ABSTRACT

Title of Dissertation:	GETTING ON THE SAME PAGE: ASSOCIATIONS OF IMMEDIACY AND CLIENT-THERAPIST ALLIANCE CONGRUENCE
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This study examined the within-dyad association of immediacy (i.e., a skill that therapists use to work with the therapeutic relationship in the here-and-now) with the strength and congruence of the working alliance across 1352 sessions of 58 adult community clients seeing 11 doctoral student therapists in individual psychodynamic-interpersonal psychotherapy. As a preliminary step, the factor structure and validity were tested for the Metacommunication in Session Questionnaire–Client Form (MSQ-C), a client-rated measure of immediacy adapted from the supervisory MSQ (Calvert, Deane, & Grenyer, 2020). After every session, clients and therapists completed the Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) and clients completed the MSQ-C. Factor analysis supported a two-factor structure for MSQ-C (Open Communication and Managing Disagreement/Discomfort factors). Validity of the MSQ-C was supported by predicted correlations with measures of helping skills, sessions quality, alliance, and therapist reported immediacy use, although some associations

varied depending on the client or therapist rater perspective. Results of multilevel, latent variable models found that when clients reported more immediacy in a session compared to their average session, they tended to report a stronger alliance; and this effect was strongest in earlier sessions, weaker in magnitude in middle sessions, and non-significant in later sessions. Results of multilevel truth-and-bias models showed that therapist alliance ratings were temporally congruent with client alliance ratings, but client-perceived immediacy did not predict alliance congruence. Limitations and future directions are discussed.

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by

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Dedication

This dissertation is dedicated to my son, Griffin Willough.

Although you have only just arrived, I know it will be my life's greatest joy to see who you become and my greatest privilege to be a part of your becoming.

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First and foremost, I would like to thank my advisor, Dennis Kivlighan, Jr.. His consistent generosity, support, and belief in me have made this journey possible. I am also grateful to Clara Hill and Charlie Gelso for sharing their clinical wisdom and research expertise, and for making this psychotherapy research possible.

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Last but not least, I am deeply grateful for the clients I have had the privilege to serve as a therapist. They have taught me so many lessons about what it means to heal, to be human, and to be authentically in relationship with others.

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Chapter 1: Introduction

The working alliance, commonly defined as the client and therapist's emotional *bond*, and their agreement on the *tasks* and *goals* of therapy (Bordin, 1979), is considered an essential ingredient in psychotherapy because it has been consistently, positively associated with treatment outcomes (e.g., Flückiger et al., 2018, 2020). The alliance is a dyadic construct because it is influenced by the interactions between the client and therapist to form a shared perspective, which can be conceptualized as alliance *congruence*, also referred to as alliance *agreement*. Much research has studied alliance strength from one rater perspective, though a growing body of research examining the alliance dyadically has shown that clients improve more when the dyad is in greater agreement about the strength of their alliance (e.g., Coyne et al., 2017; Jennissen et al., 2020; Rubel et al., 2018; Zilcha-Mano et al., 2017).

There is much left to be understood about alliance congruence, including how therapists can create and maintain it. Research has examined person-level predictors of alliance congruence like attachment styles (e.g., O'Connor et al., 2019), but these studies do not inform what therapists can do to get on the same page with their clients. The present study aimed to address this gap by examining immediacy, a skill that therapists use to process the therapeutic relationship in the here-and-now (Hill, 2020; Hill & Knox, 2009), as a predictor of alliance congruence. Associations of immediacy and alliance strength were examined, as well. As a preliminary aim, the factor structure, reliability, and validity of a novel client-rated measure of immediacy were tested.

Theory and Empirical Research on Alliance Congruence

Alliance congruence, or how similarly clients and therapists view their alliance, is clinically meaningful because it reflects how attuned therapists are to their clients' experience and how accurately therapists perceive the state of the alliance as it unfolds throughout treatment, which is essential for intervening responsively across different theoretical orientations. For example, relational (Safran & Muran, 2000), psychodynamic (Shedler, 2010), and interpersonal (Teyber & Teyber, 2017) therapies emphasize working directly with the alliance, including the therapist addressing strains in the alliance and resolving ruptures. On the other hand, a strong alliance can be a marker of client readiness for more challenging, insight-oriented interventions (Ahn & Kivlighan, 2022; Bordin, 1979). If the therapist perceives the alliance as stronger than their client does, they may use challenging interventions that the client is not prepared for, or may miss opportunities to repair ruptures. Whereas, if the therapist views the alliance as weak but their client believes it is strong, the therapist may miss opportunities to deepen the therapy that the client is in fact ready for. As well, in cognitive-behavioral therapies, a strong alliance is viewed as a pre-requisite that makes it possible for cognitive techniques to be effective (e.g., Castonguay et al., 2010), and therapists and clients need to be on the same page about the quality of their alliance to determine client readiness for such techniques (Rubel et al., 2018). In essence, when a dyad sees eye-to-eye about the strength of their alliance the therapist can intervene more appropriately. Furthermore, dyads converging in their perspectives has long been viewed as a marker of successful treatment because forming shared perspectives is advantageous in other relationship contexts (Pepinsky

& Karst, 1964). Thus, it is important to study not just alliance strength from client or therapist perspectives, but also to examine dyadic alliance perceptions from session-to-session.

Supporting this perspective, studies have examined alliance congruence as an independent variable and found that when a dyad agrees more about the strength of their alliance, client symptoms improve more (Jennissen et al., 2020; Lai et al., 2021; Marmarosh & Kivlighan, 2012; Rubel et al., 2018; Zilcha-Mano et al., 2017). These studies typically utilize polynomial regression and response surface analysis (Shanock et al., 2010) to test how the level of agreement and disagreement between client and therapist alliance ratings predict psychological distress. Within-dyad studies have illustrated this effect over time, suggesting that alliance congruence can fluctuate from session to session. For instance, in sessions with greater alliance congruence than other sessions of the same dyad, clients' subsequent symptoms were lower when assessed every 5th session in psychodynamic therapy (Jennissen et al., 2020), and when assessed every session in cognitive-behavioral therapy (Rubel et al., 2018) and at a Chinese university mental health center (Lai et al., 2020).

Between-dyad studies illustrate differences in outcomes between dyads with more or less alliance congruence on average. These studies have shown that clients had lower symptoms at one-month follow up (Zilcha-Mano et al., 2017) and improved more from intake to termination (Marmarosh & Kivlighan, 2012) when they were from a dyad that agreed more on a strong alliance compared to other dyads. Interestingly, Zilcha-Mano et al. also found that client symptoms were lower if the dyad was in greater agreement about a weak alliance compared to other dyads, which

the authors suggest may indicate alliance ruptures that were recognized and repaired. This is not to suggest that a weak alliance is good, but that seeing eye-to-eye about a poor alliance may be a prerequisite for repairing alliance ruptures, a vital process for improving symptoms and reducing unilateral termination as demonstrated by meta-analytic findings (Eubanks et al., 2018). Of note, because Zilcha-Mano et al.'s sample required a one-month follow-up assessment of symptoms, it is possible that only dyads who repaired their alliance and continued treatment were included in the study, contributing to this positive effect.

Another facet of this research has examined alliance *convergence* as an independent variable, which is operationalized as the rate at which a dyad comes to see the strength of their alliance similarly. Greater alliance convergence was associated with more improvements in generalized anxiety disorder (Coyne et al., 2017) and chronic depression (Laws et al., 2017). Nissen-Lie et al. (2020) was unable to replicate these findings in two samples of clients with more severe diagnoses and symptomatology, although they did find that alliance convergence increased in one sample. These results provide further support that dyads form a shared perspective on their alliance over time and that this has implications for treatment outcomes.

Alliance congruence has also been studied as a dependent variable by using West and Kenny's (2011) Truth-and-Bias (T&B) model to examine how client and therapist alliance ratings are related to each other over time. The T&B model simultaneously estimates *directional discrepancy*, which is the average difference between client and therapist alliance ratings; and *temporal congruence*, which is the strength of the correlation between therapist and client alliance ratings from one

session to the next. Atzil-Slonim et al. (2015) proposed that temporal congruence at the within-dyad level can be conceptualized as an indicator of how accurately therapists are tracking the alliance. This research has consistently shown that therapists' alliance ratings tend to be temporally congruent and lower on average (i.e., negative directional discrepancy) than their clients alliance ratings (Atzil-Slonim et al., 2015; Kivlighan & Marmarosh, 2016; O'Connor et al., 2019; Rubel et al., 2018).

Notably, Atzil-Slonim et al. (2015) found that therapists with more temporal congruence also appeared to rate the alliance with more directional discrepancy, which they interpreted as a "better safe than sorry" approach, such that therapists who track fluctuations in the alliance more closely may also be cautious not to overestimate its strength, an error that could lead to overlooking problems in the alliance. Rubel et al. (2018) also found that temporal congruence predicted lower symptoms, and that directional discrepancy had a quadratic relationship to client symptoms, indicating that clients improved more when therapists slightly underrated the alliance on average. Although seemingly paradoxical, Rubel et al. (2018) explained that the degree of underrating was so slight that therapists had to be in near-perfect agreement on the alliance in each session with their clients to achieve this effect. Thus, alliance congruence appears to be most effective when therapists are cautious not to overestimate the alliance.

Predictors of Alliance Congruence

Researchers have examined predictors of alliance congruence by testing moderators of the correlation between therapist and client alliance ratings with the T&B model. These studies have found that dyads' alliance ratings were more

congruent when the therapist had a more affiliative interpersonal style (Chen et al., 2018), a more secure attachment style (Kivlighan & Marmarosh, 2016), higher self-efficacy for the specific client (Lai et al., 2021); when the client and therapist had either matching or complementary attachment styles (O'Connor et al., 2019); and in sessions that client distress was lower (Atzil-Slonim et al., 2015).

These studies have primarily examined person-level moderators which provide information about therapist and client characteristics that contribute to alliance congruence, but they do not speak to *how* therapists can increase temporal congruence with their clients. Jennissen et al. (2020) postulated that higher alliance agreement may in part be due to an implicit process of therapists attuning to their clients, and not necessarily the result of explicit discussion of the alliance. No studies, however, have examined whether specific interventions contribute to alliance congruence. Given that therapist interventions contribute to alliance strength (e.g., Ackerman & Hilsenroth, 2001, 2003), it is plausible they also contribute to alliance congruence, especially skills for working directly with the therapeutic relationship. This could be tested by examining within-dyad, session-level moderator effects of therapist skills like immediacy.

Immediacy: A Skill for Working with the Alliance

Immediacy is a skill used to work in the here-and-now with the therapeutic relationship that may aid therapists in creating and maintaining alliance congruence. Hill (2020) defined immediacy as when therapists "inquire about the client's feelings regarding the therapeutic relationship or disclose how they are feeling about the client, self in relation to the client, or the therapeutic relationship" (p. 280). Of note,

the psychotherapy literature has interchangeably referred to immediacy as metacommunication (Kiesler, 1988) and as process comments (Teyber & Teyber, 2017). In the three-stage Helping Skills model (Hill, 2020; Hill & O'Brien, 1999), which organizes therapist skills into exploration, insight, and action stages, immediacy is classified as an insight skill because it aims to foster clients' awareness of their interpersonal patterns. Immediacy is also used to establish, monitor, repair, and maintain the therapeutic relationship (Hill et al., 2014; Hill, 2020), which are purposes closely aligned with therapists tracking the alliance and fostering congruence. Three case studies (Hill et al., 2008, 2014; Kasper et al., 2008) identified types of immediacy use that included negotiation of the tasks and goals of therapy (e.g., "How are you feeling about our work together?"), exploration of unexpressed feelings or making the covert overt (e.g., "I notice you keep glancing at your watch, and wonder what you're feeling right now?"), drawing parallels between other relationships and the therapy relationship (e.g., "You said no one understands you. I wonder if you feel that I won't be able to understand you, too?"), and attempts to repair ruptures (e.g., "I wonder if you are angry at me?").

Findings regarding immediacy and the alliance have been mixed, suggesting a complex relationship (Hill et al., 2014; Kuutman & Hilsenroth, 2012; Shafran et al., 2017). Case studies found that immediacy is associated with a range of positive therapy processes (e.g., Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012), including increasing clients' insight and emotional awareness, and working through issues in the therapy relationship. In a qualitative meta-analysis of 15 studies (Hill et al., 2018), enhancing the therapeutic relationship

was one of the most frequent outcomes of immediacy, suggesting that immediacy can facilitate a strong alliance.

In quantitative studies, immediacy has not been associated with alliance strength at the between-dyad level (Hill et al., 2014; Kuutman & Hilsenroth, 2012) but has been associated at the within-dyad level (Shafran et al., 2017), suggesting that immediacy contributes to session-level outcomes but perhaps not directly to case-level outcomes. Shafran et al.'s within-dyad study found more immediacy was associated with a stronger alliance later in treatment but with a weaker alliance earlier in treatment. This interaction effect could indicate that immediacy early in treatment was perhaps too intimate and strained the alliance or that therapists were using immediacy in response to a weak alliance. Later in treatment, immediacy may be more effective once a relationship has been established. As well, it is important to note that Shafran et al.'s findings are contrary to Kiesler's (1988) principal for effective immediacy that states that when therapists provide interpersonal feedback earlier in treatment, it will enable the dyad to disengage from maladaptive interpersonal cycles and be more effective than if therapists wait until later in treatment. Given the discrepancy between theory, and the small number of studies, within-dyad research on immediacy and the alliance needs to be replicated and extended.

Notably, this research has only examined associations of immediacy with the strength of the alliance from client and therapist perspectives separately, and could be extended by examining immediacy in association with the alliance dyadically. Immediacy is an especially promising skill to investigate as a predictor of alliance

congruence because it is focused on assessing and working with the therapeutic relationship. Relatedly, Li et al. (2016) found that in-session collaboration increased after immediacy interventions, which suggests a coming together occurs through processing the relationship. Immediacy may help therapists maintain alliance congruence by openly discussing how the dyad feels about their relationship, the client's progress, the goals and tasks of therapy, and through repairing ruptures.

Assessing Immediacy with Client Report

Most research has used trained judges to code immediacy events from session transcripts (e.g., Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012). This approach provides a rich, reliable method but is resource intensive and yields relatively small numbers of sessions and dyads. For example, the data utilized by Hill et al. (2014; Shafran et al., 2017) included only 16 clients, whereas a sample of 50 clients is recommended to estimate within-dyad effects (Hox et al., 2010). Immediacy also appears to be used infrequently (5% to 38% of the time; Hill et al., 2018), thus collecting data from a larger number of sessions and dyads may enhance the ability to estimate relationships between immediacy and session process and outcome. A self-report measure of immediacy could help achieve this.

The Metacommunication in Supervision Questionnaire (MSQ; Calvert, Deane, & Barrett, 2020; Calvert, Deane, & Grenyer, 2020) is one such measure that was recently developed to assess therapist trainees' perceptions of immediacy with their clinical supervisor. The MSQ is based on Hill and Gupta's (2008) conceptualization of immediacy in supervision, which directly parallels therapist use of immediacy with clients. Calvert, Deane, and Grenyer (2020) demonstrated that the

MSQ assesses immediacy on two factors: the Open Communication subscale captures immediacy used to speak directly and openly about the relationship; and the Managing Disagreement/Discomfort subscale captures immediacy used to speak directly about difficulties in the relationship. MSQ items are jargon free descriptions of therapeutic dialogue that lend themselves to being rated by clients after adjusting the language to fit the client-therapist relationship. A similar client-report approach has been reliably applied when assessing therapists use of exploration, insight, and action skills with the Helping Skills Measure (HSM; Hill & Kellems, 2002).

As well, a client report instrument could be particularly useful for assessing how clients' direct experiences of immediacy relate to outcomes, which would provide novel information from an important vantage point. The literature theorizes that processing the therapeutic relationship can provide a corrective emotional experience, helping clients to form a stronger therapeutic alliance, make changes in their relationships outside of therapy, and subsequent improvements in functioning (Hill & Knox, 2009). Clients' experiences of immediacy are central to these change processes and examining their direct experience of immediacy can add a novel, meaningful perspective to this literature. Client perspectives on immediacy have previously been assessed in case studies using a qualitative process recall approach (Hill et al., 2008; Kasper et al., 2008). No comprehensive, standardized measure of immediacy from the client perspective exists, and the available measures lack nuance because they comprise single items from broader session process scales, such as the Therapist Response Questionnaire (TRQ; Tracey et al., 1988; Li et al., 2016) and the Comparative Psychotherapy Process Scale (CPPS; Blagys & Hilsenroth, 2000, 2002).

Purpose of the Present Study

The primary aims of this study were to test whether client-perceived immediacy was associated with alliance strength and congruence. This research was carried out in two phases, using a single data set from a psychodynamic-interpersonal community clinic.

Phase 1 investigated the factor structure and validity of the Metacommunication in Session Questionnaire-Client Form (MSQ-C), a client-rated measure of immediacy created by modifying the original MSQ for the client-therapist relationship. First, I hypothesized that the MSQ-C would have a similar two-factor structure as the original MSQ, as described above (H1). For my validity hypotheses (H2A through H2I), I first expected (H2A) that MSQ-C scores would be positively correlated with therapist-reported immediacy use, indicating that when clients perceived more immediacy, therapists would also be more likely to endorse having used immediacy. I also hypothesized (H2B and H2C) that MSQ-C scores would be positively correlated with client- and therapist-ratings of exploration skills, given that immediacy typically takes place in a context of exploration and involves aspects of exploration skills (Hill, 2020). I also hypothesized (H2D and H2E) that MSQ-C scores would be positively correlated with client- and therapist-ratings of insight skills, given that immediacy is an insight skill that aims to help clients understand their interpersonal dynamics more deeply (Hill, 2020). I hypothesized (H2F and H2G) that MSQ-C scores would not be correlated with client- or therapist-ratings of action skills, since action skills focus on behavior change rather than processing the therapeutic relationship (Hill, 2020). Additionally, I hypothesized (H2H and H2I) that

MSQ-C scores would be positively correlated with client- and therapist-rated session quality, as found in previous research (Shafran et al., 2017).

Phase 2 investigated whether client-perceived immediacy was associated with alliance strength and congruence using a subsample of clients and therapists who completed ratings of the working alliance. First, I sought to replicate Shafran et al.'s (2017) study of the within-dyad association of immediacy and alliance strength, and to extend this research by utilizing a larger sample and accounting for the relationship between both client and therapist alliance perceptions. I hypothesized (H3) that client-perceived immediacy would be positively associated with alliance strength, and (H4) that this relationship would vary depending on time in therapy (Shafran et al., 2017).

Then, I investigated whether immediacy predicted alliance congruence at the within-dyad level using the T&B model. I hypothesized (H5) that therapist alliance ratings would tend to follow fluctuations in client alliance ratings from session-to-session, demonstrated by a positive effect for temporal congruence; and (H6) that therapists would rate the alliance lower than their clients on average, demonstrated by a negative effect for directional discrepancy (e.g., Atzil-Slonim et al., 2015). Finally, I hypothesized (H7) that temporal congruence of alliance ratings would be greater when clients perceived more immediacy in a session compared to their average session, indicated by a moderation effect of immediacy on the association of client and therapist alliance ratings. Although no prior research has explored the relationship between immediacy and alliance congruence, this hypothesis is based on the theoretical rationale outlined above.

Chapter 2: Methods

Study Design and Data Set

This study was a longitudinal, naturalistic design, using multilevel, correlational data from a university psychotherapy clinic. The overall data set contained 1352 sessions of 58 clients seeing 11 doctoral trainee therapists. The subsample that contained working alliance data included 1050 sessions of 38 clients seeing 7 doctoral trainee therapists. The data is multilevel due to the nesting of sessions within clients, and clients within therapists. For the primary research question, the independent variable was client-perceived immediacy, as measured by the MSQ-C. The dependent variables were alliance strength and alliance congruence as indicated by client and therapist ratings on the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006).

Participants

Clients were 58 (32 female, 19 male, 6 trans/gender non-conforming, 1 unreported) adults from the community, ages 18 to 62 (M = 27.61, SD = 9.36) whose self-identified races/ethnicities (could indicate more than one) were: 31 White/European American, 11 Black/African American, 9 Hispanic/Lantinx American, 7 Asian American/Pacific Islander, 4 Middle Eastern, 4 Multiracial, 3 International (1 Croatian International, 1 Indian International, 1 Norwegian International), 2 Native American, 2 unreported. Clients' presenting problem(s) identified at screening included (could choose more than one): anxiety (N = 43), depression (N = 36), relationship issues (N = 35), career (N = 11), grief and loss (N = 11), meaning in life (N = 11), and other (N = 20). Number of sessions ranged from 2

to 91 (*M* = 35.76, *SD* = 27.88). Baseline client distress as indicated by scores on the Outcome Questionnaire-30.2 (OQ30) ranged from 14 to 91 (*M* = 53.14, *SD* = 16.02), with 73.20% of clients at clinical levels of distress (a score of 44 or higher; Lambert et al., 2004).

Therapists were 11 (9 female, 2 male) counseling psychology doctoral students, age 26 to 35 (*M* = 29.18, *SD* = 2.75), in at least the third year of their doctoral training, whose self-identified races/ethnicities were: 4 Asian International, 3 Asian American, 2 White/European American, 1 Black/African American, 1 Hispanic/Latinx American. Caseloads ranged from 2 to 9 (*M* = 5.45, *SD* = 2.21) clients. Using the Therapist Orientation Profile Scale – Revised (TOPS-R; Worthington & Dillon, 2003) therapists identified their theoretical orientations on a 10-point scale (1 = *not at all,* 10 = *completely*) as Psychoanalytic/Psychodynamic (*M* = 8.09, *SD* = .96), Humanistic/Existential (*M* = 6.88, *SD* = 1.53), Multicultural (*M* = 6.58, *SD* = 1.85), Feminist (*M* = 4.55, *SD* = 2.11), Cognitive-Behavioral (*M* = 3.88, *SD* = 1.33), and Family Systems (*M* = 3.49, *SD* = 2.65).

Working Alliance Subsample

Clients were 38 (22 female, 9 male, 6 trans/gender non-conforming, 1 unreported) adults from the community, ages 18 to 62 (*M* = 28.86, *SD* = 9.68) whose races/ethnicities were: 20 White/European American, 9 Black/African American, 5 Asian American/Pacific Islander, 4 Hispanic/Lantinx American, 4 Middle Eastern, 3 Multiracial, 2 International (1 Indian International, 1 Norwegian International), 1 Native American, 2 unreported. Their presenting problem(s) at screening included (could choose more than one): anxiety (*N* = 30), relationship issues (*N* = 25),

depression (N = 23), meaning in life (N = 15), career (N = 11), grief and loss (N = 5), and other (N = 14). Number of sessions ranged from 2 to 91 (M = 47.16, SD = 25.93), and baseline distress on the OQ30 ranged from 14 to 89 (M = 51.31, SD = 16.48) with 66.70% of clients above the cutoff for clinical levels of distress.

Therapists were 7 (5 female, 2 male) counseling psychology doctoral students, ages 26 to 35 (M = 29.29, SD = 3.25) whose races/ethnicities were: 3 Asian American, 2 White/European American, 1 Asian International, 1 Black/African American, 1 Hispanic/Latinx American. Caseloads ranged from 2 to 9 (M = 5.71, SD = 2.43) clients. Their self-ratings on the TOPS-R were Psychoanalytic/Psychodynamic (M = 8.38, SD = .85), Humanistic/Existential (M = 6.76, SD = 1.51), Multicultural (M = 6.38, SD = 2.14), Feminist (M = 4.38, SD = 2.04), Cognitive-Behavioral (M = 3.57, SD = 1.00), and Family Systems (M = 2.67, SD = 2.03).

Measures

All measures are shown in Appendix A.

Client Ratings of Immediacy

The *Metacommunication in Session Questionnaire-Client Form* (MSQ-C) was adapted for this study from the supervisee-rated MSQ (Calvert, Deane, & Barrett, 2020; Calvert, Deane, & Grenyer, 2020) to assess client perceptions of immediacy in the therapeutic relationship by making minor changes to the language of items (e.g., changing "supervisor" to "therapist," and "supervision" to "therapy," etc.). The MSQ-C contains 12-items rated on a 4-point scale (1 = *Never*, 4 = *Often*) that capture frequency of immediacy (e.g., "I worried that my therapist was feeling something

negative toward me (e.g., frustration) and we talked about this together directly," "My therapist and I discussed whether therapy was meeting my needs," etc.). Factor analysis of the original MSQ found that the scale was comprised of two, correlated 6-item subscales: (1) *Open Communication* and (2) *Managing Disagreement/Discomfort* (Calvert, Deane, & Grenyer, 2020). Mean scores can be taken for each subscale or for all 12 items, with higher scores indicating more immediacy. For the original MSQ total scale, internal consistency αs ranged from .84 to .85 (αs for the subscales were not previously reported); and evidence of validity was demonstrated by significant, positive, moderate correlations with measures of the working alliance and real relationship (Calvert, Deane, & Barrett, 2020; Calvert, Deane, & Grenyer, 2020). The factor structure, internal consistency, and validity of the MSQ-C were examined in the present study.

Helping Skills

The *Helping Skills Measure* (HSM; Hill & Kellems, 2002) assesses skills therapists use based on the transtheoretical, three-stage Helping Skills model (Hill, 2020; Hill & O'Brien, 1999) with parallel client-rated and therapist-rated forms. Thirteen items are rated on a 5-point scale (1 = *Strongly Disagree*, 5 = *Strongly Agree*) that reflect the therapists' use of exploration, insight, and action skills on three corresponding subscales. The *Exploration* subscale (4 items; e.g., "asked questions to help me explore what I was thinking or feeling") reflects the extent therapists use interventions to explore clients' narratives, beliefs, thoughts, and feelings. The *Insight* subscale (4 items; e.g., "helped me understand the reasons behind my thoughts, feelings, and/or behaviors") reflects therapist use of interventions to help clients make

connections between past and present, challenge maladaptive beliefs, and gain insight into underlying motivations. The *Action* subscale (5 items; e.g., "helped me figure out how to solve a specific problem") captures interventions used to help clients change behavior, develop skills, solve problems, and identify resources. Hill and Kellems (2002) found the three-factor structure of the HSM was supported by factor analyses; validity was supported by positive correlations between each subscale and measures of session impact, and evidence that HSM scores increase as expected after helping skills training; and internal consistency α ranged .71 to .82 for the three subscales. In the present study, average α for internal consistency across sessions for the therapist-rated HSM was .61 (*SD* = .18) for Exploration, .68 (*SD* = .16) for Insight, and .77 (*SD* = .14) for Action. On the client-rated HSM, average αs were .79 (*SD* = .18) for Exploration, .79 (*SD* = .18) for Insight, and .88 (*SD* = .11) for Action.

Session Quality

The *Session Evaluation Scale* (SES; Hill & Kellems, 2002; Lent et al., 2006) assesses client and therapist perceptions of session quality with 5 items rated on a 5-point scale (1 = *strongly disagree,* 5 = *strongly agree*), with parallel items for the client-rated form (e.g., "I am glad I attended this session", etc.) and therapist-rated form (e.g., "my client is glad they attended this session", etc.). Two items are reverse coded before taking a mean score of all 5 items so that higher scores reflect higher perceived session quality. The fifth item ("Rate the overall effectiveness of this session") was added by Lent et al. (2006) to the original 4-item version to increase variability of scores. Internal consistency has been demonstrated by αs of .89 and .91 for the client- and therapist-rated forms, respectively (Hill & Kellems, 2002). Validity

was supported by correlations with measures of session impact, the therapeutic relationship, and helping skills (Hill & Kellems, 2002). In the present study, average α for internal consistency across sessions was .85 (*SD* = .13) for the client-rated form and .88 (*SD* = .08) for the therapist-rated form.

Therapist-Reported Immediacy Use

As part of an ongoing clinic procedure, therapists completed a checklist of session content with the instructions "Check if you and your client talked about any of the following topics during this session." Two of these dichotomous items indicated whether the session included use of *immediacy* (i.e., "__Immediacy (here and now)") and discussion of the *therapeutic relationship* (i.e., "__Therapeutic Relationship"). Because these items likely reflect different aspects of immediacy (e.g., discussing clients' in-the-moment emotional response to the therapist intervention, versus discussing the therapeutic relationship more broadly, etc.), they were combined into a single dichotomous indicator for therapist-reported immediacy. Average α for internal consistency across sessions was .69 (*SD* = .16).

Working Alliance

The *Working Alliance Inventory-Short Revised* (WAI-SR; Hatcher & Gillaspy, 2006) is a 12-item version of the original 36-item WAI (Horvath & Greenberg, 1989) that has parallel client-rated and therapist-rated forms. Based on Bordin's (1979) tripartite conceptualization of the alliance, items assess client/therapist perceptions of their agreement on *tasks* (e.g., What I am doing in therapy gives me new ways of looking at my problems), agreement on *goals* (e.g., ___ and I are working towards mutually agreed upon goals), and the quality of their

bond (e.g., I believe ___ likes me) on a 5-point scale (1 = *seldom*, 5 = *always*). A total score and subscale scores for Task, Goal, and Bond may be used, with higher scores indicating a stronger alliance. Internal consistency *α*s ranging from .81 to .93, construct validity, and convergent validity have been demonstrated for the WAI-SR in samples of clients with a range of issues and therapists practicing from a variety of treatment approaches (Hatcher & Gillaspy, 2006; Kivlighan et al., 2016; Munder et al., 2010). In the present study, average αs for internal consistency across sessions for the therapist-rated form were .88 (*SD* = .13) for the total scale, .81 (*SD* = .17) for the Goal subscale, .84 (*SD* = .11) for the Task subscale, and .80 (*SD* = .14) for the Bond subscale. For the client-rated form, αs were .90 (*SD* = .09) for the total scale, .84 (*SD* = .09) for the Goal subscale, .89 (*SD* = .10) for the Task subscale, and .76 (*SD* = .15) for the Bond subscale.

Demographics

Clients and therapists completed demographic forms that asked for age, race/ethnicity, and gender identity. As well, therapists completed the TOPS-R to assess theoretical orientation, and clients reported their presenting concerns and completed the OQ30 to assess baseline distress.

Procedures

All procedures were approved by the university's Institutional Review Board.

Recruitment

Therapists were recruited from their doctoral program to provide psychotherapy at the clinic for a minimum of two years, prior to which they complete a consent form describing all research procedures. Clients were recruited through

word of mouth, referrals from other providers, and online advertising. Therapists screened potential clients by phone to inform them of the nature of the training and research clinic, and assess the appropriateness of the clinics services for their concerns based on the following criteria: must be 18 years or older; not in concurrent psychotherapy; seeking psychodynamic/interpersonally oriented psychotherapy; no current symptoms of psychosis (e.g., hallucinations) or active suicidality; and, if taking psychotropic medication they were stabilized under the care of a provider for at least two months. Those eligible were added to the waitlist and offered an intake appointment once a therapist had an opening. Callers who did not meet the criteria or declined being added to the waitlist were provided appropriate referrals. Before intake, clients completed a consent form. The therapist who conducted the intake also provided therapy for that client. Both clients and therapists were informed they may withdraw from participation in the research at any time without consequence.

All clients and therapists at the clinic during the time of the study were included in the sample. When termination was due to therapists leaving the clinic at the end of their externship, clients were offered to transfer to a new clinic therapist. Eight clients transferred to a second therapist in this sample, so only data from work with their first therapist was included.

Therapist Training

Throughout their doctoral program therapists received training in psychodynamic and interpersonal psychotherapy, and other theoretical approaches. Their practicum experiences included readings and trainings in immediacy based on the perspectives of Hill (2020), Teyber and Teyber (2017), and Kiesler (1988).

Therapists engaged in weekly individual supervision and bi-weekly group supervision with licensed, psychodynamic/interpersonally oriented psychologists that also emphasized interpersonal process and immediacy.

Treatment

Therapists provided non-manualized, open-ended psychodynamic/interpersonal psychotherapy. Processing the therapeutic relationship and attending to ruptures and interpersonal dynamics with immediacy when clinically appropriate was emphasized in treatment. Therapists were also permitted to make departures from a psychodynamic/interpersonal approach when clinically necessary (e.g., safety planning, role playing, etc.) in order to be responsive to client needs. Sessions were 45 to 50min long and typically provided on a weekly basis, via telehealth using a secure web-based video platform due to the COVID-19 pandemic (except for 12 sessions held in person when COVID-19 restrictions lifted, which was less than 1% of the sample). At the start of this study, the clinic had been operating remotely for 2.5 months.

Data Collection

All data was collected via secure, web-delivered surveys. Clients and therapists were provided ID numbers to protect confidentiality. Therapists and clients completed the demographic forms before starting at the clinic. After every session, clients and therapists completed their respective HSM, SES, and WAI-SR forms; clients completed the MSQ-C; and therapist completed the immediacy checklist items. Therapists and clients did not have access to each other's responses. Of note,

due to changes in the clinics data collection unrelated to this study, only a subsample of clients and therapists completed the WAI-SR which was utilized in Phase 2.

Data Analysis

Phase 1: Factor Structure, Reliability and Validity of the MSQ-C

I conducted confirmatory factor analyses (CFAs) to test the hypothesized (H1) two-factor structure of the MSQ-C, with six items loading onto an Open Communication factor and six items loading onto a Managing Disagreement/Discomfort factor. CFAs were performed at the within-dyad level because the primary research questions were focused on within-dyad effects. The data set also contained a large sample of sessions for a small number of clients, which was adequate for within-dyad analysis, but not a between-dyad analysis. Thus, MSQ-C item scores were first within-dyad centered by subtracting the overall client mean for each item from the item score at each session. Two-hundred twenty-five sessions with no MSQ-C data were dropped from the data set before fitting the CFAs, resulting in a sample of 1127 sessions for these analyses.

Using MPlus version 8.6 (Muthén & Muthén, 2017), I fit a two-factor CFA with correlated factors with six-items specified to the Open Communication factor and six-items specified to the Managing Disagreement/Discomfort factor. I compared this two-factor model to a one-factor CFA with all MSQ-C items loading onto a single factor. Both models were fit using all available data and robust maximum likelihood estimation, so that they could be compared using a Satorra-Bentler scaled chi-square difference test. Of note, I also attempted to fit bi-factor and hierarchical CFAs to examine the extent to which the MSQ-C is explained by subscales and an

overall factor, however these models had convergence issues. Reliability analysis was then conducted by calculating Cronbach's α, which represents the internal consistency of the MSQ-C total scale and subscales.

Next, I tested my criterion validity hypotheses (H2A through H2I) by calculating within-dyad correlations between the MSQ-C scales and criterion variables using multilevel modeling in MPlus to account for the nested data structure (sessions nested within clients). The therapist level of the data (level 3) was not included in the models because recent research has demonstrated that modeling between-therapist effects reduces model performance and yields more biased within-dyad effect estimates, especially with small samples of therapists (Falkenström et al., 2020). Therefore, two-level models (level 1: session level; level 2: client level) were used to test within-dyad correlations of each MSQ-C scale with client- and therapist-rated measures of helping skills, session quality, and alliance; and with therapist-reported immediacy use. Because therapist-reported immediacy was a dichotomous variable, point-biserial correlations were used. Separate models were fit for each pair of variables. Within-dyad correlations were allowed to vary randomly between clients accounting for the possibility that the strength of the correlations varied depending on the client. MPlus utilized latent variable centering to disaggregate within- and between-dyad components. Bayesian estimation with all available data was used, which is robust for missing data and the small sample size of clients, and allowed the estimation of standardized effects.

Phase 2: MSQ-C Predicting Alliance Strength and Alliance Congruence

To test my hypotheses (H3 through H7) regarding immediacy as a predictor of alliance strength and alliance congruence, I fit multilevel, latent variable models with a model building approach in MPlus. As a preliminary step, I calculated Intraclass Correlation Coefficients (ICCs) for client- and therapist-rated alliance by fitting two, empty (i.e., no predictors), three-level models. The outcome variables were client-rated WAI-SR total scale mean scores in one model, and therapist-rated WAI-SR total scale mean scores in the other. The levels of analysis were the session level (level 1; within clients), client level (level 2; between clients), and therapist level (level 3; between therapists). ICCs indicated sufficient variance for a within-dyad analysis using two-level models (see Results). As noted above, recent research has shown that when within-dyad effects are of interest, omitting the therapist level (level 3) from the models yields better model performance and more accurate estimation of within-dyad effects, especially when the number of therapists is 10 or fewer like in the present sample (Falkenström et al., 2020). Therefore, I fit two-level models with Bayesian estimation using all available data, allowing level-1 within-dyad effect estimates to vary randomly between clients on level 2 to account for the possibility that within-dyad effect estimates may differ depending on the client. Standardized effects were estimated with Bayesian estimation and are interpretable as effect sizes.

Latent variable modeling was used to create the alliance and immediacy variables which had the advantage of accounting for measurement error in the analyses. The latent variables for client alliance and therapist alliance were specified with the observed Goal, Task, and Bond subscale scores for the respective client and

therapist WAI-SR forms. Because the correlation between both MSQ-C factors was large in Phase 1 (see Results), a latent immediacy variable was specified with the observed MSQ-C Open Communication and Managing Disagreement/Discomfort subscale scores. Importantly, I examined models utilizing each of the MSQ-C subscales separately, and results were consistent with the analysis using the latent variable. Therefore, I have reported just the results for models using the latent immediacy variable for concision. The specific models for each analysis are described further below.

I tested my hypotheses that the MSQ-C would be positively associated with alliance strength (H3) and that this relationship would vary over time (H4) with the following 2-level models. In Step 1, the within-dyad (level-1) predictor was latent immediacy. Because the alliance is a dyadic construct, latent client alliance and therapist alliance were entered as correlated outcome variables, allowing the model to account for the relationship between both rater perspectives. Step 2 introduced session number and the interaction of session number and immediacy on level 1. In the case of a significant interaction effect, simple slopes and intercepts were calculated and plotted. Models were compared by computing change in R^2 with an F-test for each outcome variable.

To test my hypotheses regarding dyadic alliance congruence (H5 through H7), I fit three, two-level T&B models (West & Kenny, 2011) in MPlus using the approach described by Atzil-Slonim et al. (2015). T&B models are conceptualized as testing the effect of *truth* on a *judgement*. In the case of alliance congruence, therapist alliance ratings are considered the *judgement* and entered as the outcome variable,

given that it is the therapist's responsibility to perceive the alliance accurately. Client alliance ratings are considered the *truth* and entered as the predictor variable. *Temporal congruence* is indicated by the effect of *truth* on the *judgement*, which estimates the correlation between client and therapist alliance ratings from session to session. Following West and Kenny's (2011) recommendations, the observed indicators (e.g., WAI-SR subscales) for the truth and judgement variables were centered on their overall client mean scores. This centering allowed between-dyad differences to be removed when examining within-dyad fluctuations. It also allowed the therapist alliance intercept in the models to reflect the average difference between client and therapist alliance ratings, which is referred to as the *directional discrepancy* coefficient. In the case of the multilevel, latent variable models used in this study, directional discrepancy was indicated by the level-2 means for the therapist-rated Goal, Task, and Bond subscales of the WAI-SR in the models. To estimate a single effect for directional discrepancy, I averaged the effect for each of these means. Using this approach, I fit the following three models: Step 1 was a simple T&B model with therapist alliance entered as the outcome and client alliance as the predictor on level 1; In Step 2, immediacy and its interaction with client alliance were introduced to level 1 of the model to test whether immediacy moderated the relationship between client and therapist alliance (i.e., did immediacy predict temporal congruence); and in Step 3, Session Number was introduced as a level-1 covariate to examine whether controlling for time in therapy impacted these associations. This final step served as a sensitivity analysis to test whether significant

effects remain significant when detrending the effect of time (Falkenström et al., 2017). Models were compared with an F-test for change in R^2.

Chapter 3: Results

All tables and figures are shown in Appendix B.

Preliminary Results

For the MSQ-C, 16.6% of data was missing (2.1% of which was missing because the MSQ-C was not administered for 29 sessions due to a survey error). For other measures, missing data was: 1.2% for therapist-rated HSM, 14.6% for client-rated HSM, 1.1% for therapist-rated SES, 14.4% for client-rated SES, 2.4% for therapist-rated WAI-SR, 12.6% for client-rated WAI-SR, and 1.1% for therapist-reported immediacy. The percentage of missing data in client-rated measures was likely related to the fact clients were participating in telehealth services during the COVID-19 pandemic and completed surveys online, leading to more incomplete responses than if they were completing surveys in-person. All available data was used when calculating subscale means and running analyses.

Descriptive statistics are shown in Table 1 for the MSQ-C items and in Table 2 for all other variables. Descriptive statistics were calculated across all sessions and clients, and thus reflect averages pooled across levels of the data. Skewness and kurtosis for the MSQ-C were calculated for the within-dyad-centered data that was subject to factor analysis, and were within acceptable ranges.

Phase 1: Factor Structure, Reliability, and Validity of the MSQ-C

Factor Structure and Reliability of the MSQ-C

The CFA results for the MSQ-C yielded fit indices that suggested adequate fit for the two-factor model with correlated factors (Kline, 2016): comparative fit index (CFI) = .93, root-mean-square of error (RMSEA) = .06 (90% CI: .05, .06), and standardized root-mean-square residual (SRMR) = .05. The chi square test of model fit was statistically significant, $\chi^2(53) = 240.85$, $p < 0.0001$, likely due to the large sample size of sessions which the chi square test is sensitive to. The correlation between both factors was large, positive and significant, $r = .55$, $p < .001$. Model fit indices for the one-factor solution were less adequate, compared to those of the two-factor model: CFI = .81, RMSEA = .09 (90% CI: .08, .10), SRMR = .08, chi square test of model fit, $\chi^2(54) = 528.75$, $p < 0.0001$. As shown in Table 1, standardized factor loadings for the two-factor solution were stronger than those of the one-factor, ranging from .29 to .80 (ps < .001) with all but one loading greater than .40. The data was better explained by the two-factor with correlated factors model according to a statistically significant Satorra-Bentler scaled chi-square difference test, $\chi^2(1) = 104.14$, $p < .0001$. Because these results supported my hypothesis (H1), I viewed the two-factor solution as a good model for the MSQ-C.

Reliability analysis showed average α for internal consistency across sessions was .95 (*SD* = .03) for the MSQ-C Total scale, .91 (*SD* = .11) for the Open Communication subscale, and .91 (*SD* = .06) for the Managing Disagreement/Discomfort subscale. Mean scores for the MSQ-C across all sessions

and clients were: Total, $M = 2.60$ ($SD = .89$); Open Communication, $M = 2.90$ ($SD = .94$); and Managing Disagreement/Discomfort, $M = 2.30$ ($SD = .97$).

Criterion Validity Analyses for the MSQ-C

As shown in Table 2, consistent with my hypothesis (H2A), therapist reported immediacy use had significant, positive, small to moderate correlations, as expected, with MSQ-C Total, $r = .28$, $p < .001$; Open Communication, $r = .32$, $p < .001$; and Managing Disagreement/Discomfort, $r = .14$, $p < .001$.

As expected (H2B), client-rated exploration skills had significant, small, positive correlations with MSQ-C Total, $r = .18$, $p < .001$; Open Communication, $r = .18$, $p < .001$; and Managing Disagreement/Discomfort, $r = .14$, $p < .001$. Consistent with my hypotheses (H2C), therapist-rated exploration skills also had significant, small, positive correlations with MSQ-C Total, $r = .10$, $p < .001$; Open Communication, $r = .08$, $p = .004$; and Managing Disagreement/Discomfort, $r = .09$, $p < .001$.

As well, client-rated insight skills had significant, small, positive correlations, as hypothesized (H2D), with MSQ-C Total, $r = .18$, $p < .001$; Open Communication, $r = .15$, $p < .001$; and Managing Disagreement/Discomfort, $r = .17$, $p < .001$. Therapist-rated insight skills had a significant, small, positive correlations with MSQ-C Managing Disagreement/Discomfort as expected (H2E), $r = .08$, $p = .01$; but counter to my hypotheses, was not significantly correlated with MSQ-C Total, $r = .03$, $p = .14$; or Open Communication, $r = -.01$, $p = .31$.

As expected (H2F), client-rated action skills had no significant correlation with MSQ-C Managing Disagreement/Discomfort, $r = .05$, $p = .05$; but contrary to

this hypothesis, had significant, positive, small correlations with MSQ-C Total, r = .09, p < .001; and Open Communication, r = .09, p = .003. Consistent with my hypothesis (H2G), therapist-rated action skills had no significant correlations with any of the MSQ-C scales: Total, r = -.01, p = .40; Open Communication, r = .01, p = .35; and Managing Disagreement/Discomfort, r = -.03, p = .19.

As expected (H2H), client-rated session quality had significant, positive, small correlations with each of the MSQ-C scales: Total, r = .17, p < .001; Open Communication, r = .19, p < .001; and Managing Disagreement/Discomfort, r = .09, p < .001. Consistent with my hypothesis (H2I), therapist-rated session quality also had significant, positive, small correlations with each of the MSQ-C Total, r = .09, p < .001; and Open Communication, r = .09, p = .01; but, counter to this hypothesis, was not correlated with Managing Disagreement/Discomfort, r = .05, p = .06.

Client-rated alliance had significant, positive, small correlations with MSQ-C Total, r = .20, p < .001; Open Communication, r = .19, p < .001; and Managing Disagreement/Discomfort, r = .15, p < .001. Therapist-rated alliance, however, was not significantly correlated with any of the MSQ-C scales: Total, r = .01, p = .40; Open Communication, r = .02, p = .26; and Managing Disagreement/Discomfort, r = -.01, p = .38. The associations between the MSQ-C and the alliance were further examined in Phase 2, accounting for the time in therapy.

In summary, when a client perceived more immediacy in a session compared to that client's average session, therapists were more likely to report having used immediacy, both members of the dyad tended to report more exploration skills, more insight skills, better session quality, and clients (but not therapists) rated the alliance

stronger. As well, session-to-session changes in client-perceived immediacy were mostly unrelated to action skills, except for two positive associations (MSQ-C Total and Open Communication) when action skills were rated by clients. These results generally followed the predicted pattern of correlations, supporting the validity of the MSQ-C.

Phase 2: MSQ-C as Predictor of Alliance Strength and Congruence

Preliminary Results

Means and standard deviations for the client-rated WAI-SR subscales used to create latent alliance variables were as follows: Goal, $M = 4.23$ ($SD = .68$); Task, $M = 4.17$ ($SD = .74$); Bond, $M = 4.58$ ($SD = .52$). For the therapist-rated WAI-SR subscales, means and standard deviations were: Goal, $M = 3.73$ ($SD = .69$); Task, $M = 3.52$ ($SD = .73$); Bond, $M = 4.01$ ($SD = .54$). Session Number (intake was coded as '0') ranged from 0 to 91 and had an average of $M = 35.20$ ($SD = 21.07$).

Based on the ICCs ($ps < .001$), variance explained for client-rated WAI-SR was 24.34% at level 1, 65.16% at level 2, and 10.50% at level 3; and for therapist-rated WAI-SR, 34.59% was at level 1, 18.52% was at level 2, and 46.89% was at level 3. The large variance at level 3 in therapist-rated alliance was likely due to having a small group of therapists with varying self-report styles, which has been observed in prior research with similar samples (e.g., Hatcher et al., 2020). Falkenström et al. (2020) demonstrated that even in scenarios with a large variance at the therapist-level, two-level models performed better at estimating within-dyad effects, especially when therapist sample sizes are small.

Client-Perceived Immediacy Predicting Alliance Strength

Results for the multilevel, latent variable models predicting alliance strength with immediacy are shown in Table 3. Factor loadings for the latent immediacy, client alliance, and therapist alliance variables ranged 0.59 to 0.89 (ps < .001).

In Step 1, immediacy had a significant, positive, small effect on client alliance, $B = 0.25$, $SE = 0.05$, $p < .001$; but no significant association with therapist alliance, $B = 0.00$, $SE = 0.05$, $p = 0.48$. The correlation between client alliance and therapist alliance was a significant, positive, small effect, $B = 0.29$, $SE = 0.04$, $p < .001$. The model explained 6.4% of variance in client alliance, $R^2 = 0.064$, $p < .001$; and 0.1% of variance in therapist alliance, $R^2 = 0.001$, $p < .001$. As hypothesized (H3), when clients perceived more immediacy in a session compared to the average session for that client, they reported a stronger alliance for that session. Client perceived-immediacy did not predict therapist-rated alliance strength, which was inconsistent with this hypothesis.

In Step 2, immediacy had a significant, positive, large effect on client alliance, $B = 0.55$, $SE = 0.10$, $p < .001$. The main effect for session number on client alliance was not significant, $B = 0.02$, $SE = 0.07$, $p = .35$. Consistent with my hypothesis (H4), the interaction between session number and immediacy was significant, $B = -0.19$, $SE = 0.06$, $p = .001$. The association of immediacy and therapist alliance remained non-significant, $B = 0.11$, $SE = 0.11$, $p = .18$. Session number had a significant, positive, small effect on therapist alliance, $B = 0.11$, $SE = 0.05$, $p = .02$; but no significant interaction effect with immediacy on therapist alliance, $B = -0.10$, $SE = 0.09$, $p = .16$. Client and therapist alliance had a significant, positive, medium correlation, $B = 0.30$,

SE = 0.04, $p < .001$. This model explained 9.9% of variance in client alliance, R^2 = 0.099, $p < .001$; and 3.3% of variance in therapist alliance, $R^2 = 0.033$, $p < .001$. The increase in variance explained was statistically significant for client alliance and therapist alliance, $F(3, 1041) = 13.48$, $p < .001$, and, $F(3, 1041) = 11.48$, $p < .001$, respectively. Thus, the relationship between client-perceived immediacy and alliance strength was better explained when accounting for time in therapy.

Simple slopes and intercepts (at -1 *SD, M*, and +1 *SD* for session number) were calculated for the significant interaction of session number and immediacy predicting client alliance strength. As shown in Figure 1, in earlier sessions (-1 *SD*), when clients perceived more immediacy compared to their average session, they tended to report a stronger alliance, as indicated by a significant, positive slope, *B* = 0.29, *SE* = 0.06, $p < .001$. In middle sessions (*M*), the same positive effect was found, but with a smaller magnitude, *B* = 0.14, *SE* = 0.03, $p < .001$. The slope for later sessions (+1 *SD*) was not significant, *B* = -0.02, *SE* = 0.06, $p = 0.40$. Therefore, when clients perceived more immediacy than usual in sessions earlier in treatment, they tended to report a stronger alliance. The magnitude of this effect reduced as therapy progressed, becoming smaller in middle sessions and non-significant in later sessions. These results were consistent with my hypothesis (H4) that the relationship between immediacy and alliance strength would vary depending on timing in therapy.

Client-Perceived Immediacy Predicting Alliance Congruence

Results are shown in Table 4 for the T&B models examining alliance congruence. For all three models, factor loadings for the latent client alliance, therapist alliance, and immediacy variables ranged .60 to .89 (ps < .001).

In Step 1, there was a significant, positive, moderate effect for temporal congruence, indicating that therapist alliance ratings tended to follow fluctuations in client alliance ratings closely, $B = 0.29$, $SE = 0.04$, $p < .001$. Directional discrepancy was indicated by the level-2 intercepts for therapist-rated Goal, Task, and Bond subscale scores, which were each negative (Bs = -.69 to -.88) and significant (ps < .001), suggesting that therapist alliance ratings tended to be lower than client alliance ratings on average. The pooled effect for directional discrepancy was large and negative, $B = -.77$. This model explained 8.1% of variance in therapist alliance, $R^2 = 0.081$, $p < .001$. Therefore, therapist alliance ratings tended to follow fluctuations in client alliance ratings as expected (H5), such that when clients perceived a stronger alliance than in their average session, therapists also rated the alliance stronger; and when clients rated the alliance weaker than in their average session, therapists also rated the alliance weaker. Also as expected (H6), therapist alliance ratings tended to be lower than clients' ratings on average.

In Step 2, temporal congruence remained significant and positive, $B = 0.31$, $SE = 0.04$, $p < .001$; and directional discrepancy remained significant (ps < .001) and negative (Bs = -0.65 to -0.86), with a large, pooled effect, $B = -0.75$. The correlation between immediacy and client alliance was significant, small, and positive, $B = 0.22$, $SE = 0.05$, $p < .001$. The main effect of immediacy was a significant, negative, small effect, indicating that in sessions that clients reported more immediacy, therapists tended to rate the alliance with more negative directional discrepancy, $B = -0.09$, $SE = 0.05$, $p = 0.02$. Contrary to my hypothesis (H7), there was no significant interaction effect for immediacy and client alliance on therapist alliance, $B = 0.06$, $SE = 0.07$, $p =$

0.11. Therefore, client-perceived immediacy did not predict dyadic alliance congruence. This model explained 10.2% of variance in therapist alliance, $R^2 = 0.102$, $p < .001$. The increase in variance explained was statistically significant, $F(3, 1041) = 8.12$, $p < .001$.

In Step 3 which added session number as a level-1 covariate, all effect estimates and significance levels remained the same with minor differences in magnitude. The effect of session number on therapist alliance was non-significant, $B = 0.06$, $SE = 0.07$, $p = 0.22$. Variance explained in therapist alliance was 12.3%, $R^2 = 0.123$, $p < .001$; and the increase in R^2 was statistically significant, $F(4, 1038) = 6.21$, $p < .001$. Although this model better explained the data, immediacy still did not predict alliance congruence when controlling for time in therapy. These results also indicate that detrending the effect of time in treatment did not have baring on the significant effects, which supports the reliability of these findings.

Chapter 4: Discussion

In this study of 1352 sessions of 58 clients and 11 doctoral student therapists in psychodynamic-interpersonal psychotherapy, the associations between client-perceived immediacy, alliance strength, and alliance congruence were examined. As a first step, this study examined the factor structure and validity of the MSQ-C, a client-rated measure of immediacy, and found preliminary evidence that the MSQ-C had good psychometric properties. Using the MSQ-C to assess immediacy, results showed that client-perceived immediacy was positively associated with client-rated alliance strength and that this effect was strongest in sessions earlier in treatment. This finding for alliance strength was consistent with theory regarding immediacy (i.e., Kiesler,

1988), though it differed from prior within-dyad research on immediacy (i.e., Shafran et al., 2017). Results regarding alliance congruence were consistent with prior research (e.g., Atzil-Slonim et al., 2015), demonstrating that therapist alliance ratings tended to be congruent with those of their clients from one session to the next, and that therapists rated the alliance lower on average than their clients did. Although, client-perceived immediacy did not predict alliance congruence as hypothesized.

The Metacommunication in Session Questionnaire–Client Form

The MSQ-C is a 12-item client-rated measure of immediacy which showed good psychometric properties in the preliminary phase of this study. Confirmatory factor analyses supported a two-factor structure for the MSQ-C at the within-dyad level that mirrored the factor structure identified by Calvert, Dean, and Grenyer (2020) in the original supervisee-rated MSQ. Thus, the MSQ-C captures client perceptions of the frequency of immediacy in sessions on two, correlated, 6-item factors: the Open Communication subscale and Managing Disagreement/Discomfort subscale. The consistency of the factor structure between the supervisee- and client-rated versions of the MSQ is useful because it suggests that scores on these measures are generalizable across different levels of analysis (e.g., within-person and between-person) and across different contexts (e.g., psychotherapy and clinical supervision). The MSQ-C full scale and subscales each showed high internal consistency and evidence of validity based on predicted correlations with related measures of therapist-reported immediacy, helping skills, session quality, and the working alliance.

The MSQ-C contributes a more comprehensive standardized measure of immediacy compared to other similar measures. For example, prior studies using standardized measures of immediacy (e.g., Kuutman & Hilsenroth, 2012; Li et al., 2016) have used single items that assess a here-and-now focus in session (Blagys & Hilsenroth, 2000, 2002; Li et al., 2016; Tracey et al., 1988). The MSQ-C subscales assess a much wider range of immediacy than a single, general item could. For example, the MSQ-C Open Communication subscale captures the extent that clients perceive their therapists facilitating here-and-now discussion about the clients feelings about the therapeutic relationship ("My therapist checked in with me about my feelings about what is happening between us in therapy") and to assess what is and is not working in therapy for the client ("My therapist and I monitored what was working/not working between us in therapy"). The Managing Disagreement/Discomfort subscale captures the frequency that clients perceive their therapists use immediacy to address negative processes in therapeutic relationship, such as differences of opinion ("My therapist and I had a difference of opinion and we discussed this together openly") and clients' worries about their therapists' potential negative feelings towards them ("I worried that my therapist was feeling something negative toward me (e.g., frustration) and we talked about this together directly"). These subscales capture more nuanced ways that immediacy is used to monitor and maintain the alliance, and to work through ruptures and maladaptive interpersonal patterns.

In comparison to judges' ratings of immediacy (e.g., Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008), the MSQ-C can be considered a more general measure

because it does not assess specific in-session immediacy interventions and is not honed for each specific case or sample of dyads as can be done using qualitative methods (e.g., Consensual Qualitative Research-Cases, Jackson et al., 2012). Relatedly, the MSQ-C form assesses perceived frequency of immediacy in a session but does not reflect a true count of the number of immediacy events within a session, nor does it capture the quality of immediacy, both of which can be assessed by judges' ratings (e.g., Hill et al., 2014). The MSQ-C does provide an instrument that can be used to more easily collect large samples of data needed to conduct more complex statistical analysis than can be done with small samples from qualitative data. When using the MSQ-C, the strengths and weaknesses of this approach should be considered, as well as its suitability for the specific research questions.

Validity of the MSQ-C

The validity correlations for both MSQ-C subscales were largely consistent with the hypotheses, despite some variation depending on the MSQ-C subscale and the rater-perspectives of criterion variables. Both MSQ-C Open Communication and Managing Disagreement/Discomfort were positively associated with client and therapist ratings of exploration skills. Although immediacy is not an exploration skill itself, both facets of immediacy captured by the MSQ-C subscales involve further exploration of the clients' narratives and emotions, for example, through open questions and reflections of feelings (Hill, 2020).

As well, both MSQ-C subscales were positively associated with client and therapist rated insight skills, except for therapist-rated insight skills and the Open Communication subscale, which were not correlated. Of note, the items on the HSM

Insight scale do not directly assess immediacy, but they capture other insight skills, like challenges and interpretations (Hill, 2020), that have more in common with the immediacy interventions captured by the Managing Disagreement/Discomfort subscale than with the Open Communication subscale. The lack of correlation between therapist-rated insight skills and the Open Communication subscale may reflect this distinction, especially if the therapists (who were all trained in the Helping Skills model during their doctoral program) rated the measures with greater sensitivity to these nuances.

As expected, the Managing Disagreement/Discomfort subscale was unrelated to action skills, regardless of rater perspectives. The Open Communication subscale was also uncorrelated with action skills when rated by therapists, but contrary to my hypothesis had a small correlation with client-rated action skills. Because the action skills assessed by the HSM involve skill-building and problem-solving interventions, an association with immediate, open communication about the therapeutic relationship seemed unlikely. It is possible that therapists used immediacy to check-in with clients during action-oriented interventions which is encouraged in the helping skills model (Hill, 2020), and that this was reflected by the positive association between Open Communication scores and client-rated action skills. It is also possible that when clients-rated therapists higher on the MSQ-C, they also tended to rate therapists higher on other skills, reflecting a self-report pattern.

Importantly, when clients perceived more immediacy on both MSQ-C subscales, therapists were also more likely to report having used immediacy in that session. The correlation between the MSQ-C scales and therapist reported immediacy

were the strongest of all the validity correlations, indicating a closer association than with the other criterion variables which were more indirectly related to immediacy. Although the checklist items therapists used to indicate immediacy use were not a previously validated measure of immediacy, the therapists' perspective provides promising support that changes in MSQ-C scores reflect fluctuations in immediacy from one session to the next.

Notably, therapists indicated on the dichotomous items that immediacy occurred in 49.1% of sessions, however, MSQ-C scores suggest that clients perceived immediacy occurred more often. This discrepancy is likely due to the different scales (i.e., Likert vs. dichotomous) of client- and therapist-rated variables contributing to different rater-sensitivities. For instance, therapists likely indicated immediacy occurred based on a threshold amount of immediacy in the session, whereas MSQ-C scores have more variability and may reflect client perceptions of brief immediacy interventions that may have been insufficient to cue therapists to rate the dichotomous items.

As well, the MSQ-C subscales were positively correlated with client ratings of session quality, but only the Open Communication subscale was correlated with therapist ratings of session quality. Overall, this result is consistent with Shafran et al.'s (2017) finding that in sessions with more observer-rated immediacy, clients viewed session quality higher. Thus, when clients perceive their therapists to use more immediacy to communicate openly and address difficulties in their relationship, the quality of sessions seems improved. As Shafran et al. noted, it is also possible that this correlation reflects therapists being more comfortable using immediacy when

sessions are already going well, given that immediacy is a skill that requires trust and comfort with intimacy.

Additionally, both subscales were also positively correlated with strength of client alliance ratings, but not with therapist alliance ratings, suggesting that clients (but not therapists) view the alliance stronger when they perceive more immediacy in a session. This relationship is discussed further below, regarding the predictive models of alliance strength.

The validity correlations for the MSQ-C total scale followed an identical pattern to that of the Open Communication subscale, thus providing comparable evidence of validity. Taken together, the overall pattern of validity correlations across all MSQ-C scales was as expected, providing preliminary evidence of validity for the MSQ-C.

Client-Perceived Immediacy and Alliance Strength

The finding that clients rated the alliance stronger when they perceived greater immediacy in a session is consistent with previous findings that immediacy enhances the therapy relationship (Hill et al., 2018). When examining how time in therapy moderated this effect, client-perceived immediacy had the strongest positive association with client-rated alliance in sessions that were earlier in treatment. This association reduced in magnitude in middle sessions and was no longer significant in later sessions. This result is consistent with Kiesler's (1988) hypothesis that using immediacy earlier in therapy would lead to more favorable outcomes by allowing the therapist to establish open communication with their client about their relationship, and to begin to identify maladaptive interpersonal patterns that would be addressed as

therapy progressed. This finding is also consistent with Zilcha-Mano and Errázuriz' (2017) findings that repairing ruptures early in treatment (a process that involves immediacy) contributes to a stronger alliance. When clients' experience their therapist checking in about their experience of the therapy relationship and views of the tasks and goals of therapy early on, this communicates a sense of care that strengthens the alliance. Additionally, addressing disagreements or difficult interpersonal dynamics as they arise provides an opportunity to repair ruptures in the alliance as they occur, which would also contribute to a stronger alliance. Furthermore, immediacy use earlier in treatment may help acclimate clients to communicating in what is typically an unfamiliar and intimate manner, that can set the stage for deeper use of immediacy later in treatment.

Shafran et al.'s (2017) results were only partially replicated in this study, given that there was a moderation effect of time in therapy but that it was in the opposite direction. Shafran et al. found that observer-rated immediacy had a negative relationship to the alliance in earlier sessions, and positive in later sessions. Interestingly, Shafran et al.'s finding fits with Kiesler's (1988) theory that trust must be established before immediacy can be effective. The authors suggested that, before a strong alliance is established, too much use of immediacy early in therapy could strain the alliance and that immediacy may be more helpful later in treatment when the relationship is well-established. Alternatively, the authors suggested that immediacy use in early sessions may have also been in response to a weak alliance, such that the therapists were attempting to repair ruptures (e.g., Zilcha-Mano & Errázuriz, 2017). Given the correlational nature of the data in both studies, it is

difficult to determine the direction of effects. These differing findings could be due to the much larger sample size in the present study, the different methods used to assess immediacy, or even the fact the present study was conducted via teletherapy during the COVID-19 pandemic which could have influenced immediacy use. Additionally, the present study accounted for the therapists' perceptions of the alliance in the analysis, which extended this research by accounting for dyadic information and may also have contributed to the novel results.

Notably, therapist-rated alliance was not associated with client-perceived immediacy, which is inconsistent with Hill et al. (2014) who found that the average amount of immediacy was correlated with therapist alliance ratings at the between-dyad level. Though, Hill et al.'s (2014) analysis was a simple correlation that did not account for the nesting of sessions within dyads, or the simultaneous impact of client alliance perceptions. It is possible that therapist alliance ratings have a different relationship to immediacy than client alliance ratings because therapists may be responding to their perceptions of the alliance when using immediacy, and not the other way around. For example, when they view the alliance as weak, therapists may respond by working to repair ruptures. Some evidence supporting this view was found in the models examining alliance congruence: there was a significant association of immediacy and therapist alliance ratings when centered around clients' average alliance ratings, which suggested that therapists tended to rate the alliance with greater negative discrepancy relative to client alliance ratings in sessions that clients perceived more immediacy. This result could reflect therapists using more immediacy when they view the alliance as weaker, or when there is a greater

discrepancy between client and therapist views of the relationship, which could itself represent a type of rupture. If this is the case, the relationship between therapist alliance ratings and immediacy may not be a simple, linear, unidirectional relationship. Future research should explore the reciprocal relationship between alliance strength and immediacy over time to better understand how therapists use immediacy in response to the alliance, and how the alliance is then affected by immediacy use.

Overall, the positive association between client-perceived immediacy and the strength of the working alliance reflect the importance of therapists ensuring their clients' experience open, transparent communication about the therapeutic relationship, tasks and goals of therapy, and interpersonal dynamics. Indeed, clinicians and theoreticians across a range of perspectives agree upon the importance of processing the relationship (Hill & Knox, 2009). These findings also add to the literature that suggests that the timing of immediacy interventions is important, both in terms of phase of treatment (Shafran et al., 2017) and timing within a session (Li et al., 2016). Given the small number of studies, varied methods and results, additional research is needed to better understand *when* immediacy is most helpful, and what *types* of immediacy are most helpful at different times. Nonetheless, clinicians should attend to client readiness to discuss the relationship when considering when and how to use immediacy in sessions.

Client-Perceived Immediacy and Alliance Congruence

As expected, therapist alliance perceptions were temporally congruent with session-to-session fluctuations in client alliance ratings and lower than client ratings

on average, which was consistent with prior research (e.g., Atzil-Slonim et al., 2015; Kivlighan & Marmarosh, 2016; O'Connor et al., 2019; Rubel et al., 2018). Thus, this study replicated the finding that therapists track the alliance as it unfolds but perceive it as weaker than their clients do. Researchers have interpreted this as reflecting therapists' cautiousness, what Atzil-Slonim et al. (2015) refer to as a "better safe than sorry" approach. This notion has been further supported by Rubel et al.'s finding that client symptoms improved more when therapists slightly underrated the alliance on average, but that outcomes diminish with larger underestimation or overestimation.

Contrary to my hypothesis, client-perceived immediacy was not associated with temporal congruence of therapist and client alliance ratings, as indicated by the finding that client-perceived immediacy did not moderate the within-dyad association of client and therapist alliance ratings. In other words, client's perceiving more here-and-now communication about the therapy relationship was not related to increased agreement about the quality of the alliance. This null finding is challenging to interpret given a lack of studies examining session-level predictors of alliance congruence. It is possible that client-perceptions of immediacy are not associated with alliance congruence, but that assessing immediacy from therapist or observer perspectives may yield different results. In the only other study that examined a session level moderator, Lai et al. (2021) found that in sessions when therapist self-efficacy was higher for that specific client, temporal congruence of alliance ratings was stronger. Self-efficacy represents an internal, felt sense of confidence that the therapist has with the client, which is distinct from a verbal, therapeutic communication that unfolds within a dyad such as immediacy. If future research

examining how immediacy and therapist skills relate to alliance congruence continues to yield null findings, this may suggest that alliance congruence is not the result of an explicit dialogue between client and therapist. Instead, congruence may be the result of personality characteristics that enable the therapist to be more empathically attuned to their clients, such as traits already shown to predict alliance congruence like attachment style (Kivlighan & Marmarosh, 2016; O'Connor et al., 2019) and affiliative interpersonal style (Chen et al., 2018).

Limitations and Future Directions

The results of this study must be understood in the context of important limitations. This study was conducted on a substantially larger sample size of sessions and clients than prior studies of immediacy and the alliance, and yet was still slightly underpowered to detect within-dyad effects in the main analysis examining alliance strength and congruence. Fifty level-2 units (i.e., clients) have been recommended to detect within-dyad effects (Hox, 2010), whereas this study contained only 38 clients for the main analysis which may have contributed to the null relationship between immediacy and alliance congruence. Future studies should strive to obtain more sufficient sample sizes.

The correlational nature of the data also limits the potential for inferences about the direction of the effects. Like prior research (e.g., Shafran et al., 2017), this study did not test whether immediacy influences the alliance, the alliance influences immediacy, or both. As discussed above, it is possible that there is a reciprocal relationship, such that client and/or therapist alliance ratings influence subsequent immediacy use, and vice versa. A weak alliance may precede immediacy used to

repair the therapeutic relationship, and the subsequently strong alliance may provide the trust needed to process the relationship more deeply. Future research can use methods such as dynamic structural equation modeling (McNeish & Hamaker, 2020) to investigate this potential reciprocal relationship using time-lagged alliance and immediacy data.

Therapists in the study were all doctoral trainees delivering psychodynamic-interpersonal psychotherapy, and therefore findings may differ in samples of more experienced therapists practicing from different theoretical orientations. The fact that therapists in this study were predominantly Asian is also noteworthy. Research has shown that Asian cultural norms may contribute to less comfort and less confrontational use of immediacy (Joo et al., 2019; Seo et al., 2013), and these cultural factors may have influenced the results of the present study. Another potential limitation is that therapy was delivered online through a video and audio platform due to necessary health precautions during the COVID-19 pandemic. The telehealth platform may have influenced therapists use of immediacy, and perhaps client's perceptions of immediacy.

The use of self-report measures also presents important limitations. Some amount of shared variance between immediacy, alliance, and other criterion validity variables may have been due to mono-method bias. Incorporating therapist-rated forms in this study mitigated some of this limitation by providing multiple rater perspectives. Relatedly, the client self-report method of assessing immediacy may have contributed to the null relationship with alliance congruence, and therefore future research should investigate whether observer- and therapist-ratings of

immediacy have different associations with alliance congruence. As well, investigating whether other therapist skills (i.e., exploration, insight, action, etc.) contribute to alliance congruence would help to further clarify whether alliance congruence reflects a dyad's explicit communication, implicit attunement, or both.

Additionally, further validation of the MSQ-C is needed that incorporates observer-rated methods. This could be accomplished by modifying the MSQ-C to be rated by observers, and correlating client and observer ratings. Such a study could provide important validity evidence that the MSQ-C is related to observed, in-session behavior. A therapist-rated version of the MSQ-C could also be incorporated in this study design, which would improve upon the use of dichotomous therapist-rated indicator of immediacy relied upon in this study due to the limitations of the available data.

It is also noteworthy that clients rating a measure of immediacy may have prompted them to think more about discussing the therapeutic relationship and perhaps to initiate immediacy more themselves. Although this may have unintentionally influenced the results of this study, it also points to the potential utility of the MSQ-C as an intervention, that could be especially useful for supervision. Completing a therapist-rated version of the MSQ could provide an aid to reflect on what types of immediacy trainees do or do not use with their clients, which could support existing immediacy trainings (Hill et al., 2019; Spangler et al., 2014).

The various MSQ forms could also be used to examine the effect of immediacy in supervision on trainee therapists use of immediacy with their clients. Supervisor modeling of immediacy can increase trainee self-efficacy for immediacy

(Calvert, Deane, & Barrett, 2020; Hill et al., 2019), but it is unclear how such modeling contributes to trainees work with clients. A multilevel study design of supervisor effects (e.g., Gerstenblith et al., 2022) using the available MSQ forms could investigate whether immediacy in supervision contributes to greater immediacy in trainees' sessions with their clients.

Appendix A: Measures

Metacommunication in Session Questionnaire – Client Form (MSQ-C)

Instructions: How frequently did this occur in this week's session?

Items are rated on a 4-point scale (1 = *Never*, 4 = *Often*)

1. My therapist and I talked directly about our relationship.
2. My therapist and I openly negotiated the terms of our relationship.
3. My therapist and I monitored what was working/not working between us in therapy.
4. My therapist checked in with me about my feelings about what is happening between us in therapy.
5. My therapist and I discussed whether therapy was meeting my needs.
6. I had trouble responding to someone in my life and my therapist and I discussed how I struggled with the same issue in the therapy relationship.
7. My therapist and I spoke about parallels or similarities between myself and important people in my life.
8. I worried that my therapist was feeling something negative toward me (e.g. frustration) and we talked about this together directly.
9. I felt uncomfortable or upset about something that happened in therapy and my therapist and I discussed this openly.
10. My therapist and I spoke about how comfortable we feel to discuss things openly with one another in therapy.
11. My therapist and I spoke about things that have previously been censored, concealed or unsaid in our relationship.
12. My therapist and I had a difference of opinion and we discussed this together openly.

Note. The MSQ-C was adapted from Calvert, Deane, and Grenyer's (2020) MSQ for the supervisee-supervisor relationship to be used in the client-therapist context for the present study. Open Communication subscale items: 1, 2, 3, 4, 5, 10; Managing Disagreement/Discomfort subscale items: 6, 7, 8, 9, 11, 12.

Helping Skills Measure (HSM) – Client Form

Instructions: Indicate how much each statement reflects your experiences in your most recent therapy session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful. The term helper can refer to a therapist, counselor, or any other person in the helping role.

Items are rated on a 5-point scale (1 = *Strongly Disagree,* 5 = *Strongly Agree*)

In this session, my helper...
1. asked questions to help me explore what I was thinking or feeling.
2. encouraged me to challenge my beliefs.
3. did **NOT** help me think about changes I could make in my life.
4. did **NOT** teach me specific skills to deal with my problems.
5. did **NOT** encourage me to express what I was thinking or feeling.
6. helped me become aware of contradictions in my thoughts, feelings, and/or behaviors.
7. helped my think about my concerns.
8. did **NOT** help me identify useful resources (e.g., friends, parents, advisors, schools, clergy).
9. helped me figure out how to solve a specific problem.
10. helped me understand the reasons behind my thoughts, feelings, and/or behaviors.
11. did **NOT** encourage me to experience my feelings.
12. did **NOT** discuss with me specific things I could do to make change happen.
13. helped me gain a new perspective on my problems.

Note. 'r' denotes items that need to be reverse scored before totaling subscale scores. Exploration scale items: 1, 5r, 7, 11r; Insight scale items: 2, 6, 10, 13.; Action scale items: 3r, 4r, 8r, 9, 12r.

Helping Skills Measure (HSM) – Therapist Form

Instructions: Indicate how much each statement reflects your experiences in your most recent therapy session. Please note that all of these things do not occur in every session because helpers do many different things to be helpful. The term helper can refer to a therapist, counselor, or any other person in the helping role.

Items are rated on a 5-point scale (1 = *Strongly Disagree,* 5 = *Strongly Agree*)

In this session, I…
1. asked questions to help the client explore what they were thinking or feeling.
2. encouraged the client to challenge their beliefs.
3. did **NOT** help the client think about changes they could make in their life.
4. did **NOT** teach the client specific skills to deal with their problems.
5. did **NOT** encourage the client to express what they were thinking or feeling.
6. helped the client become aware of contradictions in their thoughts, feelings, and/or behaviors.
7. helped my think about their concerns.
8. did **NOT** help the client identify useful resources (e.g., friends, parents, advisors, schools, clergy).
9. helped the client figure out how to solve a specific problem.
10. helped the client understand the reasons behind their thoughts, feelings, and/or behaviors.
11. did **NOT** encourage the client to experience their feelings.
12. did **NOT** discuss with the client specific things they could do to make change happen.
13. helped the client gain a new perspective on their problems.

Note. 'r' denotes items that need to be reverse scored before totaling subscale scores. Exploration scale items: 1, 5r, 7, 11r; Insight scale items: 2, 6, 10, 13.; Action scale items: 3r, 4r, 8r, 9, 12r.

Session Evaluation Scale (SES) – Client Form

Instructions: Indicate how much each statement reflects your experiences in your most recent therapy session.

Items are rated on a 5-point scale. The anchors for items 1 – 4 are range from 1 = *Strongly Disagree* to 5 = *Strongly Agree*; and the anchors for item 5 range from 1 = *Not Effective*, 5 = *Highly Effective*.

1. I am glad I attended this session.
2. I did **NOT** feel satisfied with what I got out of this session.
3. I thought this session was helpful.
4. I did **NOT** think this session was valuable.
5. Rate the overall effectiveness of this session.\

Note. Mean scores of all 5 items are taken after reverse scoring items 1 and 2.

Session Evaluation Scale (SES) – Therapist Form

Instructions: Indicate how much each statement reflects your experiences in your most recent therapy session.

Items are rated on a 5-point scale. The anchors for items 1 – 4 are range from 1 = *Strongly Disagree* to 5 = *Strongly Agree*; and the anchors for item 5 range from 1 = *Not Effective*, 5 = *Highly Effective*.

My client...
1. is glad they attended this session.
2. did **NOT** feel satisfied with what they got out of this session.
3. thought this session was helpful.
4. did **NOT** think this session was valuable.
5. Rate the overall effectiveness of this session.

Note. Mean scores of all 5 items are taken after reverse scoring items 1 and 2.

Working Alliance Inventory – Short Revised (WAI-SR) – Client Form

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

Items are rated on a 5-point scale (1 = *Seldom*, 5 = *Always*)

1. As a result of these sessions I am clearer as to how I might be able to change.
2. What I am doing in therapy gives me new ways of looking at my problem.
3. I believe___likes me.
4. ___and I collaborate on setting goals for my therapy.
5. ___and I respect each other.
6. ___and I are working towards mutually agreed upon goals.
7. I feel that___appreciates me.
8. _____ and I agree on what is important for me to work on.
9. I feel _____ cares about me even when I do things that they do not approve of.
10. I feel that the things I do in therapy will help me to accomplish the changes that I want.
11. _____ and I have established a good understanding of the kind of changes that would be good for me.
12. I believe the way we are working with my problem is correct.

Note. Goal items: 4, 6, 8, 11; Task items: 1, 2, 10, 12; Bond items: 3, 5, 7, 9

Working Alliance Inventory – Short Revised (WAI-SR) – Therapist Form

Instructions: Below is a list of statements about the working relationship between therapist and client. Some items refer directly to your client with an underlined space -- as you read the sentences, mentally insert the name of your client in place of ___ in the text.

Items are rated on a 5-point scale (1 = *Seldom*, 5 = *Always*)

1. As a result of these sessions _____ is clearer as to how they might be able to change.
2. My client and I both feel confident about the usefulness of our current activity in therapy.
3. I believe _____ likes me.
4. ___and I have collaborated on setting goals for therapy.
5. ___and I respect each other.
6. ___and I are working towards mutually agreed upon goals.
7. I appreciate _____ as a person
8. We agree on what is important for _____ to work on.
9. I respect ____ even when they do things that I do not approve of.
10. I feel confident that the things we do in therapy will help _____ to accomplish the changes that they desire.
11. _____ and I have established a good understanding between us of the kind of changes that would be good for _____.
12. _____ believes the way we are working with their problems is correct.

Note. Goal items: 4, 6, 8, 11; Task items: 1, 2, 10, 12; Bond items: 3, 5, 7, 9

Appendix B: Tables & Figures

Table 1

Descriptive Statistics and Structure Coefficients for the Metacommunication in Session Questionnaire–Client Form (MSQ-C)

MSQ-C Item	*M* (*SD*)	Skewness (Kurtosis)	1-Factor CFA Loadings	2-Factor CFA Loadings	
				Open Communication	Managing Disagreement
1. My therapist and I talked directly about our relationship	3.09 (1.03)	-.23 (1.22)	0.78	0.80	–
2. My therapist and I openly negotiated the terms of our relationship	2.74 (1.19)	.22 (2.24)	0.71	0.72	–
3. My therapist and I monitored what was working/not working between us in therapy	2.89 (1.06)	.12 (1.36)	0.72	0.73	–
4. My therapist checked in with me about my feelings about what is happening between us in therapy	3.14 (0.99)	-.09 (1.13)	0.69	0.69	–
5. My therapist and I discussed whether therapy was meeting my needs	2.76 (1.09)	.34 (1.45)	0.65	0.67	–
6. I had trouble responding to someone in my life and my therapist discussed how I struggle with the same issue in the therapy relationship	2.40 (1.16)	.22 (1.46)	0.39	–	0.47
7. My therapist and I spoke about parallels or similarities between myself and important people in my life	2.79 (1.09)	-.08 (2.03)	0.28	–	0.29
8. I worried that my therapist was feeling something negative towards me (e.g., frustration) and we talked about this together directly	1.95 (1.18)	-.07 (3.80)	0.37	–	0.67
9. I felt uncomfortable or upset about something that happened in therapy and my therapist and I discussed this openly	2.07 (1.20)	.16 (3.03)	0.39	–	0.65

10. My therapist and I spoke about how comfortable we feel to discuss things openly with one another in therapy	2.76 (1.14)	.42 (1.54)	0.61	0.60	–
11. My therapist and I spoke about things that have been previously censored, concealed, or unsaid in our relationship	2.34 (1.18)	.41 (1.29)	0.41	–	0.53
12. My therapist and I had a difference of opinion and we discussed this together openly	2.24 (1.19)	.04 (3.47)	0.32	–	0.49

Note. N = 1127 sessions of 58 clients. All factor loadings were significant at $p < .001$; Means and standard deviations are based on the uncentered MSQ-C item scores; Skewness and kurtosis are based on the within-dyad centered data that was subject to factor analysis. MSQ-C = Metacommunication in Session Questionnaire-Client Form; *SD* = standard deviation.

Table 2

Within-Dyad Correlations of MSQ-C with HSM, SES, WAI-SR, and Therapist-Reported Immediacy Use

Criterion Variable	*M* (*SD*)	MSQ-C Total		MSQ-C Open Communication		MSQ-C Managing Disagreement	
		r	*p*	*r*	*p*	*r*	*p*
Therapist Immediacy	–	.28	< .001	.32	< .001	.14	< .001
HSM Exploration Skills							
Client	4.72 (.46)	.18	<.001	.18	<.001	.14	<.001
Therapist	3.95 (.63)	.10	<.001	.08	.004	.09	<.001
HSM Insight Skills							
Client	4.35 (.73)	.18	<.001	.15	<.001	.17	<.001
Therapist	2.79 (.87)	.03	.14	-.01	.31	.08	.01
HSM Action Skills							
Client	4.11 (.95)	.09	<.001	.09	.003	.05	.05
Therapist	2.06 (.82)	-.01	.40	.01	.35	-.03	.19
Session Evaluation Scale							
Client	4.59 (.59)	.17	<.001	.19	<.001	.09	<.001
Therapist	3.85 (.66)	.09	<.001	.09	.01	.05	.06
WAI-SR							
Client	4.33 (.57)	.20	<.001	.19	<.001	.15	<.001
Therapist	3.76 (.58)	.01	.40	.02	.26	-.01	.38

Note. Within-dyad correlations were estimated with two-level models fit in MPlus using Bayesian estimation with all available data; MSQ-C = Metacommunication in Session Questionnaire-Client Form; HSM = Helping Skills Measure; WAI-SR = Working Alliance Inventory Short Revised; Client = Client-rated form; Therapist = Therapist-rated form; Therapist Immediacy = therapist-reported immediacy use (dichotomous variable) which had a count of 656 out of 1337 (49.1%); *SD* = standard deviation.

Table 3

Within-Dyad Immediacy as a Predictor of Client and Therapist Alliance Strength

Effect	Step 1			Step 2		
	B	*SE*	*p*	*B*	*SE*	*p*
Client Alliance by						
Client WAI-Bond	0.59	0.03	<.001	0.60	0.03	<.001
Client WAI-Task	0.79	0.03	<.001	0.79	0.02	<.001
Client WAI-Goal	0.79	0.02	<.001	0.78	0.02	<.001
Therapist Alliance by						
Therapist WAI-Bond	0.80	0.01	<.001	0.81	0.01	<.001
Therapist WAI-Task	0.86	0.01	<.001	0.86	0.01	<.001
Therapist WAI-Goal	0.89	0.01	<.001	0.89	0.01	<.001
Immediacy by						
MSQ-C-OC	0.60	0.02	<.001	0.59	0.02	<.001
MSQ-C-MD	0.72	0.03	<.001	0.72	0.03	<.001
Client Alliance on						
Immediacy	0.25	0.05	<.001	0.55	0.10	<.001
Session Number	–	–	–	0.02	0.07	0.35
Immediacy × Session Number	–	–	–	-0.19	0.06	.001
Therapist Alliance on						
Immediacy	-0.00	0.05	0.48	0.11	0.11	0.18
Session Number	–	–	–	0.11	0.05	0.02
Immediacy × Session	–	–	–	-0.10	0.09	0.16
Therapist Alliance with Client Alliance	0.29	0.04	<.001	0.30	0.04	<.001

Note. Number of Sessions were $N = 1046$, and clients were $N = 38$. WAI = Working Alliance Inventory – Short Revised; MSQ-C = Metacommunication in Session Questionnaire – Client Form; OC = Open Communication subscale; MD = Managing Disagreement/Discomfort subscale.

Table 4

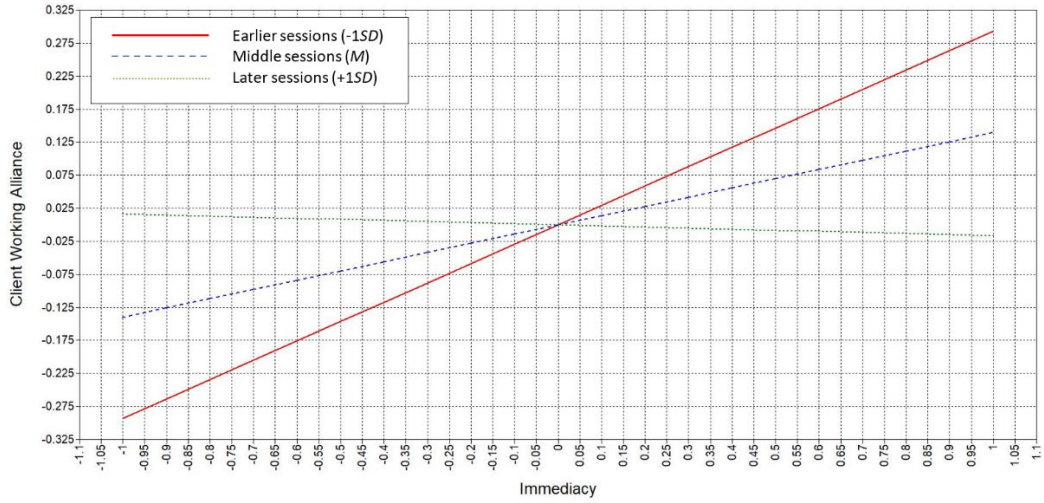
Truth-and-Bias Models for Immediacy as a Predictor of Dyadic Alliance Congruence

Effect	Step 1			Step 2			Step 3		
	B	*SE*	*p*	*B*	*SE*	*p*	*B*	*SE*	*p*
Level 1 (Within Dyad)									
Client Alliance (*Truth*) by									
Client WAI-Bond	0.60	0.02	<.001	0.60	0.03	<.001	0.59	0.03	<.001
Client WAI-Task	0.79	0.02	<.001	0.79	0.02	<.001	0.79	0.02	<.001
Client WAI-Goal	0.78	0.02	<.001	0.79	0.02	<.001	0.78	0.03	<.001
Therapist Alliance (*Judge*) by									
Therapist WAI-Bond	0.80	0.02	<.001	0.81	0.01	<.001	0.80	0.01	<.001
Therapist WAI-Task	0.86	0.01	<.001	0.86	0.01	<.001	0.86	0.01	<.001
Therapist WAI-Goal	0.89	0.01	<.001	0.89	0.01	<.001	0.89	0.01	<.001
Immediacy by									
MSQ-C-OC	–	–	–	0.60	0.02	<.001	0.60	0.02	<.001
MSQ-C-MD	–	–	–	0.72	0.03	<.001	0.72	0.03	<.001
Judge on									
Truth	0.29	0.04	<.001	0.31	0.04	<.001	0.32	0.04	<.001
Immediacy	–	–	–	-0.09	0.05	0.02	-0.11	0.05	0.02
Truth × Immediacy	–	–	–	0.06	0.07	0.11	0.11	0.07	0.07
Session Number	–	–	–	–	–	–	0.06	0.07	0.22
Immediacy with Client Alliance	–	–	–	0.22	0.05	<.001	0.22	0.05	<.001
Level 2 (Between Dyad) Intercepts									
Therapist WAI-Goal Mean	-0.74	0.18	<.001	-0.74	0.20	<.001	-0.79	0.20	<.001
Therapist WAI-Task Mean	-0.69	0.21	<.001	-0.65	0.20	<.001	-0.74	0.21	<.001
Therapist WAI-Bond Mean	-0.88	0.20	<.001	-0.86	0.20	<.001	-0.92	0.22	<.001

Note. Number of Sessions were $N = 1046$, and clients were $N = 38$. WAI = Working Alliance Inventory – Short Revised; MSQ-C = Metacommunication in Session Questionnaire – Client Form; OC = Open Communication subscale; MD = Managing Disagreement/Discomfort subscale.

Figure 1

Client-Rated Alliance Strength as Function of the Interaction Between Within-Dyad Immediacy and Session Number



Note. This interaction plot shows the simple slopes and intercepts for client-rated alliance strength as a function of the interaction of client-perceived immediacy and session number, at the within-dyad level. Greater client-perceived immediacy was associated with a stronger client-rated alliance in earlier sessions (-1*SD*), $B = 0.29$, $SE = 0.06$, $p < .001$; and at middle sessions (*M*) but with a smaller magnitude, $B = 0.14$, $SE = 0.03$, $p < .001$. The slope for later sessions (+1*SD*) was not significant, $B = -0.02$, $SE = 0.06$, $p = 0.40$.

Appendix C: Extended Literature Review

This literature review provides context for the present study by reviewing theory and research on the working alliance and immediacy. The alliance section gives a brief overview of the history and definition of the working alliance construct, then reviews commonly used measures of the alliance, followed by a review of the research supporting the link between the alliance and psychotherapy outcomes. Then, theory and research examining alliance as a dyadic construct is reviewed.

Next, the theoretical and empirical literature of immediacy is reviewed. First, immediacy is defined and approaches to measurement reviewed, followed by a review of research on immediacy and psychotherapy process and outcome, with a focus on immediacy's relationship to the alliance. Future directions for investigating the relationship between immediacy and the alliance are discussed.

The Working Alliance

The *working alliance* is one of the most widely studied constructs in the psychotherapy literature and has been consistently identified as an essential ingredient in successful treatment (e.g., Flückiger et al., 2018). Broadly, the alliance refers to the quality of collaboration between client and therapist. The notion that a positive, collaborative therapeutic relationship is vital for successful psychotherapy has its roots in psychoanalytic (Freud, 1913; Zetzel, 1956) and humanistic (Rogers, 1951) theories. Beginning with Freud (1913), psychoanalytic theorists emphasized the importance of rapport and trust in the therapeutic relationship, but viewed these qualities as emerging from the positive aspects of patients' transference (Fenichel, 1941; Freud, 1913; Sterba, 1940). In other words, the alliance was seen as an aspect of the patient's unconscious distortions, albeit, a facilitative one.

Later, theorists distinguished the alliance from the transferential aspects of the client-therapist relationship. Zetzel (1956) used the term *therapeutic alliance* in reference to clients' healthy capacity for relating to the therapist and engaging in the tasks of therapy, distinct from clients' transference. Greenson (1965, 1967) first introduced the concept of the *working alliance* to refer to client's rational capacity to align with the tasks of psychoanalysis. In Greenson's view, the conscious, rational rapport between client and therapist was as essential to analytic treatment as the notion of transference. From the humanistic lens, Roger's (1951) viewed a positive, genuine, real relationship between client and therapist as a curative treatment factor in client-centered therapy, analogous to the notion of the alliance. Roger's contributions spurred important empirical investigation into relational variables in psychotherapy process and outcome (Rogers et al., 1967), which have shaped the theory and study of the alliance.

The pan-theoretical concept of the working alliance as we know it today was developed by Bordin (1979). He defined the alliance as collaboration between client and therapist along three different processes. The processes include clients' and therapists' level of agreement on the *goals* of therapy, their agreement on the *tasks* of therapy, and the quality of their emotional *bond* (Bordin, 1979). Bordin's definition expanded the application of the working alliance to diverse theories of psychotherapy and led to the large body of alliance research that exists today. Bordin's definition is used in the present study.

Importantly, Bordin's (1979) conceptualization is not simply a capacity to form an alliance that resides in the client, but it is a dyadic process focused on

agreement and collaboration between the client and therapist. In other words, it takes two to form a working alliance. Modern relational theory (e.g., Safran & Muran, 2000) highlights the importance of a two-person perspective on the alliance, and the role of the therapist in attuning to and negotiating the alliance as it unfolds over the course of psychotherapy. This includes attending to strains or ruptures in the alliance, and intervening to repair them.

Measuring the Alliance

A proliferation of working alliance measures have been developed over the years to assess the strength of the alliance from client, therapist, and observer perspectives. Reviews have identified upwards of 30 different alliance measures (e.g., Horvath et al., 2011), therefore, the following review is not exhaustive but highlights important and widely-utilized measures.

Luborsky (1976) developed the first measures of the alliance, which were the observer-rated *Helping Alliance Counting Signs* (HAcs) and *Helping Alliance Rating* (HAr) scales. These measures were used in early studies that found alliance strength varied based on the degree of clients' improvements in symptoms, which provided early evidence of the alliance-outcome association (Luborsky, 1976). Most research as relied on four different measures of the alliance (Flückiger et al., 2018; Horvath et al., 2011), which include the *California Psychotherapy Alliance Scale* (CALPAS; Marmar & Gaston, 1988; Marmar et al., 1989), *Helping Alliance Questionnaire* (HAq; Alexander & Luborsky, 1986), *Vanderbilt Psychotherapy Process Scale* (VPPS; Gomes-Schwartz, 1978), and the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989). These four measures have been in use for over three decades

and each demonstrate sound psychometric properties (Martin et al., 2000), although they assess the alliance from somewhat different conceptualizations.

The CALPAS is an observer-rated measure that assesses the alliance on four dimensions: therapist positive contributions, therapist negative contributions, client positive contributions, and client negative contributions (Marmar et al., 1989). The HAq is a self-report measure that assesses the extent that clients view their therapists as competent and capable of providing help on one subscale, and clients' experience of working towards shared goals with their therapists on a second subscale (Alexander & Luborsky, 1986). The VPPS has client, therapist, and observer-rated forms that assess the alliance in terms of patient involvement and the therapeutic relationship on seven subscales, which include patient exploration, therapist exploration, patient participation, therapist warmth and friendliness, negative therapist attitude, and therapist directiveness (Gomes-Schwartz, 1978).

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) is the most widely used measure of the alliance, and is modeled closely after Bordin's (1979) alliance conceptualization. Accordingly, the 36-items of the WAI comprise three subscales rated on a 7-point scale, that tap client and therapists' agreement on *tasks,* agreement on *goals*, and their emotional *bond*. The WAI includes client and therapist-rated forms, as well as an observer-rated form. Subsequently, the WAI was refined into 12-item short forms, using 4-items from each subscale. These include the WAI-S (Tracey & Kokotovic, 1989), and a subsequent revision of the short-form, the WAI-SR (Hatcher & Gillaspy, 2006). These brief measures are particularly useful in

longitudinal research, given that they can be administered with relative ease after each psychotherapy session and rated from multiple perspectives.

The Alliance-Outcome Association

The alliance has been shown to be a robust predictor of treatment outcomes. Meta-analyses have consistently demonstrated that a better alliance is related to better treatment outcomes, across different measures of the alliance and outcomes, and different approaches to psychotherapy (e.g., Fluckiger et al., 2018, 2020; Horvath et al., 2011). The ubiquitous alliance-outcome association has ranged from small to moderate, with a recent meta-analysis of 295 studies and over 30,000 clients demonstrating an effect size of $r = .278$ (equivalent to a $d = .579$; Flückiger et al., 2018). These findings have led to the field of psychotherapy considering the alliance an essential common factor across all treatments (e.g., Tracey et al., 2003; Wampold, 2015).

Several methodological limitations have generated debate about the alliance-outcome association and its mechanisms. Because many early studies assessed the alliance at one time-point, around the 3rd to 5th session, and correlated the strength of the alliance at that time with post-therapy outcomes (e.g., symptom levels), the meaning of this correlation was ambiguous. For one, studies using alliance measurements at just one time point could not test whether the alliance predicted symptom change, or if the alliance was simply a biproduct of symptom change early in treatment, such that clients who improved in the first few sessions felt better about the alliance (Barber, 2009; DeRubeis et al., 2005; DeRubeis & Freeley, 1990). Secondly, without longitudinal research, it was unclear whether the alliance-outcome

association was the product of within-client processes over time, between-client differences, between-therapist differences, or all of the above (DeRubeis et al., 2005). Fortunately, research has begun to address these ambiguities using longitudinal designs and statistical techniques to disentangle within and between effects, such as data disaggregation (e.g., Wang & Maxwell, 2015) and multilevel modeling (e.g., Raudenbush et al., 2019).

Longitudinal research has overcome these limitations by using session-by-session data. These studies have demonstrated that the strength of the alliance is associated with reduction in subsequent symptoms, even after controlling for prior symptom levels or change (e.g., Barber et al., 2000; Falkenstrom et al., 2014; Zilcha-Mano et al., 2014). Importantly, growing evidence suggests a reciprocal relationship between the alliance and symptoms, with studies demonstrating that improvements in symptoms contribute to a stronger alliance, *and* a stronger alliance contributes to improvements in symptoms (e.g., Flückiger et al., 2020; Tasca & Lampard, 2012; Xu & Tracey, 2015). In a meta-analysis of 17 data sets ($N = 5350$ clients) with session-by-session alliance and symptom assessments, Flückiger et al. (2020) found that there was a significant, reciprocal, within-client association of the alliance and symptoms across the first 7 sessions of treatment. Specifically, higher alliance in one session predicted lower subsequent symptoms in the next session, and vice versa, a pattern the authors described as a "positive upward spiral" (Flückiger et al., 2020, p. 838). It makes clinical sense that helping to improve clients' symptoms would instill hope and confidence in the therapeutic process, strengthening the alliance, and, that working to build a strong alliance can also contribute to symptomatic improvements.

The alliance-outcome link has been theorized to function in two ways. Given that the alliance is an interpersonal variable, one hypothesis is that the emotional attunement of a positive therapeutic alliance can provide a corrective relational experience as the alliance develops over time (Knox et al., 2012; Safran & Muran, 2000). Based on this theory, as the alliance grows stronger or when tensions in the relationship are worked through, which has been referred to as repairing ruptures (Eubanks et al., 2018; Safran & Muran, 2000), clients' symptoms improve as a result of re-experiencing interpersonal conflicts in a new way which enables them to make changes in how they relate to others. This mechanism would be observable on the within-client level, and has been referred to as the *state-like* aspect of the alliance (Zilcha-Mano, 2017). On the other hand, forming a strong alliance has been viewed as providing a necessary pre-requisite for therapeutic strategies to be effective (Hatcher & Barends, 2006). From this perspective, a clients' characteristic ability to form a strong alliance (as well as the therapist's contributions to the alliance) is the *trait-like* aspect of the alliance, which can be observed between-clients (Zilcha-Mano, 2017). Importantly, these two mechanisms are not mutually exclusive.

Researchers using multilevel data which have begun to disentangle the contributions of within-client, between-client, and between-therapist effects in the alliance-outcome association (e.g., Coyne et al., 2019; Falkenström et al., 2013, 2014, 2016; Vrabel et al., 2015; Zilcha-Mano et al., 2015, 2016). Several studies have identified within-client effects, demonstrating that when the alliance increases, subsequent symptoms improve more (e.g., Falkenstrom et al., 2013, 2014, 2016; Coyne et al., 2019). As well, studies using methods such as cluster analysis have

examined how different within-client change patterns are associated with treatment outcomes (Kivlighan & Shaughnessy, 2000; Kramer et al., 2008, 2009; Stiles et al., 2004; Zilcha-Mano & Errázuriz, 2017). Some studies have shown that alliance rupture-repair patterns, indicated by session-to-session alliance scores that decrease followed by an increase, are associated with better treatment outcomes (Kivlighan & Shaughnessy, 2000; Zilcha-Mano & Errázuriz, 2017). Others have found that an alliance that gradually increases is associated with better outcomes (Kramer et al., 2009), or that patterns of alliance development did not have differential associations with outcomes (e.g., Kramer et al., 2008; Stiles et al., 2004).

Research has also shown that clients' average alliance ratings across treatment are associated with treatment outcomes, such that clients who form a stronger alliance on average improve more than those with a weaker alliance (e.g. Accurso et al., 2015; Coyne et al., 2019; Crits-Christoph et al., 2011; Zilcha-Mano et al., 2016). Additionally, research has suggested the therapist's role in forming the alliance contributes to outcomes (Baldwin et al., 2007; Crits-Christoph et al., 2009). For example, Baldwin et al. (2007) found that the average alliance level for therapists across all of their clients had a stronger relationship to subsequent outcomes than each individual clients' alliance, suggesting that therapists make a difference in the alliance-outcome relationship.

Taken together, this literature indicates that the alliance is indeed an important contributor to outcomes. This association also appears to be influenced by the person of the client and therapist, as well as fluctuations in the alliance over time. Understanding what contributes to fostering a strong alliance, and how therapists can

work with the alliance as it unfolds is a vital part of clarifying the alliance-outcome link. Given that within-client fluctuations in the alliance are associated with outcomes, an important area of investigation is therapists ongoing awareness of their alliance with each client, and the process through which therapeutic dyads form a shared perspective on their alliance. These aspects of the alliance can be investigated through within-client (also referred to as within-dyad) study designs, which have the additional strength of providing evidence for what therapists can do to work with the alliance from session to session.

Examining the Alliance Dyadically: Client-Therapist Alliance Agreement

Most alliance research has examined only client perspectives on the alliance and has not accounted for the therapists' perspective (Zilcha-Mano et al., 2015). Although this approach has uncovered important information about the alliance and therapy process and outcome, examining only one perspective of a dyadic construct is conceptually and methodologically limited (e.g., Zilcha-Mano, 2017). For one, Bordin's (1979) tripartite model of the working alliance specifically highlights level of agreement within a therapeutic dyad, which involves developing a shared perspective on the alliance. Relatedly, Pepinsky and Karst (1964) theorized that converging perspectives between client and therapist would be a marker of successful treatment outcomes, as this is also a marker of successful relationships in other contexts. Additionally, modern relational theories of psychotherapy (e.g., Safran & Muran, 2000) argue for a two-person perspective in psychotherapy, in which the alliance is viewed as a co-construction of the client and therapist's unique interactions that unfold over time. From this viewpoint, client and therapist perspectives on their

alliance are interdependent, reflecting judgments of shared interactions that influence each other over time. It is the intersubjectivity of the alliance that is important, and the therapist's ability to remain aware of changes in the alliance as they occur. Alliance measures like the WAI assess only one member's perception of the dyads level of agreement on the goals and tasks of therapy, and the quality of their bond. Thus, it is impossible to know whether both client and therapist view the alliance similarly when only ratings from one perspective are observed, or to observe how a shared perspective unfolds over time. As Kivlighan (2017) described, a client may perceive a high level of agreement on tasks and goals with their therapist, while the therapist does not, or vice versa. In sum, an analysis of only one perspective of the alliance cannot fully assess a dyads level of agreement, and fails to capture the relational, intersubjective dance between client and therapist as they co-create their alliance (Rozmarin et al., 2008).

The level of agreement between client and therapist ratings of the alliance may be an important marker for effective psychotherapy for several reasons. First, when client and therapist see their alliance similarly, they likely can collaborate more easily, and the therapist is able to stay attuned and responsive to their clients' needs. For example, when the dyad agrees that the alliance is strong, the therapist's accurate perception of a strong alliance may be a marker for more challenging, insight-oriented interventions. Bordin (1979) argued that a strong alliance was necessary for expressive, insight-oriented, psychodynamic work, and there is some evidence indicating that a strong alliance precedes therapists use of such interventions (Ahn & Kivlighan, 2022). When the client views the alliance as weak and the therapist

similarly perceives it as such, the therapist can explore what is going wrong, and intervene to strengthen their bond and negotiate the tasks and goals of therapy. A weak alliance may indicate a rupture in need of repair (Eubanks et al., 2018; Safran & Muran, 2000), and the therapist must accurately perceive the weak alliance in order to respond effectively. Put another way, therapists over or underestimation of the alliance relative to their client's perception of the alliance could be problematic because the therapist may miss the opportunities for deepening therapeutic work or repairing ruptures. In this sense, the degree of congruence between client and therapist alliance ratings from session-to-session can be viewed as indicating the therapist's ability to track their clients' perceptions of the alliance (e.g., Atzil-Slonim et al., 2015).

Towards the goal of better understanding the relationship between client and therapist alliance perceptions, researchers have examined associations of client and therapist's ratings with each other (see review by Tryon et al., 2007), as well as the relationship between clients' and therapists' level of agreement (i.e., congruence) on their alliance and treatment outcomes (Coyne et al., 2017; Jennissen et al., 2020; Lai et al., 2021; Laws et al., 2017; Marmarosh & Kivlighan, 2012; Nissen-Lie et al., 2020; Rubel et al., 2018; Zilcha-Mano et al., 2017). Tryon et al. (2007) performed a meta-analysis of 52 data sets of early research examining the relationship between client and therapist alliance ratings, and found a significant, positive, moderate correlation (r = .36). As well, they found that clients tended to rate the alliance higher than their therapists. These early studies of client and therapist alliance associations are limited by operationalizing agreement as the difference score of client and

therapist alliance ratings, which removes information about the alliance strength (Marmarosh & Kivlighan, 2012). They are also limited by examining only single time-points, which makes it impossible to disentangle within- and between-client effects. More recent research has used multilevel modeling approaches and longitudinal data to investigate the dyadic congruence of alliance ratings, and their association with outcomes (e.g. Atzil-Slonim et al., 2015; Marmarosh & Kivlighan, 2012).

Alliance Agreement and Psychotherapy Outcomes

Research examining client and therapist alliance agreement and treatment outcomes has done so using two, slightly different paradigms. First, studies have examined alliance *congruence/incongruence*, which refers to the level of agreement and disagreement between client and therapist on their alliance ratings in a given session (Jennissen et al., 2020; Lai et al., 2021; Marmarosh & Kivlighan, 2012; Rubel et al., 2018; Zilcha-Mano et al., 2017). Second, researchers have examined alliance *convergence/divergence*, which is the rate at which client and therapist alliance ratings become more similar or different from session to session (Coyne et al., 2017; Laws et al., 2017; Nissen-Lie et al., 2020). Research using both paradigms have found evidence that outcomes are better for dyads with more congruent alliance ratings and greater convergence on their alliance over time, although there have been some inconsistent results.

In addition to operationalizing alliance agreement in different ways, studies have examined different levels of analysis (e.g., within- and between-dyad effects). Within-dyad studies examine how fluctuations in the level of alliance congruence

from on session to the next relate to fluctuations in treatment outcomes. Whereas between-dyad studies test how outcomes differ for dyads that have more or less congruence compared to other client-therapist dyads.

Studies of alliance congruence have primarily utilized polynomial regression and response surface analysis (PRRSA; Shanock et al., 2010) to examine the degree of alliance agreement and disagreement in a given session in relationship to subsequent symptoms levels (Zilcha-Mano et al., 2017) or symptom change (Marmarosh & Kivlighan, 2012). Overall, these studies have shown that greater alliance agreement is associated with better outcomes. For instance, when examining alliance congruence in a single session, Zilcha-Mano et al. (2017) demonstrated that higher agreement on a strong or weak alliance was associated with lower symptoms at one month follow up in psychodynamic therapy. Marmarosh and Kivlighan (2012) similarly found that clients rated sessions as higher quality and their symptoms improved more across treatment when the dyad was in greater agreement on a strong alliance. Studies using longitudinal data have added more nuance to these findings by examining within-dyad, rather than between-dyad results. When examining alliance agreement and symptoms every 5th session in psychodynamic psychotherapy, Jennissen et al. (2020) found that when a dyad agreed more than usual on a strong alliance, subsequent symptoms were lower. Rubel and colleagues (2018) examined the bond component of the alliance and symptoms at the end of every session in a sample of cognitive-behavioral therapy, and similarly found that greater agreement was associated with lower subsequent symptoms. These results were replicated in a Chinese context using session-by-session data, as well (Lai et al., 2020). Given that

greater alliance agreement has been associated with better outcomes using a range of study designs, in a variety of treatments and populations, there is good evidence supporting the role of alliance agreement in effective therapy.

In PRRSA, the effect of disagreement (i.e., incongruence) is examined separately from the effect of agreement. Findings in these studies regarding alliance disagreement and outcomes have been mixed. Consistent with the notion that therapists underestimating or overestimating the alliance may lead to missed opportunities, Jennissen et al. (2020) found that greater disagreement in the alliance predicted higher subsequent symptoms regardless of who rated the alliance higher, when alliance and symptoms were assessed every 5th session. Rubel et al. (2018) found that when therapists rated the alliance weak but their client rated it as strong, next-session symptoms were higher. These findings both suggest that therapists' lack of attunement to their clients' alliance perceptions may hinder treatment efficacy.

Interestingly, studies examining alliance congruence in single sessions have found the opposite (Marmarosh & Kivlighan, 2012) or no effects (Zilcha-Mano et al., 2016). Zilcha-Mano et al. (2016) found no associations between disagreement and symptoms. Surprisingly, Marmarosh and Kivlighan (2012) found that disagreement predicted more improvements in symptoms regardless of who rated the alliance higher, which they speculated may have been due to inadvertently sampling only treatment completers with good outcomes because of their pre and post study design. These inconsistent findings may be due to varied timing of measurements, with some studies examining within-dyad effects of alliance agreement with repeated measurements (Jennissen et al., 2020; Rubel et al., 2018) and others between-dyad

effects with the alliance assessed at single sessions (Marmarosh & Kivlighan, 2012; Zilcha-Mano et al., 2017).

Of the few studies that have examined alliance convergence/divergence, clients reported better treatment outcomes in dyads whose alliance ratings converged more over the course of treatment. Utilizing dyadic multilevel modeling, Coyne et al. (2017) found that greater alliance convergence predicted greater reductions in symptoms of generalized anxiety disorder (Coyne et al., 2017). Similarly, Laws et al. (2017) found that alliance convergence was associated with greater reductions in depression symptoms. In a third study, alliance convergence increased over the course of treatment, however there were no significant associations between convergence and treatment outcomes (Nissen-Lie et al., 2020).

Taken together, the research on alliance agreement suggests that client and therapists alliance perceptions are interrelated and that forming a shared perspective on the alliance predicts positive outcomes. There is growing evidence for a positive effect of alliance agreement on treatment outcomes, whether examined at a single point in time or as convergence over the course of treatment. The effect of alliance disagreement on outcomes remains somewhat unclear, due to mixed findings, however. More research using longitudinal data is needed to better understand the role of alliance agreement and disagreement over time in psychotherapy. As well, investigation into what factors contribute to alliance agreement, and specifically what helps therapists attune to their clients' alliance perceptions more closely, may help clarify the role of alliance agreement in psychotherapy.

Tracking the Alliance: Temporal Congruence of Client and Therapist Alliance

Arguably, therapists are responsible for tracking their clients experience of therapy, including clients' perceptions of the alliance. Therapists' attunement to their clients in this way is necessary for responsive interventions, since the alliance can be an indicator for specific interventions. Thus, therapists' ability to track the alliance is another frame from which to examine alliance agreement, which has been tested with West and Kenny's (2011) Truth-and-Bias (T&B) model. The T&B model is applied to examine how judges' ratings of a dyadic construct are associated with 'true' ratings. In the case of the alliance, therapists are considered the judges and clients perceptions of the alliance are considered the 'true' ratings, given that it is therapists role to be attuned to clients' experiences of the alliance. Atzil-Slonim and colleagues (2015) applied this approach at the within-dyad level to examine client and therapist alliance agreement using session-by-session data. This makes it possible to estimate directional discrepancy, which is the average difference between client and therapist alliance ratings; and temporal congruence, which is how strongly correlated client and therapist alliance ratings are from session to session.

Studies using the T&B model have consistently found that therapist alliance ratings tend to be lower than client ratings, but temporally congruent with client alliance ratings (e.g., Atzil-Slonim et al., 2015; Kivlighan & Marmarosh, 2016; Rubel et al., 2018). Atzil-Slonim et al. (2015) examined 213 clients seen by 49 therapists and found that client and therapist alliance ratings tended to be congruent from session-to-session, suggesting therapists tracked changes in client alliance ratings, but rated the alliance lower than their clients did on average. The authors interpreted this

as reflecting therapists taking a better safe than sorry approach and being vigilant in tracking the alliance. Slightly lower ratings on average would prevent overlooking ruptures, and tracking fluctuations closely would also provide markers for specific interventions and signs of progress. Subsequent studies have replicated these results (e.g., Kivlighan & Marmarosh, 2016; O'Connor, et al., 2019; Rubel et al., 2018). O'Connor et al. (2019) found similar within-dyad effects for directional discrepancy and temporal congruence in a sample of 158 clients and 27 therapists in psychodynamic-interpersonal psychotherapy. A similar pattern of results has been identified at the between-dyad level, showing that therapists rated the alliance lower on average, but that there was a significant correlation between therapist and client ratings in samples of 580 clients in cognitive-behavioral therapy (Rubel et al., 2018) and of 64 clients seen by graduate trainee therapists (Kivlighan & Marmarosh, 2016). Importantly, Rubel et al. (2018) investigated how between-dyad directional discrepancy and temporal congruence were associated with treatment outcomes and found that client symptoms improved more when therapists slightly underrated the alliance and tracked fluctuations more closely. Notably, the relationship between directional discrepancy and outcomes was quadratic, suggesting that if the therapist was too discrepant in their alliance ratings in either direction, outcomes were diminished. This provides support for the better safe than sorry approach being effective, and also highlights the importance of therapists staying on the same page with their clients by closely monitoring the alliance.

Given the importance of alliance agreement in psychotherapy outcomes, researchers have explored potential predictors of congruence by testing moderator

variables of the correlation between client and therapist alliance using the T&B model (Atzil-Slonim et al., 2015; Chen et al., 2018; Igra et al., 2020; Kivlighan & Marmarosh, 2016; Lai et al., 2021; O'Connor et al., 2019). These studies have primarily investigated person-level moderators. For example, Kivlighan and Marmarosh (2016) examined therapist attachment style as a predictor of alliance congruence at the between-dyad level, and found that alliance ratings of therapists with more secure attachment were more discrepant, and had a weaker correlation with their clients ratings. Similarly, Chen et al. (2018) found that therapist's affiliative interpersonal style predicted alliance congruence, such that therapists with more affiliative tendencies rated the alliance with less directional discrepancy and more temporal congruence with client alliance ratings. As well, therapists with higher self-efficacy for a specific client have been shown to have less directional discrepancy and higher temporal congruence of alliance ratings (Lai et al., 2021). These findings support the notion that therapist's characteristics, specifically those related to efficacious interpersonal abilities, have greater alliance congruence and are thus more able to stay on the same page with their clients about their alliance.

O'Connor et al. (2019) simultaneously accounted for the role of client and therapist attachment style, and found that when a dyad had similar attachment styles, meaning they were both higher or lower on anxiety or avoidance, they had greater temporal congruence of alliance ratings. Complementary attachment styles, such as when one member was high on avoidance and the other was high on anxiety, were also associated with greater temporal congruence (O'Connor et al., 2019). These results further highlight the role of relational dynamics in forming a shared

perspective on the alliance, and therapist's ability to attune to the alliance as it changes over time.

Other studies have investigated the role of client diagnosis and symptom severity in alliance congruence, with varied findings depending on the level of analysis examined. Specifically, client diagnosis or overall symptom severity have not been significant moderators of alliance congruence at the between-dyad level, suggesting that average alliance agreement is similar across different diagnoses and distress levels (Atzil-Slonim et al., 2015; Igra et al., 2020). Session-level symptom distress, however, was a significant predictor of alliance congruence in Atzil-Slonim et al.'s (2015) study. Their findings indicated that therapists' alliance ratings were more discrepant on average and less congruent in sessions when clients' symptoms had increased, suggesting that fluctuations in client symptoms can influence alliance agreement at the within-dyad level. In other words, when clients' symptom distress increases substantially, therapists may have more difficulty attuning to their clients' perception of the alliance in that session.

In sum, these studies of predictors of alliance congruence highlight the complexity of the alliance as a relational construct and can aid therapists in identifying characteristics that may facilitate or hinder staying attuned to their clients' experience of the alliance. An important limitation, however, is that these moderator variables are nearly all person-level characteristics that therapists can be aware of, but cannot directly influence through interventions in a given session. Given that it is therapists responsibility to track the alliance, it is surprising that no research has investigated how therapist interventions are associated with alliance agreement from

session to session. A fruitful avenue for investigation would be to examine whether processing the therapeutic relationship (e.g., Hill & Knox, 2009) predicts alliance congruence.

Immediacy: Processing the Therapeutic Relationship

Immediacy is a multifaceted therapeutic skill used to work in the here-and-now to process the therapeutic relationship directly (Hill, 2020; Hill & Knox, 2009). Hill (2020) defines immediacy as "when helpers inquire about the client's feelings regarding the therapeutic relationship or disclose how they are feeling about the client, self in relation to the client, or the therapeutic relationship" (p. 280). Immediacy can also take place when clients initiate such discussions. Importantly, immediacy is distinct from other types of therapist self-disclosures, which do not involve the therapeutic relationship, such as disclosing similarities to their clients or facts about themselves. This conceptualization of immediacy is a part of Hill's (2020) widely utilized three-stage model of helping skills, which organizes therapeutic skills into exploration, insight, and action stages. Immediacy is considered an insight skill, given its use to help clients gain awareness of their interpersonal patterns. However, immediacy is also used for the purposes of establishing, monitoring, and maintaining the therapeutic relationship, especially in the exploration stage. Immediacy interventions such as "How are you feeling about working with me?" or "How are we doing working towards your goals?" are considered *open questions and probes about the therapeutic relationship*, and are used for this purpose (Hill, 2020). Three other types of immediacy identified by Hill (2020) include therapist disclosure of their *reactions to the client* (e.g., "I am feeling distant from you today"), *making the covert*

overt (e.g., "I notice you checking your watch, and wonder if you are eager to leave"), and *drawing parallels* to other relationships in the clients' life (e.g., "It seems like you're feeling backed into a corner by me right now, like you have with your spouse. Does this seem familiar to you?").

Hill's conceptualization of immediacy draws from similar concepts in interpersonal theories of psychotherapy such as Kiesler's (1988) *metacommunication* and Teyber and Teyber's (2017) *process comments*. For Kiesler (1988), metacommunication is when therapists disclose the impact of clients' interpersonal behaviors on them. This is a form of interpersonal feedback aimed to help clients understand and change their maladaptive behaviors, or views of themselves. Emotionally honest communication in this way is considered a powerful therapeutic tool for helping clients gain insight and make changes in their interpersonal schemas. Teyber and Teyber's (2017) concept of process comments refers to commenting or inquiring about anything transpiring between the client and therapist in the moment, and therefore encapsulates the same types of skills for working in the here-and-now as Hill's (2020) immediacy.

Given that immediacy is used to assess and maintain the therapeutic relationship (Hill, 2020), it follows that immediacy would be a useful skill for therapists to use to track their clients' alliance perceptions and come to form a shared perspective on the relationship. When the alliance is weak or a rupture has occurred, therapists must first become aware of this in order to intervene effectively (Safran & Muran, 2000). As well, Bordin (1979) theorized that a strong alliance is a precursor to using insight-oriented interventions and deepening therapeutic work. Thus, therapists

must also remain attuned to a strong alliance as it develops. In both scenarios, immediacy likely helps therapists gauge how their client views their relationship, and then to intervene responsively.

Measuring Immediacy

Unlike the working alliance, approaches to measuring therapists use of immediacy are few. Most researchers have taken a case-study approach (e.g., Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012) and utilized the Consensual Qualitative Research-Cases (CQR-C; Jackson et al., 2012) method to code the type and quality of immediacy within sessions, at the speaking-turn level. A pair of single-case studies conducted by Kasper et al. (2008) and Hill et al. (2008) developed this approach to code categories of therapist-initiated and client-initiated immediacy. The coding process involves trained judges reading transcripts and/or watching session videos together. Judge's rate various dimensions of each immediacy event independently, and then come to consensus when there is disagreement. As an example, Hill et al.'s (2008) approach involved coding (a) who initiated the immediacy (client or therapist); (b) what type of immediacy it was; (c) what the effects of the immediacy were; and (d) why immediacy was used. After reaching consensus, they also rated the depth/intensity of each immediacy event on a 5-point scale (1 = *Mundane,* 5 = *Prolonged exchange with both participants actively expressing substantial affective depth and immediate feelings*). Mayotte-Blum et al. (2012) replicated this coding approach in their case study examining longer-term psychodynamic therapy. As well, Hill et al. (2014) applied this method in a multiple-case study (Hill et al., 2014), using similar coding procedures across 16 clients. In this

study, Hill et al. (2014) also coded the consequences of immediacy (i.e., what transpired after immediacy was initiated), which captured in-session outcomes of immediacy such as helping to establish the relationship, clarify boundaries, repair ruptures, and encourage clients to express their feelings about the therapist or therapy, to name a few. Of note, Kasper et al. (2008) and Hill et al. (2008) also employed qualitative measures of client and therapists retrospective experience of immediacy events. In the *Client Immediacy Recall Questionnaire* (CIRQ; Kasper et al., 2008; Hill et al., 2008), clients are asked open-ended questions about in session discussions of the therapeutic relationship, regarding the content, the client's experience of the discussions, what they learned from it, and what was helpful/unhelpful about the immediacy. In the *Therapist Immediacy Recall Questionnaire* (TIRQ; Kasper et al., 2008; Hill et al. 2008), therapists are asked to describe their experience of immediacy use including reasons why they used immediacy and their perception of clients' responses to immediacy.

These qualitative approaches to assessing immediacy have the strength of being able to provide rich, detailed descriptions of specific immediacy events that account for the quality and depth of the immediacy, and who initiated immediacy. As well, the judges are able to immerse themselves in the data, and the findings of the consensual coding approach are allowed to emerge from the data. This process yields clinically illustrative, experience-near accounts of immediacy from multiple perspectives. A limitation is that sample sizes, even in multiple-case studies, are very small due to the time and resource intensive nature of CQR-C. As well, the inductive coding approach to CQR-C has a strength in that the analysis can closely reflect the

clinical reality of a given case, but also results in variation across studies that limits the potential for a quantitative synthesis of results. The rich detail of a CQR-C approach must be weighed against the limited generalizability of findings due to these factors.

A few standardized measures can be used to assess immediacy in psychotherapy, though most do not do so in a comprehensive fashion. The *Therapist Response Questionnaire* (TRQ; Tracey et al., 1988; Li et al., 2016) is an observer-rated measure that assesses therapists' responses on eight dimensions, which includes a single item for the immediacy dimension. This item captures whether therapist responses are focused on the here-and-now and therapeutic relationship, compared to other people or time-periods. The *Comparative Psychotherapy Process Scale* (CPPS; Blagys & Hilsenroth, 2000, 2002) is a 20-item measure that taps the use of interventions typical of psychodynamic-interpersonal and cognitive-behavioral therapies, designed to be rated by an observer, client, or therapist on a seven-point scale (1 = *not all characteristic*, 2 = *extremely characteristic*). Similar to the TRQ, a single CPPS item taps therapists use of immediacy (i.e., "The therapist focuses discussion on the relationship between therapist and patient"). The *Psychotherapy Process Q-Sort* (PPQ; Jones, 1985; Ablon & Jones, 1998) is a 100-item, non-theoretical Q-sort approach to assessing specific client-therapist interactions that can be scored on five dimensions according to a multidimensional scale analysis (Tobin, 1990 as cited by Kivlighan & Schmitz, 1992). The five dimensions are based on different weightings of scores of all 100 items, and includes a dimension that assesses the extent to which a therapist focuses on the here-and-now (i.e., the Here-and-Now

Oriented vs. Then-and-There Oriented dimension). This includes items aligned with the concept of immediacy such as “the therapy relationship is a focus of discussion”. These measures are limited given that they do not contain multiple items assessing different aspects of immediacy use. As well, the CPPS and PPQ were not initially developed to assess immediacy specifically, which raises questions about their reliability when used for this purpose.

To date, only one quantitative measure has been developed to comprehensively assess immediacy use. Calvert, Deane, and Grenyer (2020; Calvert, Deane, & Barrett, 2020) created the *Metacommunication in Supervision Questionnaire* (MSQ) to assess trainee psychotherapists’ perceptions of immediacy in supervision (Note that the term *metacommunication* has been used interchangeably with *immediacy* in the case of this instrument). The 12-items on the MSQ are rated by supervisees on a 4-point scale (1 = *Never*, 4 = *Often*), with higher scores indicating more immediacy use. Calvert, Deane, and Grenyer (2020) subjected the MSQ to a factor analysis, which identified two 6-item subscales. Items on the *Open Communication* subscale (e.g., “My supervisor checks in with me about my feelings about what is happening between us in supervision”) assess the amount that immediacy is used to talk openly about the supervisory relationship. Whereas items on the *Managing Disagreement and Discomfort* subscale (e.g., “My supervisor and I speak about things that may have previously been censored, concealed or unsaid in our relationship”) assess immediacy used to work through difficulties in the supervisory relationship, to process negative feelings, and repair ruptures.

The MSQ is the first standardized scale developed specifically to assess immediacy use. Although this measure was developed for the supervisory relationship, it is based upon Hill and Gupta's (2008) conceptualization of immediacy use in supervision which directly parallels therapists' use of immediacy with their clients. Translating this measure for use in the client-therapist relationship would provide a more adequate means than other standardized measures to collect longitudinal immediacy data with larger samples of clients and sessions. Although such a measure would not provide as detailed information about in-session processes as a CQR-C approach, larger data sets will increase the power for estimating relationships between immediacy and other process and outcome variables, as well as increase the generalizability of findings.

Empirical Research on Immediacy

A small body of psychotherapy process and outcome research has investigated immediacy, primarily using a case study approach (Hill et al., 2008; Hill et al., 2014; Kasper et al., 2008; Mayotte-Blum et al., 2012). Three single-case studies applied a CQR-C approach and investigated the use of immediacy and its effects in successful cases of psychodynamic-interpersonal psychotherapy. Each of these studies demonstrated that immediacy was used to form and negotiate the therapeutic relationship, to help clients express and tolerate their here-and-now feelings, and provide a corrective emotional experience by helping the clients come to see their relationships in a new way (Kasper et al., 2008; Hill et al., 2008; Mayotte-Blum et al., 2012). Hill et al. (2014) applied this method to a multiple-case study of 16 clients, seeing nine trainee therapists in psychodynamic-interpersonal psychotherapy. They

found that the most frequent consequences of immediacy use were the client expressing feelings about the therapist or therapy, establishing or clarifying boundaries in the relationship, the client opening up and gaining insight, no effects, and the client feeling cared for and validated. These case studies provided rich descriptions of the uses and effects of immediacy within sessions, illustrating how immediacy is used to form and maintain the alliance, as well as to help clients process affects and gain insight. The single case studies (Kasper et al., 2008; Hill et al., 2008; Mayotte-Blum et al., 2012) found that ratings of the alliance on standardized measures were strong, but did not examine direct associations of alliance scores and immediacy use. Of these studies, Hill et al. (2014) was the only to examine associations of immediacy and alliance ratings, described below.

A handful of quantitative studies have examined the relationship between immediacy use and the strength of the alliance, most of which have examined between-dyad associations (e.g., Foreman & Marmar, 1985; Hill et al., 2014; Kivlighan & Schmitz, 1992; Kuutman & Hilsenroth, 2012) with mixed results. Two early studies utilized the PPQ and found that there was greater focus on the here-and-now therapy relationship in cases with improving alliances, compared cases with stable, poor alliances (Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992), which provides some evidence that immediacy use may help strengthen the alliance. In Hill et al.'s (2014) multiple-case study, they examined between-case associations of overall immediacy use and alliance strength, and found that therapist-rated alliance was positively associated with overall frequency of immediacy use, but client-rated alliance was not. Kuutman and Hilsenroth (2012) assessed frequency of immediacy

with observer ratings on the single CPPS item in the third session of psychodynamic psychotherapy, and found no significant associations with client-rated alliance. These mixed findings are in contrast to consistent case-study findings that immediacy helps to negotiate and strengthen the alliance. Making sense of the mixed findings is difficult given the varied instruments and time-intervals used to assess immediacy in these studies.

Immediacy may not be directly related to overall, case-level outcomes, but instead, related to session-level outcomes, which within-dyad studies have examined (Shafran et al., 2017; Li et al., 2016). Shafran et al. (2017) re-analyzed the data from Hill et al.'s (2014) multiple-case design using Hierarchical Linear Modeling (HLM; Raudenbush et al., 2019) and found that there was a significant within-dyad (between-session) association of immediacy and client-rated alliance on the WAI-SR. This effect was moderated by time in treatment, such that more immediacy use early in treatment was associated with a weaker alliance. Later in treatment, immediacy was associated with a stronger alliance. The authors suggested that the negative association early in treatment could be the result of therapists focusing on the here-and-now relationship before clients felt trust and safety had been established, which could be intimidating, resulting in lower alliance ratings. On the other hand, Shafran et al. (2017) also suggested that therapists could have been using more immediacy early in treatment in sessions when the alliance was low to work through ruptures and strengthen the alliance (Safran & Muran, 2000). Because of the correlational nature of the findings, this remains unclear. Notably, Shafran et al. (2017) found a positive within-dyad association between clients' evaluations of sessions and immediacy,

which suggests that clients viewed sessions positively when therapists used more immediacy, regardless of timing in treatment. In a related study, Li et al. (2016) assessed immediacy and client collaboration using judges' ratings on the TRQ across the first 4 sessions of three client-therapist dyads. Results showed that greater immediacy was associated with subsequent increases in client collaboration, but only when immediacy took place near the end of sessions rather than the beginning. Immediacy too early in a session may similarly be jarring, and thus have not spurred collaboration. Collaboration is a central aspect of the alliance (Bordin, 1979), thus, this finding adds support for the notion that immediacy contributes to the alliance, and highlights the importance of therapists' timing.

Although results of individual quantitative studies have varied, a qualitative meta-synthesis of 15 studies conducted by Hill et al. (2018) found that improving the therapeutic relationship was one of the most frequent outcomes of immediacy. Taken together, this research suggest that immediacy has a positive impact on alliance strength, and that timing in treatment or in a given session may affect this association. Notably, this research has only addressed how immediacy relates to alliance strength, but not how it relates to dyadic alliance congruence.

Conclusions and Future Directions for the Study of the Alliance and Immediacy

The working alliance is one of the most widely studied psychotherapy constructs, with considerable evidence of a positive relationship between a strong alliance and favorable treatment outcomes. Yet, there is still much to be understood about the mechanisms of the alliance outcome association, and what contributes to a strong alliance. A growing area of research has examined the alliance dyadically by

considering both client and therapists' perspectives simultaneously (e.g., Jennissen et al., 2020; Kivlighan, 2007; Lai et al., 2021; Marmarosh & Kivlighan, 2012; Rubel et al., 2018; Zilcha-Mano et al., 2016, 2017). This research has found that treatment outcomes are better when a dyad is in greater agreement about their alliance ratings (e.g., Jennissen et al., 2020; Rubel et al., 2018). Some research has examined how client and therapist attributes, like attachment styles, contribute to alliance agreement (e.g., O'Connor et al., 2019). There remains a gap in this literature, given that no research has examined how therapist skills impact alliance agreement. This is an important area of investigation because therapist skills are trainable (Hill et al., 2019), and can therefore be improved to help therapists better track and work with the alliance.

Immediacy is a skill used to work directly with the therapeutic relationship to assess, improve, and maintain the alliance, as well as to help clients gain insight into their interpersonal patterns. Immediacy has been associated with alliance strength (e.g., Shafran et al., 2017) and may be related to alliance congruence. There is a need for more studies with larger samples to clarify the association between immediacy and the alliance. Studies of between-dyad correlations of immediacy and the alliance have relied on small samples. For example, Kuutman and Hilsenroth (2012) examined single-session data across 75 clients, and Hill et al. (2014) aggregated data across sessions for just 16 clients. Shafran et al.'s (2017) within-dyad study examined associations of immediacy and alliance strength across 364 sessions for those 16 clients. Although this study advanced the literature, it is limited because approximately 50 or more clients are needed to accurately estimate within-dyad

effects in a two-level model (Hox et al., 2010). Thus, replication of this research with a larger number of sessions and dyads is needed. To this end, a self-report measure such as the MSQ would prove useful if adapted to the client-therapist relationship. Although quantitative studies using self-report measures provide less detailed accounts of immediacy in comparison to case-study approaches, they can yield more generalizable findings that are useful alongside case-study findings.

Additionally, no research has examined how immediacy relates to dyadic aspects of the alliance. Immediacy has only been associated with client ratings of alliance strength (e.g., Kuutman & Hilsenroth, 2012; Shafran et al., 2017) or to therapist and client ratings of alliance strength separately (e.g., Hill et al., 2014). Given that immediacy is a variable focused on processing the relationship, it follows that it may have an important relationship with dyadic perspectives on the alliance. Therapists' use of immediacy may help them better attune to their clients and form more congruent perspectives on the alliance with their clients. Future research could examine how immediacy use is related to client-therapist alliance congruence by applying West and Kenny's (2011) T&B model to longitudinal, session-by-session data of the alliance and immediacy.

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