frequency" of events might not give the full picture; one therapist had cases with different outcomes, which might provide evidence for the importance of patient characteristics in the process of immediacy in treatment. Instead, a temporal examination of immediate outcomes of different types of immediacy events for different clients (antecedent, during, and subsequent patient involvement) would likely have been illuminating.

Future Directions

To address the limited statistical power of our mixed-method study, future studies with larger samples and analyses of all sessions within a treatment are warranted. Future studies on therapeutic immediacy in relation to treatment outcome are warranted in order to provide more specific clinical implications for practice and therapist training (e.g., what are the "dos" and "don'ts" when engaging in evocative conversations about the therapeutic relationships with patients, and what considerations should take place in terms of time in treatment, type of patient, severity of depression symptoms, or patient's readiness to change). To increase the external validity of these exploratory findings, further research is needed on the role of therapeutic immediacy in treatments with larger, more diverse patient groups, therapists, and different therapy modalities that place varying degrees of importance on the use of immediacy. Furthermore, this study was not designed to examine the impact of patients and therapist characteristics on the therapeutic process, and future research with larger samples would be needed to control for these potential confounding effects of the use of immediacy in treatment. In addition, it would also be helpful to utilize a model that links immediacy to immediate outcomes (i.e., proximal) rather than just to treatment outcomes (i.e., distal).

Clinical Implications and Conclusions

Although this small-scale case study does not allow for generalizations to clinical practice, several related hypotheses about possible effective and ineffective therapist behaviors within therapeutic immediacy may be of interest for future research. First, we might expect that effective immediacy interventions are characterized by keeping patients highly involved, specifically through encouraging them to express feelings about the treatment and the therapist. It can be further hypothesized that these discussions should occur preferably earlier rather than later in the treatment so that there are ample opportunities to repair and strengthen the therapeutic alliance. Finally, therapists' positive feedback about patients' engagement and progress could help to sustain hope and motivation throughout treatment, especially when the treatment is going well.

On the other hand, low patient involvement may be counterproductive to treatment outcomes. Failed or low-quality immediacy events may possibly be the therapist's direct responsibility, including moving away from patients' feelings, following the patients' lead to problem solve, or overwhelming the patient with too many evocative immediacy questions at once without giving the patient a chance to reflect and respond. This said, based on this small-scale case study, it remains unclear if therapists should allow resistant patients to move past a discussion of the here-and-now or if this avoidance should be brought to the patient's attention.

This study's two good outcome cases do, however, provide examples of how a therapist might successfully engage in immediacy work with depressed patients. For example, therapists may want to take active initiative to draw parallels between a patient's relationships outside the session/relational pattern and the patient–therapist interaction in the here-and-now. Therapists may also want to assess their patient's feelings about the therapist's specific behavior/intervention, as well as the overall progress and outcome of the treatment. Lastly, it may be important for therapists to explicitly disclose positive feelings about the patient, as well as acknowledge their own intentions and mistakes. Future larger scale research is warranted to test these hypotheses and examine the proximal and distant outcomes of these different techniques of utilizing therapeutic immediacy in treatments with depressed patients.

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