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Therapist self-disclosure (TSD) and immediacy (Im; see next section for operational definitions) have long been controversial. Psychoanalytic theorists (Curtis, 1981, 1982; Greenson, 1967) traditionally urged analysts to be blank screens, allowing clients to project their feelings and perceptions onto the clinician. More recent relational psychoanalysts (Eagle, 2011; Levenson, 2010; McWilliams, 2004), by contrast, have suggested that therapists can facilitate the therapeutic process by disclosing and talking about the relationship. Humanistic theorists (Bugental, 1965; Farber, 2006; Jourard, 1971), having long advocated therapist transparency and genuineness, have viewed TSD and Im as curative elements of **psychotherapy**. Cognitive therapists (Beck, Rush, Shaw, & Emery, 1979) often view TSD and Im as beneficial to address problems that arise in the relationship.

Beyond such theoretical propositions, however, we need empirical evidence about TSD and Im to guide their use. TSD has generated a great deal of research interest, but most of these studies have been analogue and correlational, making it difficult to draw conclusions about subsequent processes that might be associated with these interventions. Im research is more recent and has used more clinically relevant methods, but except for Hill and Knox (2009), the Im literature has rarely been reviewed. Furthermore, the subsequent processes associated with TSD and Im have not been compared. The purpose of the present article is therefore to conduct an original meta-analysis of the extant empirical literature to determine what we know about the subsequent processes of TSD and Im in **psychotherapy** with actual clients.

Definitions

Until recently, TSD was considered to be a broad category that included all therapist utterances that had any reference to self. Through research (Hill, Mahalik, & Thompson, 1989; Pinto-Coelho, Hill, & Kivlighan, 2016), we have come to recognize that there are many distinct interventions under this broad umbrella category. One cluster of interventions has now been labeled as TSDs, whereas another cluster has been labeled as Im. Furthermore, within the Im cluster, additional interventions have been included that are used to talk about the immediate relationship but which are not directly referencing the therapist.

TSD can be defined as "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 256). We further narrowed this definition to involve a *verbal* revelation about the therapist's life *outside of therapy*. We explicitly excluded from this definition nonverbal self-disclosures (e.g., a family photo on the desk) because we sought to focus on verbal statements that therapists share with clients. We also excluded disclosures within or about the therapeutic relationship because we consider these to be Im (see the following text). According to Hill (2014), TSDs can be about feelings (e.g., "I get angry when someone pushes in front of me like that"), similarities (e.g., "I also had an anxiety disorder"), insight (e.g., "When I was a student, I realized that I had difficulty studying because I was distracted because of my parents' divorce"), or strategies (e.g., "I try to eat fruits and vegetables and walk every day"). Therapists presumably use TSD to establish a bond, to help clients feel normal or understood, and to encourage more client disclosure (Hill, 2014). Other terms used to describe this construct include self-revealing disclosures, extratherapy disclosures, self-disclosing disclosures, and transparency.

Im can be defined as "a discussion of the therapeutic relationship by both the therapist and client in the here-and-now, involving more than social chitchat (e.g., 'It's nice to see you')" (Hill, 2014) or "any discussion within the therapy session about the relationship between therapist and patient that occurs in the here-and-now, as well as any processing of what occurs in the here-and-now patient-therapist interaction" (Kuutmann & Hilsenroth, 2012). Im thus involves therapists talking about the therapy relationship in the present moment with the client, and includes asking about immediate feelings and thoughts (e.g., "How are you feeling talking about this with me?"), expressing immediate feelings (e.g., "I'm feeling annoyed that you are frequently late for sessions"), drawing parallels with other relationships (e.g., "You said no one seems to care about you. . . . I wonder if you feel that I don't care about you?"), making the covert overt (e.g., "You seem so quiet. . . . I wonder how you feel about being here?"), acknowledging a breach in the relationship (e.g., "We seem to have reached an impasse"), and trying to repair ruptures (e.g., "I apologize for saying something offensive to you"). Intentions for Im include encouraging clients to express unstated feelings; attempting to negotiate, enhance, or repair the therapy relationship; and modeling appropriate ways to interact with others during conflict (Hill, 2014). Other terms that have been used to describe this construct are metacommunication, relational events, processing the therapy relationship, discussions about the here-and-now in the here-and-now, in vivo work, and present-focused work.

Thus, both interventions are defined broadly, can be used for a variety of intentions, and may be associated with a range of subsequent processes. They differ, however, in that TSDs tend to be brief and not generate further

discussion (Pinto-Coelho et al., 2016), whereas Im tends to involve a number of interchanges as therapist and client discuss and process their feelings about the relationship (Hill et al., 2014).

Frequency of Occurrence of TSD and Im

In a previous review of studies, 0% to 4% of all therapist responses were coded as TSD (which included both TSD and Im; Hill, 1986). In a multiple case study, eight experienced therapists across a range of theoretical orientations used TSD (including both TSD and Im) in 1% of their responses (Hill et al., 1988). Im, when considered separately, was used extensively (12%, 34%, and 38%, respectively) in three successful cases with experienced interpersonally oriented therapists (Hill et al., 2008; Kasper, Hill, & Kivlighan, 2008; Mayotte-Blum et al., 2012), although it was used less frequently (an average of 5% of the time) by nine psychodynamic-interpersonal doctoral student therapists (Hill et al., 2014) and one acceptance and commitment therapist (Berman et al., 2012). In sum, when coded together, TSD and Im occurred infrequently (0% to 5%), but when coded separately, Im occurred more often (5% to 38%), especially with interpersonally oriented therapists (12% to 38%). Hence, we can conclude that, although these interventions are used infrequently on average, there is a wide range of usage depending on therapist theoretical orientation and other factors.

Measures

TSD and Im have most often been measured by judgments of therapist behavior in **psychotherapy** sessions. Trained judges code these interventions as present or absent in sentences or speaking turns in taped or transcribed sessions, using clearly defined categories that include TSD/Im as one category (Hill, 1978; Stiles, 1979). The advantages of this method are that TSD/Im can be clearly identified, their context can be investigated, the manner in which they are presented can be assessed, and observable subsequent processes can be determined. Disadvantages are that agreement among judges is often marginal because it is difficult to distinguish among verbal response modes that focus on grammatical form and ignore intent, quality, or manner of delivery, thus having low clinical relevance; coding requires transcripts and is thus highly time consuming, and the inner experiences of therapists and clients are not assessed.

TSD/Im have also been assessed by providing clients or therapists with a definition, typically at the beginning of an interview about their experiences, and having them retrospectively report specific instances of these interventions within sessions or treatments. An advantage of this method is that the inner experiences of clients and therapists can be assessed, and these experiences are often different from those of judges watching sessions. Thus, these measures probably are more valid because they reflect experiences of the participants in the room. A disadvantage is that bias occurs in retrospective recall, given that feelings and reactions often change over time (e.g., an immediate reaction might be subsequently altered as the client further reflects on the experience during an interview). An additional disadvantage is that it is difficult to identify the location in a session when recalled TSDs/Ims occurred, thus making it challenging to assess the interventions' context, manner of delivery, and associated subsequent processes.

A third method for assessing TSD and Im involves estimates of how often or how effectively these behaviors occurred during an entire session. In this method, trained judges listen to entire sessions and estimate how frequently or how well the therapist used these interventions. Three widely used session-level measures are the Multitheoretical List Of Therapeutic Interventions (McCarthy & Barber, 2009), the **Psychotherapy** Q-Set (Jones & Pulos, 1993), and the Comparative **Psychotherapy** Process Scale (Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005). For example, in the Q-Set, TSD is assessed by the item, "Therapist self-discloses"; Im is assessed by the item, "The therapy relationship is a focus of discussion." An advantage of this session-level method is that the relative occurrence of many techniques can be measured in an economical manner because transcripts are not required and coding takes little more than the hour required to watch as to where they occurred in the session.

Disadvantages are that individual interventions are not identified, thus context and delivery manner cannot be assessed, and it is not possible to identify the specific associated subsequent processes. In fact, judges might base their judgments on an impression of the therapist's overall behavior rather than on whether the specific behaviors occurred (e.g., judges may rate that the therapist seemed open and approachable rather than that the therapist made a specific verbal disclosure). Note that these session-level measures can also be completed after sessions by therapists or clients participating in the treatment.

Clinical Examples

To give readers a sense of how these interventions are used in practice, we provide a few examples (both clients provided informed consent and are de-identified). First is a helpful TSD reported by a 33-year-old female client who had been seeing her male therapist for 11 years (Knox, Hess, Petersen, & Hill, 1997). The client reported that early in the relationship, she had difficulty trusting her therapist and thus hesitated to open up to him. She expressed confusion about what the relationship should be and often tested her therapist to see if he would prove trustworthy. At times, she needed him to be responsive, and he was not. She did, however, view him as patient, open, and reliable. At the time of the TSD, she thought he would not understand her struggle with drugs, so she asked him if he had ever tried street drugs. The therapist disclosed to her that he had, in fact, tried street drugs. This disclosure shocked the client and made her rethink her assumptions and stereotypes, and also allowed her to use the therapy relationship as a learning ground for other relationships in her life. This disclosure challenged the client's perspective of her therapist, making him more human and more similar to her, thereby increasing her respect for him, making her feel closer to him, and balancing the relationship: "It made him a lot more human than I was feeling at the time . . . and changed the whole perspective immediately . . . and made him sort of a kindred spirit in a way" (Knox et al., 1997, p. 280).

An example of a helpful Im interaction comes from an investigation of Im events in a case study of **psychotherapy** (Hill et al., 2014). The client was a 52-year-old divorced and remarried man in treatment with a single 27-year-old female therapist. In the intake session, the therapist asked the client how he felt working with her, given that she was younger and female. The client said that it was a little startling, although he knew that younger people had expertise that he did not. The client then asked the therapist how it felt to work with him, given that he was older than she. The therapist said it was different, but she felt they could work at it together. At the end of the intake session, when the therapist again checked in with the client, the client said that things were fine, and he felt like he could talk to her.

Another Im example from this case occurred in Session 38 after the client had shared a lengthy story. When the therapist gently challenged the client to talk about his feelings, the client "bristled" and said he could not express his feelings quickly. The therapist asked if it was okay to ask about the client's reactions, to which the client responded that it was okay but that he would probably "bristle," as had just occurred. In response to the therapist's query about what she should do if the client indeed bristled, the client said to "just let it go." After further probing, the client admitted that he did not like to be interrupted when telling a story. They then agreed to keep track of what was going on between them as the work progressed. These examples illustrate how Im was used regularly and productively throughout this therapy to monitor the relationship.

Results of Previous Reviews

Although Hill and Knox (2002) and Henretty and Levitt (2010) both reviewed TSD studies, most of the reviewed studies were analogue. Focusing here on the small section of the review about the subsequent processes associated with TSD in actual therapy, Hill and Knox concluded that TSD was perceived as helpful with regard to immediate outcome (i.e., proximal effects or client responses in the moment), although the distal effects on ultimate treatment outcome (i.e., measurable client changes at therapy termination, such as symptom

reduction or skill development) were unclear. Immediate helpful effects of TSD described by clients included feeling understood, safer, trusted, comfortable, more open, more present, less protective, special, important, and closer to the therapist. Clients also explained that TSD validated their feelings; helped them feel better outside of therapy, for example by leading to insights into family dynamics that enabled them to forgive themselves and others; and changed how clients saw the therapist by fostering trust in the therapist, equalizing the relationship, enabling clients to see the therapist as a real person, and making it easier to talk to the therapist (Hill & Knox, 2002).

In a narrative review of 14 select studies of **psychotherapy**, Ackerman and Hilsenroth (2001) found that when TSD revealed too much of therapists' personal conflicts, it could threaten therapy boundaries and weaken the alliance. More recently, Henretty, Currier, Berman, and Levitt (2014) conducted a meta-analysis of 53 experimental studies, each of which compared a control condition in which counselors did not disclose to one or more TSD conditions. They noted, however, that 94% of the studies were analogue. Overall, TSD was found to have a positive impact on clients, with clients having favorable perceptions of disclosing counselors (vs. nondisclosing counselors) and rating themselves more likely to disclose to them.

Hill and Knox (2009) provided a narrative review of therapist interventions (including Im but not TSD) that are effective for processing the therapeutic relationship. In terms of positive outcomes, they reported that Im was useful for resolving misunderstandings and ruptures in therapy, clients felt validated and cared for when the therapist expressed positive feelings toward the client, and Im helped with negotiation of the therapy relationship. In addition, Im facilitated the client having a corrective relational experience, opened up the client to a new type of relationship, and reduced client defenses. Although negative effects of Im were rare, clients occasionally felt puzzled by it, felt pressured to respond, and felt awkward and confused about the therapist caring for them beyond the professional bond.

Purpose of the Present Study

We found no existing meta-analyses comparing how clients respond following TSDs and Ims. Thus, there is clearly a need for such a review of this literature. Because most of the studies in this area used a qualitative approach, we decided that it would be most appropriate to conduct a qualitative meta-analysis (QMA; Hill, Knox, & Hess, 2012). Given the nature of qualitative and naturalistic studies, we stress that we are not asserting causality but are looking for evidence of what occurs following and is perhaps associated with these therapist interventions. Our first purpose, then, was to meta-analyze the findings for TSD and Im considered together. Out next purpose was to search for possible moderators of how these interventions are experienced and received.

Qualitative Meta-Analytic Review of TSD and Im

Inclusion and Exclusion Criteria

In our review, we only included studies published in English. We used five steps to identify possible studies: (a) We included studies identified in earlier reviews; (b) we manually examined the last 15 years of *The Counseling Psychologist*, *Counseling Psychology Quarterly Journal of Consulting and Clinical Psychology*, *Journal of Counseling Psychology*, ***Psychotherapy***, and ***Psychotherapy*** *Research*; (c) we searched reference lists of relevant published articles; (d) we conducted PsycINFO searches using related terms (disclosure, extratherapy disclosure, here and now, immediacy, metacommunication, present focus, relational events, self-disclosing disclosure, self-disclosure, self-revealing disclosure, therapeutic processes, and transparency); and (e) we sent queries to Society for **Psychotherapy** Research and Society for Counseling Psychology listservs and to authors who had conducted TSD/Im research, asking for published or unpublished studies written in English. The only unpublished data we found were about unhelpful TSDs: These were from the data set included in the Knox et al. (1997) study where both helpful and unhelpful TSDs were investigated, but only the results for the helpful TSDs

were published; the data for unhelpful TSDs were included here to provide a more complete picture of the subsequent processes associated with TSDs.

To be included in our pool of studies, TSD and/or Im had to be specifically identified as occurring in actual **psychotherapy** sessions using one of two methods: (a) coded by trained judges from transcripts of therapy sessions (b) during interviews or in surveys, clients or therapists identified specific TSDs or Ims that they recalled as having occurred during therapy sessions. Our rationale was that only if specific TSDs/Ims were identified could their subsequent processes be identified as being associated with the interventions. Researchers had to clearly state to how many of the participants each subsequent process applied (e.g., "78% of the clients reported . . ." vs. a vague statement suggesting that TSD/Im was helpful without identifying for how many in the sample such a statement was true).

We did not require that the subsequent processes be in the exact next speaking turn but did require that they occurred relatively soon afterward within the session and were judged by the researchers as having been associated with the TSD or Im. For example, in a task analysis of the final sample of their study, Safran and Muran (1996) reported that Im started a sequence of events that occurred after the Im; thus, these subsequent events seemed to be connected to the Im. We relied on the investigators' determination that the subsequent processes were associated with the TSDs and Ims.

We excluded studies using analogue designs, in which nonclients read a transcript or watched a video portrayal of a therapist offering a TSD or Im and rated how much they liked it or how helpful it would be (e.g., Dowd & Boroto, 1982; McCarthy & Betz, 1978). Although analogue methods allow for clear operationalization of the independent variable, they lack external validity and have questionable connection to the actual therapy process (Kushner, Bordin, & Ryan, 1979). Similarly, we excluded studies that asked about general attitudes toward TSD/Im (e.g., preference for using or receiving TSD). We also excluded correlational studies of the association between the frequency of TSD/Im and session or treatment outcome (e.g., Kuutmann & Hilsenroth, 2012; Lingiardi, Colli, Gentile, & Tanzilli, 2011) because there was no reliable way of knowing that the TSD's or Im's were associated with the processes that occurred in a subsequent speaking turn.

We included three studies solely using quantitative rather than qualitative analyses. One study (Barrett & Berman, 2001) was an experimental study in which the number of TSDs was manipulated (therapists were asked to increase or decrease the number of TSDs used), and so the effects of TSDs on subsequent process within the whole session could be determined. Researchers in the other two studies (Hill et al., 1988; Li, Jauquet, & Kivlighan, 2016) coded therapist TSD/Im and client behavior in the subsequent speaking turn and analyzed the data quantitatively. The rationale for including these studies was that there seemed to be a clear association between the TSDs/Ims and the subsequent client behavior.

Procedures for Conducting the QMA

All decisions were made via consensus among the three authors. This consensus procedure involved considerable discussion and checking/rechecking the data to ensure that we were tabulating and interpreting the data as fairly and consistently as possible.

We first recorded, for each study, the terms used by the authors of the studies for the subsequent processes (e.g., gained insight) associated with specific TSDs/Ims. We then developed categories (e.g., enhanced therapy relationship) from the data by putting together those terms that seemed to reflect similar processes (e.g., for enhanced therapy relationship, we had examples of clarified tasks of therapy, negotiated boundaries, client had a corrective relational experience, client expressed positive feelings about therapist, repaired rupture in relationship).

As a team, we next consensually went back and coded each process listed in each study into one of the new categories. This coding required extensive discussion because different terms were often used to express similar processes (e.g., what we categorized as insight might have been called new learning or new understanding). We revised the categories frequently throughout this process to make them as clear as possible. After all processes were initially coded, we rechecked the coding and refined the categories. Table 1 shows the final list of categories.

Table 1

Categories of Subsequent Processes for Therapist Self-Disclosure and Immediacy
1. Client mental health functioning improved (e.g., decreased symptomatology and increased interpersonal functioning [e.g., enhanced relationships
with others outside therapy]); improved intrapersonal functioning (e.g., more positive self-image or self-healing), behavioral changes (e.g., stopped
drinking or lost weight)
2. Client opened up/explored/experienced feelings
3. Client gained insight
4. Client felt understood, normalized, and reassured
5. Client used immediacy
6. Overall helpful (nonspecific) for client
7. Enhanced therapy relationship (clarified tasks of therapy, negotiated boundaries, client had a corrective relational experience, client expressed
positive feelings about therapist, and repaired rupture in relationship)
8. Impaired therapy relationship (e.g., client felt a lack of clarity about the relationship, role confusion blurred boundaries, and rupture)
9. Client had negative feelings/reactions
10. Client openness/exploration/insight was inhibited
11. Overall not helpful (nonspecific) for client
12. Negative effects for therapist
13. Overall neutral reactions/no changes for client

Categories of Subsequent Processes for Therapist Self-Disclosure and Immediacy

As we proceeded, we developed several decision rules. First, each category was coded as simply present or absent rather than indicating intensity or how many times the category was mentioned if different terms were used. A second decision rule emerged because studies involved widely differing numbers of cases. Because averaging across studies would assign disproportionally greater weight to those studies with fewer participants, we instead counted the number of cases to which each subsequent process applied in each study. This approach was straightforward for qualitative studies that provided numbers of participants for each clinical consequence, but was problematic for qualitative studies that only noted whether the findings were general (applied to all or all but one), typical (applied to more than half of the participants), or variant (applied to fewer than half of the participants). In these cases, we estimated the number for whom the clinical consequence applied as falling in the midrange of the frequency grouping (e.g., if a finding was typical in a sample of 13, we estimated that the result fit for nine participants).

As noted earlier, we converted quantitative findings to qualitative results for three studies, using a method developed for the present study but based on the principles of QMA (Hill, Knox, & Hess, 2012). Using Cohen's (1988) standards for estimating effect sizes (d > .20 or r > .10 is a small effect, d > .50 or r > .30 is a medium effect, and d > .80 or r > .50 is a large effect), we equated a small effect size with a variant finding (fewer than half of the participants), a medium effect size with a typical finding (more than half), and a large effect size with

a general finding (all or all but one of the participants). Thus, in a sample of 30 participants, and using the midpoint of the variant, typical, and general category ranges, a small effect was counted as nine participants, a medium effect as 22 participants, and a large effect size as 29 participants.

Tabulation of Results

Table 2 presents the data for each study. The first column provides the study citation. In the second column, we describe the sample, the type of intervention (TSD or Im), the type of event (positive, negative, and mixed), and the data analysis method. In the third column, we list in descending order of frequency the specific subsequent processes linked with the TSD or Im. In the fourth column, we present the category into which each subsequent process was coded. In the fifth column, we note the number of cases for whom the process applied, divided by the total number of cases in the study.

Study	Description of Study: description of sample (includes theoretical orientation and experience level of therapist and diagnosis of client); type of intervention (TSD or Im); type of events (positive, negative, or mixed); and method of analysis (qualitative or experimental)	Subsequent processes	Category	Number/ Total
1. Agnew et al. (1994)	Case study of a good outcome case of eight sessions of psychodynamic-interpersonal psychotherapy with an adult female client with depression and anxiety and an experienced male therapist; Im; good sessions selected based on alliance ratings; task analysis with judges coding sessions	Developed an understanding of roles and responsibilities, consensus about relationship, renegotiation of relationship Explored parallel situations outside therapy, enhanced exploration New styles of relating outside of therapy	7 2 1	1/1 1/1 1/1
2. Audet (2011); Audet and Everall (2010)	Nine adult clients with a range of diagnoses were interviewed about experiences with TSDs given by therapists from a range of experience levels; therapy ranged from five to 100_ sessions and was completed at time of interview; clients	Positive experiences Humanized therapist, enabled client to recognize therapist's fallibility, deformalized therapy, equalized power difference, positively affected therapist's credibility/competence, contributed to atmosphere of comfort/ease, removed client from "hot seat" Elicited more openness in relationship, divulged thoughts/feelings that were difficult to relay Resonated with client's	6 7 2 4 13 11 10 8	7/9 7/9 7/9

	selected events but not necessarily positive; qualitative	experiences/psychotherapy needs Did not alter client's perceptions of therapist's professional qualities Negative experiences, negatively affected therapist's credibility/competence, minimized therapist's professional role, felt overwhelming Client felt discomfort/hesitancy Humanized therapist beyond client's preferred boundaries/blurred psychotherapy boundaries		
3. Barrett and Berman (2001)	36 adult community clients and 18 doctoral student therapists; therapists increased number of TSDs with one client and decreased TSDs with another client, type of therapy not specified but in a university counseling center; reciprocal TSDs; experimental quantitative with clients rating post session	Decreased symptomatology, *d* = .91 Client liked therapist, *d* = .94		
4. Bennett, Parry, and Ryle (2006)	Four good outcome cases (data from two poor outcome cases were not included because they did not involve Im); 16 to 24 sessions of cognitive analytic therapy with adult clients with borderline personality disorder and experienced therapists; Im; repaired ruptures; task analysis with judges coding enactments in 66 sessions that had an alliance threat (based on alliance ratings) of four cases	Exploration and clarification of what was collaboratively felt, understandings were elaborated, doubts and objections were explored, understanding and assimilating warded-off feelings Linking and explanation, negotiation (acceptance of link was amplified, further explanation, consensus (association to other events, origins in past), closure Consensus (agreement about event) New ways of behaving (changes in patterns/aims)		
5. Berman et al. (2012)	Three adult female clients with anorexia paired with one early-career therapist for 17 sessions of acceptance	Client increased exploration, expressed feelings, more assertive about voicing negative reactions to therapist Client was confused about when it was okay to share feelings, client felt disregarded,		

	and commitment therapy; Im; all relational events within treatment; qualitative (CQR), with judges coding therapy sessions	client felt forced to recommit to therapy Client felt controlled/frustrated Therapeutic bond was strengthened Client was more assertive about stating needs Client gained insight into relational patterns Client was less open in expression		
6. Friedlander et al. (2018)	Case study of a six-session psychotherapy with an adult female client and an experienced female psychodynamic therapist; Im; positive events (corrective relational experiences); qualitative with judges coding process in session and participant accounts	Client had a corrective experience 7 1/1 More productive narrative-emotion processes, fewer problem markers 2 1/1 More change markers (more unexpected outcomes) 1 1/1 More change markers (discovery storytelling)		
7. Hanson (2005)	18 adult clients of unspecified diagnoses currently in open-ended therapy with unspecified therapists were interviewed, although authors indicated only 17 for some analyses; range of events; quantitative and qualitative analyses	Client found TSD/Im helpful, client experienced non- TSD/Im as unhelpful 6 18/18 Fostered alliance/egalitarian relationship, established credibility 7 18/18 Damaged alliance, insufficient to repair rupture, client "managed" relationship, relationship was nonegalitarian/inappropriately egalitarian 8 16/17 Role and skills modeling 1 12/18 Validated clients and their decisions/actions/reality, normalized, moral solidarity 4 10/18 Client insight/learning 3 9/18 Invalidated client, dissonance 9 5/17 Inhibited client disclosure 10 4/17 Not useful		
8. Hill et al. (1988); Hill, Mahalik, and Thompson (1989)	Eight adult female anxious clients and eight experienced therapists (most psychodynamic) for 12 sessions; TSD and Im combined; all TSD/Im events in cases; judges coded interventions and subsequent processes, and data were analyzed quantitatively. Only three of the eight many TSD/Im, so N is three for this table	The category of TSD/Im was associated with the highest client helpfulness ratings 6 3/3 The category of TSD/Im was associated with the highest level of client experiencing		

9. Hill et al. (2003)	13 experienced therapists from a range of theoretical orientations were interviewed about their experiences of anger directed at them from adult clients who were mild to moderately impaired; Im; positive events (resolution of client anger events); qualitative (CQR) analyses	Anger typically diminished, client variantly made positive changes (e.g., started going to Alcoholics Anonymous and stopped drinking) 1 9/13 Therapeutic relationship improved (variant) 7 4/13 Neutral/mixed outcomes (variant) 13 4/13 Negative outcomes (variant)		
10. Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996)	11 experienced therapists from a range of theoretical orientations were interviewed about their experiences with impasses in long-term psychotherapy with adult clients with a range of diagnoses; Im; negative events (impasses); qualitative (CQR) analyses	Terminated unilaterally (typical) 11 8/11 Therapists typically ruminated, tried to figure out what went wrong, had self-doubts about abilities, changed strategies with other clients as a result of experience, and worried about clients who quit		
11. Hill et al. (2008)	Case study of one depressed/anxious adult female client and an experienced interpersonally oriented male therapist for 17 sessions of psychotherapy; Im; all events included; qualitative (CQR), with judges coding all Im events in therapy sessions	Negotiated therapeutic relationship, established rules, client had a corrective relational experience 7 1/1 Expressed genuine positive feelings about therapist to therapist 5 1/1 Opened up and explored deeply 2 1/1 Client cared more about self, was self-healing, was more genuine, trusted self more in relationships with mother and partners 1 1/1 Client understood relationships in new way		
12. Hill et al. (2014)	16 cases of open-ended psychodynamic-interpersonal psychotherapy with adult community clients and doctoral-student therapists; Im; all events included; qualitative (CQR) with judges	Established/clarified boundaries, helped establish therapeutic relationship, client had corrective relational experience, helped repair ruptures 7 11/16 Negative effects on clients 11 11/16 Client expressed feelings about therapist/therapy 5 8/16 Client opened up 2 8/16 Client gained insight 3 7/16 No effects, clients said neutral or ambivalent		

	coding all Im events in therapy sessions	things about I, in interviews 13 4/16 Client felt validated, cared for 4 2/16 Changed relationships outside therapy		
13. Iwakabe and Conceição (2016)	Four best examples of metatherapeutic processing selected by the originator of accelerated experiential dynamic psychotherapy, clients were all seen by one experienced female therapist; Im (metatherapeutic processing); positive events; qualitative (task analysis) with judges coding events.	Client gained relief (facial expression softened, removed emotional burden) 6 4/4 Client affirmed self and others (recognized inner strength, had a compassionate view of self and others, let go of criticism and need for control of self/others), client had a sense of peacefulness, client gained greater satisfaction and replenishment, client engaged in new emotional coping strategies 1 4/4 Client got enlivened (positive and vigorous emotions), client grieved (did not last long but came from processing and then shifted back to positive) 2 4/4 Client became aware of self-limiting beliefs and behaviors (identified dysfunctional beliefs and relationship patterns)		
14. Kasper, Hill, and Kivlighan (2008)	Case study of an adult female client and an interpersonally oriented male therapist in 12 sessions of psychotherapy; Im; all events included; qualitative (CQR), with judges coding all Im events in therapy sessions	Client was immediate in 79% of speaking turns after therapist Im, whereas client was immediate in 20% of speaking turns when therapist did not use immediacy, _2 _ 169.75, *p* _ .001, client talked about relationship issues that would not have otherwise discussed 5 1/1 Client involvement was lower during Im events than before, *d* _ .36, or higher after immediacy events, *d* _ .47 10 1/1 Client opened up/expressed feelings that did not usually allow herself 2 1/1 Client felt closer to therapist, client felt cared for by therapist 7 1/1 Client felt satisfied with session 6 1/1 Client felt pressured to respond, client felt awkward/ vulnerable/challenged/hurt/confused about what immediacy was for, client engaged out of deference to therapist's authority		
15a. Knox et al. (1997)	13 adult clients with a range of presenting problems were interviewed about their experiences with therapists from a range of theoretical orientations; TSD; helpful events;	Therapist was seen as more real, therapeutic relationship was seen as improved/equalized 7 9/13 Client felt normalized or reassured 4 9/13 Client gained insight and perspective to make changes 3 8/13 Client used therapist as a model 1 5/13 Negative influence on therapeutic relationship and therapy 8		

	qualitative (CQR) with judges coding interview	4/13 Neutral 13 4/13 Negative influence on therapy		
15b. Knox et al. (1997)	13 adult clients with a range of presenting problems were interviewed about their experiences with therapists from a range of theoretical orientations; TSDs; unhelpful TSDs (only nine clients identified unhelpful events); qualitative (CQR) with judges coding interviews; these data were not published	Negative feelings/reactions 9 8/9 Negative influence on therapy 11 4/9 Negative influence on therapy relationship 8 4/9 Client gained new insight/perspective to make changes 3 4/9 Therapist seen as more human, relationship improved, equalized therapy relationship		
16a. Kronner and Northcut (2015)	Eight gay male therapists were interviewed about experiences with an adult, gay, male depressed/anxious client in long-term therapy; TSD (historical, philosophical, and emotional); all events included; qualitative (grounded theory	Client experienced as positive 6 8/8 Client experienced as negative 11 6/8 Client experienced as neutral		
16b. Kronner and Northcut (2015)	Eight gay male therapists were interviewed about experiences with an adult, gay, male depressed/anxious client in long-term therapy; Im (historical, philosophical, and emotional); all events included; qualitative (grounded theory)	Client experienced as positive 6 8/8 Client experienced as negative 11 6/8 Client experienced as neutral		
17. Li, Jauquet, and Kivlighan (2016)	The first four sessions at a college counseling center with three student clients and three therapists (two doctoral interns and one experienced); Im; judges coded therapy sessions and data were analyzed	Metacommunication in one speaking turn was associated with increased client collaboration in the next speaking turn more in latter half of sessions, standardized _ _ .23 (interpret same as *r*), and when therapist communicates with a tentative, nondominant manner, standardized _ _ .12, with some neutrality, standardized _ _ .18		

	quantitatively for associations between Im and client collaboration			
18. Mayotte-Blum et al. (2012)	Case study of one White adult female client with acute stressors paired with an experienced White male relational psychodynamic therapist in long-term psychodynamic therapy; Im; all events included; judges coded therapy sessions, and data were analyzed qualitatively using consensual qualitative research (CQR)	Client had more ability to tolerate and explore deeply painful and shameful feelings 2 1/1 Client had a new relational experience with therapist 7 1/1 Client communicated positive feelings (e.g., gratitude) to therapist who she was initially ambivalent about trusting		
19a. Pinto-Coelho et al. (inpress)	13 experienced therapists of a variety of theoretical orientations were interviewed TSD; helpful; qualitative (CQR) analyses of interviews	Deepening of psychotherapy work (exploration) 2 10/13 Deepening of psychotherapy work (insight) 3 10/13 Clients stated that TSDs were helpful 6 8/13 Improved therapeutic relationship, client connected more with therapist, client saw therapist as more human, client idealized therapist less 7 8/13 Alleviated client negative feelings, increased hope, made changes in life 1 5/13 Therapist had ambivalent feelings about TSD		
19b. Pinto-Coelho et al. (inpress)	13 experienced therapists of a variety of theoretical orientations were interviewed; TSD; unhelpful (only 11 indicated unhelpful events); qualitative (CQR) analyses of interviews	Client had negative reactions 9 11/11 Therapist regretted using TSD, therapist questioned appropriateness of TSD with this client		
20. Rhodes, Hill, Thompson,and Elliott (1994)	11 clients were interviewed about misunderstanding but only five indicated anything about Im; Im; positive events (resolution of misunderstandings); qualitative (CQR) analyses of interviews	Resolution occurred (general), relationship was enhanced/repaired (general) 7 5/5 Work continued and client continued to grow (general)		

21. Safran and Muran (1996)	Six cases of 20 session cognitive-interpersonal therapy (no information provided about clients and therapists but assume therapists were experienced); Im; positive events (repaired ruptures); qualitative (task analysis) coding of therapy sessions	Client disclosed about block to discussing rupture, client asserted self, client explored avoidance, client self-asserted 2 6/6 Client expressed negative feelings about rupture, client explored rupture experience		

We tallied the results across studies for each subsequent process. For example, using a hypothetical example of process X, if X was mentioned once in a case study, it was coded 1/1; if it occurred nine times out of 13 cases in a qualitative study, it was coded 9/13; if it occurred zero times in a qualitative study of 15 people, it was coded 0/15, and if it was a medium effect in a study of 30, it was coded 22/30. Thus, averaging across the four studies, we could conclude that X occurred for 32 of 59 participants (.54 or 54%).

A complication arose in considering studies that only examined predetermined subsequent processes as opposed to inductively allowing processes to emerge. For example, in their experimental study, Barrett and Berman (2001) asked clients to complete measures of symptomatology and liking of the therapist, so their data could not be used to estimate other possible subsequent processes. For the three studies for which only predetermined processes were investigated, we put "na" in the corresponding cells of the table to show that these categories were not assessed in this study and thus not counted for these categories.

We a priori agreed to use the criterion (Ladany, Thompson, & Hill, 2012) that categories had to differ by at least 30% to be considered different. Thus, a process that occurred for 70% of cases was considered to have occurred more often than a process that occurred for 40% of cases.

Results and Discussion

Table 3 shows the data for each of the subsequent processes across all 21 studies (total sample of 184 cases) for both TSD and Im. The most frequently occurring subsequent processes across all studies were enhanced therapy relationship, improved client mental health functioning, client gained insight, and overall helpful for client. The least frequently occurring subsequent processes were inhibited client openness/exploration and negative effects for therapist. From this analysis, we can conclude that the subsequent processes of TSD and Im were predominantly positive, a finding that is consistent with previous reviews (Hill & Knox, 2002, 2009).

Table 3
Number of Clients in 21 Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
2	0/9	7/9	0/9	7/9	0/9	7/9	7/9	2/9	0/9	3/9	4/9	0/9	5/9
3	35/36	na	na	na	na	na	35/36	na	na	na	na	na	na
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
7	12/18	0/18	9/18	10/18	0/18	18/18	18/18	16/17	5/17	4/17	0/18	0/18	1/17
8	na	3/3	na	na	na	3/3	na	na	na	na	na	na	na
9	9/13	0/13	0/13	0/13	0/13	0/13	4/13	0/13	0/13	0/13	4/13	0/13	4/13
10	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	8/11	8/11	0/11
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16
13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
15ab	5/22	0/22	12/22	9/22	0/22	0/22	13/22	8/22	8/22	0/22	6/22	0/22	4/22
16ab	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
19ab	5/24	10/24	17/24	0/24	0/24	8/24	8/24	0/24	11/24	0/24	0/24	0/24	3/24
20	0/5	0/5	0/5	0/5	0/5	5/5	5/5	0/5	0/5	0/5	0/5	0/5	0/5
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
A	78	51	56	28	18	54	111	28	27	9	39	8	27
B	184	154	148	148	148	151	184	147	147	147	148	148	147
C	.42	.33	.38	.19	.12	.36	.60	.19	.18	.06	.26	.05	.18

Note. A = total number of participants who had this consequence across all studies; B = total number of participants across all studies; C = percentage of participants who had this consequence across all studies; na = not applicable. Because of the design of the study, this consequence was not included and thus could not be found.

Table. Number of Clients in 21 Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
2	0/9	7/9	0/9	7/9	0/9	7/9	7/9	2/9	0/9	3/9	4/9	0/9	5/9
3	35/36	na	na	na	na	na	35/36	na	na	na	na	na	na
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
7	12/18	0/18	9/18	10/18	0/18	18/18	18/18	16/17	5/17	4/17	0/18	0/18	1/17
8	na	3/3	na	na	na	3/3	na	na	na	na	na	na	na
9	9/13	0/13	0/13	0/13	0/13	0/13	4/13	0/13	0/13	0/13	4/13	0/13	4/13
10	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	8/11	8/11	0/11
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16

13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
15ab	5/22	0/22	12/22	9/22	0/22	0/22	13/22	8/22	8/22	0/22	6/22	0/22	4/22
16ab	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
19ab	5/24	10/24	17/24	0/24	0/24	8/24	8/24	0/24	11/24	0/24	0/24	0/24	3/24
20	0/5	0/5	0/5	0/5	0/5	5/5	5/5	0/5	0/5	0/5	0/5	0/5	0/5
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
A	78	51	56	28	18	54	111	28	27	9	39	8	27
B	184	154	148	148	148	151	184	147	147	147	148	148	147
C	.42	.33	.38	.19	.12	.36	.60	.19	.18	.06	.26	.05	.18

Note. A = total number of participants who had this consequence across all studies; B = total number of participants across all studies; C = percentage of participants who had this consequence across all studies; na = not applicable. Because of the design of the study, this consequence was not included ld not be found.

Moderator Variables

Beyond the overall findings noted earlier, and given the heterogeneity among the 21 studies, we searched for moderator variables that might have influenced the results. Specifically, we first examined the TSD and Im results separately and then compared them.

TSD studies

Five studies focused on TSD as a separate skill (i.e., not combined with Im), encompassing a total of 99 cases. Table 4 shows that the four most frequently occurring subsequent processes for TSD were enhanced therapy relationship, client gained insight, client mental health functioning improved, and overall helpful for client. These results should be viewed with caution, however, given the small number of studies, the range of TSDs in these studies (e.g., reciprocal, historical, philosophical, emotional, and unspecified), the range of methods of analysis (experimental, phenomenological, grounded theory, and consensual qualitative research), and the range of perspectives (client ratings after session, interviews of clients, and interviews of therapists).

Table 4

Number of Participants in Therapist Self-Disclosure Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
2	0/9	7/9	0/9	7/9	0/9	7/9	7/9	2/9	0/9	3/9	4/9	0/9	5/9
3	35/36	na	na	na	na	na	35/36	na	na	na	na	na	na
15ab	5/22	0/22	12/22	9/22	0/22	0/22	13/22	8/22	8/22	0/22	6/22	0/22	4/22
16ab	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
19ab	5/24	10/24	17/24	0/24	0/24	8/24	8/24	0/24	11/24	0/24	0/24	0/24	3/24
D	45	17	29	16	0	23	63	10	19	3	18	0	18
E	99	63	63	63	63	63	99	63	63	63	63	63	63
F	.45	.27	.46	.25	.00	.37	.64	.16	.30	.05	.29	.00	.29

Note. D = total number of participants who had this consequence for studies involving only therapist self-disclosure; E = total number of participants for studies involving only therapist self-disclosure; F = proportion of participants who had this consequence for studies involving only therapist self-disclosure.

Table 4: Number of Participants in Therapist Self-Disclosure Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
2	0/9	7/9	0/9	7/9	0/9	7/9	7/9	2/9	0/9	3/9	4/9	0/9	5/9
3	35/36	na	na	na	na	na	35/36	na	na	na	na	na	na
15ab	5/22	0/22	12/22	9/22	0/22	0/22	13/22	8/22	8/22	0/22	6/22	0/22	4/22
16ab	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
19ab	5/24	10/24	17/24	0/24	0/24	8/24	8/24	0/24	11/24	0/24	0/24	0/24	3/24
D	45	17	29	16	0	23	63	10	19	3	18	0	18
E	99	63	63	63	63	63	99	63	63	63	63	63	63
F	.45	.27	.46	.25	.00	.37	.64	.16	.30	.05	.29	.00	.29

Note. D = total number of participants who had this consequence for studies involving only therapist self-disclosure; E = total number of participants for studies involving only therapist self-disclosure; F = proportion of participants who had this consequence for studies involving only therapist self-disclosure.

Im studies

Table 5 shows the subsample analyses of the 15 studies that focused on Im as a separate skill, encompassing 78 cases. The three most frequently occurring subsequent processes were enhanced therapy relationship, client opened up, and overall not helpful. Thus, there were mostly positive, but also some negative, processes.

Table 5
Number of Participants in Immediacy Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
9	9/13	0/13	0/13	0/13	0/13	0/13	4/13	0/13	0/13	0/13	4/13	0/13	4/13
10	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	8/11	8/11	0/11
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16
13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
16b	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
20	0/5	0/5	0/5	0/5	0/5	5/5	5/5	0/5	0/5	0/5	0/5	0/5	0/5
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
G	21	31	18	2	18	18	30	2	3	2	29	8	14
H	75	78	75	75	75	75	75	75	75	75	75	75	75
I	.28	.40	.24	.03	.24	.24	.40	.03	.04	.03	.39	.11	.19

Note. G = total number of participants who had this consequence for studies involving only immediacy; H = total number of participants for studies involving only immediacy; I = proportion of participants who had this consequence for studies involving only immediacy.

Table 5: Number of Participants in Immediacy Studies for Whom Subsequent Processes Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
9	9/13	0/13	0/13	0/13	0/13	0/13	4/13	0/13	0/13	0/13	4/13	0/13	4/13
10	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	0/11	8/11	8/11	0/11
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16
13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
16b	0/8	0/8	0/8	0/8	0/8	8/8	0/8	0/8	0/8	0/8	6/8	0/8	6/8
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
20	0/5	0/5	0/5	0/5	0/5	5/5	5/5	0/5	0/5	0/5	0/5	0/5	0/5
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
G	21	31	18	2	18	18	30	2	3	2	29	8	14
H	75	78	75	75	75	75	75	75	75	75	75	75	75
I	.28	.40	.24	.03	.24	.24	.40	.03	.04	.03	.39	.11	.19

Note. G = total number of participants who had this consequence for studies involving only immediacy; H = total number of participants for studies involving only immediacy; I = proportion of participants who had this consequence for studies involving only immediacy.

Table 6

Number of Participants in Immediacy Studies Examining Positive Events (Repaired Ruptures) With Experienced Therapists (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4
6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
J	10	16	9	0	6	4	6	0	0	0	0	0	0
K	16	16	16	16	16	16	16	16	16	16	16	16	16
L	.62	1.00	.56	.00	.38	.25	.38	.00	.00	.00	.00	.00	.00

Note. J = total number of participants who had this consequence for immediacy studies using task analysis on positive events; K = total number of participants for immediacy studies using task analysis on positive events; L = proportion of participants who had this consequence for immediacy studies using task analysis on positive events.

Table 6: Number of Participants in Immediacy Studies Examining Positive Events (Repaired Ruptures) With Experienced Therapists (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
4	4/4	4/4	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4

6	1/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
13	4/4	4/4	4/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4
21	0/6	6/6	0/6	0/6	6/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6	0/6
J	10	16	9	0	6	4	6	0	0	0	0	0	0
K	16	16	16	16	16	16	16	16	16	16	16	16	16
L	.62	1.00	.56	.00	.38	.25	.38	.00	.00	.00	.00	.00	.00

Note. J = total number of participants who had this consequence for immediacy studies using task analysis on positive events; K = total number of participants for immediacy studies using task analysis on positive events; L = proportion of participants who had this consequence for immediacy studies sis on positive events.

Table 7

Number of Participants in Qualitative Immediacy Studies Examining Both Positive and Negative Events With Range of Experience Level of Therapists for Whom the Consequence Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
M	2	15	9	2	12	1	5	2	3	2	11	0	4
N	22	25	22	22	22	22	22	22	22	22	22	22	22
O	.09	.60	.41	.09	.55	.05	.23	.09	.14	.09	.50	.00	.18

Note. M = total number of participants who had this consequence for immediacy studies using qualitative analysis on range of positive and negative events; N = total number of participants for immediacy studies using qualitative analysis on range of positive and negative events; O = proportion of participants who had this consequence for immediacy studies using qualitative analysis on range of positive and negative events.

Table 7: Number of Participants in Qualitative Immediacy Studies Examining Both Positive and Negative Events With Range of Experience Level of Therapists for Whom the Consequence Applied (Categories in Columns and Studies in Rows)

Category/Study	1	2	3	4	5	6	7	8	9	10	11	12	13
5	0/3	3/3	1/3	0/3	1/3	0/3	1/3	2/3	2/3	1/3	0/3	0/3	0/3
11	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
12	1/16	8/16	7/16	2/16	8/16	0/16	11/16	0/16	0/16	0/16	11/16	0/16	4/16
14	0/1	1/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
17	na	1/3	na	na	na	na	na	na	na	na	na	na	na
18	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
M	2	15	9	2	12	1	5	2	3	2	11	0	4
N	22	25	22	22	22	22	22	22	22	22	22	22	22
O	.09	.60	.41	.09	.55	.05	.23	.09	.14	.09	.50	.00	.18

Note. M = total number of participants who had this consequence for immediacy studies using qualitative analysis on range of positive and negative events; N = total number of participants for immediacy studies using qualitative analysis on range of positive and negative events; O = proportion of y studies using qualitative analysis on range of positive and negative events.

Given that there were 15 Im studies, we could begin to investigate sources of heterogeneity. We compared five studies involved task analyses of rupture repairs with experienced therapists (hence all positive events, see Table 6) with six qualitative studies of all events occurring within sessions (both positive and negative, see Table 7) with a mixture of inexperienced and experienced therapists (also compared in Table 8, Column 5 vs. Column 6). Both sets of studies involved judges coding the events. We found three differences (>30%), such that the five repaired ruptures studies had more improved mental health functioning, more client opening up, and less overall not helpful than the six studies that included both positive and negative events. Thus, not surprisingly, those studies that included only positive events (repaired ruptures) with experienced therapists had more positive subsequent processes than did those studies including a range of positive and negative events with less experienced therapists. Because these two sets of studies varied, however, both in terms of type of event and level of therapist experience, and there was a small number of studies and participants, we cannot be sure about to what to attribute these differences.

Table 8
Summary of Percentages of Subsequent Processes Across Different Types of Studies

Category	Overall 21 studies (%)	Five TSD studies (%)	15 Im studies (%)	Five task analysis studies of positive Im events (%)	Six qualitative studies of positive and negative Im events (%)
1. client mental health functioning improved	42	45	28	62	9
2. client opened up	33	27	40	100	60
3. client gained insight	38	46	24	56	41
4. client felt understood, reassured, normalized	19	25	3	0	9
5. client used more Im	12	0	24	38	55
6. overall helpful for client	36	37	24	25	5
7. enhanced therapy relationship	60	64	40	38	23
8. impaired therapy relationship	19	16	3	0	9
9. client had negative feelings/reactions	18	30	4	0	14
10. inhibited client openness	6	5	3	0	9
11. overall not helpful for client	26	29	39	0	50
12. negative effects for therapist	5	0	11	0	0
13. neutral/no changes for client	18	29	19	0	18

Note. TSD = therapist self-disclosure; Im = immediacy.

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9. client had negative feelings/reactions	18	30	4	0	14
10. inhibited client openness	6	5	3	0	9
11. overall not helpful for client	26	29	39	0	50

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13. neutral/no changes for client	18	29	19	0	18

Comparison of TSD and Im

To compare TSD and Im directly, we chose a subset of the six Im studies mentioned in the previous paragraph because they most closely aligned with the five TSD studies (see Table 8 Columns 3 and 6). Studies in the two subsamples were similar in that all included both positive and negative events, although they varied in other ways (of the TSD studies, two involved client interviews, two involved interviews with experienced therapists, and one involved an experimental manipulation with doctoral-student therapists; all of the six Im studies involved trained judges coding in-session therapist behaviors and a range of experience levels of therapists). Hence, in addition to differences in findings between samples being due to the type of intervention (TSD vs. Im), differences could have been due to differences in the experience level of therapists, research approach (interviews vs. coding of behavior), or perspective (judges, therapists, clients). With these limitations in mind, we tentatively explore differences between the two subsamples.

We found five meaningful differences (>30%). TSD, as compared with Im, resulted in more improved mental health functioning, more overall helpful for client, and more enhanced therapy relationship, but less client opening up and less client use of Im. Thus, it appeared that TSDs and Ims were associated with different subsequent processes. These differences make some sense given the differences in the structure and function of the two interventions, as described in the studies in this review. With TSDs, therapists typically focus mostly on clients, use themselves to facilitate client exploration (e.g., "When I have been in your situation, I felt angry. I wonder if you feel that way?"), and aim to foster understanding and better mental health functioning. In contrast, Ims are often used to process the relationship and therefore are more often collaborative and focus on both participants (e.g., "You mentioned not feeling respected in relationships, and I'm wondering how you're feeling about our relationship?").

Client Contributions

There were not enough studies to investigate client contributions to TSD and Im. Two studies, though, point to intriguing possibilities that could be examined in future research. In the study by Berman et al. (2012), the same therapist worked with three clients. One client had more positive subsequent processes associated with Im than did the other two, which the authors attributed to this client being more compliant and willing to go along with the therapist's directives. In the Hill et al. (2014) study on Im, client attachment style emerged as a moderator: With clients who were securely as compared with those who were fearfully attached, therapists' Im focused more on tasks and ruptures, were of lower quality, were initiated more often by clients, and were shorter in length. We also suspect that client preferences/expectations about TSD and Im, culture, presenting problems, severity of psychopathology, and therapist attachment style would moderate processes, but such conclusions await further investigation.

Diversity Considerations

All of the studies were published in English, and most were conducted within the United States. Diversity (e.g., gender, race/ethnicity, sexual orientation, and socioeconomic status) of clients and therapists could not be addressed in the QMA because of the small sample size and lack of adequate information about diversity variables in the published studies. Given that the outcome of these interventions could vary considerably based on culture, further study is needed. For example, Hill (2014) noted that Im can feel rude and intrusive to clients from non-Western cultures and that TSD can be particularly important for culturally diverse clients who need reassurance that the therapist can be trusted.

Conclusion

When considered together, the subsequent processes associated with TSD and Im were largely positive. When directly compared, some differences appeared. TSDs were more likely to be associated with improved mental health functioning, overall helpful for client, and enhanced therapy relationship, suggesting that these are helpful, supportive interventions. In contrast, Ims were more likely to be associated with clients opening up and using Im, suggesting that these are useful interventions for dealing with problems in the therapeutic relationship. Because of the small number of studies and small number of participants within studies, these findings are tentative and beg for further research.

Although most of the subsequent processes were positive, we would be remiss not to mention that there were negative effects in up to 30% of the cases in these studies. Clients can sometimes react negatively to hearing about therapists' personal lives or to talking openly about the therapeutic relationship. Similarly, therapists can feel vulnerable and incompetent. Thus, these interventions can often be helpful but sometimes can have negative consequences. Cautions are discussed in the section on therapeutic implications.

Limitations of the Research

We cannot assume causality between TSD/Im and their subsequent processes because all but one of these studies were naturalistic rather than experimental. We did require that subsequent processes occurred in the next speaking turn or were judged to be associated with the TSD/Im, but of course in naturalistic therapy a multitude of other variables are occurring so that it is difficult to determine what leads to what.

Second, a wide range of interventions was included under the umbrella of TSD (e.g., disclosures of feelings, thoughts, insights, strategies, or similarities) and Im (e.g., sharing feelings about therapy or client, inquiring about client's feelings or reactions, or trying to negotiate the relationship), which potentially clouds the integrity of the constructs. Furthermore, TSDs and Ims are verbal statements accompanied and modified by nonverbal behaviors (e.g., head nods, encouraging gestures, or facial expressions) and used within the context of a therapeutic relationship, which suggests that these interventions are multifaceted rather than "pure" or unidimensional. The use and subsequent processes of each inevitably vary according to the specific client, therapist, and context.

In addition, there were only 21 studies included in the QMA, and these studies were quite heterogeneous. There was wide variation across the studies in terms of type of intervention (TSD vs. Im), type of event selected (positive only, range of positive and negative, and negative only), perspective (coding by trained judges, interviews of therapists or clients), and method (experimental, task analysis, and consensual qualitative research). Some evidence suggested that the valence of the event (positive vs. a range of valences) may influence results. Most studies also inadequately described the type of therapy (e.g., psychodynamic) involved or the diagnosis/presenting problems of the clients.

Finally, we did not compare the subsequent processes of TSD and Im with other interventions (e.g., reflections of feelings and interpretations), so we do not know whether the processes were unique. Similarly, it is important to recognize that therapists likely did not use TSDs or Im on a random basis but rather for specific intentions in specific contexts. Different contexts could have led therapists to choose other interventions. Thus, we do not know if TSD or Im would have proven more or less effective than other potential interventions.

Implications for Therapeutic Practice

Both TSD and Im typically produced positive subsequent processes for clients, suggesting that therapists might consider using them. It is worth noting that despite their positive effects, previous research (Hill et al., 1988, 2014) has shown that both TSD and Im occur relatively infrequently in **psychotherapy**, and reviews and

theoretical guidelines (Audet & Everall, 2003; Henretty & Levitt, 2010; Hill & Knox, 2002; Watkins, 1990) have stressed the need to use them sparingly and deliberately.

More specifically, the results of the QMA indicate that with effective TSDs, therapists focus on clients and use themselves to facilitate client exploration, which fosters understanding and better functioning. Therapists might thus consider disclosing when clients feel alone, vulnerable, and in need of support. To learn that clients are not the only ones who have felt lonely or distressed can provide a sense of universality.

In contrast, therapists often use Im to negotiate and address problems in the relationship. Therapists might thus consider using Im primarily to help clients open up and talk about underlying feelings, especially when negotiating the therapeutic relationship. Talking about the relationship, however, has potential for volatility as problems are illuminated, so therapists will need to be aware of, open to, and prepared to address their own and clients' reactions.

Integrating the findings of the QMA with those in the broader TSD and Im literature (Audet, 2011; Audet & Everall, 2003, 2010; Hanson, 2005; Henretty & Levitt, 2010; Hill, 2014; Hill et al., 1989, 2014; Pinto-Coelho et al., 2016, 2018; Safran & Muran, 1996), we offer the following recommendations for using TSD: (a) Be cautious, thoughtful, and strategic about using TSD, (b) have a client-focused intention for using TSD, (c) evaluate how clients might respond and whether TSD is likely to help clients, (d) make sure the therapeutic relationship is strong before using TSD, (e) use TSD sparingly, (f) keep the disclosure brief with few details, (g) disclose resolved rather than unresolved material, (h) make the TSD relevant to client material, (i) focus on similarities between therapist and client, (j) focus on the client's rather than on the therapist's needs, (k) turn the focus back to the client after delivering the TSD, (l) observe the client's reaction to the TSD, and (m) assess the effectiveness and decide whether it will be appropriate to use TSD again. For Im, we recommend the following: (a) Be aware that Im often involves lengthy processing; (b) if therapists want clients to be immediate, they should be immediate with their own feelings; (c) be attentive to how the client responds to Im given that many clients are not comfortable with it, and it is sometimes associated with negative effects; and (d) examine countertransference and seek consultation to ensure that therapists are acting in the best interests of clients when using Im.

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