Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra

IMERSÃO E DISTANCIAMENTO EM PSICOTERAPIA PARA A DEPRESSÃO

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Tese no âmbito do Doutoramento em Psicologia, Especialidade em Psicologia Clínica, orientada pelo Professor Doutor João Manuel de Castro Faria Salgado e pelo Professor Catedrático Jubilado Doutor José Augusto da Veiga Pinto de Gouveia e apresentada à Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra.

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The good life is a process, not a state of being. It is a direction not a destination.

(Carl Rogers in “On becoming a person: A therapist's view of psychotherapy”, 2012, p. 186)

Resumo

Na última década, a imersão (perspetiva egocêntrica) e o distanciamento (perspetiva de observador) sobre experiências negativas têm sido alvo de crescente interesse pela investigação dado o seu potencial para uma reflexão adaptativa, bem como desadaptativa dessas experiências. A investigação nesta área tem ocorrido, sobretudo, em contexto experimental/laboratorial, considerando o distanciamento, em oposição à imersão, como uma perspetiva benéfica na reflexão da experiência. A partir destes resultados têm sido lançadas indicações sobre as suas vantagens em psicoterapia, nomeadamente ao nível da redução da ativação emocional de emoções negativas e da reconstrução da experiência. Contudo, estes estudos parecem não se enquadrar naquilo que são as necessidades e características de um processo terapêutico. Uma visão sincrónica sobre as perspetivas imersa e distanciada não vai ao encontro da noção de mudança em psicoterapia, em particular no que respeita à transformação dinâmica e integrada dos processos ao longo do tratamento. Além disso, avaliar a adaptabilidade da perspetiva pelo nível de bem-estar, nomeadamente pela ativação emocional de emoções negativas, não é coerente com o papel positivo e importante do envolvimento emocional na promoção da mudança clínica. Sendo assim, a presente dissertação propôs-se a clarificar o papel da imersão e do distanciamento em psicoterapia no tratamento da depressão. Com este objetivo, foram realizados quatro estudos que adotaram uma abordagem mais flexível e longitudinal destes fenómenos, enquadrando-se esta dissertação na investigação de processo-resultado. Especificamente, o estudo 1 teve como objetivo analisar a evolução da imersão e do distanciamento ao longo da resolução terapêutica de uma experiência problemática; a relação entre imersão/distanciamento e os sintomas depressivos; e a relação entre estas perspetivas e a ativação emocional. O estudo 2 pretendeu avaliar quando e como a imersão e o distanciamento podem ser úteis/prejudiciais na mudança clínica, comparando a evolução destas perspetivas ao longo da terapia e a sua relação com os sintomas em casos de sucesso e insucesso terapêutico. O estudo 3 pretendeu analisar a relação entre a evolução da imersão/distanciamento e a assimilação de experiências problemáticas, bem como a associação entre estas perspetivas e os diferentes estádios de mudança terapêutica. Por último, o estudo 4 teve como objetivo avaliar a relação entre a flexibilidade entre estas perspetivas numa fase intermédia da terapia e os sintomas depressivos no final do tratamento. Em termos metodológicos, foram realizados dois estudos de caso de sucesso (estudos 1 e 3) e dois estudos com casos de sucesso e insucesso terapêutico (estudos 2 e 4). Os casos analisados foram selecionados do ensaio clínico *Estudo de depressão do ISMAI e* acompanhados em terapias contrastantes, nomeadamente a terapia cognitivo-comportamental e terapia focada nas emoções. Foram usadas diferentes medidas de processo, tais como: *Measure of Immersed and Distanced Speech* para a avaliar a imersão e o distanciamento; *Client Emotional Arousal Scale-III* para

avaliar a ativação emocional; e *Assimilation of Problematic Experiences Scale* para avaliar os níveis de mudança terapêutica. A flexibilidade foi determinada pelo número e magnitude das transições entre as duas perspetivas. Foram usadas o *Beck Depression Inventory-II* e o *Outcome Questionnaire-10.2* como medidas de resultado. Os resultados dos estudos revelaram um padrão de evolução de imersão/distanciamento associado à mudança clínica caracterizado por maior imersão inicial seguida do aumento substancial do distanciamento (estudos 1, 2 e 3). Estes resultados apontam para benefícios do aumento do distanciamento no alcance de melhores níveis de bem-estar em termos de sintomatologia (estudos 1 e 2) e de estados emocionais mais positivos (estudo 1), bem como na criação de *insight* e resolução efetiva do problema (estudo 3). Inversamente, a estabilidade no padrão de reflexão marcado por elevada imersão em todo o processo parece ser prejudicial (estudo 2). Contudo, estas observações não invalidam a importância da imersão em psicoterapia. A imersão inicial pode ser útil para superar estados de evitamento e para a consciencialização e clarificação do problema. Além disso, o papel positivo da imersão estendeu-se também a um nível elevado de mudança, nomeadamente na aplicação de novas compreensões no sentido de resolver o problema (estudo 3). Os resultados também revelaram que maior flexibilidade entre imersão e distanciamento na fase intermédia da terapia parece estar associada a melhores resultados em termos de sintomas depressivos no final do tratamento (estudo 4). Em conjunto, esta dissertação salienta a importância das duas perspetivas – imersão e distanciamento – na psicoterapia para a depressão, assumindo-as como mecanismos coordenados e dinâmicos, integrados no processo de mudança.

PALAVRAS-CHAVE: imersão, distanciamento, psicoterapia; depressão; investigação de processo-resultado; terapia cognitivo-comportamental; terapia focada nas emoções; ativação emocional, sintomas, mudança clínica, flexibilidade.

Abstract

In the last decade, immersion (egocentric perspective) and distancing (observer perspective) on negative experiences have been the subject of increasing interest in research given their potential for adaptive as well as maladaptive reflection on these experiences. Research in this area has been mainly conducted in experimental/laboratory context, considering distancing, as opposed to immersion, as a beneficial perspective in the reflection on experiences. Departing from these results, indications about its advantages in psychotherapy have been raised, namely in the reduction of the emotional arousal of negative emotions and in the reconstruction experiences. However, these studies do not seem to fit in the requirements and characteristics of a therapeutic process. A synchronous view of the immersed and distanced perspectives does not meet the concept of change in psychotherapy, more precisely with respect to the dynamic and integrated transformation of processes throughout treatment. Moreover, assessing the adaptability of the perspective through the level of well-being, namely through the emotional arousal of negative emotions, is not consistent with the positive and important role of emotional involvement in the promotion of clinical change. Thus, the present dissertation proposed to clarify the role of immersion and distancing in psychotherapy in the treatment of depression. With this objective, four studies were carried out with a more flexible and longitudinal approach on these phenomena, framed within process-outcome research. Specifically, study 1 aimed to analyze the evolution of immersion and distancing during the therapeutic resolution of a problematic experience, the relationship between immersion/distancing and depressive symptoms, and the relationship between these perspectives and emotional arousal. Study 2 aimed to assess how and when immersion and distancing may be useful/harmful to clinical change, comparing the evolution of these perspectives throughout therapy and its relationship with symptoms in good and poor outcome cases. Study 3 intended to analyze the relationship between the evolution of immersion/distancing and the assimilation of problematic experiences, as well as the association between these perspectives and the different stages of therapeutic change. Finally, study 4 aimed to assess the relationship between flexibility between perspectives in the intermediate phase of therapy and depressive symptoms at the end of treatment. Methodologically, two case studies with good-outcome cases (studies 1 and 3) and two sample studies with good and poor outcome cases (studies 2 and 4) were carried out. The analyzed cases were selected from the ISMAI Depression Study and were followed in contrasting therapies, namely cognitive-behavioral therapy and emotion focused therapy. Several process measures were used, such as the Measure of Immersed and Distanced Speech to assess immersion and distancing; Client Emotional Arousal Scale-III to assess emotional arousal; Assimilation of Problematic Experiences Scale to assess therapeutic change levels. Flexibility

was determined by the number and magnitude of transitions between perspectives. The Beck Depression Inventory-II and the Outcome Questionnaire-10.2 were used as outcome measures. The results of the studies revealed an evolution pattern of immersion/distancing associated with clinical change characterized by greater initial immersion followed by a substantial increase of distancing (studies 1, 2 and 3). These results point to the benefits of increasing distancing in achieving better levels of well-being in terms of symptomatology (studies 1 and 2) and more positive emotional states (study 1), as well as in creating insight and effective problem solving (study 3). Conversely, stability in the reflection pattern characterized by high immersion throughout the process appears to be harmful (study 2). However, these observations do not invalidate the importance of immersion in psychotherapy. Initial immersion may be useful in overcoming avoidance states and in raising awareness and clarification of the problem. Moreover, the positive role of immersion also extended to a high level of change, namely on the application of new understandings to solve the problem (study 3). Results also revealed that greater flexibility between immersion and distancing in the intermediate phase of therapy appears to be associated with better outcomes in terms of depressive symptoms at the end of treatment (study 4). Altogether, this dissertation stresses the importance of both perspectives – immersion and distancing - in psychotherapy for depression, assuming them as coordinated and dynamic mechanisms, integrated in the process of change.

***KEYWORDS**: immersion, distancing, psychotherapy; depression; process-outcome research; cognitive behavioral therapy; emotion focused therapy; emotional arousal, symptoms, clinical change, flexibility.*

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Introdução

As experiências autobiográficas negativas são parte da experiência humana, contribuindo para a definição e idiossincrasia do *Self* (Rogers, 1961; Stiles, 1990). Atribuir significado a estas experiências é um processo comum do indivíduo que consegue, assim, processar e integrar a experiência emocional (Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Norcross, Krebs, & Prochaska, 2011; Stiles, 2011). Face a este tipo de experiências, que podem ser dolorosas e até perturbadoras, a maior parte de nós, quase intuitivamente, tende a refletir sobre elas na esperança de compreender os nossos sentimentos e de apaziguar o sofrimento (Smith & Alloy, 2009). De facto, vários estudos têm demonstrado os benefícios da reflexão de experiências problemáticas na saúde psicológica (Pennebaker & Chung, 2007; Wilson & Gilbert, 2008).

Ao refletirmos sobre a experiência, temos a oportunidade de a representar e elaborar cognitivamente, o que potencialmente facilita a adaptação, sendo isto fundamental para melhorar a forma como nos sentimos (e.g., Beck, 1970; Gross, 2013). Contudo, o processo de reflexão também pode ter um efeito prejudicial, ou seja, por vezes, ao refletirmos sobre a experiência negativa, ficamos presos/as a um processo de pensamento rígido e pouco produtivo, que não permite fazer sentido da mesma de um modo ajustado (Brosschot, Gerin, & Thayer, 2006; Denson, Spanovic, & Miller, 2009; Gotlib & Joormann, 2010), podendo mesmo intensificar os estados emocionais negativos. Importa, então, perceber quais são as condições para uma reflexão bem-sucedida.

Numerosos estudos experimentais/laboratoriais têm sido realizados para dar resposta a esta questão (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2011; Kross, Gard, Deldin, Clifton, & Ayduk, 2012). Esses estudos indicam a perspetiva usada na reflexão da experiência negativa como fundamental para determinar a adaptabilidade dessa reflexão. Especificamente, consideram que a experiência pode ser refletida segundo uma perspetiva imersa, i. e., de um ponto de vista egocêntrico; ou distanciada, i. e., de um ponto de vista de observador (Nigro & Neisser, 1983; Robinson & Swanson, 1993). Os estudos têm sido congruentes na interpretação dos resultados, considerando a perspetiva distanciada como benéfica, uma vez que, sendo uma perspetiva mais ampla sobre a experiência, facilita a reconstrução dos sentimentos e a atribuição de significado (e.g., Ayduk & Kross, 2008, 2010b), permitindo uma baixa ativação emocional de emoções negativas (e.g., Kross et al., 2014; Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012). Inversamente, a perspetiva imersa tem sido considerada como desvantajosa, uma vez que, constituindo uma perspetiva em que há um foco nos pensamentos, sentimentos e comportamentos primários associados à experiência, os pensamentos negativos ficam acessíveis de tal forma que absorvem a nossa atenção, alimentando círculos de ruminação (e.g., Ayduk & Kross, 2010a;

Kross, Ayduk, & Mischel, 2005) e intensificando o mal-estar sentido (Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012).

Assim, com base nos estudos experimentais/laboratoriais, conclui-se que a perspetiva distanciada, em contraste com a imersa, é uma perspetiva produtiva quando usada na reflexão da experiência negativa. Em termos clínicos, esta conclusão levanta várias questões, tais como: Devemos evitar a perspetiva imersa quando lidamos com experiências pessoais problemáticas? E em psicoterapia, estes resultados também são válidos? É de salientar que a maior parte destes estudos experimentais não usou amostras clínicas, nem se focou em processos de psicoterapia. Além disso, um dos argumentos usados como efeito negativo da imersão (ou perspetiva imersa), em oposição ao distanciamento (ou perspetiva distanciada), é o aumento da ativação emocional de emoções negativas. Contudo, existem várias modalidades terapêuticas (e.g., Greenberg, 2002; Samoilov & Goldfried, 2000) apoiadas empiricamente (e.g., Foa & Kozak, 1986) que defendem a ativação emocional de conteúdo negativo como necessária para promover mudança, uma vez que permite um contacto efetivo com a experiência emocional, fundamental para a consciencialização da mesma e posterior reatribuição de significado (e.g., Greenberg, Rice, & Elliott, 1993; Wilson & Gilbert, 2008). Neste sentido, fica a dúvida se a perspetiva imersa pode ser simultaneamente associada ao sofrimento psicológico como também parte de uma resposta corretiva, análoga ao que acontece, por exemplo, com o aumento da temperatura corporal, que é tanto um indicador de infeção, como parte da defesa do organismo contra essa mesma infeção.

Sendo assim, de que forma a imersão e o distanciamento se relacionam com a ativação emocional e com a sintomatologia no sucesso terapêutico? Se tivermos em conta uma perspetiva desenvolvimental da mudança em psicoterapia, um dos primeiros passos do trabalho terapêutico é ativar conteúdos negativos que são parcial ou totalmente evitados impedindo o progresso terapêutico (Caro Gabalda & Stiles, 2009; Elliott et al., 2013). Assim, fomentar o envolvimento emocional com a experiência torna-se fundamental, sendo este um pressuposto transversal a diferentes modalidades terapêuticas (Fosha, 2000; Greenberg, 2002; Samoilov & Goldfried, 2000). Para tal, são normalmente usadas estratégias que envolvem contactar com a experiência na perspetiva de primeira pessoa, privilegiando pensamentos, sentimentos e comportamentos primários associados à experiência negativa, o que corresponde a um movimento de imersão (e.g., Clark e Beck, 2010; Greenberg, 2002). Por exemplo, várias terapias experienciais incentivam os/as clientes a reexperienciarem no próprio momento da terapia estados emocionais desadaptativos que causam sofrimento psicológico, de modo a ficarem *próximos/as* da experiência, como primeiro passo para processar esses estados emocionais previamente evitados (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002).

Um outro exemplo são as estratégias comportamentais de exposição, em que é solicitado aos/às clientes detalhes da experiência, pensamentos, sentimentos do ponto de vista egocêntrico de forma a ativar estes processos e, pela exposição contínua, tolerar o medo do confronto com a experiência e alterar a crença de que ela é potencialmente perigosa (Hofmann & Otto, 2008; Payne, Ellard, Farchione, Fairholme, & Barlow, 2014). Portanto, estas estratégias terapêuticas,

integradas em protocolos de psicoterapia eficazes, parecem indicar um papel importante da imersão na mudança clínica.

Em suma, apesar de vários estudos atribuírem benefícios ao distanciamento e consequências negativas à imersão, há também outras propostas que sugerem que esses efeitos podem ser opostos, nomeadamente em psicoterapia. Se, por um lado, a elevada imersão pode estar associada à ruminação e à desregulação emocional, impedindo o controlo emocional necessário para a reconstrução da experiência, por outro lado, a reduzida imersão poderá significar falta de envolvimento com a experiência emocional. Tal cenário levanta um problema de estudo interessante: qual o papel relativo de cada uma das perspetivas ao longo do processo psicoterapêutico? Será que a perspetiva imersa é favorável em estádios iniciais da terapia, sendo a perspetiva distanciada mais favorável em estádios posteriores?

Importa, assim, esclarecer quando e como a imersão e o distanciamento são úteis em psicoterapia. Para tal, é necessário o desenvolvimento de estudos longitudinais na população clínica que permitam avaliar a evolução destes dois fenómenos ao longo do tratamento, bem como examinar o modo como os mesmos estão envolvidos no processo de mudança psicoterapêutico.

Neste sentido, a presente dissertação propôs-se a clarificar o papel da imersão e do distanciamento em psicoterapia através da realização de estudos longitudinais sobre estes dois fenómenos ao longo do processo terapêutico de casos com perturbação depressiva major acompanhados em modalidades terapêuticas contrastantes e com diferentes resultados. Tal é particularmente importante pelo facto de a perturbação depressiva major estar associada a processos de ruminação (e.g., Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008), sendo, assim, pertinente compreender e testar a influência destas duas perspetivas na manutenção e na melhoria clínica desta condição.

1. Enquadramento Conceptual da Imersão e do Distanciamento na Reflexão de Experiências Pessoais Problemáticas

Na reflexão de experiências pessoais podemos assumir dois tipos de perspetivas: imersa ou distanciada (Kross et al., 2012; Nigro & Neisser, 1983). Estas perspetivas posicionam-nos de forma contrastante em relação à experiência, quase como se adotássemos ângulos diferentes de reflexão sobre a mesma experiência. Numa abordagem mais metafórica, se a experiência for a de ver um filme, ao assumirmos uma perspetiva imersa estaremos no lugar de uma das personagens, enquanto se assumirmos uma perspetiva distanciada estaremos no sofá a observar o filme, ou seja, a observar essa mesma personagem e o que se passa à sua volta.

Especificamente, a imersão é uma perspetiva egocêntrica no sentido em que o *Self* que reflete sobre a experiência no momento atual coincide com o *Self* que experienciou o evento no passado (Nigro & Neisser, 1983; Robinson & Swanson, 1993), ou seja, a pessoa assume o mesmo ponto de vista sobre a experiência. Assim, nesta perspetiva, a experiência é representada na primeira pessoa (“O que aconteceu”; “O que eu senti”; “O que eu pensei”) (Ayduk & Kross,

2010b), sendo que os relatos verbais da experiência focam-se, essencialmente, em descrições concretas e detalhadas dos eventos (e.g., Kross et al., 2005; Kross et al., 2012) e os pensamentos, sentimentos e comportamentos originais/primários associados à experiência tendem a repetir-se (Nigro & Neisser, 1983; Robinson & Swanson, 1993). A título exemplificativo, imaginemos que a "Maria" (caso fictício), na tentativa de compreender os seus sentimentos, está neste momento a refletir sobre uma situação em que não foi convidada para um evento organizado pelo grupo de amigos (*Porque é que **eu** me senti daquela forma naquela situação?)*. Uma possível ilustração da perspetiva imersa seria:

> *Estávamos todos juntos (amigos) a conversar sobre viagens quando o João falou do passeio que fizeram ao Gerês (descreve o que o João disse) e eu percebi que combinaram esta saída e não me incluíram. Senti-me tão angustiada que desatei a chorar mal saí dali. Não consigo deixar de pensar como sou invisível para toda a gente.*

Neste exemplo, a "Maria" focou-se no que aconteceu e expressou sentimentos e pensamentos que ocorreram naquele evento.

Contrariamente à imersão, no distanciamento, o *Self* que reflete sobre a experiência no momento atual está separado do *Self* que experienciou o evento no passado (Nigro & Neisser, 1983; Robinson & Swanson, 1993), ou seja, a pessoa assume um ponto de vista de observador sobre a experiência. Assim, nesta perspetiva, a experiência é representada na terceira pessoa, vendo-se a si mesma na experiência (Ayduk & Kross, 2010b). A "Maria", ao refletir sobre a situação acima referida, estaria numa perspetiva distanciada ao perguntar-se a si mesma: "Porque é que a **Maria** se sentiu daquela forma naquela situação?". Esta posição de observador sobre a própria experiência permite obter uma visão mais ampla sobre as diferentes facetas que a envolvem (Kross et al., 2012). Os relatos verbais focam-se sobretudo na exploração e na explicação de pensamentos, sentimentos e comportamentos, integrando diferentes aspetos da experiência em afirmações que sugerem *insight* e resolução (e.g., Kross et al., 2005; Kross et al., 2012). Uma possível ilustração da perspetiva distanciada no caso "Maria" seria:

> *Eu tenho estado ausente do meu grupo de amigos. Também não os convido para sair e não fui só eu que não fui. Acho que fiquei assim porque me senti rejeitada. Parece que parto sempre do princípio de que sou inferior aos outros. Talvez isto venha desde o fim do meu relacionamento com o João, pois, desde essa altura, que me vejo como inferior às outras raparigas.*

Neste exemplo, a "Maria" não se focou na descrição do evento em específico, mas, em vez disso, expressou uma visão mais ampla sobre o seu padrão de comportamento nas relações com os outros e forneceu uma possível razão para isso.

É de notar que existem outros conceitos relacionados e que se sobrepõem à noção de distanciamento, o que não se verifica com o conceito de imersão. O distanciamento colide com o

conceito de distância psicológica, amplamente estudado em psicologia social e na investigação clínica (e.g., Ayduk & Kross, 2010a), pelo que importa diferenciar os dois conceitos. A distância psicológica é caracterizada pela distância do *Self* relativa à experiência imediata (experiência egocêntrica direta) a um estímulo no aqui e agora, isto é, dimensão ao longo da qual um objeto ou evento pode estar afastado do *Self* (Liberman & Trope, 2008; Trope & Liberman, 2010), permitindo uma imagem mais alargada sobre a experiência (Fujita, Trope, Liberman, & Levin-Sagi, 2006; Trope & Liberman, 2003). Por exemplo, o modelo da Teoria do Nível Construtivo (*Construal Level Theory;* Bar-Anan et al., 2006) conceptualiza a distância psicológica em quatro dimensões: temporal (distância em termos de tempo), espacial (distância em termos de espaço físico), social (distância em relação aos outros) e hipotética (probabilidade de um evento acontecer). O distanciamento, em particular, é uma perspetiva usada na reflexão da experiência que implica distância psicológica do *Self* em relação aos seus pensamentos, sentimentos e comportamentos (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2017), mas não é uma dimensão da distância psicológica, pois não mede a distância à experiência imediata (Soderberg, Callahan, Kochersberger, Amit, & Ledgerwood, 2015). De acordo com uma vasta linha de investigação (e.g., Ayduk & Kross, 2008, 2009, 2010b; Kross & Ayduk, 2008, 2009; Kross, et al., 2005), o distanciamento poderá ser uma estratégia a usar na reflexão da experiência negativa para criarmos distância psicológica dos nossos próprios sentimentos dolorosos que emergem no contacto egocêntrico direto com essa experiência.

Um dos conceitos mais próximos de distanciamento é o de descentração. A descentração é uma variável metacognitiva que implica a capacidade de observar os próprios pensamentos e sentimentos num estado de aceitação e não-julgamento, considerando-os como objetos temporários na nossa mente (Fresco et al., 2007), ou seja, nesta perspetiva, a realidade é reconhecida como mutável e não absoluta (Safran & Segal, 1990). Portanto, para estarmos envolvidos/as num processo de descentração, numa primeira instância, teremos de "sair da sua experiência imediata" (Safran & Segal, 1990, p. 117). De acordo com o modelo de processos metacognitivos proposto por Bernstein et al. (2015), sair da experiência imediata reflete um processo de desidentificação da experiência interna, isto é, os estados internos são experienciados como separados do *Self* que experienciou o evento, mais propriamente a partir da perspetiva de terceira pessoa (Kross et al., 2005; Tagini & Raffone, 2010). Assim, Bernstein et al. (2015) reconhecem o distanciamento como um processo chave na descentração pela promoção da desidentificação dos estados internos, ou seja, olhar para a experiência numa perspetiva de terceira pessoa (distanciamento) facilita o processo de deixar de conceber os pensamentos, emoções e sensações como partes integrantes do *Self* e passar a considerá-los como elementos separados que não definem a sua identidade (desidentificação da experiência interna).

Congruentemente, outros processos metacognitivos requerem a perspetiva distanciada sobre a experiência, uma vez que sair da experiência imediata e subjetiva é uma condição necessária nestes processos (e.g., Bernstein et al., 2015; Wells, 2000). Especificamente, a posição de terceira pessoa facilita a observação dos estados internos como eventos psicológicos,

fundamental para a compreensão dos nossos próprios processos cognitivos (Dimaggio et al., 2009; Dimaggio & Lysaker, 2015; Segal, Williams, & Teasdale, 2013). Por exemplo, a metaconsciência é considerada a capacidade de perceber os processos que ocorrem na consciência (Teasdale et al., 2002). Este processo transcende a consciência do conteúdo (e.g., "Estou a pensar que sou um falhado"), pela observação do processo que envolve o conteúdo (e.g., "Estou a ter um pensamento autocrítico"), ou seja, implica a desidentificação da experiência subjetiva (Bernstein et al., 2015; Vago & Silbersweig, 2012).

É de salientar que, embora o distanciamento seja um fenómeno comum a vários processos associados ao bem-estar psicológico, quer o distanciamento, quer a imersão são apenas duas perspetivas sobre a experiência, não garantindo uma representação produtiva e fiel da realidade (Nigro & Neisser, 1983; Robinson & Swanson, 1993). Contudo, um alargado corpo de investigação experimental e laboratorial tem contribuído para demonstrar a influência destas perspetivas na adaptabilidade da reflexão de experiências pessoais problemáticas (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2011; Kross et al., 2005; Kross et al., 2012; Kross et al, 2014).

1.1. O papel da imersão e do distanciamento na reflexão adaptativa versus desadaptativa de experiências pessoais problemáticas

Há mais de 40 anos que a investigação procura dar resposta a questões acerca da produtividade de refletir sobre experiências pessoais negativas, tais como: refletir sobre experiências perturbadoras é sempre benéfica? As pessoas sentem-se melhor quando refletem sobre os conteúdos negativos? Diversos estudos revelam benefícios da reflexão de experiências problemáticas na saúde psicológica (e.g., Pennebaker & Chung, 2007; Wilson & Gilbert, 2008). De acordo com esta linha de investigação, a reflexão permite representar cognitivamente a experiência, condição necessária para que ocorra a mudança na forma como pensamos sobre a mesma, alcançando novos significados e melhorando o modo como nos sentimos (e.g., Gross, 2013; Ray, Wilhelm, & Gross, 2008; Wilson & Gilbert, 2008). Não obstante, outros estudos revelam que refletir sobre a experiência problemática pode ser contraproducente. Durante o processo de reflexão acedemos a pensamentos de teor negativo e, na tentativa de os compreender, ficamos presos/as aos mesmos, repetindo círculos rígidos de pensamento que dificultam a criação de novos significados, entrando-se num processo de ruminação (Brosschot et al., 2006; Denso et al., 2009; Gotlib & Joormann, 2010; Moulds, Kandris, & Williams, 2007). A ruminação, por sua vez, intensificará o afeto negativo, agravando o mal-estar sentido (Nolen-Hoeksema, 1991; Nolen-Hoeksema et al., 2008).

Face a estas evidências empíricas contraditórias, diversos estudos procuram dar resposta à questão: "Quais são as condições para uma reflexão adaptativa vs. desadaptativa?" (Kross & Ayduk, 2017, p. 83). Esses estudos identificam a perspetiva usada na reflexão da experiência negativa (i.e., experiências emocionais associadas a conteúdos emocionalmente dolorosos) como determinante na adaptabilidade dessa reflexão. Em particular, a imersão tem sido considerada

uma perspetiva desadaptativa, enquanto o distanciamento tem sido considerado uma perspetiva adaptativa. Estas premissas são baseadas nos potenciais efeitos de cada uma na reconstrução da experiência (e.g., Ayduk & Kross, 2010b; Etzel, 2017; Kross & Ayduk, 2011; Kross et al., 2012) e na ativação emocional de emoções negativas (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012).

Na reflexão de uma experiência negativa a partir de uma perspetiva imersa obtemos uma imagem pobre e simplista, na medida em que o foco é dirigido a detalhes concretos e dolorosos, nomeadamente a pensamentos, sentimentos, comportamentos primários/originais e outros aspetos específicos dos eventos (McIsaac & Eich, 2002). Estes elementos absorvem a nossa atenção, tornando-se presentes e intensificando-se, o que dificulta a exploração de novos significados. O foco contínuo em pensamentos e sentimentos perturbadores (imersão) alimenta círculos de ruminação (Ayduk & Kross, 2010a; Kross et al., 2005) e aumenta a intensidade (Kross et al., 2014; Kross et al., 2012) e a duração do afeto negativo (Verduyn et al., 2012).

Inversamente, na reflexão de uma experiência negativa a partir de uma perspetiva distanciada obtemos uma imagem mais rica e abrangente sobre as diversas facetas da experiência (McIsaac & Eich, 2002), facilitando a construção de novos significados (e.g., Ayduk & Kross, 2008) e a resolução de problemas (e.g., Ayduk & Kross, 2008, 2010b), isto é, a reconstrução da experiência (e.g., Etzel, 2017; Kross & Ayduk, 2011; Kross et al., 2005; Kross et al., 2012). Kross e Ayduk (2017) assemelham este processo ao que acontece quando pedimos um conselho a um amigo sobre um problema que nos é penoso ou difícil de resolver. Por norma, fazemo-lo porque estamos de tal forma envolvidos/as na experiência que se torna demasiado difícil raciocinar objetiva e distanciadamente sobre os aspetos pessoais que envolvem o problema. Por sua vez, o amigo, estando psicologicamente distante do problema, é capaz de raciocinar construtivamente sobre esses mesmos aspetos, fornecendo conselhos importantes e sensatos. Assim, a perspetiva de terceira pessoa (amigo) implica menor envolvimento emocional, o que parece facilitar o processo de reflexão adaptativa da experiência. De facto, os estudos têm salientado os benefícios do distanciamento pela capacidade de inibir a ativação emocional de emoções negativas na reflexão de experiências negativas problemáticas. Especificamente, ao contrário do que acontece na imersão, quando adotamos uma perspetiva distanciada, o afeto tende a diminuir em termos de intensidade (Kross et al., 2014; Kross et al., 2012) e de duração (Verduyn et al., 2012).

Estes resultados levam os investigadores a reconhecerem no distanciamento a capacidade de regulação emocional (e.g., Ayduk & Kross, 2008, 2010b; Kross et al., 2012; Wisco & Nolen-Hoeksema, 2011). Uma das formas de explicar esta melhor regulação emocional poderá ser o facto de o distanciamento implicar uma mudança de foco de pensamento. Mais detalhadamente, quando assumimos a perspetiva distanciada, em comparação com a perspetiva imersa, focamo-nos menos em conteúdos emocionalmente ativadores e mais na reconstrução da experiência, favorecendo a redução do mal-estar sentido (e.g., Kross & Ayduk, 2008; Kross et al., 2005; Schartau, Dalgleish, & Dunn, 2009). Por exemplo, estudos que se debruçaram sobre os efeitos da

imersão e do distanciamento na reflexão de experiências negativas passadas verificaram que maiores níveis de distanciamento predizem menores níveis de afeto negativo e esta relação é mediada pelo aumento da reconstrução da experiência negativa (e.g., Grossmann & Kross, 2010; Park, Ayduk, & Kross, 2016; Penner et al., 2016).

A menor ativação de emoções promovida pelo distanciamento tem efeitos imediatos ou a curto-prazo, mas também a longo-prazo. Estudos em que os/as participantes foram divididos/as em dois grupos (um grupo em que adotaram uma perspetiva distanciada e outro grupo em que adotaram uma perspetiva imersa) revelaram que os/as do grupo distanciado mencionaram sentir menos mal-estar quando lhes foi solicitado para refletirem sobre as mesmas experiências uma semana depois (Ayduk & Kross, 2008; 2009). Sendo assim, o distanciamento revelou ser uma estratégia útil para criar alívio emocional quando refletimos sobre experiências penosas, o que se assemelha à distração.

A distração é uma estratégia muitas vezes usada quando recontamos algo doloroso como forma de reduzir as emoções negativas (Lench, Bench, & Davis, 2015; Rusting & Nolen-Hoeksema, 1998). Apesar desta convergência entre o distanciamento e a distração, estes processos distinguem-se a longo prazo. De facto, investigações que avaliaram as implicações do distanciamento, imersão e distração no afeto a curto e a longo prazo, mostraram que, a curto prazo, não foram encontradas diferenças significativas entre os/as participantes dos grupos de distanciamento e distração, mas sim entre estes grupos e o grupo de imersão, ou seja, os grupos de distração e distanciamento apresentaram menores níveis de mal-estar do que o grupo de imersão. No entanto, a longo prazo (7 dias depois), não sendo manipulada nenhuma das estratégias, o grupo inicial de distanciamento apresentou menos ativação emocional negativa do que os grupos de distração e imersão. Para além destes resultados, o grupo de distanciamento reportou ruminar menos na experiência negativa entre as duas sessões do estudo do que o grupo de distração (Ayduk & Kross, 2008). De acordo com os estudos, o alívio emocional na distração é temporário, pois quando paramos de nos distrair, as emoções negativas são novamente ativadas. Pelo contrário, no distanciamento, muda a representação mental da experiência (reconstrução da experiência), prevenindo a ruminação e permitindo que esses efeitos emocionais sejam duradouros (Ayduk & Kross, 2008; Kross & Ayduk, 2008).

Vários estudos são consistentes quando sugerem o distanciamento como estratégia útil na prevenção da ruminação, impedindo, assim, uma ativação emocional excessiva (Ayduk & Kross, 2008, 2010a; Berman et al., 2011; Kross, 2009; Kross et al., 2005). O distanciamento tem sido associado, por isso, à reconstrução de experiências negativas problemáticas (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009), funcionando como um mecanismo contra a ruminação (Ayduk & Kross, 2008, 2010a; Berman et al., 2011; Kross, 2009; Kross et al., 2005) e a favor da regulação emocional (e.g., Ayduk & Kross, 2008, 2010b; Berman et al., 2011; Kross & Ayduk, 2017; Kross et al., 2012; Mischel & Ayduk, 2004). A ruminação e a desregulação emocional dificultam a resolução adaptativa de experiências negativas de conflitos e de ofensas interpessoais, pois induzem o comportamento fisicamente violento ou a hostilidade (e.g.,

Bushman, Bonacci, Pedersen, Vasquez, & Miller, 2005). Consistentemente, a investigação sobre a imersão e o distanciamento em experiências negativas de hostilidade tem revelado que o distanciamento atenua o comportamento agressivo (Ayduk & Kross, 2010a, 2010b; Mischkowski, Kross, & Bushman, 2012). Nesse sentido, Mischkowski et al. (2012) revelaram que, face a comportamentos provocatórios, os/as participantes do grupo distanciado apresentaram poucos pensamentos de agressividade em relação ao outro, menos sentimentos de raiva e menos comportamentos agressivos, quando comparado com os/as do grupo de imersão.

Portanto, face a experiências negativas, adotar uma perspetiva imersa ou distanciada tem diferentes implicações na forma como pensamos (recontar vs. reconstruir), sentimos (maior ou menor ativação de emoções negativas) e nos comportamos (maior ou menor comportamento agressivo). Dadas estas implicações, adotar uma destas perspetivas pode representar maior ou menor vulnerabilidade a problemas na saúde física (e.g., Ayduk & Kross, 2008; Wisco et al., 2015) e psicológica (e.g., Kross & Ayduk, 2009; Kross et al., 2012).

Em termos físicos, a resposta de stress face a situações psicologicamente dolorosas é comum e adaptativa. Contudo, a contínua exposição ao stress pela recordação de aspetos negativos dos eventos tem como efeito o aumento da tensão arterial, podendo levar a problemas cardiovasculares. A perspetiva distanciada sobre esses eventos tem sido associada a menor reatividade cardiovascular. Mais concretamente, a tensão arterial retorna à estabilidade mais rapidamente quando a reflexão sobre a experiência problemática ocorre segundo uma perspetiva distanciada do que segundo uma perspetiva imersa. Neste sentido, os estudos sugerem que o distanciamento pode funcionar como facilitador da recuperação fisiológica ao stress (e.g., Ayduk & Kross, 2008; Kross & Ayduk, 2010b). Um estudo com veteranos de guerra diagnosticados com stress pós-traumático corrobora estes resultados ao mostrar que estes participantes, quando refletiram sobre a sua experiência de trauma, apresentaram menores níveis de reatividade fisiológica em termos de frequência cardíaca e condutância da pele no grupo distanciado do que no grupo imerso (Wisco et al., 2015).

Em termos psicológicos, a imersão tem sido associada a estados psicopatológicos devido à vulnerabilidade à ruminação e à ativação emocional negativa (Brosschot et al., 2006; Bushman, 2002; Nolen-Hoeksema et al., 2008). Embora seja comum adotarmos uma perspetiva imersa quando recordamos experiências negativas (e.g., Nigro & Neisser, 1983; Robinson & Swanson, 1993), torna-se problemático quando ficamos presos/as a um processo de ruminação e assoberbados/as pelas nossas emoções que nos fazem sentir pior, criando condições para o desenvolvimento de psicopatologia (Nolen-Hoeksema et al., 2008). Por exemplo, a ruminação prediz (Ciesla & Roberts, 2007) e exacerba (Takagishi, Sakata, & Kitamura, 2013) o humor deprimido, sendo considerado um processo cognitivo que desencadeia e mantém a depressão e a disforia (e.g., Nolen-Hoeksema et al., 2008). Coerentemente, os estudos têm mostrado que pessoas com sintomatologia depressiva tendem a analisar a experiência segundo uma perspetiva imersa (Kross & Ayduk, 2009; Kross, Davidson, & Ochsner, 2009; Kross et al., 2012). Contudo, nos estudos realizados com pessoas avaliadas com sintomatologia depressiva verificou-se que

estas mesmas pessoas foram capazes de mudar de perspetiva, adotando uma perspetiva distanciada, e que nesta posição exibiram menos efeitos negativos depois de refletirem sobre as memórias emocionalmente perturbadoras, nomeadamente: menor reatividade emocional face ao afeto negativo (Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen-Hoeksema, 2011), níveis mais baixos de acessibilidade ao pensamento negativo, bem como menos descrição e mais reconstrução da experiência problemática, apresentando menor sintomatologia depressiva (Kross, et al., 2012).

As mudanças parecem também ocorrer a nível cerebral. No estudo de Kross, Davidson, Weber e Ochsner (2009), o distanciamento está associado à redução da ativação do córtex cingulado anterior subgenual. Esta área do cérebro representa um papel fundamental na depressão e na ruminação, uma vez que se apresenta com elevados níveis de ativação em pessoas deprimidas (Ressler & Mayberg, 2007; Rodríguez-Cano, Sarró, Monté, & Maristany, 2014). Outros estudos (Dorfel et al., 2014; Koenigsberg et al., 2009, 2010) associam o distanciamento à redução da ativação da amígdala, uma área também alterada na depressão e com influência no humor negativo. Embora a investigação não reúna consenso quanto à área do cérebro que é ativada, os estudos são unânimes ao considerarem o distanciamento, em oposição à imersão, como uma estratégia útil para perturbações que são mais vulneráveis ao afeto negativo e à ruminação, pois facilita uma reflexão adaptativa de experiências pessoais problemáticas (e.g., Ayduk & Kross, 2010b; Kross, 2009; Kross & Ayduk, 2008; Kross et al., 2009). Neste sentido, Kross (2009) sugere que a mudança de perspetiva, de imersão para distanciamento, sobre as experiências que desencadeiam afeto negativo favorece a reflexão adaptativa, quer na população não clínica, quer na população clínica.

Os benefícios na regulação emocional têm, também, sido estendidos ao afeto positivo. Park et al. (2014) sugerem que o distanciamento pode funcionar como uma ferramenta útil para ajudar as pessoas a lidar com reações emocionais positivas intensas, como é o caso da fase maníaca na perturbação bipolar. Dados os benefícios da perspetiva distanciada, alguns estudos têm sido desenvolvidos com vista a testarem algumas medidas para induzirem as pessoas a adotarem uma perspetiva distanciada, no sentido de servir como estratégia de intervenção e de prevenção de estados disfuncionais, nomeadamente o uso da terceira pessoa quando se refere a si mesma ("ele/ela" ou o próprio nome) (e.g., Kross et al., 2014).

Em suma, segundo os estudos apresentados, levar as pessoas a refletir sobre experiências negativas a partir de uma perspetiva distanciada permite mudanças na forma como estas representam cognitivamente essas experiências e isso tem implicações positivas no modo como pensam, sentem e se comportam. Assim, o distanciamento, em detrimento da imersão, tem sido concebido como uma perspetiva adaptativa na reflexão de experiências pessoais problemáticas, funcionando como um mecanismo benéfico para a saúde e facilitador do processamento dessas mesmas experiências (e.g., Etzel, 2017; Kross & Ayduk, 2017). As vantagens ao nível da reconstrução da experiência negativa, impedindo a ruminação e/ou reduzindo a ativação de emoções negativas, têm sido transversais nos estados psicopatológicos estudados. Como tal,

vários estudos sugerem vantagens terapêuticas do uso desta perspetiva também pela população clínica (e.g., Ayduk & Kross, 2010b; Etzel, 2017; Kross, 2009; Kross & Ayduk, 2008, 2017; Kross et al., 2009).

No entanto, a metodologia usada nos estudos até agora elencados levanta algumas questões quanto à generalização dos resultados encontrados para a população clínica alvo de processo psicoterapêutico. Para que se perceba a relevância deste ponto, é importante fazer uma breve revisão dos procedimentos experimentais gerais utilizados pelos mesmos para avaliar a imersão e o distanciamento.

Os estudos realizados nesta área assentaram sobretudo em dois métodos: manipulação das perspetivas ou classificação da perspetiva assumida de acordo com uma escala de Likert. No primeiro método referido (manipulação das perspetivas), os/as participantes eram instruídos/as a assumirem uma das perspetivas enquanto se recordavam de uma experiência negativa. A título de exemplo, a instrução dada aos/às participantes para assumirem uma perspetiva imersa num dos estudos foi a seguinte:

> *"Volte para a hora e local da experiência que acabou de se lembrar e veja a cena a acontecer na sua mente. Agora veja a experiência a desenrolar-se através dos seus próprios olhos como se estivesse a acontecer novamente. Repita o evento à medida que este se desenrola na sua imaginação através dos seus próprios olhos…".* (Kross & Ayduk, 2017, p. 87).

Por sua vez, a instrução dada aos/às participantes para assumirem uma perspetiva distanciada foi a seguinte:

> *"Volte para a hora e local da experiência que acabou de se lembrar e veja a cena a acontecer na sua mente. Agora, dê alguns passos para trás. Afaste-se da situação a um ponto em que pode assistir ao desenrolar do evento à distância e pode ver-se a si mesmo/a no evento. Ao fazer isso, concentre-se no que agora se tornou distante de si. Agora observe a experiência a ocorrer novamente como se estivesse a acontecer distante de si. Repita o evento à medida que este se desenrola na sua imaginação como se estivesse a observar o seu EU distante…".* (Kross & Ayduk, 2017, p. 87).

A partir deste procedimento, os/as participantes que receberam as instruções para a perspetiva imersa constituíram o grupo imerso, enquanto os/as participantes que receberam as instruções para a perspetiva distanciada constituíram o grupo distanciado. Posteriormente, para cada grupo foi solicitado que refletissem e analisassem os sentimentos relativos à sua experiência enquanto mantinham a perspetiva adotada inicialmente. Diferentes tipos de análise foram realizados de seguida com o objetivo de perceber o impacto destas instruções na forma como as pessoas pensam, sentem e se comportam (e.g., Ayduk & Kross, 2008, Kross & Ayduk, 2008; Kross et al., 2012; Grossmann & Kross, 2010; Park et al., 2016). Neste sentido, este método considerava que as instruções dadas serviam como garantia de que todos os/as participantes perceberiam o que era pedido e que estariam a seguir a perspetiva solicitada.

No segundo método (classificação da perspetiva assumida de acordo com uma escala de Likert), os/as investigadores/as procuraram avaliar a imersão/distanciamento espontâneos e, por isso, não manipularam as perspetivas. Ao invés disso, após a reflexão sobre a experiência negativa, foi solicitado aos/às participantes para classificarem o quanto estiveram imersos/as ou distanciados/as (e.g., Ayduk e Kross, 2010b; Verduyn et al., 2012). A escala variava entre 1 e 7 (1 = predominantemente imerso/a; 4 = ambos, mais ou menos igual; 7 = predominantemente distanciado/a). Como forma de garantir que todos os/às participantes classificariam corretamente o grau de imersão/distanciamento, foi-lhes transmitida uma pequena instrução para o preenchimento da escala e uma explicação breve sobre os conceitos:

> *"…até que ponto sentiu-se como se fosse um/a observador/a distanciado/a do que aconteceu (isto é, assistiu ao desenrolar do evento como um/a observador/a, no qual poderia ver-se a si próprio/a de longe) ou sentiu-se como um/a participante imerso/a na experiência (ou seja, viu o evento repetir-se através de seus próprios olhos como se estivesse ali novamente)…".* (Kross & Ayduk, 2017, p. 90).

Posteriormente a esta classificação, eram realizadas as análises. De acordo com este método, a breve instrução dada para a classificação da escala era suficiente para garantir que todos/as os/as participantes compreenderam os conceitos e que a classificação dada por cada participante foi uma representação real da reflexão realizada.

Já Kuyken e Moulds (2009) usaram, na sua amostra clínica, um método diferente dos restantes estudos. Neste estudo, os/as participantes foram convidados/as a recuperarem memórias à medida que lhes eram apresentadas duas listas de palavras: uma lista de palavras que correspondiam a emoções positivas e outra a emoções negativas. Posteriormente, os/as participantes classificaram a perspetiva usada sobre essas memórias numa escala dicotómica, ou seja, pontuaram se viram a cena através de seus próprios olhos (imersão) ou se viram a cena como se fossem alguém de fora (distanciamento). Neste estudo, há uma conjugação entre experiências de conteúdo negativo e positivo, podendo ser uma variável com implicações nos resultados. Também neste método a breve instrução dada para a classificação de imersão/distanciamento é considerada suficiente para garantir que todos os/as participantes compreenderam os conceitos, sendo a classificação uma representação real da reflexão realizada.

Estes procedimentos levantam algumas questões quanto aos procedimentos usados, nomeadamente:

a) O procedimento de manipulação das perspetivas assume que as instruções são eficazes. No entanto, não existem garantias ou verificação rigorosa de tal resultado. Será que os/as participantes ficaram de facto imersos/as ou distanciados/as? E será que, quando as perspetivas foram manipuladas, os/as participantes se mantiveram na mesma perspetiva ao longo de toda a reflexão?;

b) A classificação da perspetiva segundo uma escala de Likert ou uma escala dicotómica parece ser um procedimento algo rudimentar do ponto de vista psicométrico para garantir fiabilidade nos resultados obtidos. Seriam, por isso, aconselháveis meios que pudessem

consolidar esta linha de estudo;

c) Os estudos na área quase só se focam em experiências negativas. Salienta-se, como exceção, o estudo de Kuyken e Moulds (2009), através do qual foram estudadas experiências negativas e positivas. Será que os efeitos da imersão/distanciamento seriam diferentes se fossem avaliados em experiências negativas e em experiências positivas separadamente? Por exemplo, Verduyn et al. (2012), com o seu estudo sobre a duração do afeto de acordo com a perspetiva usada na reflexão da experiência, lança a sugestão muito pertinente de que o distanciamento poderá ser útil em experiências negativas para minimizar os efeitos negativos; inversamente, a imersão poderá ser útil em experiências positivas para maximizar os seus efeitos.

Estes aspetos metodológicos levantam algumas questões relativamente ao método usado para avaliar as variáveis centrais nesta área e sinalizam a importância de um aprofundamento e consolidação dos métodos. Além disso, no que toca a aplicar estes resultados à psicoterapia, deveremos avançar com mais prudência. Um aspeto particularmente importante para o propósito do presente trabalho prende-se com o facto da quase totalidade destes estudos se afastar da realidade vivida num processo psicoterapêutico. Na revisão da literatura a este respeito, só encontramos um estudo que envolvia a avaliação dos efeitos da psicoterapia no distanciamento e imersão, comparando os valores destas duas variáveis antes e depois da intervenção. É particularmente relevante notar que esse estudo apresentou resultados contraditórios com a imagem global anteriormente partilhada. Especificamente, o estudo de Kuyken e Moulds (2009), integrado no ensaio clínico que comparava a terapia cognitiva baseada em *mindfulness* (MBCT; mindfulness-based cognitive therapy) com o tratamento a partir de medicação antidepressiva em participantes diagnosticados/as com depressão, mostrou que os/as que adotaram uma perspetiva imersa no pré-tratamento em MBCT obtiveram menores níveis de sintomatologia depressiva no pós-tratamento.

Estes resultados lançam, assim, algumas dúvidas quanto ao papel do distanciamento na psicoterapia. Estas dúvidas são exacerbadas pelo facto de noutros estudos na área, onde alguma intervenção psicológica foi facultada, as perspetivas usadas pelos/as participantes terem sido avaliadas apenas antes da intervenção psicológica, não nos dando informação quanto aos benefícios/malefícios das mesmas ao longo do processo terapêutico. Aliás, quase todos estes estudos focaram as suas análises num momento específico, adotando uma visão sincrónica sobre estas perspetivas – e quando não o fizeram, os intervalos de tempo considerados entre as avaliações foram muito curtos (por exemplo, uma semana). Sendo assim, ficamos sem uma imagem clara dos efeitos da psicoterapia nas duas perspetivas em análise. Além disso, sabendo-se que a terapia ocorre ao longo de um processo acompanhado de diversas mudanças (e.g., Caro, Gabalda, & Stiles, 2009; Gonçalves & Ribeiro, 2012), podemos questionar se estas perspetivas terão efeitos diferentes em momentos ou fases terapêuticas distintas.

Portanto, a investigação na área é quase unânime ao reconhecer o potencial da perspetiva distanciada na saúde física e mental na reflexão de experiências pessoais problemáticas, sugerindo que a perspetiva usada é uma variável relevante em terapia. Contudo, algumas questões

metodológicas já referidas colocam em causa a generalização dos resultados obtidos para o processo terapêutico. Assim sendo, lançamos a questão: quais são os efeitos da imersão e do distanciamento na mudança clínica em psicoterapia? É essa questão que iremos explorar ao longo do próximo tópico.

2. O Papel Paradoxal da Imersão e do Distanciamento na Mudança em Psicoterapia

As pessoas procuram ajuda psicológica no sentido de melhorar as estratégias para lidar com as suas experiências problemáticas que provocam pensamentos e sentimentos desconfortáveis e dolorosos. Assim, a população clínica parece ser a população que mais beneficia de estratégias que impedem estilos de resposta desadaptativos. Sendo a psicoterapia um contexto privilegiado no que concerne à reflexão de experiências pessoais problemáticas (Smith, Glass, & Miller, 1980), os estudos experimentais/laboratoriais apontam o distanciamento como uma estratégia com potencial a nível terapêutico, nomeadamente em problemáticas vulneráveis ao afeto negativo e à ruminação. Estes estudos defendem que, mesmo na população clínica, o distanciamento, em oposição à imersão, permite que o indivíduo lide e processe as experiências negativas de modo adaptativo, devido aos seus efeitos na redução da ativação emocional (e.g., Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen- Hoeksema, 2011) e reconstrução da experiência (e.g., Etzel, 2017; Kross et al., 2012). Contudo, estudos sobre imersão/distanciamento durante o processo terapêutico não foram encontrados e os resultados, sobretudo experimentais/laboratoriais, possuem alguns constrangimentos metodológicos, tal como foi referido no ponto anterior desta introdução. Além disso, numa análise atenta da literatura existente acerca da utilidade de alguns fenómenos em contexto terapêutico, conseguimos extrapolar indicações convergentes, mas também divergentes dos estudos experimentais/laboratoriais quanto ao papel de cada uma destas perspetivas na reflexão de experiências negativas. Por exemplo, conseguimos encontrar indicações teóricas quanto aos benefícios do distanciamento no tratamento psicológico. Paradoxalmente, também conseguimos encontrar investigação que sugere efeitos negativos desta perspetiva em psicoterapia, contribuindo para a manutenção dos estados psicopatológicos (e.g., Gross, 2007; Kennedy-Moore & Watson, 2001).

Relativamente aos benefícios do distanciamento no tratamento psicológico, de acordo com a investigação sobre a regulação emocional em psicoterapia, a reavaliação cognitiva tem sido identificada como uma estratégia eficaz para obter controlo emocional sobre situações potencialmente dolorosas, mais precisamente para obter a diminuição da experiência emocional negativa (Gross, 1998, 2015; Gross & John, 2003). Esta estratégia consiste em reinterpretações baseadas em evidências realistas de situações que provocam a emoção, o que implica uma postura de observador em relação a diferentes facetas da experiência, ou seja, um ponto de vista mais abrangente e diferenciado do ponto de vista inicial (Gross, 2007). A reavaliação cognitiva permite, assim, mudar o significado emocional de situações negativas ou ameaçadoras e obter respostas emocionais mais adaptativas (Duckworth, Gendler, & Gross, 2016; Gross, 2015). Esta

estratégia é baseada nas técnicas de terapia cognitiva tradicionais. Por exemplo, no protocolo de regulação emocional de Gross (2007), face a pessoas com pensamentos de sobrestimação do perigo e catastrofização, típicos na depressão e ansiedade, é aplicada a reavaliação cognitiva, ensinando os/as clientes a usarem técnicas de reestruturação cognitiva para avaliar situações de forma adaptativa. De facto, a terapia cognitiva assume o distanciamento em relação às experiências pessoais negativas como uma pré-condição essencial na reestruturação cognitiva, a fim da reconstrução de pensamentos desadaptativos e consequente mudança terapêutica (Beck, 1970; Ma & Teasdale, 2004). Esta fase do tratamento conduz ao alívio dos sintomas clínicos e facilita a aplicação dos outros componentes do tratamento em clientes que se preparam para enfrentar estímulos que provocam emoções negativas (Beck, 1970; Gross, 2007). Assim, ensinar os/as clientes a refletirem, cada vez mais autonomamente, sobre a sua experiência negativa de forma distanciada é um objetivo da terapia, pois julga-se ser essencial para o trabalho terapêutico, mas também para a eficácia do tratamento a longo prazo – os/as clientes conseguirem, após o término da terapia, refletir sobre a sua experiência de forma regulada e produtiva, impedindo recaídas (Ingram & Hollon, 1986).

A reflexão distanciada sobre experiências pessoais problemáticas parece ser um princípio inerente à terapia cognitiva, mas também a outras modalidades terapêuticas como, por exemplo, o *mindfulness*. Na terapia de *mindfulness*, a descentração é um ingrediente de base (e.g., Hayes-Skelton & Graham, 2012), conceito que se sobrepõe ao distanciamento (Bernstein et al., 2015), tal como já foi referido nesta introdução.

Também em terapias mais experienciais como a terapia focada nas emoções, encontramos tarefas e técnicas, frequentemente aplicadas em fases mais tardias do processo terapêutico, que são consistentes com a perspetiva distanciada. Por exemplo, no "trabalho de cadeira" (tarefa típica da terapia focada nas emoções para o tratamento da depressão) o/a cliente é incentivado/a a distinguir diferentes partes de si como duas personagens ou "vozes" distintas com o objetivo de criar novos significados. Esta tarefa promove uma leitura mais diferenciada da sua dinâmica interna, fomentando a perspetiva de observador sobre estas personagens ou "vozes". Observá-las ajuda a perceber o seu funcionamento e a criar formas alternativas de interpretar a experiência (Greenberg & Watson, 2006). Aliás, uma das técnicas usadas nesta tarefa é tratar as diferentes partes de si por "tu" ou pelo próprio nome e, de acordo com o estudo de Kross et al. (2014), referir-se a si mesmo/a pelo próprio nome é uma estratégia que induz o distanciamento. A terapia focada nas emoções também parece promover o distanciamento no sentido de regular as emoções intensas de afeto negativo que levaram o/a cliente a ficar assoberbado/a. "Limpar o espaço" é uma tarefa ilustrativa deste fenómeno. Aqui, o/a cliente é convidado/a a criar uma "distância de trabalho", isto é, a observar o objeto problemático fora de si, num lugar à sua escolha, de forma a criar um espaço seguro e distante da questão problemática em causa (Elliott et al., 2004). Assim, pretende-se baixar a ativação emocional de emoções negativas.

Numa análise global, as evidências até agora apresentadas sobre o distanciamento em psicoterapia são consistentes com os estudos experimentais/laboratoriais quanto à importância do

distanciamento, quer do ponto de vista da reconstrução da experiência (e.g., Etzel, 2017; Kross et al., 2012), quer do ponto de vista da diminuição do afeto negativo (e.g., Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen- Hoeksema, 2011). Sendo assim, em psicoterapia devemos fomentar o distanciamento e evitar a imersão?

Na verdade, tendemos a olhar para o distanciamento como um mecanismo que permite alcançar uma visão mais realista e produtiva, uma vez que nos coloca numa posição mais ampla sobre a experiência, expressando conteúdos que sugerem *insight* e resolução. Contudo, tal como foi referido no início desta dissertação, estes conteúdos podem não ser uma representação fiel ou produtiva da realidade. A investigação tem mostrado que uma das estratégias para evitar o sofrimento é racionalizar sobre a experiência negativa. A racionalização é um processo semelhante à reavaliação cognitiva e, por isso, envolve uma postura de observador, muito embora ocorra de uma forma desajustada. Esta estratégia consiste na reinterpretação da situação com base em evidências que apenas permitem um alívio imediato, mas é ineficaz na resolução do problema e na gestão das emoções negativas (Gross, 2007).

Concebamos o exemplo da "Maria" mencionado aquando da definição de imersão e distanciamento. Face à mesma experiência (a "Maria" não foi convidada para um evento organizado pelo grupo de amigos), uma outra ilustração da perspetiva distanciada menos adaptativa poderia ser:

> *Agora, olhando para o meu passado, vejo que me sinto muitas vezes rejeitada pelos meus amigos. Nunca me tinha apercebido disto. Talvez eu não deva investir nas relações. Realmente, consigo fazer as mesmas coisas sozinha sem precisar de lidar com este tipo de problemas.*

Neste exemplo, a "Maria" não se focou na descrição do problema e expressou uma visão mais ampla sobre seu padrão de comportamento nas relações com os outros, fornecendo uma possível resolução. Contudo, numa análise mais fina, a reinterpretação dada à situação é inválida, pois as amizades para si são importantes, pelo que esta é apenas uma forma de evitar o sofrimento associado ao evento. Provavelmente, isto funcionará temporariamente, uma vez que não a move para uma ação no sentido de resolução efetiva do problema.

As estratégias de evitamento nem sempre são problemáticas, uma vez que permitem a regulação emocional de conteúdos penosos, culminando em melhores resultados sintomatológicos (e.g., Bonanno, Keltner, Holen, & Horowitz, 1995; Gross, 2007; Kennedy-Moore & Watson, 2001). Além disso, estas ajudam a lidar com questões iminentes do dia-a-dia de modo mais eficaz e funcional (Gross, 2007). No entanto, o uso contínuo de estratégias de evitamento pode gerar e manter estados psicopatológicos (e.g., Gross, 2007; Moroz & Dunkley, 2019), potenciando as preocupações e as crenças irrealistas (e.g., Akbari & Khanipour, 2018) e protelando a resolução dos problemas (Kashdan, Barrios, Forsyth, & Steger, 2006). O sofrimento pode atingir proporções de tal forma elevadas que as pessoas acham-se incapazes de lidar com ele. O envolvimento emocional é visto como perigoso, insuportável, gerando medo de falhar ou de serem "absorvidas" pelas emoções negativas. O evitamento é uma estratégia que permite atenuar

essas emoções, pelo não contacto com as mesmas, mas não permite infirmar as crenças acerca da sua perigosidade. Aliás, esta estratégia valida e potencia a sensação de ineficácia para lidar com o problema, alimentando círculos de preocupação e medo da re-experienciação (e.g., Espejo, Gorlick, & Castriotta, 2017; Kashdan et al., 2006). É o caso de pessoas com perturbação de stress pós-traumático (PSPT), que pelo medo do sofrimento associado ao trauma, evitam esse sofrimento bloqueando o confronto adaptativo com as memórias do trauma (e.g., Berntsen, Willert, & Rubin, 2003). Consistentemente, McIsaac e Eich (2004) verificaram, no seu estudo, que os/as participantes expostos/as ao trauma com PSPT usavam mais a perspetiva de observador quando recordavam memórias emocionais relacionadas com o trauma do que os/as participantes sem PSPT. Além disso, a maior parte dos/as participantes que usou a perspetiva de observador afirmou que o fez para evitar a re-experienciação do trauma (McIsaac & Eich, 2004). Face a estes resultados, os autores sugerem que a perspetiva de observador pode representar um mecanismo usado por estas pessoas para evitar o conteúdo emocional negativo e a ansiedade decorrentes das memórias traumáticas.

À semelhança do que acontece na PTSD, outros problemas psicológicos, como a ansiedade (e.g., Mkrtchian, Aylward, Dayan, Roiser, & Robinson, 2017; Kashdan et al., 2014) e a depressão (e.g., Huang, Chen, & Tseng, 2019), são, muitas vezes, geridos e mantidos a partir de estratégias de evitamento (Coles, Turk, Heimberg, & Fresco, 2001; Gross, 2007), impedindo as pessoas de usufruir dos benefícios da emoção (Gross, 2007; Kennedy-Moore & Watson, 2001). Mais concretamente, a emoção "fornece informações importantes sobre os nossos estados internos e externos, e isso pode ser necessário para identificar e compreender as emoções antes de decidir se e como regulá-las" (Gross, 2007, p. 555).

De facto, diversas modalidades terapêuticas (e.g., Greenberg, 2002; Samoilov & Goldfried, 2000) apoiadas empiricamente (e.g., Foa & Kozak, 1986) incentivam o envolvimento emocional como forma de impedir o evitamento e de beneficiar das vantagens da emoção, sobretudo numa fase inicial do processo terapêutico. Para tal, usam estratégias que sugerem imersão (e.g., Clark & Beck, 2010; Greenberg, 2002), o que nos dá indicações teóricas acerca dos benefícios da imersão em psicoterapia e contraria o papel exclusivamente negativo da imersão defendido pelos estudos experimentais/laboratoriais. É o caso das terapias experienciais, nomeadamente a terapia focada nas emoções, que privilegia o envolvimento emocional pelo contacto com os estados emocionais desadaptativos que causam sofrimento. O objetivo central é que os/as clientes tomem consciência dos seus estados internos, de modo a processá-los e a transformá-los (Elliott et al., 2004; Greenberg, 2002). De acordo com esta modalidade terapêutica, a pessoa precisa de estar *perto da sua própria experiência,* considerando que a única forma de a mudar é através dela mesmo – "the only way out is through" (Pascual-Leone & Greenberg, 2007, p. 875). Por exemplo, no tratamento da depressão, o primeiro passo da intervenção é adquirir acesso gradual ao estado depressivo central desadaptativo, que pode envolver emoções nucleares diferentes, como a vergonha ou medo (Greenberg & Watson, 2006). Para isso, o/a cliente é estimulado/a a refletir sobre essas emoções dolorosas num contexto acolhedor e seguro a partir de uma perspetiva de

primeira pessoa (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006). O/A terapeuta pode sugerir a reflexão da experiência a partir da perspetiva imersa solicitando ao/à cliente que se foque nos estados físicos e emocionais que esse episódio provoca (Elliott et al., 2004). O intuito deste exercício é que a emoção seja sentida, isto é, ativada para ser re-experienciada no presente – aqui e agora (Elliott et al., 2004; Greenberg, 2002). Estes dados são consistentes com os estudos experimentais/laboratoriais quanto ao potencial da imersão na ativação emocional (e.g., Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen-Hoeksema, 2011). No entanto, aqui a ativação emocional de conteúdo negativo é vista como adaptativa, permitindo tomar consciência do seu estado interno e combater o evitamento, aprendendo a tolerar e a aceitar as emoções dolorosas subjacentes (Greenberg, 2004). Segundo este modelo, a ativação emocional é o primeiro passo no sentido da criação de novos significados, bem como de respostas emocionais mais adaptativas, compatíveis com as necessidades do/a cliente (Elliott et al., 2004; Greenberg & Watson, 2006). Coerentemente, dados empíricos mostram que a ativação emocional é um processo que estimula a ativação de estruturas e informações emocionais, permitindo uma maior consciencialização e facilitando a reatribuição de significado e transformação emocional (e.g., Elliott et al., 2013; Greenberg et al., 1993; Pennebaker & Graybeal, 2001; Smyth, 1998; Wilson & Gilbert, 2008).

O contacto com a experiência, envolvendo ativação emocional, é também um princípio de base das estratégias de exposição realizadas na terapia comportamental (Hofmann & Otto, 2008; Payne et al., 2014), sendo que, também aqui, a imersão parece ter um papel importante. Especificamente, o/a cliente é incentivado/a a ativar as sensações físicas e as emoções temidas ficando imerso/a na situação por tempo suficiente até diminuir essa ativação. Vários exercícios, envolvendo imersão na experiência perturbadora, podem ser necessários para impedir o evitamento e para o/a cliente desenvolver um processo de habituação à ativação das sensações físicas e emocionais indesejadas. Isso, por sua vez, permite a diminuição da ativação e desperta o/a cliente para a avaliação do significado e do impacto da sua experiência (Kennedy-Moore & Watson, 2001; Payne et al., 2014). O objetivo é facilitar a reavaliação das suas crenças, percebendo que o sofrimento é tolerável e gerível e não tão perigoso como previa (Payne et al., 2014).

Mesmo a terapia cognitiva, no início do trabalho, fomenta o envolvimento emocional, ainda que isso cause sofrimento. Para o efeito, parece incentivar a reflexão da experiência a partir da perspetiva de primeira pessoa. Neste tipo de modalidade terapêutica, o/a terapeuta procura que o/a cliente expresse a sua perspetiva de primeira pessoa sobre os eventos de modo a aceder a crenças/pensamentos disfuncionais, muitas vezes evitados ou desconhecidos, e que podem estar a manter um padrão de pensamento patológico. Aceder a crenças/pensamentos disfuncionais é o primeiro passo no sentido da criação de visões alternativas mais realistas sobre a experiência (e.g., Beck, 1970, 1979; Young, Rygh, Weinberger, & Beck, 2014). Por exemplo, de modo a contornar as estratégias de evitamento na PSPT e aceder aos pensamentos disfuncionais relacionados com o trauma, Clark e Beck (2010), no seu protocolo de intervenção nesta

perturbação, indicam como estratégia escrever uma história detalhada acerca do evento traumático. É solicitado ao/à cliente que reflita sobre os pensamentos, sentimentos e comportamentos tal como foram experienciados no momento do trauma, ou seja, segundo a perspetiva de primeira pessoa. A construção de uma narrativa sobre os eventos dolorosos, ainda que seja descrita sob um ponto de vista egocêntrico, promove a sensação de controlo sobre algo que inicialmente parece ser incontrolável, criando a oportunidade de a reconstruir.

No mesmo sentido, Stiles (1995) afirma que as autorrevelações do tipo "eu penso…", "eu sinto-me…", típicas de uma perspetiva de primeira pessoa (Nigro & Neisser, 1983; Robinson & Swanson, 1993), embora possam provocar elevados níveis de sofrimento, são importantes na integração e na assimilação das experiências problemáticas (Stiles, 1995). Assim, em psicoterapia, atribuir à perspetiva imersa uma conotação negativa pela ativação emocional de conteúdo doloroso, tal como é sugerida pelos estudos experimentais/laboratoriais (e.g., Kross et al., 2014; Verduyn et al., 2012), não parece ser propriamente adequado face àquilo que é o papel da ativação emocional neste contexto. Pelo contrário, a ativação emocional tem um papel positivo e importante na promoção da mudança clínica, sobretudo em fases iniciais da terapia, sendo um princípio transversal a várias abordagens terapêuticas (Fosha, 2000; Greenberg, 2002; Samoilov & Goldfried, 2000).

Com base nestes dados, será que a reflexão segundo uma perspetiva imersa em experiências pessoais negativas pode predizer o movimento no sentido da mudança, mesmo que isso não implique elevados níveis de bem-estar? Por outras palavras, será que em psicoterapia a diminuição da imersão é um resultado esperado, mas não propriamente um processo negativo? Podemos argumentar que a imersão pode ser uma perspetiva produtiva e necessária, envolvendo a ativação emocional, através da qual os/as terapeutas e clientes têm acesso a experiências muito dolorosas, o que vai permitir um trabalho terapêutico adicional. Esta hipótese é baseada nas indicações teóricas e empíricas explanadas nesta secção acerca das potencialidades da imersão na ativação emocional a fim de permitir o envolvimento com a experiência. Contudo, também foram encontradas, paradoxalmente, potencialidades do distanciamento pelas razões contrárias, nomeadamente pela redução da ativação emocional de conteúdo negativo, permitindo a reconstrução da experiência (Beck, 1970; Ma & Teasdale, 2004), tal como defendido pelos estudos experimentais/laboratoriais (e.g., Etzel, 2017; Kross et al., 2012). Todavia, de acordo com Carryer e Greenberg (2010), o mais prejudicial em terapia não é a fraca ou a elevada intensidade da emoção, mas sim a frequência com que a ativação ocorre. No tratamento da depressão, por exemplo, a frequência moderada, em oposição a frequências elevadas ou baixas, de intensa ativação emocional promove a diminuição de sintomas depressivos e psicopatológicos e o aumento da autoestima no final do tratamento. Especificamente, o insucesso terapêutico pode dever-se a dois extremos: demasiada ou pouca quantidade de ativação emocional. Por um lado, a reduzida quantidade de ativação emocional pode indicar falta de envolvimento com a experiência, bem como evitamento. Por outro lado, a excessiva ativação emocional pode levar à desregulação emocional, impedindo o progresso terapêutico (Carryer & Greenberg, 2010). Sendo assim,

podemos questionar o potencial da imersão sobre as experiências problemáticas pessoais quando ocorre de forma prolongada. Por outras palavras, será que o foco excessivo na experiência negativa a partir de uma perspetiva imersa é prejudicial, comprometendo o resultado terapêutico? Considerando também os resultados dos estudos experimentais/laboratoriais, excessiva imersão pode promover a ruminação (e.g., Ayduk & Kross, 2010a; Kross et al., 2005) e demasiada ativação emocional (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012), dificultando o controlo emocional necessário para a reconstrução da experiência. Em contrapartida, o distanciamento pode ser útil para alcançar uma reflexão mais adaptativa.

Tomando em consideração estas possibilidades, será que estas perspetivas são mutuamente exclusivas em relação à sua utilidade na mudança em psicoterapia? Podemos colocar a hipótese da imersão e do distanciamento coocorrerem de forma benéfica em psicoterapia, sendo a imersão útil até um certo ponto do processo terapêutico, a partir do qual o distanciamento é necessário. De uma maneira mais geral, um dos primeiros passos em psicoterapia é o envolvimento com a experiência, refletindo sobre os conteúdos negativos na perspetiva de primeira pessoa. Por um lado, isso levará à ativação emocional de emoções negativas, enquanto, por outro lado, facilitará a criação de uma nova consciência acerca da própria experiência, abrindo caminho para o distanciamento, o qual poderá ser útil nos estádios posteriores da terapia.

Portanto, várias hipóteses podem ser lançadas, e todas sugerem implicações na mudança clínica, salientando a pertinência de estudos que permitam esclarecer o papel da imersão e do distanciamento em psicoterapia, nomeadamente na reflexão de experiências pessoais negativas. Mais detalhadamente, revela-se fundamental o desenvolvimento de estudos que esclareçam a relação entre imersão/distanciamento e ativação emocional, bem como estudos que clarifiquem em que condições a imersão e o distanciamento são úteis e prejudiciais na mudança clínica. Para dar resposta a estas necessidades, julga-se fundamental ter em consideração algumas questões metodológicas para a investigação na área que não foram endereçadas em estudos anteriores.

Em primeiro lugar, olhar para as perspetivas imersa e distanciada de forma sincrónica parece ser uma visão demasiado simplista e redutora, impossibilitando a avaliação do potencial real destes dois fenómenos. As indicações teóricas, que foram apontadas ao longo desta secção sobre a imersão e o distanciamento em psicoterapia, sugerem a importância destes fenómenos em momentos específicos do processo de intervenção psicológica, o que realça a importância de estudos longitudinais nesta área.

Em segundo lugar, e na sequência do ponto anterior, até ao momento, os estudos sobre imersão e distanciamento avaliam estas perspetivas em momentos específicos, considerando a adaptabilidade destas perspetivas segundo alguns parâmetros, como a ativação emocional (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012) e a reconstrução da experiência (e.g., Etzel, 2017; Kross et al., 2012). Isto, para além de ter por base uma visão estática em relação ao problema, ou seja, não tem em conta a fase de resolução em que se encontra, apenas fornece uma leitura rígida em relação às próprias perspetivas, sendo estas consequentemente classificadas como opostas e independentes. Contudo, em psicoterapia a mudança passa pela transformação

dinâmica e integradora dos processos que a envolvem (Fisher, Newman, & Molenaar, 2011; Gonçalves, Matos, & Santos, 2009; Heinzel, Tominschek, & Schiepek, 2014; Pascual-Leone, 2009; Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011; Stiles, 2011). Neste sentido, torna-se fundamental analisar como a imersão e o distanciamento podem ser enquadrados noutros modelos desenvolvimentais de mudança, mais precisamente, analisar como estas perspetivas estão envolvidas no processo de mudança psicoterapêutica, bem como delinear análises mais detalhadas que permitam testar possíveis dinâmicas entre os fenómenos.

Em terceiro lugar, e integrando os pontos anteriores, estudos de processo-resultado serão necessários para compreender o papel da imersão e do distanciamento em psicoterapia. Os estudos de processo-resultado permitem alargar o conhecimento sobre os fenómenos relacionados com o resultado terapêutico e a mudança psicoterapêutica (Llewelyn, Macdonald, & Aafjes-van Doorn, 2016). Para além de permitirem detetar os processos promotores de mudança, estes estudos facilitam o desenvolvimento de teorias que suportem a prática clínica e podem apoiar os/as terapeutas em formas mais eficazes de intervir (Hardy & Llewelyn, 2015). Neste sentido, acredita-se que este tipo de estudos sobre imersão e distanciamento seja vantajoso, uma vez que poderá fornecer indicações úteis para melhorar a qualidade e a eficácia das intervenções.

Em suma, caracterizar o distanciamento como benéfico e a imersão como prejudicial quando refletimos sobre experiências pessoais problemáticas parece não ser totalmente representativo do que se passa em psicoterapia. Conseguimos encontrar indicações que sugerem exatamente o contrário. Este facto lança dúvidas quanto ao potencial destas perspetivas, quer a nível da recuperação clínica, quer ao nível da manutenção de estados psicopatológicos. Clarificar o papel da imersão e do distanciamento em psicoterapia revela-se assim fundamental. Neste sentido, são necessários estudos de processo-resultado em contexto psicoterapêutico que permitam uma visão mais integrada e longitudinal sobre estes fenómenos.

3. Papel da Imersão e do Distanciamento em Psicoterapia: A Presente Dissertação

A presente dissertação pretende clarificar o papel da imersão e do distanciamento em psicoterapia. Os objetivos centrais prendem-se em colmatar a lacuna da investigação sobre estas perspetivas no processo terapêutico, bem como contribuir com conhecimento que possa ser útil para aprimorar a qualidade da prática clínica. Neste sentido, foram desenvolvidos quatro estudos (apresentados nos próximos capítulos) que visam dar resposta às questões e hipóteses elencadas ao longo desta introdução.

Para o efeito, o primeiro trabalho realizado no âmbito desta dissertação foi a criação de uma medida para identificar a perspetiva imersa e distanciada em psicoterapia. Esta medida tem o nome de "Medida do Discurso Imerso e Distanciado" (MIDS – *Measure of Immersed and Distanced Speech*; Barbosa, Silva, Castro, Pinto-Gouveia, & Salgado, 2017) e esteve na base dos quatro estudos referidos. A MIDS é uma medida observacional que permite identificar estas duas perspetivas a partir do discurso transcrito do/a cliente. Foi baseada na definição teórica dos estudos mais relevantes sobre estas perspetivas (e.g., Ayduk & Kross, 2010b; Kross & Ayduk,

2008, 2009; Kross et al., 2005; Kross et al., 2012; Nigro & Neisser, 1983; Robinson & Swanson, 1993), classificando o discurso de acordo com cinco categorias mutuamente exclusivas. As *afirmações de descrição* (*what statements*) e *afirmações de atribuição* (*attributive statements*) são representativas do discurso imerso, enquanto as *afirmações de insight* (*insight statements*) e as *afirmações de resolução* (*closure statements*) são representativas do discurso distanciado. Quando numa parte do discurso estas categorias não são passíveis de serem identificadas, o excerto é classificado como *outras afirmações*. Relativamente às categorias de imersão, estas focam-se na perspetiva de primeira pessoa, privilegiando relatos verbais centrados em detalhes dos eventos, bem como pensamentos, sentimentos, comportamentos originais/primários, tal como experienciados pelo/a cliente: "o que aconteceu / o que eu pensei" (*afirmações de descrição*) ou "como me senti" (*afirmações de atribuição*). Por sua vez, as categorias de distanciamento focam-se na perspetiva de observador, privilegiando relatos verbais centrados na explicação/exploração e integração de várias particularidades da experiência (*afirmações de insight*), ou uma visão ampla sobre a experiência, tendo em consideração as experiências presentes e passadas (*declarações de resolução*). A Tabela 1 descreve mais detalhadamente esta medida, e contempla relatos verbais ilustrativos de cada categoria.

Cabe ressaltar que a MIDS visa identificar a perspetiva imersa ou distanciada, considerando o conteúdo das afirmações que, segundo dados empíricos, mostram a perspetiva egocêntrica ou de observador, independentemente do caráter adaptativo desse conteúdo, isto é, o conteúdo pode não ser uma representação fiel ou produtiva da realidade. A título de exemplo, nas *afirmações de insight* o/a cliente pode relatar uma compreensão das causas dos seus sentimentos que não é adaptativa, semelhante ao exemplo da "Maria", que adotou uma perspetiva distanciada desajustada à realidade.

Em relação ao discurso analisado, este pode ser definido de acordo com a finalidade e interesses do estudo (e.g., problema clínico, temas ou episódios específicos, momentos de mudança) para posteriormente ser codificado. O procedimento de codificação envolve duas fases: a fase de treino e a fase de aplicação da MIDS. As duas fases são asseguradas por, pelo menos, dois/duas juízes/as independentes. O primeiro passo é a fase de treino, que inclui a leitura e a discussão de artigos relevantes sobre imersão e distanciamento e do manual de procedimento da MIDS. Ainda nesta fase, os/as juízes/as treinam a codificação em material de treino. Este procedimento decorre até os/as juízes/as atingirem um acordo satisfatório entre eles/elas (Kappa de Cohen ≥ .75; Hill & Lambert, 2004).

O passo seguinte consiste em codificar a transcrição que será alvo de estudo. A unidade de análise poderá ser: pequenos segmentos/frases de acordo com o processo de *unitizing* (ver Hill & O'Brien, 1999), permitindo uma análise microanalítica; ou excertos de texto delimitados pelos marcadores das diferentes categorias de discurso (categorias representativas do discurso imerso e distanciado). Relativamente ao processo de *unitizing,* este inclui um procedimento sistemático (ver Hill & O'Brien, 1999) para a segmentação das transcrições de psicoterapia em unidades de análise ou "unidades de resposta" (pequenos segmentos/frases), rastreando mudanças no discurso

do/a cliente. Portanto, o/a juiz/juíza deve aplicar a MIDS a cada unidade de análise, classificando cada uma delas com uma categoria de discurso imerso ou distanciado. Os/As dois/duas juízes/as devem codificar independentemente todas as unidades de análise de forma sequencial. Após a codificação, um índice de confiabilidade é calculado para avaliar a concordância entre os/as juízes/as (Hill & Lambert, 2004). As divergências entre estes/estas são resolvidas por consenso (ver Hill et al., 2005). Idealmente, os/as codificadores/as devem ser cegos/as aos diferentes parâmetros associados aos materiais em análise, como o resultado terapêutico e o tipo de terapia.

Tabela 1. Breve Descrição das Categorias de Imersão e Distanciamento

Tipo de discurso	Categorias	Conteúdos	Exemplos
Imerso	Afirmações de descrição	O/A cliente descreve uma sequência de eventos.	"Ele gritou comigo e tratou-me mal."
			"Ele disse-me para me afastar."
		O/A cliente descreve pensamentos e comportamentos específicos e originais.	"Fui para o meu quarto e chorei durante imenso tempo."
			"O meu trabalho não vale nada".
	Afirmações de atribuição	O/A cliente atribui características a si mesmo/a ou a outras pessoas sem explicar ou fornecer razões para elas.	"Ele era mau."
			"Eu era idiota."
		O/A cliente descreve sentimentos ou outros estados internos.	"Eu sinto-me triste."
			"Eu sinto-me feliz."
			"Eu tenho uma grande dor e uma inquietação permanente."
Distanciado	Afirmações de *insight*	O/A cliente descreve as causas subjacentes ao evento, os seus sentimentos, comportamentos e cognições.	"Ele não me respeita porque eu nunca estabeleci limites."
		O/A cliente estabelece relações entre comportamentos, sentimentos ou cognições.	"Talvez eu tenha reagido dessa maneira porque senti que ele me rejeitou."
		O/A cliente expressa uma nova compreensão sobre os próprios comportamentos, sentimentos ou cognições.	"Pode ter sido de alguma forma irracional, mas agora entendo melhor a minha motivação."
	Afirmações de resolução	O/A cliente avalia a sua experiência passada sob uma perspetiva ampla, levando em conta as experiências passadas e atuais para dar sentido aos seus sentimentos e experiências.	"Eu olho para trás e vejo que o sofrimento tem que ver com a forma como interpretei as críticas. Agora sei que as críticas podem ser construtivas e isso não significa que os outros não gostem de mim."
		O/A cliente estabelece relações (contrastes ou similitudes) entre comportamentos passados e presentes, sentimentos ou cognições.	"Hoje eu sei que sou valorizada pelo meu pai."
			"Hoje em dia mal abraço o meu pai, enquanto antigamente éramos como irmãos".
		O/A cliente expressa sentimentos ou pensamentos sobre experiências passadas.	"Estou tão feliz por saber que essa parte do meu passado acabou."
			"Eu vejo o meu passado como um momento difícil da minha vida que trouxe implicações para o que sou hoje."

Após a elaboração desta medida, foram realizados alguns cálculos estatísticos com 15 casos codificados com a MIDS, a fim de calcular as suas qualidades psicométricas. Os resultados preliminares indicaram elevada consistência interna para a imersão (α = .95) e para o distanciamento (α = .91), bem como uma boa a forte confiabilidade entre os/as juízes/as (Kappa de Cohen variou entre .75 a .96) (Hill & Lambert, 2004). Para além de termos evidências positivas quanto à sua validade, a MIDS permite contornar algumas dificuldades decorrentes das medidas usadas nos estudos anteriores, tais como: (1) a subjetividade do/a participante em avaliar a sua própria perspetiva, (2) a impossibilidade de captar mudanças na perspetiva, e (3) a dificuldade de análises mais detalhadas sobre a imersão e o distanciamento ao longo do processo terapêutico.

Dadas as potencialidades desta medida, e de acordo com as necessidades de investigação na área, foram delineados os quatro estudos da presente dissertação que se enquadram na investigação de processo-resultado e privilegiam a perspetiva longitudinal sobre a imersão e o distanciamento em psicoterapia. Neste âmbito, foram analisados casos acompanhados em modalidades terapêuticas contrastantes, nomeadamente terapia cognitivo-comportamental e terapia focada nas emoções, e também casos com diferentes resultados no tratamento da perturbação depressiva major. É do interesse político-social a atenção clínica e científica dada a este tipo de perturbação, não só pelos números alarmantes de pessoas diagnosticadas com depressão (em Portugal, o cenário é preocupante, estimando-se que atinja quase 20% da população), mas sobretudo por se julgar ser das perturbações mentais mais incapacitantes a nível mundial (WHO, 2018). Assim, estudos que possam contribuir com informação adicional para a melhoria da eficácia dos tratamentos revelam-se particularmente importantes.

Dado este panorama, mas também o facto da perturbação depressiva major estar associada a processos de ruminação (Ciesla & Roberts, 2007; Nolen-Hoeksema et al., 2008; Takagishi et al., 2013), considera-se pertinente compreender o papel da imersão e do distanciamento na manutenção do estado psicopatológico e na recuperação clínica desta condição em contexto terapêutico. Salienta-se, ainda, que todos os estudos realizados no âmbito desta dissertação incluíram procedimentos que garantiram a análise circunscrita do conteúdo de experiências pessoais problemáticas, de modo a contornar o problema metodológico de análise de conteúdos de outra natureza. Além disso, foi também privilegiado, em todos os estudos, o recurso a excertos ilustrativos dos fenómenos apresentados. O objetivo é tornar mais clara a forma como a imersão e o distanciamento podem manifestar-se na prática, fornecendo aos leitores proximidade psicológica com os fenómenos em estudo. Este procedimento foi inspirado em Morrow (2005) que defende que "assim como os números contribuem para o 'poder' persuasivo de uma investigação quantitativa, as palavras reais dos participantes são essenciais para persuadir o leitor de que as interpretações do investigador são de facto as experiências vividas dos participantes" (p. 256).

Relativamente ao primeiro estudo[1], este partiu da necessidade de serem criados estudos clínicos que analisassem a imersão e distanciamento ao longo do processo terapêutico, e que esclarecessem a relação entre estas perspetivas, a ativação emocional e a mudança clínica. A nossa hipótese era de que a fase inicial da terapia envolvesse elevada imersão, bem como elevada ativação de emoções negativas, dada a partilha de experiências negativas. Posteriormente, poderiam ser necessárias mudanças na ativação emocional e na perspetiva usada. Assim, esperava-se que a imersão inicial fosse um passo necessário para que depois ocorresse um aumento gradual do distanciamento, acompanhado de menor ativação emocional das emoções negativas em fases posteriores. Neste sentido, o referido estudo propôs-se a analisar: (1) a evolução da imersão e do distanciamento ao longo da resolução terapêutica de uma experiência problemática; (2) a relação entre imersão/distanciamento e os sintomas depressivos; e (3) a relação entre estas perspetivas e a ativação emocional. As análises foram realizadas num caso de sucesso acompanhado em terapia cognitivo-comportamental. Este é, portanto, um estudo de caso e enquadra-se na perspetiva *theory building case studies*, que defende que a análise exaustiva de casos clínicos tem o poder de informar e corroborar a teoria pré-existente ou, pelo contrário, infirmar essa teoria e levar à sua modificação e transformação na presença de novas observações, contribuindo para o seu aperfeiçoamento (e.g., Stiles, 2007, 2015).

O segundo estudo[2] surgiu da importância da realização de trabalhos que suportem os resultados encontrados no primeiro estudo, nomeadamente no que se refere à trajetória desenvolvimental da imersão e do distanciamento ao longo do processo terapêutico. De forma distinta, este estudo teve por base a terapia focada nas emoções com o propósito de avaliar se os resultados obtidos no estudo inicial seriam transversais a outra modalidade terapêutica. Para além disso, procurou-se clarificar em que condições a imersão e o distanciamento podem ser úteis ou prejudiciais na mudança clínica. Mais concretamente, pretendeu-se dar resposta às seguintes questões de investigação: Será que o sucesso da reflexão de experiências negativas em psicoterapia está associado ao desenvolvimento de distanciamento? Será que o foco excessivo na experiência negativa a partir de uma perspetiva imersa é prejudicial, comprometendo o resultado terapêutico? Será que a perspetiva imersa é benéfica até um certo ponto do processo terapêutico? Com estes objetivos, o estudo comparou o padrão de evolução da imersão e do distanciamento ao longo do processo terapêutico em seis casos acompanhados em terapia focada nas emoções com resultados terapêuticos contrastantes – três casos de sucesso vs. três casos de insucesso. Analisou também a relação entre a mudança de perspetiva e a mudança dos sintomas depressivos.

O primeiro e o segundo estudos foram realizados no sentido de clarificar a forma como a imersão e o distanciamento podem ocorrer ao longo da terapia, e de que modo isso está associado ao bem-estar e à mudança clínica. Contudo, com esses trabalhos não foi possível perceber

[1] Este estudo foi publicado na revista científica *Research in Psychotherapy: Psychopatology, Process and Outcome* com os seguintes autores: E. Barbosa, M. Amendoeira, T. Ferreira, A. S., Teixeira, J. Pinto-Gouveia, & J. Salgado (2017).

[2] Este estudo foi publicado na revista científica *Psychotherapy Research* com os seguintes autores: E. Barbosa, S. Silva, J. Pinto-Gouveia, & J. Salgado (2017).

detalhadamente até que ponto estas perspetivas se coordenam no processo de mudança terapêutica, o que será particularmente importante para a criação de potenciais orientações mais precisas para a prática clínica. Para responder a esta necessidade, o terceiro estudo[3] recorreu a uma análise mais específica sobre estes fenómenos à luz de um modelo desenvolvimental de mudança, nomeadamente o Modelo de Assimilação de Experiências Problemáticas (Stiles, 2011; Stiles et al., 1991).

A relevância deste modelo teórico para o processo de mudança terapêutica tem sido corroborada por numerosos estudos empíricos (Basto, Pinheiro, Stiles, Rijo, & Salgado, 2017; Basto, Stiles, Rijo, & Salgado, 2018; Brinegar, Salvi, & Stiles, 2008; Caro Gabalda, 2011; Caro Gabalda, Stiles, & Pérez Ruiz, 2016; Gray & Stiles, 2011; Honos-Webb, Stiles & Greenberg, 2003; Knobloch, Endres, Stiles & Silberschatz 2001; Mendes et al., 2016; Ribeiro, Braga et al., 2016; Ribeiro, Cunha et al., 2016). O modelo de assimilação explica o processo de mudança psicoterapêutico a partir da integração gradual da experiência problemática no *Self* (Stiles et al., 1990; Stiles et al., 1991). De acordo com o modelo, o problema ocorre quando a experiência em questão é incompatível com a estrutura organizada e estável do *Self,* construída com base noutras experiências passadas. Em psicoterapia, a mudança ocorre quando a experiência problemática é assimilada, ou seja, quando o/a cliente cria pontes de significado entre a experiência e a estrutura do *Self*. Assim, é atribuído significado à experiência, permitindo a sua integração no *Self* de forma harmoniosa, repondo a coerência e o equilíbrio interno. Esta conexão favorece o retorno ao bem-estar psicológico e o funcionamento adaptativo (Honos-Webb & Stiles, 1998; Honos-Webb et al., 1999; Stiles & Brinegar, 2007; Stiles, 2011). Para que isto aconteça, em psicoterapia, a experiência problemática é trazida à consciência, clarificada, compreendida e, posteriormente, assimilada. Esta gradual integração da experiência problemática ocorre numa progressiva sequência de oito estádios, desde o evitamento da experiência até à completa assimilação e mestria do problema (Caro Gabalda & Stiles, 2009; Stiles, 1999; Stiles et al. 1991).

O interesse por este modelo prende-se, fundamentalmente, com dois aspetos. Um deles é o facto deste modelo ser transteórico (e.g., Osatuke et al., 2005), ou seja, ocorre independentemente do modelo psicoterapêutico utilizado, o que nos proporciona maior probabilidade de os resultados encontrados serem generalizáveis a outras terapias. O outro aspeto é o facto de o modelo conceptualizar a mudança a partir de uma perspetiva integradora e abrangente, oferecendo uma interpretação mais dinâmica sobre a imersão e o distanciamento. Mais concretamente, o modelo de assimilação sugere que o progresso terapêutico evolui do evitamento da experiência problemática para a imersão profunda à medida que o problema surge (estádio 2), e depois para um maior distanciamento (estádio 3 em diante), atingindo uma perspetiva mais ampla e integrada sobre a experiência anteriormente problemática. Contudo, esta hipótese carece de suporte empírico. Neste sentido, o terceiro estudo propôs-se a analisar a evolução da imersão, do distanciamento e da assimilação de experiências problemáticas num caso

[3] Este estudo foi publicado na revista científica *Psychotherapy Research* com os seguintes autores: E. Barbosa, A. B. Couto, B. Stiles, J. Pinto-Gouveia, & J. Salgado (2018)

de sucesso de terapia focada nas emoções, bem como a associação entre estas perspetivas e os diferentes estádios de mudança terapêutica. À semelhança do primeiro estudo, este trabalho insere-se na perspetiva "*theory building case studies*", procurando contribuir para o refinamento da teoria (e.g., Stiles, 2007, 2015).

Tendo em conta os resultados dos estudos anteriores, o quarto estudo[4] baseou-se na teoria dos sistemas dinâmicos para avaliar, a um nível microanalítico, possíveis dinâmicas entre a imersão e o distanciamento. Tal estudo assumiu e testou a relação dinâmica e integradora das perspetivas imersa e distanciada como potencialmente contributivas para o processo de mudança em psicoterapia. Mais precisamente, avaliou a capacidade de transitar de uma perspetiva para a outra, ou seja, o desenvolvimento de uma maior flexibilidade entre perspetivas aquando da reflexão da experiência problemática, como um processo promotor de mudança e bem-estar. Apesar da mudança em psicoterapia sugerir uma evolução progressiva, vários estudos constatam, numa análise mais detalhada, a existência de um padrão irregular (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Mendes et al., 2016). De acordo com a teoria dos sistemas dinâmicos, períodos de instabilidade, caracterizados por maior flexibilidade na forma como os processos se manifestam, são necessários para quebrar padrões rígidos e desajustados e alcançar uma nova e mais adaptativa configuração do *Self* (Fisher et al, 2011). Além disso, vários estudos apoiam a associação entre a instabilidade e melhores resultados terapêuticos (e.g., Gumz et al., 2010; Hayes et al., 2007). Sabendo que a reflexão sobre a experiência pode ser desvantajosa quando ficamos presos/as a um processo de pensamento rígido e que isso está associado a várias formas de psicopatologia, como é o caso da depressão (Ciesla & Roberts, 2007; Nolen-Hoeksema et al., 2008; Takagishi et al., 2013), este estudo pretendeu avaliar se maior flexibilidade na reflexão da experiência (capacidade em mover-se de uma perspetiva para a outra) contribui para melhores resultados nos sintomas depressivos. Neste sentido, a imersão e o distanciamento foram analisados momento-a-momento na fase intermédia da terapia (fase de trabalho) numa amostra de 17 casos acompanhados em terapia cognitivo-comportamental e terapia focada nas emoções. Medidas de flexibilidade foram usadas para essa análise, para, posteriormente, ser calculada a relação entre a flexibilidade entre perspetivas na fase intermédia do processo terapêutico e os sintomas clínicos no final do tratamento.

Serão de seguida apresentados na íntegra os quatro estudos desenvolvidos no âmbito desta dissertação.

[4] Este estudo encontra-se submetido à revista científica *Psychotherapy Research* com os seguintes autores: E. Barbosa, M. Sousa, J. Pinto-Gouveia, & J. Salgado.

ESTUDO 1 - IMMERSION AND DISTANCING ACROSS THE THERAPEUTIC PROCESS: RELATIONSHIP TO SYMPTOMS AND EMOTIONAL AROUSAL

Barbosa, E., Amendoeira, M., Ferreira, T., Teixeira, A. S., Pinto-Gouveia, J., & Salgado, J. (2017). Immersion and distancing across the therapeutic process: Relationship to symptoms and emotional arousal. *Research in Psychotherapy: Psychopathology, Process and Outcome, 20*(2), 110-121. doi:10.4081/ripppo.2017.258

1. Abstract

Objectives: This study aims to clarify the roles of immersion and distancing (that is, reflection on an experience from an egocentric point of view or as an observer, respectively) on therapeutic change analyzing (1) the evolution of these two perspectives across the resolution of a clinical problem, and (2) the relationship between immersion/distancing with symptoms and emotional arousal. **Method:** We extracted all the passages of speech pertaining to the most relevant clinical problem of a good outcome case of depression undergoing cognitive-behavioral therapy. We assessed the distancing/immersion of these extracts using the Measure of Immersed and Distanced Speech, and emotional arousal with the Client Emotional Arousal Scale-III. The symptoms were assessed from the Beck Depression Inventory-II and Outcome Questionnaire-10.2. **Results:** Immersion was associated with symptoms and negative emotions, while distancing was associated with clinical well-being and positive emotions. Immersion was still dominant when depressive symptoms were below the clinical threshold. **Conclusions:** Clinical change was associated with a decrease in immersion and an increase in distancing. The dominance of immersion does not necessarily indicate a bad outcome.

Keywords: immersion, distancing, emotional arousal, symptoms, cognitive-behavioral therapy

2. Introduction

When reflecting on personal experiences, individuals may assume two different perspectives: immersed or distanced (Kross, Gard, Deldin, & Clifton, 2012; Nigro & Neisser, 1983). When immersed, individuals reflect on their experience from a first person perspective, since the experiencing and reflecting selves coincide. The original thoughts, feelings, behaviors and events repeat themselves (e.g., "My boyfriend said he wanted to pursue a new life, so I feel sad and unloved. I'll never be happy."). In a distanced perspective, individuals reflect on their experience from an observer stance, i.e., the reflecting self is separated from the self that is experiencing. People can see themselves in the experience (e.g., "I was exposed to lots of humiliations, which made me prone to think that others are better than me, or that I have no value.").

Several experimental studies have suggested that the perspective adopted in the reflection of negative experiences has different consequences in terms of well-being and mental health (e.g., Bruehlman-Senecal, Ayduk, & John, 2016; Cao & Decker, 2015; Kross et al., 2014; White, Kross, & Ducjworth, 2015; Kross et al., 2012; Mischkowski, Kross, & Bushman, 2012; Shepherd, Coifman, Matt, & Fresco, 2016). Mainly, distancing has been conceived as a psychological perspective that facilitates adaptive analysis and favors the capacity of modulating emotional arousal. Specifically, several studies have revealed that reflecting from a distanced perspective is associated with shorter duration of negative episodes (Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012) and attenuation of emotional intensity (Kross et al., 2014; Kross et al., 2012), as well as better self-control in challenging situations (Mischkowski et al., 2012). Moreover, experimental studies have shown that as opposed to immersion, in distancing people focus on the broader and abstract context (e. g., Kross & Ayduk, 2011) and less on the specific feelings, thoughts and events of the experience that would intensify negative affect, allowing one to reconstruct negative feelings and to give meaning to the experience (Ayduk & Kross, 2010b; Kross & Ayduk, 2011; Kross et al., 2012). The distancing has proved beneficial regardless of the person's age (e.g., Grossmann & Kross, 2014). All these results suggest that distancing, when compared with immersion, is associated with greater ability to regulate emotional arousal triggered by negative personal experiences. Accordingly, research on emotion regulation has been proposing the use of reappraisal strategies – which involve an observer stance – as ways of changing the emotional meaning of negative or threatening situations and achieving more adaptive emotional responses (Duckworth, Gendler, & Gross, 2016; Gross, 2015). Distancing has also been presented as a protective mechanism against depression. An experimental study with people with depressive symptoms revealed that, while analyzing negative feelings, changing from an immersed to a distanced perspective engendered lower arousal of emotions, lower frequency of depressotypic thoughts and higher probability of achieving insight and closure (Kross et al., 2012). Often the focus on specific internal states from an immersed perspective involves people in ruminative cycles, which are common in depression, while distancing would reduce rumination (e.g., Ayduk & Kross, 2010a; Kross et al., 2012).

On the basis of these observations, experimental studies consider distancing, in contrast to immersion, as a productive perspective when dealing with negative experiences, which stresses its potential role as a change mechanism in psychotherapy of depression. Indeed, some therapeutic modalities are based on a similar conceptualization of distanced self-reflection from specific interventions. For example, cognitive-behavioral therapy (CBT) encourages clients to assume such a decentered stance towards their personal experiences when restructuring negative thoughts and promoting therapeutic change (e.g., Beck, 2011). More specifically, clients are encouraged to view a belief as a hypothesis rather than as a fact, which involves distancing of oneself from a belief to allow a more broad and objective analysis of it. In this way, clients can progressively arrive at an alternative view of the experience, changing the belief. Consequently, the negative affect is reduced, emotional reactions become understandable, and new and more adaptive behaviors are adopted when they are confronted with day-to-day difficulties (DeRubeis, Webb, Tang, & Beck, 2010). The use of distancing to help clients regulate and modulate their affective reactions, also occur in other therapeutic models, such as emotion-focused therapy (EFT): when a client feels overwhelmed by painful emotions, therapists guide clients to observe inner feelings, while distancing language is encouraged (e.g., using his or her own name instead of 'I) in order to promote emotional regulation (Elliott, Watson, & Greenberg, 2004). Another example in CBT (Beck, 2011), but also in other types of therapy (e.g., Greenberg & Watson, 2006), is the assignment of awareness homeworks, in which the therapist suggests the client to observe his or her emotional reactions or actions between sessions, aiming to promote a better self-understanding and to perceive links between events, feelings, and behaviors.

Overall, immersion on negative contents is expected to be associated with more emotional arousal, while distancing is expected to be associated with less emotional arousal, namely of negative emotions, and so better well-being and more adaptive psychological states. This is in line with what we would expect from a good outcome case in psychotherapy: since the person will in the end be better prepared to deal with the problematic issues, he or she will be less emotionally aroused by them.

However, does this mean that emotional arousal is something to be avoided in therapy? Or does it mean that the decrease of emotional arousal is an expected outcome, but not necessarily a negative process? Several approaches and empirical findings attribute a positive role to emotional arousal. Different psychotherapeutic orientations, ranging from psychodynamic (Fosha, 2000), experiential (Greenberg, 2002), or CBT (Samoilov & Goldfried, 2000), have suggested that, in the initial phases of therapy, emotional arousal and its expression are necessary to promote change. The arousal of emotions has been frequently considered as a process that fosters the arousal of emotional structures and information, allowing for a greater awareness and facilitating the reattribution of meaning (e.g., Greenberg, Rice & Elliott, 1993; Pennebaker & Graybeal, 2001; Smyth, 1998; Wilson & Gilbert, 2008). It is also important to stress that there are experiential and cognitive-behavioral treatments, for example, in which emotional arousal of negative experiences is considered as a central part of a key process of change, namely, emotional

processing (Greenberg, 2002; Greenberg & Safran, 1987; Rachman, 1980). Emotional processing involves, firstly, arousing emotions, as well as, experiencing or be in live contact with experience, which suggests immersion in emotional experience. Only then is possible, in emotional processing, the meaning-making of emotional experience, transforming the maladaptive emotions that underlie and influence how the client feels, thinks, and behaves (Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Greenberg & Watson, 2006; Greenberg, 2010). Also Kennedy-Moore and Watson (2001) suggested that immersed emotional expression is beneficial as a first step toward change. Specifically, the contact with painful material leads to greater arousal of negative emotional states, and in several situations this will pave the way for a later understanding of the emotional pain as tolerable and acceptable, and for mastering negative feelings. Consequently, people feel encouraged to evaluate the meaning of the experience. Therefore, it can be argued that immersion may be a productive and necessary therapeutic process involving emotional arousal, and by which therapists and patients gain access to very painful experiences in order to allow further therapeutic work. This seems to be the case, for example, in the narrative retelling of traumatic episodes while working with patients with post-traumatic stress disorder (Foa, Zoellen, Feeny, Hembree, & Alvarez-Conrad, 2002; Jaycox, Foa, & Morral, 1998). This suggestion may seem consistent with some forms of therapy. For example, in CBT, therapists encourage clients to describe emotional events aiming to access their cognitive and emotional components, namely dysfunctional thoughts to be restructured (Beck, 2011). In line, EFT argues that clients need to get in touch with their core maladaptive states, in order to become aware of their internal states, and then to process and transform them. As the EFT motto claims, ‘the only way out is through’ (Pascual-Leone & Greenberg, 2007).

Moreover, the encouraging of an immersed perspective is a procedure used when emotions are avoided (typically in clients distant from their emotions) (Elliott et al., 2004). Sometimes, people reflect according to a distanced perspective to avoid the psychological distress caused by painful emotions of negative events (e.g., Foa & Kozak, 1986). This strategy may be dysfunctional, once it complicates access to important information about the experience, hindering the long-term resolution of distress (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Kashdan, Barrios, Forsyth, Steger, 2006). In this sense, as immersion may be dysfunctional when leads to rumination and excessive negative affect (e.g., Ayduk & Kross, 2010a; Kross et al., 2012), distancing may also not always be adaptive in therapy when used to avoid the experience. In sum, in spite of the general trend accentuating the benefits of distancing and the negative consequences of immersion, there are also other findings suggesting that in some circumstances these effects can be quite the opposite. Thus, the role of immersion and distancing in psychotherapy needs to be further clarified.

Based on this previous research on emotional arousal and therapeutic models, we developed the following global hypothetical theoretical framework. On the one hand, immersion in negative experiences can lead to increase the arousal of painful emotions. On the other hand, the arousal of painful emotions can lead to increase immersion on negative experiences.

However, both processes in the initial phase of therapy promote the contact with emotional experience, developing the awareness of the different facets of experience, which may justify, in some cases, an increase of specific or general clinical symptoms. Then, the change in reflection and in arousal is need. On the one hand, the greater awareness about experience may encourage the client to adopt a distanced perspective, leading to less emotional arousal of painful emotions. On the other hand, the reduction of emotional arousal of painful emotions, i.e., better ability of emotional regulation, facilitates the distancing when reflecting on negative experiences. Regardless of the process involved, we hypothesize greater distancing accompanied by less emotional arousal of negative emotions at a later stage of therapy. In a more general vein, one of the first steps of psychotherapy is sharing the content of negative experiences. This will create a high level of negative arousal and immersion while paving the way to the creation of a new awareness of one's own experience – and therefore, promoting distancing in the later stages of therapy. However, this view still needs empirical support.

Furthermore, there are some key issues left unaddressed by previous experimental studies. First, most of these studies did not use clinical samples, and there has been no study focused on psychotherapy and its effects. Second, in these studies participants were assessed only once or over a period of a week or less (e.g., Mischkowski et al., 2012). Thus, it is important to develop longitudinal studies of psychotherapy cases analyzing immersed and distanced perspectives over longer periods of time, in order to test the relationship of these perspectives with emotional arousal and clinical change. Finally, previous studies assessed immersion and distancing using a self-report scale among participants after a reflection task of an experience (e.g., Kross et al., 2012; Mischkowski et al., 2012), or experimental manipulation from instructions provided to participants (e.g., Wang, Lin, Huang, & Yeh, 2012). We still lack an observational measure of distancing and immersion in order to study the therapeutic client's discourse as it unfolds.

In this single case study, we aimed to analyze the development of immersion and distancing throughout a therapeutic process, as well as the relationship of both these perspectives with emotional arousal and depressive symptoms, using an observational measure based on procedures and characteristics of immersion and distancing extracted from previous studies. We selected a good outcome case of CBT, since, in this type of therapy, an observer stance towards personal experiences is promoted by the repeated reality testing of dysfunctional automatic thoughts (Beck, 2011). Therefore, we expected an increase of distancing over time, and a decrease of immersion. However, we had no specific anticipated hypothesis regarding the relative frequency of these two perspectives. In a perhaps simplistic reading of previous experimental studies, immersion can be regarded as a dysfunctional perspective (associated with rumination and high levels of negative affect), and therefore, we may expect a good outcome to be associated with very low frequency by the end of the therapy; on the other hand, therapy sessions may always involve some degree of immersion in problematic states. Therefore, it may be the case that some degree of immersion may always be needed. Thus, from the Simulation Modelling Analysis

(SMA; Borckardt & Nash, 2014), as an advanced statistical program that uses a bootstrap sampling method allowing the control of autocorrelation, we will test the following main hypothesis: a) if, generally, immersion is associated with clinical problems, and distancing with overcoming those problems, then we expect to find high levels of immersion at beginning of therapy, and an increase of distancing throughout therapy, as well as a positive relationship between this pattern of evolution and symptomatic improvement; b) However, if immersion may be used in a productive way during therapy, then we expect to find high levels of immersion in different phases of therapy; c) Moreover, if distancing is associated with greater emotional control than immersion, then we expect that arousal of negative emotions to be negatively related with distancing and positively related with immersion.

3. Method

3.1. Client

Laura (pseudonym), a 33 year old woman, married, with one daughter, was unemployed at the time of her participation in the ISMAI Depression Project ("Decentering and Change in Psychotherapy") funded by the Portuguese Foundation for Science and Technology (Salgado, 2014). This is a randomized clinical trial that compared CBT and EFT for major depressive disorder (MDD). The following inclusion criteria were set: diagnosis of major depressive disorder, a global assessment of functioning higher than 50, and no medication. Exclusion criteria were: being under another form of treatment for depression; current or previous diagnosis of at least one of the following DSM–IV Axis I disorders: panic, substance abuse, psychosis, bipolar, eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, or schizotypal personality disorder; or high risk of suicide. All these criteria were assessed by the Structural Clinical Interviews for the DSM-IV-TR I (First, Spitzer, Gibbon, & Williams, 2002) and II (First, Gibbon, Spitzer, Williams & Benjamin, 1997) and the Beck Depression Inventory-II (BDI-II) for the Portuguese population (Coelho, Martins, & Barros, 2002). Laura was diagnosed with moderate MDD and no other disorders, meeting all the inclusion criteria and none of the exclusion criteria of the clinical trial. She was randomly assigned to CBT and attended 16 weekly sessions plus follow-up sessions at 1, 3, 6, 9 and 12 months. As defined by the clinical trial protocol, all sessions were video recorded.

Psychological treatment, as well as the collection and processing of data for research purposes followed principles and standards included in the ethics code (American Psychological Association's – APA - Ethical Principles of Psychologists and Code of Conduct, as well as the Code of Ethics of Portuguese Psychologists). In this sense, after receiving information about the purposes and procedures of the clinical trial, all clients gave their written consent for using their data in scientific publications.

At treatment termination, Laura had recovered and showed reliable and clinically significant change (Comer & Kendall, 2013) according to the cut-off score of 13 points on the

Portuguese version of the Beck Depression Inventory-II (BDI-II; Coelho et al., 2002) and the Reliable Change Index of 7.75, calculated from the psychometric information on the BDI-II. More specifically, her pre-therapy BDI-II score was 31, which had dropped to zero by the end of therapy. This score on the BDI-II was maintained across all the available follow-up sessions, namely at 1, 3, 6 and 9 months after concluding therapy.

3.2. Therapist

Laura's therapist was female, with 12 years of experience as a psychotherapist. She had a CBT background, and had received further training in the treatment manual used in this trial before starting to treat Laura. She also received weekly supervision for this case. The supervision was carried out in a group, made up of all the clinical trial´s therapists who followed the CBT protocol, and was leaded by the most experienced CBT therapist.

She followed a CBT protocol for the treatment of the depression (Beck, Rush, Shaw, & Emery, 1979). The 16-session protocol is based on the principle that the interpretations or cognitions about reality determine emotions and behaviors; consequently, dysfunctional interpretations of reality promote emotional disorders. This protocol includes cognitive and behavioral techniques. The purpose is to promote changes in emotions and behaviors by changing biased ways of seeing the world. This therapist received further training in the treatment manual and she also received weekly supervision for this case.

3.3. Process Measures

3.3.1. Assimilation of Problematic Experiences Scale (APES). This scale is used to assess the degree of resolution of a clinical problem measured by assimilation levels of the problematic experience, ranging from level 0 (the client is unaware of the problem) to level 7 (the client successfully uses solutions in new situations). Higher levels of assimilation mean higher levels of resolution (see Caro Gabalda & Stiles, 2009; Basto, Pinheiro, Stiles, Rijo, & Salgado, 2016). In this study, APES was used in order to ensure that immersion and distancing were analyzed across the therapeutic change of a clinical problem (from unresolved to resolved problem). See more details in Procedures ("selection of the main clinical problem").

A study performed with a sample of 22 Portuguese clients diagnosed with major depression disorder (Basto, Stiles, Rijo, & Salgado, 2017), showed a high interrater reliability (Cicchetti, 1994) on APES ratings (Intraclass Correlation Coefficient [ICC] ranged from ICC [2,2] = 0.81 to ICC (2,2) = 0.96).

3.3.2. Measure of Immersed and Distanced Speech (MIDS). The MIDS was based on theoretical definition and relevant prior research (e.g., Kross et al., 2012; Ayduk & Kross, 2010b; Nigro & Neisser, 1983) for the identification of immersion and distancing from client speech. This is an observational measure that assesses immersion and distancing from client

speech in transcribed sessions. The client's speech is categorized according to five mutually exclusive categories: *what statements* and *attributive statements* (that represent immersed speech), *insight statements* and *closure statements* (distancing speech), and *other statements* (in situations in which none of the previous categories are applicable), as described in Table 2.

The study about MIDS' validation is under preparation. Preliminary results revealed a high internal consistency for both immersion (α = .95) and distancing (α = .91). The interrater reliability (Hill & Lambert, 2004) for raters' pairs was good to strong (Cohen´s Kappa ranged from .75 to .96).

Table 2. Brief Description of Immersed and Distanced Speech Categories

Type of speech	Categories	Contents	Examples
Immersed	What statements	Client describes a specific chain of events.	"He yelled at me and treated me badly."
			"He told me to back off."
		Client describes specific and original thoughts or behaviors	"I went to my room and cried for a long time."
			"My work is worthless."
	Attributive statements	Client ascribes characteristics to self or others without explaining or providing reasons to them.	"He was mean."
			"I was kind of stupid."
		Client describes feelings or other internal states.	"I feel sad."
			"I feel happy."
			"I have a great pain and a permanent restlessness."
Distanced	Insight statements	Client describes the causes underlying the event, his or her feelings, behaviors and cognitions.	"He does not respect me because I never established any limits."
		Client establishes relations between behaviors, feelings or cognitions.	"Maybe I reacted that way because I felt he rejected me."
		Client expresses new awareness about own behaviors, feelings or cognitions.	"It may have been somehow irrational but now I better understand my motivation then."
	Closure statements	Client indicates he or she assesses a past experience from a broad perspective, taking into account past and current experiences to make sense of feelings and experiences.	"I look back and I see that suffering had to do with how I interpreted criticisms. Now I know that critical remarks can be constructive and it does not mean that others do not like me."
		Client establishes relations (contrasts or similitudes) between past and present behaviors, feelings or cognitions.	"Today I know that I'm valued by my father."
			"Today I barely hugged my father, whereas before we were like brothers"
		Client expresses present feelings or thoughts about past experience or situations	"I thought about how glad I am that part of my past is over."
			"I see my past as a difficult moment of my life that brought implications in what I am today."

3.3.3. Client Emotional Arousal Scale-III (CEAS-III). The CEAS-III (Warwar & Greenberg, 1999) was developed to identify and assess the emergence of emotions based on the evaluation of audio or videotaped psychotherapy sessions. To assess the emotion and its valence, the client's primary emotion in the session segment under evaluation was identified and categorized according to a list of 15 emotion categories, taking into account the client's voice and body expressions.

Warwar and Greenberg (2000) found interrater reliability coefficients of .70 for modal and of 0.73 for peak arousal ratings.

3.4. Outcome Measures

3.4.1. BDI-II. The BDI-II (Beck, Steer, & Brown, 1996; Portuguese version by Coelho et al., 2002) is a self-report inventory designed to measure the severity of depression. Scores above 13 signify clinically significant levels of depression. This measure has an internal consistency (Cronbach's alpha) of .89. The psychometrics qualities found in the Portuguese version and American version were consistent (Coelho et al., 2002).

3.4.2. Outcome Questionnaire-10.2 (OQ-10.2). The OQ-10.2 (Lambert et al., 1998) is a self-report inventory intended to assess general clinical outcome. This measure is a brief version (with 10 items) of OQ-45.2, which was translated and adapted to Portuguese by Machado and Fassnacht (2014). The total score may range from 0 to 40. Higher scores indicate greater severity of clinical problems. This measure has an internal consistency (Cronbach's alpha) of .88 (Seelert, 1997) and a test–retest reliability of .62 (Lambert, Finch, Okiishi, & Burlingame, 2005).

The scores of the Portuguese OQ-10 for the entire sample of the clinical trial (n=64; Salgado, 2014), from which the case for this study was selected, show an internal consistency of .88 (Cronbach's Alpha) and a test-retest reliability of .74 over a 1-week interval.

3.5. Procedures

3.5.1. Selection of the main clinical problem. Our analysis was restricted to the moments pertaining to the main clinical problem which was solved across therapy, since only this would allow us to focus on occasions during which negative contents were directly or indirectly involved from unresolved to resolved. Two judges were involved in this task: a PhD student and a Master's degree student in clinical psychology with training and experience in CBT. Initially, they participated in a training phase that included reading and discussing journal articles and previous rating manuals, and practicing the coding procedures. This phase lasted about two months and was guided by a researcher who was expert in this type of procedure. The training phase was deemed concluded when the judges reached the reliability criterion in coding

procedure, namely an Intraclass Correlation Coefficient (ICC; Shrout & Fleiss, 1979) higher than.70 (considered high reliability by Hill & Lambert, 2004).

After a training phase, the judges catalogued the main problematic experiences reported by Laura and identified the passages that pertained to each clinical problem. The passages were delimited by two judges jointly from transcripts sessions. Raters independently identified the level of assimilation for each passage. Problems that reached at least level 4 in the APES at the end of the process were considered solved (e.g., Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). We found a single clinical problem that was defined as *perfectionism.* It comprised 74.5% of her sessions (measured in terms of the proportion of number of words). Laura presented a main maladaptive scheme of *perfectionism* that provided a sense of failure when she was not able to meet her expectations. This perception of herself was present in many areas of her life, such as body image, occupational performance, and her relationship with her mother. This problem was quite improved across the process. At the beginning of therapy, Laura was not able to clearly formulate her problem, expressing overgeneralized distressing thoughts, revealing an overall perception of herself as "incompetent", and psychological pain around her main areas of concern (e.g., eating habits, performance). At the middle of therapy, Laura worked on her cognitive scheme of worthlessness and she began considering other perspectives about her clinical problem. At the end of therapy, Laura already assumed a new understanding of her problem and reality (e. g., "I am no better or worse than anyone else", "I do not have to be perfect") and showed a positive affective tone. She was capable of a metacognitive position, understanding the change process from the beginning to the end of treatment. The clinical problem was present in all 16 sessions of the therapeutic process. The average level of assimilation ranged from 2.2 (session 1) to 5.4 (session 16), indicating that this clinical problem went from unresolved, at the beginning of therapy, to resolved at the end of therapy.

3.5.2. Analysis of the main clinical problem.

3.5.2.1. ***Unitizing.*** The unitizing process involved two steps. Firstly, two judges (a PhD student and a Master's student in clinical psychology) received training on the unitizing procedure. For that, the judges followed the guidelines described by Hill and O'Brien (1999) until reaching an agreement of above 90% in three training sessions. After a training phase, the pair of judges divided the passages pertaining to *perfectionism* into units of analysis. These units corresponded to independent grammatical sentences, allowing detect small changes in the client's speech. For example, in the Laura turn-taking pertaining to *perfectionism*: "I cannot explain why I have such a need to be perfect. Why am I so afraid of the possibility of other people judging or evaluating me?", the judges found two units of analysis: "I cannot explain why I have such a need to be perfect" and "Why am I so afraid of the possibility of other people judging or evaluating me?".

3.5.2.2. *Immersed and distanced speech.* Following the unitizing of the passages pertaining to the main clinical problem, each unit of analysis was analyzed with the MIDS to assess the presence of immersed and distanced speech. Initially, the same judges that were involved in the unitizing process underwent intensive training about immersed and distancing speech that consisted of reading relevant articles and manuals, and practicing the coding procedures in a therapeutic case. Should be noted that one of judges (PhD student) was expert in this type of procedure. This phase lasted about three months and was deemed concluded once the judges reached an acceptable Cohen's kappa (Cohen's kappa ≥ .75) (Hill & Lambert, 2004).

Then, these judges independently coded each unit of analysis for the presence or absence of five mutually exclusive categories (*what statements*, *attributive, insight statements*, *closure statements and other statements*).

3.5.2.3. Emotional arousal and valence. Four judges (three PhD students, and one Master's student in clinical psychology) used the CEAS-III. The CEAS-III assessed the presence of emotional arousal and identified its affective valence, classifying the emotion as positive or negative. The training phase consisted of approximately 40 hours in which videotapes were viewed and discussed until an acceptable agreement (Cohen's kappa = .75) among four raters was reached (Hill & Lambert, 2004). Then, two teams of two judges were created. Sessions were distributed randomly for each team. The judges watched the video recording of each session in order to identify, by consensus, emotional episodes (EEs) pertaining to *perfectionism*. The identification of the EEs was carried out in this study in order to detect the segments of psychotherapy where the client experienced an emotion, following the procedures adopted in previous relevant studies regarding the identification of emotional responses or action tendencies. Thus, all EEs within clinical problem was consider, once that the EEs give the moments in which the client expresses an emotion in response to some situation or context (Greenberg & Korman, 1993). The beginning of the EE was defined when an emotion emerged regarding a thematic content. The end of EE was noted as when at least one of the following situations occurred: the emotion identified finished, a new emotional response was expressed, or the thematic content changed (see Greenberg & Korman, 1993). Judges independently classified the emotion contained in each one of the EEs. Finally, these emotions were grouped according to their affective valence (positive or negative). The following segment illustrates an EE pertaining to *perfectionism* classified with negative valence:

> "or to say 'look I really got fat' I am very ashamed about that and those people who do not see me for some time. I think – I almost panic to find someone, because it really is… because it´s a big difference, if I showed you a picture before and after the difference is huge, twenty kilos of difference, it really is. So ah, this is how I feel, I feel bad, I can't see myself in the mirror".

The arousal of positive and negative emotions was measured by the relative frequency of units of analysis belonging to each emotional valence.

3.5.3. Reliability. The average reliability calculated by the ICC (Gwet, 2014) for assimilation levels coding process was high, ICC (2,1) = .93. In the unitizing procedures judges reached an agreement above 90%, as recommended by Hill and O'Brien (1999). The global Cohen´s kappa for immersion/distancing and for emotional arousal coding processes was .83 and .80, respectively, which showed a strong interrater reliability (Gwet, 2014). Disagreements in all measures were solved by consensus (see Hill et al., 2005). The application of each scale (APES, MIDS and CEAS-III) was performed by different judges who were blind to the results obtained with the other scales.

3.5.4. Outcome assessment. The depressive symptoms were assessed by the BDI-II in sessions 1, 4, 8, 12 and 16 (sessions where the BDI-II was applied in accordance with the assessment protocol of the clinical trial). The clinical symptoms were assessed by OQ-10.2 in all sessions.

3.5.5. Quantitative analysis. Spearman's *rho* correlations, computed on the basis of SMA (Borckardt & Nash, 2014), were used to analyze the evolution of immersed and distancing speech in terms of occurrence over time and slope vector (that is, the trend direction), and to analyze the relationship between immersion/distancing with emotional arousal and general clinical symptoms. SMA was developed to deal with the statistical problems caused by case-based time series studies and it uses a bootstrap sampling method, controlling for autocorrelation. The correlation between immersed/distanced speech and BDI-II was not carried out due to the restricted number of observations with BDI-II.

4. Results

4.1. Immersion and Distancing

The relative frequency of immersed speech was substantially higher than the relative frequency of distanced speech in all phases, except for the last two sessions (see Figure 1 and Table 3). This revealed that immersion was the dominant perspective in the therapeutic process. A significant decrease was observed in immersed speech from the initial to the middle phase, both in terms of relative frequency, $r_s(11) = -.64$, $p = .028$, and slope vector, $r_s(11) = -.71$, $p = .014$. From the middle to final phase, there were no significant differences in relative frequency, $r_s(11) = -.41$, $p = .179$, or in the slope vector, $r_s(11) = -.44$, $p = .184$, for this type of speech, suggesting stability of immersed speech from the middle phase onwards. Regarding distanced speech, significant increases were observed from the initial phase to the middle phase, both in terms of relative frequency, $r_s(11) = .58$, $p = .049$, and slope vector, $r_s(11) = .65$, $p = .033$. From the middle to final phase, there were no significant differences in terms of relative frequency,

$r_s(11) = .46$, $p = .223$, or slope vector, $r_s(11) = .55$, $p = .121$, for this type of speech, also suggesting stability of distanced speech from the middle phase onwards.

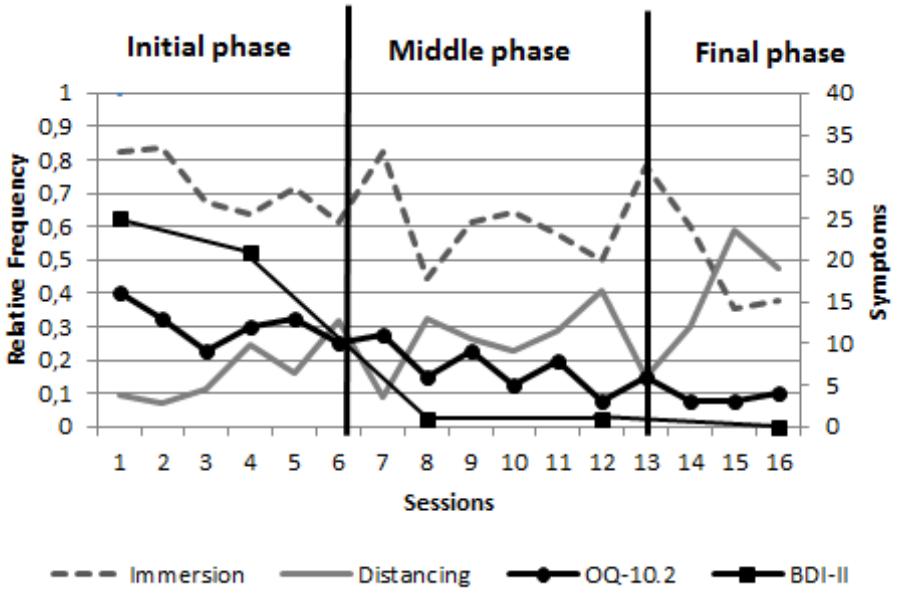

Figure 1. Relative frequency of immersion and distancing and clinical symptoms throughout therapy

Table 3. Relative Frequency of Type of Speech and Emotional Arousal by Phase of Treatment

	Initial phase		Middle phase		Final phase		Total	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Immersed speech	.74	.07	.62	.12	.52	.18	.63	.15
Distanced speech	.14	.07	.25	.09	.38	.17	.26	.15
Negative emotions	.37	.13	.17	.11	.14	.17	.22	.17
Positive emotions	.09	.09	.22	.13	.28	.15	.20	.15

The following passages illustrate the change from an immersed speech to a distanced speech regarding her experience of unemployment. In the first passage (session 3, initial phase) Laura adopted an immersed speech, while in the second passage (session 16, final phase) Laura adopted a distanced speech.

> **Therapist**: What do you think about what others think about this situation?
> **Laura**: I think others think 'she is unemployed because she is not competent in what she does and therefore she was fired' or 'she is unemployed because she has a good life, she is financially sustained by her husband.' This is what I think. [...]
> **Therapist**: And for this reason you must feel shame, isn't it?
> **Laura**: I don't know, but that's what I feel. (session 3)

Laura: [...] I felt guilty because I thought I had failed, right? As a person I had failed.
Therapist: Hm-hm.
Laura: I failed because I could not stand the pressure and I got sick [...] and I think maybe the key was to realize that I am like other people. (session 16)

4.2. Immersion/Distancing and Clinical Outcome

There was a significant positive relationship between immersed speech and general clinical outcome (OQ-10.2), $r_s(16) = .75$, $p = .001$. Conversely, a negative relationship was observed between distanced speech and general clinical outcome, $r_s(16) = -.74$, $p = .0001$. According to Figure 1, depressive symptoms at the beginning of therapy were moderate (BDI-II = 25), decreased in the following assessments, and disappeared in the last session (BDI-II = 0). General clinical outcome improved across sessions, reaching no clinical relevance at the end of therapy (OQ-10.2 = 4). Immersion was still the most prevalent speech when the BDI-II scores were already under the clinical threshold (sessions 8 and 12).

4.3. Immersion/Distancing and Emotional Arousal

One hundred and seventy-five EEs were identified, corresponding to 41.5% of the client's speech. According to Table 3, there was a decrease of negative emotions and an increase of positive emotions across the therapeutic process. A significant positive relationship between immersed speech and negative emotions, $r_s(16) = .80$, $p = .0001$, and distanced speech and positive emotions, $r_s(16)= .73$, $p = .0001$, and a significant negative relationship between immersion and positive emotions, $r_s(16) = -.69$, $p = .001$, and distancing and negative emotions, $r_s(16)= -.87$, $p = .0001$, were observed.

5. Discussion

This longitudinal analysis revealed a pattern of immersion and distancing throughout the therapeutic resolution of a clinical problem: immersion decreased and distancing increased, especially from the initial to the middle phase of the therapy. Moreover, in the last two sessions, we witnessed a dominance reversal, in which distancing became more frequent than immersion. We can find links between the cognitive behavior therapy, namely the intervention protocol for depression (Beck et al., 1979), and these results. According to this therapeutic approach, from the beginning of the middle or "working" phase is common to apply cognitive techniques, which encourage the clients to analyze and adopt new perceptions of the reality, i.e., clients are encouraged to focus less in their initial point of view about experience (first-person perspective) and seek new alternatives through an observer position of life experiences. For example, specific cognitive techniques to help the client challenge negative automatic thoughts involves distancing

of oneself from a belief to allow a more broad and objective analysis of it, typically in cognitive restructuring (DeRubeis et al., 2010), which seems consistent with significant decrease of immersion and increase of distancing. Should be noted that these techniques are closely associated with the metacognitive functioning (Dobson & Dozois, 2010). Specifically, to decenter from thoughts, and thereby view thoughts as events in the mind, allowing to understand one's own cognitive processes as well as other's minds, is a metacognitive ability (Segal et al., 2002, 2013). In this sense, distancing may be the one of the steps involved in the metacognitive process. Regarding the dominance of distancing in the last two sessions, it also seems to be in accordance to the intervention CBT protocol for depression (Beck et al., 1979), in which therapists help client to analyze the changes across therapeutic process and to assume an observer position (the client is prompted to assess a past experience from a broad perspective, taking into account past and current experiences).

This pattern of decreasing of immersion and increasing of distancing was related with a decrease to a non-clinical level of symptoms. These results are consistent with experimental studies that consider distancing as an important perspective in reconstruction of the experience (Ayduk & Kross, 2010b; Kross & Ayduk, 2011; Kross et al., 2012) and well-being (e.g., Bruehlman-Senecal; Mischkowski et al., 2012). In addition, we observed a positive relationship between immersion and negative emotions, and between distancing and positive emotions, which is also consistent with the view that immersion on problematic states tends to support negative affect, while more distancing feeds more positive states (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012). Thus, the high immersion and low distancing may be associated with depressive states, emotional distress and unresolved problems in therapy. Some cautions should be taken while considering these results. Our results are basically correlational, and therefore, it is necessary to consider other possible explanations (e.g., the significant increase of distancing may have been a result of the symptomatic change, and not the reversal, or even caused by a third variable).

One important finding in our study was that immersion was dominant in different phases of the resolution of the clinical problem, showing that a high frequency of immersion does not impair the prospects of a good outcome at case level. The dominance of immersion throughout the different phases of the treatment make us suspect that immersed speech is the type of speech requested more often in therapy. Clients need to provide the therapist with context about their personal view on their experience, spending more time in immersion than in distancing. Moreover, we found therapy sessions in which the depressive symptoms were below the clinical threshold, even when immersion was the dominant perspective. In light of this result, the legitimacy of considering immersion as a maladaptive perspective is not completely clear. Immersion and negative emotional arousal can be interpreted as parts of a first step in therapy sessions, especially in the first phase of the process. In our case, this was the developmental pathway of the client: she started by bringing and expressing negative material, in an immersed way, and then progressively became better able to deal with that material in a more distanced and

productive way. Therefore, change may be more a feature of the general variation of immersion/distancing (decrease of immersion and increase of distancing across therapy) than of their absolute presence or even dominance. Our observations are also congruent with clinical premises of CBT: initially, the client is expected to retell the problem according to her/his personal perspective, and afterwards, by applying several strategies, such as cognitive restructuring, an observer stance is developed (e.g., Beck, 2011). However, there are some possibilities that should be considered. First, the evolution pattern found in this case may be due to the evolution of the emotional arousal across therapy, i. e, the increase of negative emotions may lead to an immersed reflection on negative experience and the increase of positive emotions may facilitate a distanced reflection on negative experience. Second, we found immersion as the dominant speech during therapy, with exception of the two last sessions. This result points to the possibility that immersion is the perspective most used by clients in psychotherapy. In this context, clients need to recount their problematic experience, describing thoughts, feelings, behaviors and events, in order to be worked on later. This type of reflection may demand more time in therapy than distancing. Third, the high immersion did not prevent the therapeutic success. Probably, therapy, being a safe and controlled context, facilitates the immersed expression without both rumination and excessive emotional arousal of negative emotions.

6. Conclusions

Overall, the longitudinal analysis seems to shed some light on the process. The present study emphasizes the importance of more self-reflection regarding the problematic experience, from an observer perspective, towards higher adaptive integration of the experience, higher capacity of emotional regulation, and well-being. This evolution from high immersion at initial phase to more distancing across therapy suggests implications for clinical practice: a regular pattern characterized by constant immersed speech across the therapy may signal that the client is not progressing as desired, and may benefit from techniques that promote distancing. However**,** the polarized perspective of immersion and distancing seems unable to fully explain the change in clinical problems. Thus, based on the present study, we are proposing that these two processes may be both important in a good outcome. Immersion may also be necessary in the therapeutic process, since it is balanced with distancing moments.

However, we are in need of more empirical studies with larger clinical samples, including contrasting studies with poor outcome cases. We could then observe if different therapies present a similar pattern in terms of immersion and distancing evolution, and if emotional arousal varies according to the type of therapy applied. Although clients with depression may have a similar evolution pattern of immersion and distancing in different types of therapy, probably the time spent in each perspective may be different. For example, it is possible that in solution-focused therapy clients are more encouraged to take a distanced perspective rather than in emotion-

focused therapy. In addition, studies on immersion and distancing in the treatment of different disorders are necessary. Do clients with anxiety present the same evolution pattern of immersion and distancing as clients with depression? People with anxiety tend to avoid contact with some experiences. It is possible that these clients take a distanced perspective as an avoidance mechanism, which probably would require immersion as a first step in psychotherapy.

Furthermore, there are some issues that should be studied. For CBT (e.g., Beck, 2011) and literature on the role of cognitive reappraisal in emotional regulation (Duckworth, Gendler, & Gross, 2016; Gross, 2015), change in psychological well-being is associated with change in how the client thinks and responds to the experience, rather than an increase in distancing alone. Finally, it would also be important to test the influence of the therapist in the client´s speech.

7. References

Ayduk. Ö., & Kross, E. (2010a). Analyzing negative experiences without ruminating: The role of self-distancing in enabling adaptive self-reflection. *Social and Personality Psychology Compass, 4*, 841-854. doi:10.1111/j.1751-9004.2010.00301.x

Ayduk, Ö., & Kross, E. (2010b). From a distance: implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology, 98*, 809-829. doi:10.1037/a0019205

Basto, I., Pinheiro, P., Stiles, W. B., Rijo, D., & Salgado, J. (2016). Changes in symptoms intensity and emotion valence during the process of assimilation of problematic experience: A quantitative study of a case of cognitive-behaviorral therapy. *Psychotherapy Research.* doi:10.1080/10503307.2015.1119325. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/10503307.2015.1119325

Basto, I., Stiles, W. B., Rijo. D., & Salgado, J. (2017). *Does assimilation of problematic experiences predict a decrease in symptom intensity?* Manuscript in preparation.

Beck, A. T., Rush, J. A., Shaw, B. F. & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: The Psychological Corporation, Harcourt Brace & Company.

Beck, J. S. (2011). *Cognitive behavior therapy: Basic and beyond* (2nd ed.). New York: The Guilford Press.

Borckardt, J., & Nash, M. (2014). Simulation modelling analysis for small sets of single-subject data collected over time. *Neuropsychological Rehabilitation, 24,* 492–506. doi:10.1080/09602011.2014.895390

Bruehlman-Senecal, E., Ayduk, Ö., John, O., & John, O. P. (2016). Taking the long view: Implications of individual differences in temporal distancing for affect, stress reactivity, and well-being. *Journal of Personality and Social Psychology*. doi:10.1037/pspp0000103

Cao, X. & Decker, D. L. (2015). Psychological distancing: The effects of narrative perspectives and levels of access to a victim's inner world on victim blame and helping intention. *International Journal of Nonprofit and Voluntary Sector Marketing, 20,* 12-24. doi:10.1002/nvsm.1514

Caro Gabalda I., & Stiles, W. (2009). Retrocessos no contexto da terapia linguística de avaliação [Setbacks in the context of linguistic therapy of evaluation]. *Análise Psicológica, 27,* 199-212. doi: 10.14417/ap.205

Cicchetti, D. V. (1994). Guidelines, Criteria, and Rules of Thumb for Evaluating Normed and Standardized Assessment Instruments in Psychology. *Psychological Assessment, 6,* 284-290.

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory-II. *European Psychiatry, 17*, 222-226. doi: 10.1016/S0924-9338(02)00663-6

Comer, J. S. & Kendall, P. C. (2013). Methodology, design, and evaluation in psychotherapy research. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 21-48). Hoboken, NJ: Wiley.

Detert, N. B., Llewelyn, S., Hardy, G. E, Barkham, M., & Stiles, W. B. (2006). Assimilation in good- and poor-outcome cases of very brief psychotherapy for mild depression: An initial comparison. *Psychotherapy Research, 16*, 393-407. doi:10.1080/10503300500294728

DeRubeis, R. J., Webb, C. A., Tang, T. Z., & Beck, A. T. (2010). Cognitive therapy. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 277-316). New York, NY: Guilford Press.

Dobson, K. S., & Dozois, D.J. (2010). Historical and philosophical bases of the cognitive behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 3-38). New York, NY: Guilford Press.

Duckworth, A. L., Gendler, T. S., & Gross, J. J. (2016). Situational strategies for self-control. *Perspectives on Psychological Science, 11,* 35-55. doi:10.1177/1745691615623247

Elliott, R., Greenberg, L. S., Watson, J., Timulak, L., & Freire, E. (2013). Research on humanistic-experiential psychotherapies. In M. Lambert, *Handbook of psychotherapy and behavior change* (pp 495-538). New Jersey: John Wiley & Sons, Inc.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion focused therapy: The Process-Experiential Approach to Change.* Washington, D.C.: America Psychology Association.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II).* (J. Pinto-Gouveia, A. Matos, D. Rijo, P Castilho, & M. Salvador, Trans.). Washington, D.C.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L, Gibbon, M., & Williams, J. B.W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version (SCID-I-RV)*. (A. Costa Maia, Trans.). New York: Biometrics Research.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*, 20-35.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70,* 1022-1028.

Fosha, D. (2000). *The transforming power of affect: A model of accelerated change.* New York: Basic Books.

Greenberg, L. (2002). *Emotion-Focused Therapy: coaching clients to work through their feelings*. Washington: America Psychology Association.

Greenberg, L. (2010). *Emotion-focused therapy: Theory, research, and* practice. Washington, DC: American Psychological Association.

Greenberg, L. S., & Korman, L. (1993). Assimilating emotion into psychotherapy integration. *Journal of Psychotherapy Integration, 3*, 249–265.

Greenberg, L. S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by moment process*. New York, NY, US: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change*. New York: Guilford Press.

Greenberg, L. S., & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington, D. C.: American Psychological Association.

Gross, J. J. (2015). Emotion regulation: Current status and future prospects. *Psychological Inquiry, 26*, 1-26. doi:10.1080/1047840X.2014.940781

Grossmann, I., & Kross, E. (2014). Exploring solomon's paradox self-distancing eliminates the self-other asymmetry in wise reasoning about close relationships in younger and older adults. *Psychological Science, 25*, 1571-1580. doi:10.1177/0956797614535400

Gwet, K. L. (2014). *Handbook of inter-rater reliability: The definitive guide to measuring the extent of agreement among raters* (4th Ed.), Gaithersburg, Maryland: Advanced Analytics, LLC.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*, 1152-1168.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi:10.1037/0022-0167.52.2.196

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84-136). Hoboken, New Jersey: Wiley.

Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight and action*. Washington, DC: American Psychological Association.

Jaycox, L. H., Foa, E. B., & Morral, A. R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology, 66*, 185-192.

Kashdan T. B., Barrios V., Forsyth J. P., Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy 44*, 1301-1320

Kennedy-Moore, E., & Watson, J. (2001). How and when does emotional expression help? *Review of General Psychology, 5*, 187-212. doi:10.1037/1089-2680.5.3.187

Kross, E., & Ayduk, Ö. (2011). Making meaning out of negative experiences by self-distancing. *Current Directions in Psychological Science*, *20*, 187-191. doi: 10.1177/0963721411408883

Kross, E., Bruehlman-Senecal, E., Park, J., Burson, A., Dougherty, A., Shablack, H.,Bremner, R., Moser, J., & Ayduk, Ö. (2014). Self-talk as a regulatory mechanism: How you do it matters. *Journal of Personality and Social Psychology, 106,* 304–324. doi:10.1037/a0035173

Kross, E., Gard, D., Deldin, P., Clifton, J., & Ayduk, Ö. (2012). "Asking why" from a distance: Its cognitive and emotional consequences for people with major depressive disorder. *Journal of Abnormal Psychology*, *121*, 559-569. doi:10.1037/a0028808

Lambert, M. J., Finch, A. M., Okiishi, J., & Burlingame, G. M. (2005). *OQ-10.2 Manual*. American Professional Credentialing Services, LLC.

Lambert, M. J., Finch, A. M., Okiishi, J. C., Burlingame, G. M., McKelvey, C., & Reisinger, C. W. (1998). *Administration and scoring manual for the OQ-10.2: An adult outcome questionnaire for screening individuals and population outcome monitoring*. American Professional Credentialing Services LLC.

Mischkowski, D., Kross, E., & Bushman, B. J. (2012). Flies on the wall are less aggressive: Self-distancing "in the heat of the moment" reduces aggressive thoughts, angry feelings and aggressive behavior. *Journal of Experimental Social Psychology, 48,* 1187-1191. doi: 10.1016/j.jesp.2012.03.012

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*, 467-482. doi: 10.1016/0010-0285(83)90016-6

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through". *Journal of Consulting and Clinical Psychology, 75*, 875-887. doi:10.1037/0022-006X.75.6.875

Rachman, S. (1980). Emotional processing. *Behaviour Research and Therapy*, *18*, 51-60. doi: 10. 1016/0005-7967(80)90069-8

Samoilov, A., & Goldfried, M. R. (2000). Role of emotion in cognitive-behavior therapy. *Clinical Psychology: Science and Practice, 7,* 373-385. doi:10.1093/clipsy.7.4.373

Seelert, K. R. (1997). *Validation of a brief measure of distress in a primary care setting*. Unpublished masters thesis, University of Utah, Salt Lake City.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse*. New York: Guilford Publication.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York: Guilford Publication.

Shepherd, K. A., Coifman, K. G., Matt, L. M., Fresco, D. M. (2016). Development of a self-distancing task and initial validation of responses. *Psychological Assessment, 28,* 841-855. doi:10.1037/pas0000297

Smyth, J. M. (1998).Written emotional expression: Effect sizes, outcome types, and moderating variables. *Journal of Consulting and Clinical Psychology, 66,* 175-184. doi: 10.1037/0022-006X.66.1.174

Verduyn, P, Mechelen, I. V., Kross, E., Chezzi, C., & Bever, F. V. (2012). The relationship cetween self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion, 12*, 1248-1263. doi:10.1037/a0028289

Warwar, S. H., & Greenberg, L. S. (1999). *Client Emotional Arousal Scale–III.* Unpublished manuscript, York University, Toronto, Ontario, Canada.

Wang, Y., Lin, Y., Huang, C., & Yeh, K. (2012). Benefitting from a different perspective: The effect of a complementary matching of psychological distance and habitual perspective on emotion regulation, *Asian Journal of Social Psychology, 15,* 198–207. doi:1 0.1111/j.1467-39X.2012.01372.x

White, R. E., Kross, E., Duckworth, A. L. (2015). Spontaneous self-distancing and adaptive self-reflection across adolescence. *Child Development, 86,* 1272-128. doi:10.1111/cdev.12370

Wilson, T. D., & Gilbert, D. T. (2008). Explaining away a model of affective adaptation. *Perspectives on Psychological Science, 3*, 370-386. doi:10.1111/j.1745-6924.2008.00085.x

ESTUDO 2 – HOW AND WHEN IMMERSION AND DISTANCING ARE USEFUL IN EMOTION FOCUSED THERAPY FOR DEPRESSION

Barbosa, E., Silva, S., Pinto-Gouveia, J., & Salgado, J. (2017). How and when immersion and distancing are useful in emotion focused therapy for depression. *Psychotherapy Research*. doi:10.1080/10503307.2017.1411626

1. Abstract

Objective: The potential benefit or harm of immersion (egocentric perspective) and distancing (observer perspective) on negative experiences is unclear and has not been empirically investigated in therapy. This is a first exploratory study aimed to analyze and compare the perspectives adopted on reflection (immersion and distancing) of negative experiences across therapy and the relationship between them and depressive symptoms in contrasting therapeutic outcomes of Emotion-Focused Therapy. ***Method:*** Three good-outcomes cases and three poor-outcomes cases of EFT, diagnosed with mild to moderate depression at the beginning of therapy, were randomly selected. Immersion and distancing on negative experiences were analyzed using the Measure of Immersed and Distanced Speech. The depressive symptoms were assessed by the Beck Depression Inventory-II. ***Results:*** Significant differences across sessions were only found in the good-outcome cases which showed a significant decrease of immersion and an increase of distancing, and this evolution pattern was found related to the reduction of symptoms. Moreover, at the beginning of therapy, distancing was higher in the poor-outcome cases rather than in the good-outcome cases. ***Conclusion:*** The progressive and significant evolution from higher immersion at the initial phase to higher distancing in the final phase may be helpful in EFT for depression.

Keywords: immersion, distancing, emotion focused therapy, depression

2. Introduction

Reflecting on a problematic experience is the key to making sense of the feelings it evokes (Pennebaker, 1997; Wilson & Gilbert, 2008). Immersion and distancing are two possible perspectives to such reflection. Immersion occurs when the person analyses the experience from a first person (egocentric) perspective (McIsaac & Eich, 2004; Nigro & Neisser, 1983; Robinson & Swanson, 1993) whereas distancing involves analysing the experience from a third person (observer's) perspective (Nigro & Neisser, 1983; Robinson & Swanson, 1993). Experimental research suggests that immersion is a non-adaptive way of approaching negative experiences whereas distancing is more helpful (e.g., Ayduk & Kross, 2010a, 2010b). These results seem consistent with good psychotherapy outcomes, i.e., cases where the client becomes increasingly capable of distancing from problematic experiences. Nevertheless some clinical and therapeutic models, such as the assimilation model and emotion-focused therapy for depression (EFT) suggest that in psychotherapy there is a more complex, dynamic and developmental relationship between distancing and immersion. Specifically, these two models admit that in the initial phases of therapeutic work clients must be allowed to immerse themselves in their negative experiences, to pave the way for later distancing. In this study we explore this more complex view, comparing the trajectories of immersion and distancing in six cases of EFT (poor-outcome n = 3; good-outcome n = 3).

2.1. Empirical Findings on Immersion and Distancing

During immersion people reflect on the experience from a first person perspective ('I think…', 'I feel...'), i.e., according to their own point of view. The original thoughts, feelings, behaviors and events repeat themselves (McIsaac & Eich, 2004; Nigro & Neisser, 1983; Robinson & Swanson, 1993) and verbal accounts of the experience are essentially concrete descriptions of its particularities (e.g., Kross, Ayduk, & Mischel, 2005; Kross, Gard, Deldin, Clifton, & Ayduk, 2012). The following quotation provides an example of a mother's immersed perspective on a dispute with her child: "My son told me that I do not have time for him. I am a bad mother, it's really painful".

In contrast, a distanced perspective involves reflecting on the experience from an observer's perspective (Nigro & Neisser, 1983; Robinson & Swanson, 1993), which promotes a broader and abstract view of feelings, thoughts and behaviors, like a big picture about experience (Kross et al., 2012). Some authors consider that distancing amounts to the disidentification from one's internal experiences, i.e., "the experience of internal states as separate from one's self" (Bernstein, et al., 2015, p. 6). Distanced verbal accounts focus less on the concrete details of the experience and more on explaining and exploring it, in way of insight or closure (e.g., Kross et al., 2005; Kross et al., 2012). A distanced perspective on the pain caused by the mother-child dispute above could take the following form: "The pain is because I know that I could do better if I spent less time at work. He was just asking for my attention, I know he loves me".

There are several concepts related to and overlapping with distancing, such as decentering and metacognitive awareness. According to the metacognitive process model proposed by Bernstein et al. (2015), distancing is one of the key processes in decentering. As a metacognitive ability to observe one's own thoughts and feelings as temporary and objective events (Fresco et al, 2007; Safran & Segal, 1990), decentering involves a complex state of inter-related processes that can be described as follows: the awareness of subjective experience (metacognitive awareness, which can be deliberately promoted by mindfulness) initiates two related processes, namely the disidentification from internal experience and reduced-reactivity to thought content. Drawing on this model, one of the steps towards decentering and meta-awareness is self-distancing, which promotes the disidentification from internal experience. Self-distancing is reciprocally related to the reduction in reactivity to the content of the mind (which is related to cognitive defusion).

Studies on immersion and distancing have focused on experimental manipulation of self-observation. They indicate that people who assume an immersed perspective on negative experiences (i.e., personal experiences associated with painful emotional content) tend to describe a sequence of events, thoughts, feelings or behaviors, that paints a simplistic picture of the experience and hinders broad, comprehensive analysis (Ayduk & Kross, 2010b; Kross & Ayduk 2008, 2009; Kross et al., 2005; Kross et al., 2012). Furthermore, the focus on internal states may feed ruminative cycles. Rumination, in turn, exacerbates negative affect, which can become overwhelming (Nolen-Hoeksema, 1991; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Thus, immersion can give rise to rumination, which makes people feel worse and constrains the construction of new meanings (Ayduk & Kross, 2008, 2010a; Berman et al., 2011; Kross, 2009; Kross et al., 2005). The distress caused by immersion makes people physically and psychologically vulnerable. For example, immersion reduces the probability of cardiovascular recovery from stress episodes and reduces problem solving ability (Ayduk & Kross, 2010b), as well as increases the probability of an angry or aggressive response to provocation (Mischkowski, Kross, & Bushman, 2012) and it is associated with psychopathological states (Brosschot, Gerin, & Thayler, 2006; Bushman, 2002; Nolen-Hoeksema et al., 2008). In particular, people with depression tend to analyze the experience from an immersed perspective (Kross & Ayduk, 2009; Kross, Davidson, Weber, & Ochsner, 2009; Kross et al., 2012), which enhances their emotional reactivity (Berman et al., 2011), particularly with respect to negative affect (Kross & Ayduk, 2008; Kross et al., 2012). All these findings suggest that immersion is a non-adaptive perspective on painful experiences, carrying health risks and hindering attempts to give meaning to those experiences (e.g., Ayduk & Kross, 2010b; Kross, 2009). In contrast, distancing is a different and more helpful way of reflecting on problematic experiences (e.g., Ayduk & Kross, 2010a, 2010b; Berman et al., 2011; Kross, 2009). Experimental studies have emphasized that distancing is an adaptive perspective in the reflection of painful experiences because it tends to involve more reconstruction and less recounting than immersion (Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009). Distancing facilitates the attribution of new meanings and helps people to make

sense of problematic experiences (Ayduk & Kross, 2008) and resolve problems (e.g., Ayduk & Kross, 2008, 2010b). Indeed, some therapeutic models are based on using a similar form of distanced self-reflection to create alternative narratives of an experience. For example, cognitive therapy encourages clients to assume an observer and distanced stance on their personal negative experiences and considers this an important technique for restructuring negative thoughts and promoting therapeutic change (e.g., Beck, 2011). Moreover, prioritizing reconstruction over recounting inhibits excessive increases in negative affect (Ayduk & Kross, 2008; Kross et al., 2012), i.e., promotes greater emotional control. Specifically, when a painful experience is analyzed from a distanced perspective, negative affect presents less reactivity (e.g., Ayduk & Kross, 2008, 2010b; Gruber, Havey, & Jonson, 2009; Kross & Ayduk, 2009), duration (Kross & Ayduk, 2011; Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012) and intensity (Ayduk & Kross, 2008; Kross et al., 2005; Kross & Ayduk, 2008) than when it is analyzed from an immersed perspective. All these results are consistent with the research on emotional regulation about the benefits of reappraisal strategies – which involve taking an observer's perspective on a personal negative experience and reviewing one's initial appraisal in order to create new and adaptive emotional meanings and responses (e.g., Gross, 2015; Gross & Thompson, 2007). Based on these findings, the experimental studies suggest that distancing may help to prevent rumination (Ayduk & Kross, 2008, 2010a; Berman et al., 2011; Kross, 2009; Kross et al., 2005). Particularly in depression, distancing is associated with lower levels of depressotypic thought accessibility (Kross et al., 2012), less depressive affect (Kross & Ayduk, 2008; Kross et al., 2012) and lower emotional reactivity (Kross & Ayduk, 2009) in comparison with immersion. All these empirical findings support the view that distancing, unlike immersion, is generally beneficial to physical and psychological health. Therefore, they suggest that immersion and distancing are opposite and independent perspectives.

The assimilation model of problematic experiences (negative experiences that were not assimilated into the self) offers a different and integrative understanding. According to this model, painful or even traumatic experiences tend to be automatically avoided if they evoke strong negative emotion (Stiles, 2011; Stiles et al., 1991), but this makes it difficult to achieve an adaptive integration of them. Thus, the assimilation model posits that clinical change is a sequential process that may involve both immersion and distancing at different points in the process (Caro Gabalda & Stiles, 2009; Stiles et al., 1991). Therapeutic change may involve progression from avoidance of the problem to deeper immersion in problematic contents, making them more available to subjective awareness, and only once the client has immersed in the experience will he or she be able to benefit from adopting a more distanced perspective in order to achieve a broader understanding and a greater mastery of the problem (Caro Gabalda & Stiles, 2009; Stiles, 2011; Stiles et al., 1991). Thus, the assimilation model suggests a developmental perspective on immersion and distancing. This interpretation is congruent with EFT for depression treatment.

2.2. Immersion and Distancing in EFT for Depression

The experiential therapies, such as EFT, promote immersion in the initial phase of treatment by encouraging contact with, and reflection on maladaptive emotional states that cause psychological distress, activating them so that they are re-experienced in the here-and-now (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002). This is in accordance with experimental studies regarding the potential of immersion for the activation of emotional content (e.g., Kross et al., 2012). However, EFT admits potential therapeutic benefits of immersion on the treatment of the depression. According to Pascual-Leone and Greenberg (2007), EFT brings the individual closer to his or her personal experience (*experience-near*). The client needs to get in touch with his or her core maladaptive states in order to become aware of his or her internal states and then process and transform them. The guiding principle of EFT is that 'the only way out is through' (Pascual-Leone & Greenberg, 2007, p. 875). Hence, clients are encouraged to reflect on painful emotions from a first person perspective, in a welcoming and safe context (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006). All this emotional work relies on a safe and solid therapeutic alliance, based on empathy and the therapist's presence. A secure therapeutic alliance promotes a collaborative focus on the client's internal states and current sense of self (Greenberg & Watson, 2006; see Paivio, 2013). Exploratory empathic responses, which are typical from EFT, on a first phase, precisely envisage a deeper contact with painful underlying emotional experiences, which implies an immersed perspective. In summary, EFT encourages clients to adopt an immersed perspective as the first step towards emotional change and as a means of helping the client to process emotional states that were previously partially or totally avoided. This approach is also consistent with the assimilation model (e.g., Stiles, 2011).

In the later stages of the therapeutic process, treatment for depression involves specific therapeutic tasks that promote a different, more distanced perspective, allowing new meanings to emerge. In some of these therapeutic tasks (e.g., chair work) the client is invited to treat different parts of his or her self as different characters or 'voices', addressing them as a 'you' or even using one's own name. Recent research on immersion and distancing showed that referring to oneself by name enhanced distancing when talking about the self (Kross et al., 2014), which seems that also happens in chair work (Greenberg & Watson, 2006). Distinguishing between different parts of the self promotes a more differentiated view of one's internal dynamics, feeding an observer perspective on the original problem and alternative ways of construing the experience. This more distanced perspective helps "clients and therapists define areas of inquiry that they can then pursue in the session to increase understanding of client functioning and to explore alternatives" (Greenberg & Watson, 2006, p. 213). These EFT assumptions are consistent with experimental studies on the benefits of distancing in the reconstruction of experience (Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009), and with the assimilation model's account of the association between distancing and more advanced stages of change (e.g., Stiles, 2011). EFT also provides techniques that promote emotional regulation through distancing (Elliott et al., 2004). For

example, when clients feel overwhelmed by painful emotions, EFT therapists can use the 'clearing a space' therapeutic task. The aim of the task is to help the client build a 'working distance' between him or herself and the problematic issues. A working distance is defined as an observational perspective on a problematic object that involves an optimal and regulated state of emotional arousal. The role of distancing in promoting emotional regulation in EFT is consistent with experimental findings on the association between distancing and reduced duration of emotion (Kross & Ayduk, 2011; Verduyn et al., 2012). In fact, Carryer and Greenberg (2010) have shown that emotional arousal is beneficial in experiential therapies when it is expressed in moderate amount. In other words, both marginal and overwhelming emotional arousal predict poorer outcomes to therapy. On the one hand, reduced amount of time expressing emotion may signal lack of involvement with emotional experience, like avoidance or intellectualization. On the other hand, spending too much time expressing emotion may be associated to emotional dysregulation, hindering emotional processing. These findings suggest that although immersion may play an important role in therapy by the contact with emotional experience, spending too much time immersed in one's problematic experiences may be harmful, while distancing may be helpful to achieve a better reflection of the experience.

In short, there are several hypotheses to consider. First, it is legitimate to propose a development vision regarding immersion and distancing in therapy, namely in EFT for depression. We can hypothesize that the immersed perspective may be beneficial in the earlier phases of the therapeutic work, allowing the access to relevant emotional contents, while the distanced perspective may be more relevant in more advanced stages of therapy. Second, poor-outcomes to EFT for depression may be associated with an excessive focus on negative experiences from an immersed perspective. Excessive immersion may promote rumination, excessive emotional arousal and emotional dysregulation, thus inhibiting the emotional control needed to reconstruct the experience in an adaptive way.

2.3. Purpose of the Study

Currently, there is a need for longitudinal research on immersion and distancing in clinical samples. This study sought to explore how and when immersion and distancing are associated with success in EFT for depression. To do this we compared how clients who had good- and poor-outcomes to EFT for depression reflected on their negative experiences during therapy. More specifically the aims were: a) to compare the frequency and evolution pattern of immersion and distancing in the two groups; b) to analyze the relationship between changes in the frequency of immersion/distancing when reflecting on problematic experiences and changes in the scores of the depressive symptoms.

3. Method

3.1. Participants

3.1.1. Clients. Five women and one man aged between 23 and 48 years (M = 35.5, SD = 10.17) participated in the study. They were participating in a randomized clinical trial named 'Decentering and change in psychotherapy – ISMAI Depression Study' (Salgado, 2014) comparing the effectiveness of cognitive behavioral therapy (CBT) and EFT as treatments for major depressive disorder. All participants in the clinical trial met the following inclusion criteria: diagnosis of major depressive disorder; not taking medication; Global Assessment of Functioning (GAF) score higher than 50. The exclusion criteria were: client currently receiving other treatment for depression; high risk of suicide; current or previous diagnosis of substance abuse; psychosis; bipolar disorder; eating disorder; panic disorder (DSM-IV Axis I disorders); schizotypal, borderline and antisocial disorder (DSM-IV Axis II disorders). These criteria were assessed by the Structural Clinical Interviews for the DSM-IV-TR I (First, Spitzer, Gibbon, & Williams, 2002) and II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), and the Beck Depression Inventory-II (BDI-II) for the Portuguese population (Coelho, Martins, & Barros, 2002). Clients who met the criteria for participation in the clinical trial received 16 weekly sessions of psychotherapy. Assignment to therapeutic modality (CBT or EFT) was random. All cases in the clinical trial were classified as having a good- or poor-outcome according to Jacobson and Truax's (1991) criteria. The good-outcome cases of the clinical trial showed reliable and clinically significant change in symptoms: at the end of therapy depressive symptoms were below the BDI-II cut-off score (13 points) and there was reliable change during therapy (see Jacobson, Roberts, Berns, & McGlinchey, 1999; Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson, 2002), exceeding the Reliable Change Index of 7.75, calculated from the total sample of the clinical trial and taking into account the psychometric data for the Portuguese version of the BDI-II. Thus, all good-outcome cases of the clinical trial were recovered cases. The poor-outcome cases have not meet at least one of the criteria mentioned above (depressive symptoms below the BDI-II cut-off score, and reliable change during therapy). Five EFT therapists participated in the clinical trial and there was no significant association between therapist and clinical outcome, $\chi^2(5) = 2.80$, $p = .732$.

For this study we randomly selected three good-outcome and three poor-outcome cases from the pool of EFT cases in the clinical trial. As shown in Table 4, the good-outcome cases of this study met the two criteria for classification of good-outcome cases imposed by the clinical trial. In the poor-outcome cases BDI-II scores in the last session were above the normal range (>13 points). One poor-outcome case was a 'responder' (reliable change, but depressive symptoms in the last session did not change to the normative range). None of the poor-outcome cases showed evidence of deterioration (see Table 4). The sociodemographic profiles of the good- and poor-outcome cases included in this study were similar with respect to gender, $\chi^2(1) = 1.20$,

p= .273, age, U = 4.00, p = .827, civil status, $\chi^2(2) = 1.33$, p = .513, and education level, U = 3.00, p = .700.

Table 4. Evolution of Depressive Symptoms in the 6 Cases (BDI-II)

Group	Case	Session 1	Session 4	Session 8	Session 12	Session 16
Good-outcome group	Case 1	19	15	18	8	2
	Case 2	15	27	0	0	1
	Case 3	28	19	11	4	1
Poor –outcome group	Case 4	32	26	22	18	29
	Case 5	25	19	18	23	16
	Case 6	22	21	18	23	22

All clients gave their informed consent for using their data in scientific publications. According to ethics protocol of this clinical trial, as well as principles and standards of the American Psychological Association, clients received information about the purposes and procedures of the clinical trial and their personal information was de-identified to protect their anonymity.

3.1.2. Therapists. The good-outcome cases were treated by three therapists: two women and one man aged between 31 and 42 years (M = 35.5, SD = 4.97) with PhD. The duration of their experience as therapists ranged between 4 and 19 years (M = 11, SD = 6.16) and their experience with EFT ranged between 1 and 3 years (M = 2, SD = 0.82). The poor-outcome cases were treated by two male therapists aged between 31 and 44 years, one of them with PhD and other with master's degree. The duration of their experience as therapists ranged between 2 and 21 years (M = 14.33, SD = 8.73) and their experience with EFT ranged between 1 and 5 years (M = 3.33, SD = 1.70). The male therapist responsible for one of the good-outcome cases also treated two poor-outcome cases. All therapists received six months (80 hours) of training in the specific therapeutic protocol for the treatment of depression (see Elliott et al., 2004; Greenberg, Rice, & Elliott, 1993), as well as weekly supervision sessions during their intervention in cases pertaining to the clinical trial.

The protocol is based on working at the emotional level, seeking to influence cognitive and behavioural change. The goal in EFT is to promote emotional processing. The therapists help clients gain access to maladaptive emotional schemes, in order to transform them. Clients are then capable of understanding the differences between present and past experiences, and identifying their needs. In this process new experience meanings will emerge, facilitating the adaptive resolution of the problematic experience (Elliott et al., 2004; Greenberg & Watson, 2006).

3.2. Process Measures

3.2.1. Measure of Immersed and Distanced Speech (MIDS). The MIDS allows for identifying the immersed and distanced perspectives concerning experience through client speech (immersed and distancing speech). This measure, based on theoretical definition and relevant prior research (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009; Kross et al., 2005; Kross et al., 2012; Nigro & Neisser, 1983; Robinson & Swanson, 1993), categorizes the client speech according to different statements (i.e., subcategories of immersed and distanced speech) which contents are representative of immersed or distanced perspective. The immersed and distanced perspectives are manifested in people's speech respectively by the focus on the description of the experience or on the explanation/exploration of it. The immersed subcategories aim to identify the first person perspective about experience, namely 'what happened/ what did I think' (*what statements*), and 'how did I feel' (*attributive statements*). They include client's speech focused on the description of events, original thoughts, feelings, and behaviors as experienced by the client. The distanced subcategories aim to identify the observer perspective about experience. They include client speech focused on explaining and exploring different facets of the experience (*insight statements*) or a broader view, based on past and current experiences (*closure statements*). According to MIDS, the client's speech that reveal closeness to the first-person experience (or an egocentric point of view) is categorized as immersed, while speech elaborating a broader picture about experience (or an observer point of view) is defined as distanced. This categorization is independent of the potential adaptive potential of that reflection. For example, when a client assesses a negative experience from a broader perspective, associating past and current experiences, or making conclusions about his/her feelings, that speech is classified as distanced (*closure statements*), even if the assessment and conclusions expressed by the client is not clinically productive or somehow biased. When none of immersed or distanced subcategories are identified, they are considered as *other statements* (see Table 5 for more details).

Preliminary results of a study assessing the validity of MIDS (Barbosa, Silva, Castro, Pinto-Gouveia, & Salgado, 2017) indicate a high internal consistency for both immersion (α = .95) and distancing (α = .91) and good to strong inter-rater reliability (Hill & Lambert, 2004) for raters' pairs (Cohen's kappa ranged from .75 to .96).

Table 5. Brief Description of Immersion and Distancing Subcategories

Type of speech	Subcategories	Contents	Examples
Immersed	What statements	Client describes a specific chain of events.	"He yelled at me and treated me badly."
			"He told me to back off."
		Client describes specific and original thoughts or behaviors	"I went to my room and cried for a long time."
			"My work is worthless."
	Attributive statements	Client ascribes characteristics to self or others without explaining or providing reasons to them.	"He was mean."
			"I was kind of stupid."
		Client describes feelings or other internal states.	"I feel sad."
			"I feel happy."
			"I have a great pain and a permanent restlessness."
Distanced	Insight statements	Client describes the causes underlying the event, his or her feelings, behaviors and cognitions.	"He does not respect me because I never established any limits."
		Client establishes relations between behaviors, feelings or cognitions.	"Maybe I reacted that way because I felt he rejected me."
		Client expresses new awareness about own behaviors, feelings or cognitions.	"It may have been somehow irrational but now I better understand my motivation then."
	Closure statements	Client indicates he or she assesses a past experience from a broad perspective, taking into account past and current experiences to make sense of feelings and experiences.	"I look back and I see that suffering had to do with how I interpreted criticisms. Now I know that critical remarks can be constructive and it does not mean that others do not like me."
		Client establishes relations (contrasts or similitudes) between past and present behaviors, feelings or cognitions.	"Today I know that I'm valued by my father."
			"Today I barely hugged my father, whereas before we were like brothers"
		Client express present feelings or thoughts about past experience or situations	"I thought about how glad I am that part of my past is over."
			"I see my past as a difficult moment of my life that brought implications in what I am today."

3.3. Outcome Measures

3.3.1. BDI-II. This study used the BDI-II adapted for a Portuguese population by Coelho and collaborators (2002), from Beck, Steer, and Brown (1996). The BDI-II is a 21-item self-report inventory designed to measure the degree of depression. Responses on each item are scored on a scale ranging from 0 to 3. The total scores can range from 0 to 63. Specifically, scores below 13 are considered to be in the normal range, whereas scores between 14 and 19 indicate mild to moderate levels of depression, scores between 20 and 28 indicate moderate to severe depression, and a total of 29 or more indicates a severe level of depression. The internal consistency (Cronbach's Alpha) of the total BDI-II score was .89 (Coelho et al., 2002). The

psychometrics qualities found in the Portuguese version of this measure were consistent with the ones found in the American version (Coelho et al., 2002).

3.4. Procedures

The six cases (three good-outcomes; three poor-outcomes) were randomly chosen from the EFT group in the larger clinical trial. We analyzed five sessions of therapy for each case (sessions 1, 4, 8, 12 and 16) in order to explore changes in immersion and distancing across therapy. These sessions were chosen because they belong to different phases of the therapeutic process (see Basto, Stiles, Rijo, & Salgado, in press; Hill, 2009), allowing to obtain an overview about the evolution of the variable under study; and because they were the sessions in which the clinical trial protocol specified that clients should complete the BDI-II, thus allowing us to explore the association between this quantitative measure of depressive symptoms and qualitative measures. The sessions were transcribed according to the procedure described by Mergenthaler and Stinson (1992) and then subjected to a two-step analysis. In the first step, for each case, the client's main problematic experience was identified. Although this procedure is not necessary for the determination of the type of perspective used by the client in therapy, it has been applied in this study in order to ensure that immersion and distancing were only analyzed with respect to negative emotional content. In the second step this experience was coded in terms of immersed and distanced speech. Symptoms were also assessed in the same sessions from the outcome measure (BDI-II), aiming to analyse the relationship between depressive symptoms and immersion/distancing during reflection on the main negative experience.

3.4.1. Identification of the main problematic experience. We followed the procedures adopted in previous studies regarding the identification and definition of relevant problematic experiences in psychotherapy (e.g., Brinegar, Salvi, Stiles, & Greenberg, 2006; Caro Gabalda & Stiles, 2013; Honos-Webb, Stiles, & Greenberg, 2003; Stiles, Meshot, Anderson, & Sloan, 1992). This task was conducted by a total of eight judges, one judge had a PhD in clinical psychology, one was a PhD student in clinical psychology and six were Master's students in clinical and health psychology. In preparation the judges read and discussed relevant prior studies about problematic experiences, as well as clinical sessions in which the procedures for identifying problematic experiences were applied. This training phase lasted two months and was guided by a researcher who was expert in this type of procedure. Each case was assessed by a team of two judges who carefully and independently read the 5 sessions, then jointly constructed a clinical formulation, identifying, by consensus, the problematic experiences (central clinical problems). Then the judges worked together to identify excerpts in the transcripts where each problematic experience appeared that were then marked with different colors. Specifically, the excerpts of the problematic experiences were identified from content (what was talked about) (Brinegar et al., 2006; Caro Gabalda & Stiles, 2013). Finally, the main problematic experience was identified through a consensual discussion between the two judges about the clinical relevance of the

content. In all cases, the problematic experience selected in each session occupied more than 70% of the client´s speech (ranging from 72% to 86%).

3.4.2. Analysis of problematic experience in terms of immersion and distancing. The problematic experiences in all cases were analyzed in terms of immersion and distancing using the MIDS. The MIDS was applied by a PhD student in clinical psychology, who was experienced in use of the measure, and three Master's students in clinical and health psychology. There were two phases to application of the MIDS: the training phases and the identification phase in which judges identified the type of speech present in excerpts dealing with the previously identified problematic experiences. In the training phase the judges received intensive training in identifying immersed and distanced speech. This involved reading relevant articles and manuals and practicing the coding procedures on material from therapy sessions until they achieved an acceptable Cohen's kappa (Cohen's kappa ≥ .75) (Hill & Lambert, 2004). This phase lasted about three months. In the second phase, each Master's student randomly coded two cases with the PhD student. The PhD student was aware of the clinical outcome of the cases analyzed but the other judges were blind to this condition. The 5 sessions of each case were rated independently by the two judges. Representative excerpts dealing with problematic experience were analyzed to determine the presence of the various subcategories of immersion (*what statements* and *attributive statements*) and distancing (*insight statements* and *closure statements*). If none of the subcategories were present, the statement was classified as *other*. The rating process involved defining, within the parts of the transcript involving a problematic experience, the beginning and the end of stretches of speech belonging to subcategory. The beginning of the stretch was delimited by the presence of contents that characterize that subcategory. In turn, the end of the stretch was delimited by the absence of those contents and/or the presence of contents that characterize another subcategory, or by the end of excerpt analyzed (see table 5). When the classification of the judges did not coincide, this was considered a disagreement, which was later solved by consensual discussion between them (see Hill et al., 2005). Cohen's kappa for judge pairs ranged from .75 to .83. When aggregated the subcategories of immersion and subcategories of distancing, Cohen's kappa ranged from .78 to .86. These results indicate strong inter-rater reliability (Cohen's kappa > .75; Hill & Lambert, 2004). The main output variable was the relative frequency of each type of speech (immersed or distanced), which was calculated taking into account the number of words occupied by each type of speech and the total number of words per session. Specifically, for each session, the stretches identified with subcategories of immersed speech were grouped, as well as, the stretches identified with subcategories of distanced speech. After that, the number of words for each group (immersed speech and distanced speech) was counted. In calculating the total number of words per session we ignored the number of words coded 'other', as they represented very small passages of the session (M = 2.8% per session) in which the judges were not able to identify the type of underlying speech. The Mann-Whitney U test was used to analyze the differences between the good- and poor-outcome groups regarding

the presence of immersion and distancing in therapy. The Friedman test was used to analyze within-group changes during therapy.

We also selected representative excerpts of immersed and distanced speech from one good-outcome case (Elizabeth) and one poor-outcome case (Peter) to illustrate the quantitative results. The client names are fictitious.

3.4.3. Outcome assessment. In all cases clients completed the BDI-II at sessions 1, 4, 8, 12 and 16. In this study, the results of BDI-II in these sessions were used to obtain a general description of the depressive symptoms in the good- and poor-outcome groups across sessions (Figures 2 and 3). In order to analyze the relationship between changes in the immersion/distancing and changes in the depressive symptoms, we used the results of BDI-II at the first and last session (sessions 1 and 16, respectively). We calculated the changes in BDI-II scores and in the relative frequencies of immersed/distanced speech between these sessions. Spearman's rho correlations were used to assess the relationships between depressive symptoms and immersion/distancing.

Should be noted that in this study, we reported only the results found concerning to the distanced speech due to the dependence of the data on the relative frequencies of immersed and distanced speech, ensuring adequate statistical evidence. Actually, since the category "Other" was residual, the values of immersion and distancing are almost symmetrical, and clearly dependent (see figures 2 and 3). Thus, the results we will report about distanced speech are symmetrical to the ones regarding immersed speech. There was only one exception to this decision in our report of results: we reported the frequencies of both distancing and immersion in figures 2 and 3 in order to make it clear the dependency of these two categories.

4. Results

4.1. Occurrence of Distancing in Good- and Poor-Outcome Groups

At the beginning of therapy the good- and poor-outcome groups had similar levels of depressive symptoms as measured by the BDI-II, $U = 2.00$, $z = -1.09$, $p = .275$.

The good- and poor-outcome groups presented significant differences on overall relative frequency of distanced speech during the therapeutic process, $U = 0.00$, $z = -1.96$, $p = .050$, $r = -.80$. The relative frequency of distanced speech was higher in the good-outcome group ($M = 35.13$; $SD = 5.88$, 95% CI [20.52, 49.75]) than in the poor-outcome group ($M = 22.43$; $SD = 5.06$, 95% CI [9.85, 35.00]). Regarding the relative frequency of distanced speech produced in each session (see Table 6), in good-outcome group it ranged from 6.65% to 80.63%, whereas in poor-outcome group it ranged from 8,57% to 52.28%. The distanced speech was the speech less used across sessions in the poor-outcome cases, except in one session of the case 5, in which the

distanced speech was dominant in the last session (relative frequency of distanced speech was 52.27%). In the good-outcome cases, there was a dominance reversal in the speech used in the last session of all cases and session 12 in one of the cases (case 2), in which the distanced speech became the more frequent speech (ranging from 50.85% to 80.63%).

Table 6. Evolution of Distanced Speech in the 6 Cases

		Number of words total per session					Number of word of distanced speech					Relative frequency of distanced speech (%)				
		Sessions					Sessions					Sessions				
Group	Case	1	4	8	12	16	1	4	8	12	16	1	4	8	12	16
Good-outcome group	Case 1	4102	3906	6088	4667	6284	456	1009	2039	2204	3866	11.12	25.83	33.49	47.23	61.52
	Case 2	5248	5372	10224	9825	10017	442	357	3864	6043	5094	8.42	6.65	37.79	61.51	50.85
	Case 3	4770	2231	3494	1686	1797	344	411	1014	745	1449	7.21	18.42	29.02	44.19	80.63
Poor – outcome group	Case 4	2523	3161	2463	1477	2410	287	839	660	429	1119	11.38	26.54	26.80	29.05	46.43
	Case 5	5283	6116	4248	2526	3212	1023	887	603	504	1679	19.36	14.50	14.19	19.95	52.27
	Case 6	3995	3911	3109	2102	2638	567	335	827	537	509	14.19	8.57	26.60	25.55	19.29

4.2. Evolution of Distancing in Good- and Poor-outcome Groups

In the first session of the therapy, all poor-outcome cases showed higher relative frequency of distanced speech (ranging from 11.38% to 19.36%) than the good-outcome cases (ranging from 7.21% to 11.12%). Comparing the first and last sessions of each case, both poor- and good-outcome cases showed higher relative frequency of the distanced speech in the last session (see Table 6 and Figures 2 and 3).

Overall, in both good- and poor- outcome groups, the distanced speech increased throughout the therapy. Although this evolution has been common to all cases, the good-outcome cases showed a more pronounced evolution than the poor-outcome cases (see Table 6 and Figures 2 and 3). For example, one good-outcome case (case 1) and one poor-outcome case (case 4) started therapy with very similar relative frequencies of distanced speech (11.12% and 11.38%, respectively), however, when comparing the evolution of the speech in the two cases, the distanced speech in the good- outcome case had a more accentuated, steeper increase of distanced speech across sessions, reaching a higher relative frequency of the distanced speech in the last session than the poor-outcome case (61.52% and 46.43%, respectively; see Table 6). Friedman's test was used to evaluate the differences between groups in distanced speech across sessions. In the good-outcome group the distanced speech showed significant changes: the relative frequency of distanced speech increased during the course of therapy, $\chi^2(4) = 10.93$, $p = .027$. Figure 2 shows that this trend was most pronounced between session 8 and the end of therapy, with distanced speech being the more frequent speech, especially in the last session (ranging from 50.85% to 80.63%; see Table 6). Conversely, in the poor-outcome group there was no significant differences in the relative frequencies of distanced speech across sessions, $\chi^2(4) = 6.67$, $p = .155$. Figure 3 shows that distanced speech remained considerably low throughout the therapy in all cases. The increase of distanced speech in the poor-outcome group was less pronounced than in

the good-outcome group and more evident in last session (ranging from 19.29% to 52.27%; see Table 6).

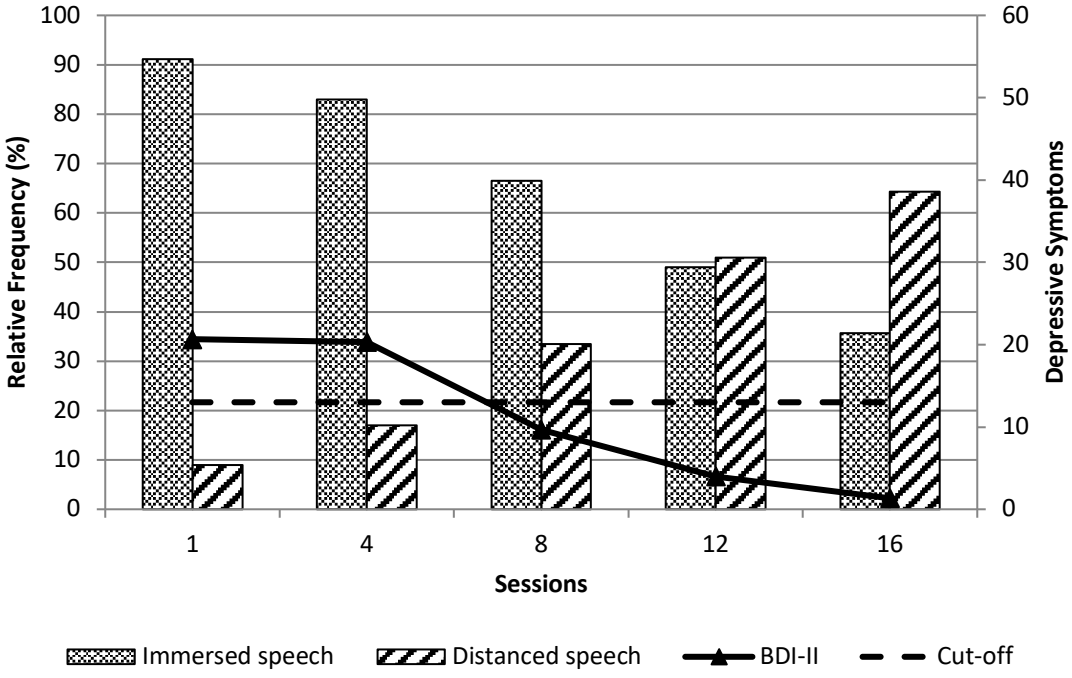

Figure 2. Evolution of immersed and distanced speech and clinical symptoms in the good outcome-group

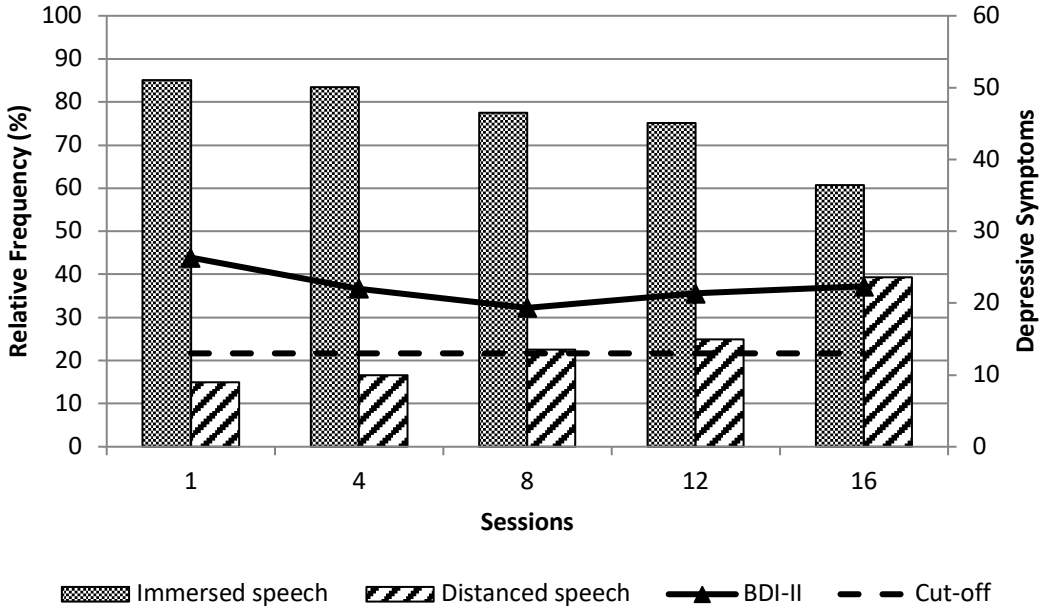

Figure 3. Evolution of immersed and distanced speech and clinical symptoms in the poor-outcome group

The following passages are taken from the initial, middle and final phases of therapy in a good-outcome case and a poor-outcome case. The text coded as immersion is shown in italics and text coded as distancing is underlined. First we present passages from the good-outcome case (Elizabeth) which deal with the problematic experience of *feeling worthless as mother and as woman*. In the first passage (session 1, initial phase) Elizabeth adopted an immersed speech, focusing on the specific events associated with her divorce and expressing her feelings, her inner experience and her thoughts and perceptions.

> **Client:** *It did not have to be like this - just as I think that my parents did not have to do that to us* [she is referring to her childhood experience of family violence]*, my children did not have to go through their parents' separation either (...) He* [her ex-husband] *was extremely selfish, the money could not be lacking for his things, even if that means their children would starve and I: did not tolerate this type of things and…when my children were sick, he left home and said to me 'look if you need anything you have the telephone here' ... I feel there was a great injustice (...) but in relation to my children of course I disappoint them, of course* [referring to her divorce] *I destroyed everything they wanted for themselves.*

In the next passage (session 8, middle phase) Elizabeth's speech was characterized by more frequent, more coordinated transitions between immersion and distancing. In her immersed speech, she described her private experiences and thoughts about the impact of divorce on her children. In her distanced speech, she established connections between the experiences and thoughts, creating new meanings.

> **Client**: *I feel I destroyed the dreams of my children to have a house (...);* but recovering some situations, maybe now they feel the house like a real home*. Before, my children were always willing to leave the house (...)* they could have the same motivation as me, because I was also willing to leave the house too, right? (...) Now they really feel well!

The last passage of the good-outcome case (session 16, final phase) is dominated by distanced speech, which was more frequent than in the previous phases. Elizabeth explored the differences between how she was in the past and how she is now, providing an overview of the changes and how they occurred. She explored how her perceptions of her childhood experiences and their overall impact had changed.

> **Client**: Let's say I was illiterate, now I know how to read - I am exactly the same person but with completely different attitudes and: *initially, everything was very confusing, there were those two voices in my head, if one of them said 'yes', another said 'no'.* I think that maybe it was what made me stress a lot, because I was having a conflict with myself, right? (...) after all, I had many good times and I wasn't remembering them. I needed to feel that I was there too, I was also a child (...) life goes on and it depends on me now.

The next passages were taken from a poor-outcome case (Peter) in which the problematic experience was *feeling a failure*. The first passage illustrates the predominance of immersed

speech. Peter focused on his internal state, activating painful emotions in relation to himself passively and repeatedly. Distanced speech occurred when the client represented his experience in metaphorical terms.

> **Client**: (...) *I do not like my personality I feel huge shame about how I am. I also do not like my way of thinking* (…)
> **Therapist**: But when you say that you feel ashamed, you feel ashamed because you are not able to make progress with work for your thesis?
> **Client**: *I am ashamed by the development my life has taken* (…)
> **Client**: (...) it's like a cone turned upside down, a cone-shaped building turned upside down... a bench full of people looking at me and throwing something at me.

Even after a few sessions (session 8, middle phase), Peter continued to consider himself a failure and to focus on his fears. Unlike in the good-outcome case, his speech continued to deal repetitively with the internal states associated with the problematic experience.

> **Client**: *I'm afraid of the novelty, I'm afraid of making a wrong decision, I'm afraid I'm disappointing people, I'm afraid of many things*
> **Therapist**: That's a lot of fears
> **Client**: *yes (hmm hmm) basically I'm quiet even when I'm right*

In the last passage (session 16, final phase) Peter uses more distanced speech than in the other phases, taking a broader perspective and analyzing his potential, but most of his distanced speech consists of a metaphorical description of his painful experiences. In other words, Peter's use of distanced speech was largely restricted to metaphorical descriptions of his problematic experience and he quickly returned to an immersive perspective:

> **Client**: I think I'm better because I'm more aware of things that happen and I can analyze them in a way, I'm better at analyzing them (...) but there are things that I could not make progress with, *because of me (...) I get a bit frustrated, sometimes I feel a bit useless, and this ends up affecting my self-esteem a bit and that's already not high (...) I feel humiliated*, it's like being in the middle of a million people and someone kicks a ball and the ball hits me in the face, *that's the feeling that annoys me.*

4.3. Distancing and Depressive Symptoms

Figures 2 and 3 provide an overview about the evolution of depressive symptoms in good- and poor-outcome groups, respectively. Figure 2 shows that in the good-outcome cases, the depressive symptoms had a clear decrease throughout sessions. In turn, Figure 3 shows that in poor-outcome cases depressive symptoms were steady throughout sessions. In more detail, in the good-outcome cases, two cases presented no significant clinical depressive symptoms from session 8 onwards (cases 2 and 3, with BDI-II scores of 0 and 11, respectively) and one case from session 12 onwards (case 1, with BDI-II score of 8; see Table 4). It is important to underline that in these sessions the BDI-II scores were below the clinical threshold and distanced speech was

still the less frequent speech (relative frequency of distanced speech ranged from 29.02% to 47.23%; see Tables 4 and 6 and Figure 2). In the poor-outcome group, all cases remained symptomatic across sessions (BDI-II scores ranged from 16 to 32; see Table 4 and Figure 3).

Statistical analysis showed that there were strong correlation ($r_s > \pm .70$, $p < .05$; Cronk, 2006) between change in depressive symptoms (the difference between BDI-II scores at the session 1 and at the session 16) and change in relative frequency of the type of speech. Specifically, the change in depressive symptoms over the entire course of therapy was negatively correlated with change in distanced speech, $r_s = -.81$, $p = .05$.

5. Discussion

This study suggests that at the beginning of therapy high immersion was common to both good- and poor-outcome cases, providing corroboration for the notion that depression is associated with an immersed perspective (Kross & Ayduk, 2009: Kross et al., 2012). However, the good- and poor-outcome groups differed in terms of the frequency of immersion/distancing and the course of changes in their relative frequency during therapy. The differences between groups were consistent with several aspects of our initial hypotheses. First, the good-outcome group spent a higher proportion of therapy in distancing than the poor-outcome group (and correspondingly adopted an immersed perspective for a lower proportion of the time). This difference was linked to significant changes in immersion/distancing during the course of effective EFT. In the good-outcome cases distancing increased (and correspondingly immersion decreased) during the course of therapy, whereas it remained stable in poor-outcome cases. Additionally, unlike in the poor-outcome group, in the good-outcome group distancing predominated at the end of therapy. These results suggest some support to the hypothesis about the association between the poor outcomes to EFT for depression and the excessive and continuous focus on negative experiences from an immersed perspective.

Second, the differences between groups in the evolution of immersion/distancing were not related to the intensity of symptoms at the start of therapy as there was no group difference in BDI-II scores at the beginning of therapy. The change in perspective over the course of therapy was, however, related to change in depressive symptoms, which is also aligned with the hypothesis that a progressive increase in distancing would be associated with therapeutic success. This is consistent with theory concerning the relationships between distancing and symptom relief (Ayduk & Kross, 2008, 2010b; Kross & Ayduk, 2008; Kross et al., 2005, 2012; Verduyn et al., 2012) and problem solving (Ayduk & Kross, 2010b; Stiles, 2011). Our result may be interpreted in two opposing ways. It is possible that, in this sample, change in the severity of depressive symptoms prompted changes in the perspective adopted during reflection on negative experiences. Alternatively, changes in perspective may have promoted change in the severity of depressive symptoms. Of course, we also need to acknowledge the possibility of a third variable causing both changes in depression and in the reflective perspective.

Third, unlike what might have been expected given the results of previous experimental studies (e.g., Ayduk & Kross, 2010b; Kross et al., 2012), distancing was more frequent in the poor-outcome cases than the good-outcome cases in the first session, suggesting that more frequent distancing early in therapy is not necessarily a predictor of good therapeutic outcome. This result also suggests that in this sample, it is the progressive transition from immersion to distancing that distinguishes between cases with good- and poor-outcomes, rather than the frequency of immersion/distancing at a given moment. Moreover, the high levels of immersion early in therapy possibly had a positive impact, promoting adaptive reflection on the problematic experience. This is in accordance with our hypothesis that immersion may initially have positive therapeutic effects, but needs to be followed by an increase of the distanced perspective about experience. Another interesting aspect of our results was that the good-outcome cases had subclinical levels of depression even when immersion was high. This suggests that reflecting on problematic experience from an immersed perspective may be an important part of the therapeutic process. In other words, while our results show an association between the increasing of the distanced perspective and decreasing of depressive symptoms, they do not show to be beneficial avoiding the immersed perspective in therapy. Actually, this suggests that, at least in this sample, immersion may have been an important element of the process – and actually an opportunity to promote clinical change and distancing. However, our results also showed that immersion does not always result in such opportunities being taken, since in the poor-outcome cases immersion remained relatively stable and high throughout therapy. It seems likely that continuous immersion results in persistent activation of clinical symptoms; this interpretation is consistent with experimental findings on how immersion affects the duration (Kross & Ayduk, 2011; Verduyn et al., 2012) and intensity of symptoms (Ayduk & Kross, 2008; Kross & Ayduk, 2008; Kross et al., 2005). If further confirmed with new studies and larger samples this gives rise to the hypothesis that immersion may be helpful when it is regulated, i.e., not continuous or indefinite. On the one hand, reflection on problematic experience from a regulated immersed perspective may promote increased awareness and acceptance of it and hence the adoption of a new perspective (distanced perspective), which in turn allows for the creation of new meanings. This suggestion is consistent with studies showing that egocentric contact with painful experience allows one to access, tolerate and accept it and thus facilitates evaluation of its meaning (see Kennedy-Moore & Watson, 2001). On the other hand, it is also possible that a progressive increase of distancing facilitates emotional regulation and hence avoidance of uncontrolled, persistent immersion. This suggestion is consistent with experimental studies and EFT regarding the benefits of distancing in emotional control (Ayduk & Kross, 2008; Elliott et al., 2004; Kross et al., 2012). All this reflection need to be tasted.

There are other issues that are not yet clear. Immersion and distancing co-occurred in all therapeutic processes, with immersion the dominant perspective overall. There are several possible interpretations of this finding and they are not mutually exclusive. One is that EFT makes use of immersion; its focus on feeling and processing painful emotions may necessarily

involve immersion in difficult experiences (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006). A second interpretation assumes that immersion is the perspective most commonly taken by clients in psychotherapy. Revealing the difficult and painful experiences for which one is seeking help may be a necessary preliminary step in the therapeutic process. Lastly, some therapeutic tasks, such as chair work, may imply the two perspectives. In this task, for example, the client may start by contact with inner feelings from an immersed perspective, but in later phases a distanced perspective may dominate in order to feed new meaning-making.

6. Conclusion, Limitations and Future Studies

When analyzing the good-outcome cases, we found a trend that suggests a progressive transition from immersion, which dominates the initial phase, to distancing, which is used more frequently in the final phase. At the same time, immersion still accounts for a large part of the therapeutic conversation even in later phases of the process, and even when symptoms are already within the normative range. Finally, the poor-outcome cases and good-outcome cases showed an equivalent level of distancing at the beginning of the process. Based on these observations, we are putting forward a hypothesis that immersion and distancing play complementary roles in clinical change.

This study had some limitations that restrict the conclusions that can be drawn. They should be addressed in future studies. First, we analyzed immersion and distancing in a small sample of clients who were all suffering from depression and all went through the same kind of therapy. The very small sample did not permit more formal analyses of trajectories of change that account for dependency in data. It would be interesting to attempt to replicate our findings with a larger sample and to investigate whether they generalize to other therapies and other disorders. Second, one of the judges involved in qualitative analysis of the data was aware of the clinical outcomes, and with knowledge on the previous experimental studies on distancing and immersion. This may have worked as a potential confound. Nevertheless, we limited this potential effect in two ways: by always having a second judge blind to the results; and by always having the two judges coding 100% of the material. The Cohen's kappa values also reveal a satisfactory agreement, which gives credit to the coding process. Third, only passages referring to problematic experiences of five sessions of therapy were analyzed in each case and so our findings need to be interpreted with caution. However, measures were taken to minimize bias in the data generated: coding was carried out by pairs of judges; a large number of judges was used; the six cases were randomly chosen; the sessions analyzed were taken from different phases of therapy in order to reflect as closely as possible any changes occurring during the therapeutic process; the excerpts analyzed dealt with the problematic experience in order to ensure that analysis of immersion and distancing was limited to negative emotional content.

Finally, our results create an hypothesis that deserves further study, namely, that regulated use of immersion and distancing has therapeutic benefits. For clinical and theoretical reasons it is important to test this hypothesis and to investigate the processes involved in

regulation of immersion. A moment-by-moment detailed analysis of immersion and distancing might provide insight about the potentialities of the dynamic between them for clinical change. These types of studies may lead to improvements in therapy by enabling therapists to promote the use of the most appropriate perspective at each stage in therapy.

7. References

Ayduk, Ö., & Kross, E. (2008). Enhancing the Pace of Recovery, Self-Distanced Analysis of Negative Experiences Reduces Blood Pressure Reactivity. *Psychological Science, 19*, 229-231. doi: 10.1111/j.1467-9280.2008.02073.x

Ayduk. Ö., & Kross, E. (2010a). Analyzing negative experiences without ruminating: The role of self-distancing in enabling adaptive self-reflection. *Social and Personality Psychology Compass, 4*, 841-854. doi:10.1111/j.1751-9004.2010.00301.x

Ayduk, Ö., & Kross, E. (2010b). From a distance: implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology, 98*, 809-829. doi:10.1037/a0019205

Barbosa, E., Silva, S., Castro, D., Pinto-Gouveia, J., & Salgado, J. (2017). *Development and validation of the Measure of Immersed and Distanced Speech.* Manuscript in preparation.

Basto, I., Stiles, W. B., Rijo, D., & Salgado, J. (in press). Does assimilation of problematic experiences predict a decrease in symptom intensity? *Clinical Psychology & Psychotherapy*. doi:10.1002/cpp.2130

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II (BDI-II)*. San Antonio, TX: Psychological Corporation.

Beck, J. S. (2011). *Cognitive behavior therapy: Basic and beyond* (2nd ed.). New York: The Guilford Press.

Berman, M. G., Peltier, S., Nee, D. E., Kross, E., Deldin, P. J., & Jonides, J. (2011). Depression, rumination and the default network. *Social Cognitive and Affective Neuroscience, 6,* 548-555. doi:10.1093/scan/nsq080

Bernstein, A., Hadash, Y., Lichtash, Y., Tanay, G., Shepherd, K., & Fresco, D. (2015). Decentering and related constructs: A critical review and meta-cognitive processes model. *Perspectives on Psychological Science 10*(5):599-617. doi:10.1177/1745691615594577

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180. doi:10.1037/0022-0167.53.2.165

Brosschot, J. F., Gerin, W., & Thayer, J. F. (2006). The perseverative cognition hypothesis: A review of worry, prolonged stress-related physiological activation, and health. *Journal of Psychosomatic Research, 60*, 113-124. doi:10.1016/j.jpsychores.2005.06.074

Bushman, B. J. (2002). Does venting anger feed or extinguish the flame? Catharsis, rumination, distraction, anger, and aggressive responding. *Society for Personality and Social Psychology, 28*, 724-731. doi:10.1177/0146167202289002

Caro Gabalda, I., & Stiles, W. (2009). Retrocessos no contexto da terapia linguística de avaliação [Setbacks in the context of linguistic therapy of evaluation]. *Análise Psicológica, 27,* 199–212. doi:10.14417/ap.205

Caro Gabalda, I., & Stiles, W. B. (2013). Irregular assimilation progress: Reasons for setbacks in the context of linguistic therapy of evaluation. *Psychotherapy Research, 23*, 35-53. doi.org/10.1080/10503307.2012.721938

Carryer, J., & Greenberg, L. (2010). Optimal Levels of Emotional Arousal in Experiential Therapy of Depression. *Journal of Consulting and Clinical Psychology, 78*(2), 190-199. doi:10.1037/a0018401

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory-II. *European Psychiatry, 17*, 222-226. doi:10.1016/S0924-9338(02)00663-6

Cronk, B. C. (2006). *How to use SPSS: A step-by-step guide to analysis and interpretation* (4th ed.). Glendale, CA: Pyrczak Publishing.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion focused therapy: The Process-Experiential Approach to Change.* Washington, D.C.: America Psychology Association.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II).* (J. Pinto-Gouveia, A. Matos, D. Rijo, P Castilho, & M. Salvador, Trans.). Washington, D.C.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L, Gibbon, M., & Williams, J. B.W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version (SCID-I-RV)*. (A. Costa Maia, Trans.). New York: Biometrics Research.

Fresco, D., Moore, M., Van Dulmen, M., Segal, Z., Ma, S., Teasdale, J., & Williams, J. M. (2007). Initial psychometric properties of the experiences questionnaire: Validation of a self-report measure of decentering. *Behavior Therapy, 38*(3), 234-246. doi:10.1016/j.beth.2006.08.003

Greenberg, L. S. (2002). *Emotion-Focused Therapy: coaching clients to work through their feelings*. Washington: America Psychology Association.

Greenberg, L. S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by moment process*. New York, NY, US: Guilford Press.

Greenberg, L. S., & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington, D. C.: American Psychological Association.

Gross, J. J. (2015). Emotion regulation: Current status and future prospects. *Psychological Inquiry, 26*(1), 1-26. doi.org/10.1080/1047840X.2014.940781

Gross, J. J., & Thompson, R. A. (2007). Emotion regulation: Conceptual foundations. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 3–24). New York: Guilford Press.

Gruber, J., Harvey, A., & Johnson, S. (2009). Reflective and ruminative processing of positive emotional memories in bipolar disorder and healthy controls. *Behaviour Research and Therapy, 47*, 697-704. doi:10.1016/j.brat.2009.05.005

Hill, C. E. (2009). *Helping skills: Facilitating exploration, insight, and action* (3rd ed.). Washington, DC: American Psychological Association.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi:0.1037/0022-0167.52.2.196

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84-136). Hoboken, New Jersey: Wiley.

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50*, 189-198. doi:10.1037/0022-0167.50.2.189

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology, 67*, 300-307. doi:10.1037/0022-006X.67.3.300

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12-19. doi:10.1037/0022-006X.59.1.12

Kennedy-Moore, E., & Watson, J. (2001). How and when does emotional expression help? *Review of General Psychology, 5*, 187-212. doi:10.1037/1089-2680.5.3.187

Kross, E. (2009). When the self becomes other: Toward an integrative understanding of the processes distinguishing adaptive self-reflection from rumination. *Annals of the New York Academy of Sciences, 1167*, 35-40. doi:10.1111/j.1749-6632.2009.04545.x

Kross, E., & Ayduk, Ö. (2008). Facilitating adaptive emotional analysis: Distinguishing distanced-analysis of depressive experiences from immersed-analysis and distraction. *Personality and Social Psychology Bulletin, 34*, 924-938. doi:10.1177/0146167208315938

Kross, E., & Ayduk, Ö. (2009). Boundary conditions and buffering effects: Does depressive symptomology moderate the effectiveness of selfdistancing for facilitating adaptive emotional analysis? *Journal of Research in Personality, 43,* 923-927. doi:10.1016/j.jrp.2009.04.004

Kross, E., & Ayduk, Ö. (2011). Making Meaning out of Negative Experiences by Self-distancing. *Current Directions in Psychological Science, 20*, 187-191. doi:10.1177/0963721411408883

Kross, E., Ayduk, Ö., & Mischel, W. (2005).When asking ''why'' does not hurt: Distinguishing rumination from reflective processing of negative emotions. *American Psychological Society, 16*, 709-715. doi:10.1177/0963721411408883

Kross, E., Bruehlman-Senecal, E., Park, J., Burson, A., Dougherty, A., Shablack, H., Bremner, R., Moser, J., Ayduk, O. (2014). Self-talk as a regulatory mechanism: How you do it

matters. *Journal of Personality and Social Psychology, 106*, 304–324. doi:10.1037/a0035173

Kross, E., Davidson, M., Weber, J., & Ochsner, K. (2009). Coping with emotions past: The neural bases of regulating affect associated with negative autobiographical memories. *Biological Psychiatry, 65*, 361-366. doi:10.1016/j.biopsych.2008.10.019

Kross, E., Gard, D., Deldin, P., Clifton, J., & Ayduk, Ö. (2012). "Asking why" from a distance: Its cognitive and emotional consequences for people with major depressive disorder. *Journal of Abnormal Psychology*, *121*, 559-569. doi:10.1037/a0028808

McGlinchey, J.B., Atkins, D.C., & Jacobson, N.S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy, 33*, 529–550. doi: http://dx.doi.org/10.1016/S0005-7894(02)80015-6

McIsaac, H. K., & Eich, E. (2004). Vantage point in traumatic memory. *Psychological Science, 15*, 248-253. doi:10.1111/j.0956-7976.2004.00660.x

Mergenthaler, E., & Stinson, C. (1992). Psychotherapy transcription standards. *Psychotherapy Research, 2,* 125-142. doi:10.1080/10503309212331332904

Mischkowski, D., Kross, E., & Bushman, B. J. (2012). Flies on the wall are less aggressive: Self-distancing "in the heat of the moment" reduces aggressive thoughts, angry feelings and aggressive behavior. *Journal of Experimental Social Psychology, 48,* 1187-1191. doi:10.1016/j.jesp.2012.03.012

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*, 467-482. doi:10.1016/0010-0285(83)90016-6

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*, 569-582. doi:10.1037/0021-843X.100.4.569

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*, 400 424. doi:10.1111/j.1745-6924.2008.00088.x

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through". *Journal of Consulting and Clinical Psychology, 75*, 875-887. doi:10.1037/0022-006X.75.6.875

Paivio, S. C. (2013). Essential Processes in Emotion-Focused Therapy. Psychotherapy, 50(3), 341-345. doi:10.1037/a0032810

Pennebaker, J. W. (1997). Writing about emotional experience as a therapeutic process. *Psychological Science, 8*(3), 162-166. doi:10.1111/j.1467-9280.1997.tb00403.x

Robinson, J. A., & Swanson, K. K. (1993). Field and observer modes of remembering. *Memory, 1*, 169-184. doi:10.1080/09658219308258230

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. Jason: Aronson.

Salgado, J. (2014). *ISMAI depression project: Results of a comparative clinical trial of EFT and CBT.* Paper presented at 45th International Annual Meeting of Society for Psychotherapy Research, Copenhagen, Denmark.

Stiles, W. B., Morrison, L. A., Haw, S. K., Harper, H., Shapiro, D. A., & Firth-Cozens, J. (1991). Longitudinal study of assimilation in exploratory psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 28*, 195–206. doi:10.1037/0033-3204.28.2.195

Stiles, W. B., Meshot, C. M., Anderson, T. M., & Sloan, W. W. (1992). Assimilation of problematic experiences: The case of John Jones. *Psychotherapy Research, 2,* 81-101. doi:10.1037/0033-3204.38.4.462

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research*, *21*, 367–384. doi:10.1080/10503307.2011.582186

Verduyn, P, Mechelen, I. V., Kross, E., Chezzi, C., & Bever, F. V. (2012). The relationship cetween self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion, 12*, 1248-1263. doi:10.1037/a0028289

Wilson, T. D., & Gilbert, D. T. (2008). Explaining away a model of affective adaptation. *Perspectives on Psychological Science, 3*, 370-386. doi:10.1111/j.1745-6924.2008.00085.x

ESTUDO 3 – IMMERSION AND DISTANCING DURING ASSIMILATION OF PROBLEMATIC EXPERIENCES IN A GOOD-OUTCOME CASE OF EMOTION-FOCUSED THERAPY

Barbosa, E., Couto, A. B., Basto, I., Stiles, W. B., Pinto-Gouveia, J., & Salgado., J. (2018). Immersion and distancing during assimilation of problematic experiences in a good-outcome case of emotion-focused therapy. *Psychotherapy Research, 28*(2), 313-327. doi:10.1080/10503307.2016.1211347

1. Abstract

Objective: Some studies have suggested that a decrease in immersion (egocentric perspective on personal experiences) and an increase in distancing (observer perspective on personal experiences) are associated with the resolution of clinical problems and positive outcome in psychotherapy for depression. To help clarify how this change in perspectives relates to clinical change, the present study compared changes in immersion and distancing across therapy with progress in one client's assimilation of her problematic experiences.

Method: We analyzed all passages referring to the central problematic experience in a good outcome case of emotion-focused therapy for depression using the Measure of Immersion and Distancing Speech and the Assimilation of Problematic Experiences Scale.

Results: Results showed that immersion and distancing were associated with different stages of assimilation. Immersion was associated with stages of emerging awareness and clarification of the problem and in the application of new understandings to daily life. Distancing was associated with problem solving and attaining insight.

Conclusion: The decrease of immersion and increase of distancing associated with therapeutic improvement should not be taken as a recommendation to avoid immersion and encourage distancing. Immersion and distancing may work as coordinated aspects of the processes of psychotherapeutic change.

Keywords: Immersion, distancing, assimilation, change and emotion-focused therapy

2. Introduction

Immersion and distancing are contrasting perspectives on one's own emotional experiences. Immersion refers to viewing experience from an egocentric stance, whereas distancing refers to viewing it from an observer stance (Nigro & Neisser, 1983; Robinson & Swanson, 1993). In experimental work immersion in negative emotional content has been seen as representing a risk to psychological health (Kross & Ayduk, 2008; Kross, Gard, Deldin, Clifton, & Ayduk, 2012), whereas a distancing perspective on such content has been seen as promoting health benefits (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009, 2011; Kross et al., 2012).

The assimilation model of psychological change offers a different, more dynamic interpretation of these observations, suggesting that immersion in problematic experiences may be a necessary step in the psychotherapeutic process and distancing may represent, at different points in the change process, either avoidance of problems or a process of understanding and mastering problems (Stiles, 2011; Stiles et al., 1991). We investigated the quantitative and qualitative relation of immersion and distancing to stages of assimilation by tracking them across sessions in a good-outcome case of emotion-focused therapy (EFT; Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Watson, 2006).

2.1. Immersion and Distancing as Two Perspectives Toward Previous Experience

Immersion and distancing are contrasting perspectives that a person can adopt towards his or her previous experience. Immersion refers to taking an egocentric point of view about a personal experience, considering the self who analyzes the previous emotional experience here and now as coincident with the self who experienced the event (Nigro & Neisser, 1983; Robinson & Swanson, 1993). Specifically, the experience is viewed in the first person, that is, the person sees the experience "through his/her own eyes" (Ayduk & Kross, 2010b, p. 810). The original thoughts, feelings, behaviors and events repeat themselves as the person replays the event (Nigro & Neisser, 1983; Robinson & Swanson, 1993). In contrast, distancing refers to taking an observer point of view about a personal experience, considering the self who analyzes the previous emotional experience here and now as separate from the self who experienced the event (Nigro & Neisser, 1983; Robinson & Swanson, 1993), similar to a "fly on the wall" that can see itself in the experience (Ayduk & Kross, 2010b, p. 809). The experience is analyzed in the third person, so that the person has a broader vision about the experience, considering the big picture rather than focusing on concrete details (Nigro & Neisser, 1983; Robinson & Swanson, 1993).

Studies, in which participants' verbalized analysis of their experience according to an immersed or distanced perspective, provide illustrations of how each of these perspectives are manifested in speech: focusing on the description of the experience or on the explanation/exploration of it. When people describe their experience from an immersed perspective, they tend to recount specific particularities of the experience (what happened; what I felt). In contrast, when people describe an experience from a distancing perspective, they tend to

recount less and, instead, focus on explaining and exploring the experience, integrating different aspects of the experience, making statements that suggest insight and closure (e.g., Kross, Ayduk, & Mischel, 2005; Kross et al., 2012). For instance, when reflecting on a rejection experience, an individual may focus on explaining what led to it, what consequences it had on his life, and how well he handled it. These observer-like positions towards their experiences and internal states characterize distancing, focusing on explaining them rather than just describing and re-experiencing them.

An illustration of the immersed perspective is: "My mother told me that I do not worry about my parents. So, I could not leave the house. I felt sad. They don't understand my point of view". In this example the individual focused on what happened (what mother said), and expressed original feeling and thought that occurred in that event. An illustration of the distanced perspective is: "I am passive in relationships with others because I do not want to be rejected by them". In this example, the individual did not focus on the specific event, but, instead, expressed a broader vision about her/his behavior pattern in relationships with others and provided a possible reason to that.

2.1.1. Immersion and distancing in psychological health. It has been suggested that immersion in problematic experiences can lead to rumination cycles, which involve continued focus on thoughts and feelings associated with negative experiences (Ayduk & Kross, 2010a; Kross et al., 2005). Rumination can prevent the creation of new meanings, while the emotional arousal exacerbates the negative states, making people feel overwhelmed (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Rumination predicts (Ciesla & Roberts, 2007) and exacerbates (Takagishi, Sakata, & Kitamura, 2013) depressive moods. Consistently, experimental studies have shown that immersion is the most common perspective in people with depression (Kross & Ayduk, 2009; Kross et al., 2012).

In contrast, distancing facilitates reconstruction of experience (Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009; Kross et al., 2005). Analyses have shown that distancing helps people to make meaning out of problematic experiences and to gain a sense of closure, improving the emotional well-being (e.g., Kross & Ayduk, 2011; Kross et al., 2012). In comparison with immersion, distancing is associated with lower emotional reactivity (Ayduk & Kross, 2010b; Gruber, Harvey, & Jonson, 2009; Kross & Ayduk, 2009), shorter duration (Kross & Ayduk, 2011; Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012), and lower intensity (Kross & Ayduk, 2008; Kross et al., 2005) of positive and negative emotional states (Gruber et al., 2009). Some authors have suggested that the immersed perspective may be adaptive in dealing with positive experiences, enhancing positive emotional states, whereas distancing may be adaptive in dealing with problematic experiences, preventing an excessive increase of negative emotional states (Ayduk & Kross, 2010a; Gruber et al., 2009; Verduyn et al., 2012).

This conception of immersion and distancing has emerged mainly from cross-sectional experimental studies, in which each person was assessed on only one occasion or over a period of

a week or less, and immersion and distancing were considered as individual difference variables or as alternative strategies for dealing with emotional issues. Longitudinal studies of clients in psychotherapy suggest important modifications to the static view.

Our clinical studies of EFT and Cognitive Behavior Therapy (CBT) for depression have found that both good and poor outcome cases show a high frequency of immersion and a low frequency of distancing at the start of therapy (Barbosa, Amendoeira et al., 2016; Barbosa, Lourenço, Amendoeira, Pinto-Gouveia, & Salgado, 2013; Barbosa, Silva, Pinto-Gouveia, & Salgado, 2016). The high immersion and low distancing persisted throughout therapy in poor outcome cases of EFT (Barbosa, Silva, Pinto-Gouveia et al., 2016), whereas there was a decrease in immersion and an increase in distancing across treatment in both EFT (Barbosa, Silva, Pinto-Gouveia et al., 2016) and CBT (Barbosa, Amendoeira et al., 2016) good outcome cases (Barbosa et al., 2013). Additionally, immersion was associated with negative emotions and distancing with positive emotions (Barbosa, Amendoeira et al., 2016). Extrapolating from the experimental studies (e.g., Ayduk & Kross, 2010a, 2010b; Kross & Ayduk, 2009; Kross et al., 2005; Kross et al., 2012), it might seem plausible that, in viewing their problematic experiences from an immersed perspective, people focus on painful details, exacerbating negative affect and maintaining depression. However, immersion was the dominant perspective throughout therapy and immersion was significantly higher in good outcome cases than poor outcome cases at the start of the therapy in the EFT cases (Barbosa, Silva, Pinto-Gouveia et al., 2016).

Some treatment approaches, including EFT, suggest that immersion in negative feelings can be beneficial when people are too distanced from their emotions (e.g., Elliott et al., 2004). Some authors have argued for the importance of the emotional expression--an immersed perspective--for activation of painful emotions and subsequent mastery of them (e.g., Kennedy-Moore & Watson, 2001). The "fever model of disclosure" (Stiles, 1995), for example, suggests that increased expression of subjective states (e.g., “I think …”, “I feel…”), which are typical of the immersed perspective (e.g., Kross et al., 2005), can be both an indicator of psychological distress and part of a corrective response, just as an increased body temperature is both an indicator of infection and part of a bodily defense against it. To put it another way, an immersed perspective may be an effect as much as a cause of emotional distress and depression.

2.2. Assimilation Model and Change in Psychotherapy

The assimilation model (Stiles, 2011; Stiles et al., 1991) offers a way to synthesize this pattern of results. It suggests that, in successful therapy, problems progress through a sequence of stages or levels and that immersion and distancing may be emphasized at different points in these stages of change (Caro Gabalda & Stiles, 2009; Stiles et al., 1991).

The assimilation model suggests that the self is composed of multiple internal voices, which normally form a stable and organized structure called the community of voices (Honos-Webb & Stiles, 1998). The voices are composed of traces of past experiences. The traces (voices) are activated when current experiences are similar to those past experiences in some way. They

emerge to help the person deal adaptively with current experiences by using knowledge from the previous ones (Caro Gabalda & Stiles, 2009; Stiles, 2011). New experiences are usually assimilated smoothly, maintaining a stable and organized community structure (Stiles, 2011). Psychological distress arises, however, when the new experiences are not compatible with the community of voices, that is, when they are traumatic, painful, or grossly inconsistent with the usual self (Stiles, Osatuke, Glick, & Mackay, 2004). When the traces of such problematic experiences are addressed, they may produce strong negative affect and/or avoidance. That is, the self becomes selective and rigid in some respects, avoiding new experiences that are incompatible. For example, a dominant voice (representing the community) that takes the position "I should be perfect" may be incompatible with an experience that suggests "I am failing". A minor failure may produce strong negative affect and the voice of the failure experience may be avoided or suppressed. In psychotherapy, change (assimilation) occurs by the creation of meaning bridges, which are semiotic links between problematic voices and the community of voices (Stiles, 2011). Assimilation takes place in a sequence of stages (Stiles et al., 1991), from dissociation of the problematic voice (in extreme cases) to its complete assimilation. The sequence is summarized in the Assimilation of Problematic Experience Scale (APES; Caro Gabalda & Stiles, 2009; Stiles et al., 1991), shown in Table 7.

Table 7. Brief Description of Assimilation of Problematic Experiences Scale

Assimilation level	Cognitive content	Emotional content
0. Warded off/ Dissociated	Content is unformed; client is unaware of the problem.	Distress may be minimal, reflecting successful avoidance.
1.Unwanted thoughts/ Active avoidance	Content includes distressing thoughts. Client prefers not to think about it.	Strong negative feelings.
2.Vague awareness/ Emergence	Client acknowledges his problematic experience and describes the distressing thoughts, but cannot formulate the problem clearly.	Feelings include acute psychological pain or panic.
3.Problem statement/ Clarification	Includes a clear statement of a problem, that is, something that could be worked on.	Feelings are mainly negative but manageable, not panicky.
4.Understanding/ Insight	The problematic experience is placed into a schema, formulated, understood, with clear connective links (meaning bridge).	There may mixed feelings with some unpleasant recognitions, but also with curiosity or even pleasant surprise.
5.Application/ Working through	The understanding is used to work on a problem, so there are specific problem-solving efforts.	Affective tone is positive and optimistic.
6. Resourcefulness/ Problem solution	Client achieves a solution for a specific problem. As the problem recedes, feelings become more neutral.	Feelings are positive, satisfied and proud of accomplishment.
7. Integration/ Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

Note: adapted from Caro Gabalda and Stiles (2009)

2.3. Immersion and Distancing in the Assimilation Process

The assimilation model suggests that across the lower APES stages (0 to 2) the client progresses from dissociation or avoidance of problematic experiences to deeper and more vivid awareness. This entails increasingly powerful negative emotions (Stiles et al., 2004). To cast this in the immersion/distancing framework of the present study, the client may be expected to move from avoidance at APES 0 to full immersion in the problematic experience at APES 2. Subsequently, as the problem is formulated, understood, and mastered (APES 3 and higher), the client is increasingly able to analyse the experience from a broader perspective, promoting insight, creating alternatives and solving the problem (Caro Gabalda & Stiles, 2009; Stiles, 2011; Stiles et al., 1991). In immersion/distancing terms, the client should move from deep immersion at APES 2 to increasing distancing from the problematic experience at APES 3 and beyond. Putting this another way, at lower APES levels (particularly APES 2) the client speaks mainly *from* the problematic and dominant voices, whereas at higher APES levels of assimilation, the client can also speak *about* the problematic and dominant voices (Honos-Webb & Stiles, 1998).

In summary, the assimilation model suggests that therapeutic progress evolves from avoidance when the problem is warded off, to deep immersion as the problem emerges, and then to greater distancing, representing a broader, integrative perspective on the formerly problematic experience.

2.4. Purpose and Hypotheses of the Study

This study explored how immersion, distancing, and assimilation of a problematic experience evolved across sessions in a good outcome case of EFT. We tested the simple linear hypothesis that immersion would decrease and distancing would increase across successful therapy, as the person moves from a dysfunctional state to a normal state. We also examined the assimilation model's suggestion that immersion should be the main perspective at APES stage 2, whereas distancing should be increasingly prominent at higher APES stages. Looking more closely, we also sought to examine how both immersion and distancing are involved in the process of psychotherapeutic change. Our approach can be described as theory-building case study research (Stiles, 2009), intended to contribute to an assimilation model understanding of immersion and distancing phenomena. In theory-building research, each case has the ability to strengthen, weaken, or change the theory through new observations.

3. Method

3.1. Participants

Alice (a pseudonym) was a 26-year-old woman, Portuguese, single and Catholic. She was diagnosed with moderate major depressive disorder in the “Decentering and change in psychotherapy” study (Salgado, 2008), a randomized clinical trial that compared CBT with EFT

for depression. Alice was treated in the EFT arm of the study and was considered to have had a good outcome, as described later.

Alice's main problems concerned her insecurity and lack of assertiveness in her relationships with her parents, brother, boyfriend and at work. Alice felt unable to become independent of her parents or to oppose their conservative cultural values (e.g., to marry before living with her boyfriend, not to come home late). She was distressed by her parents' critical reaction to her failures in meeting those values and by her own need to be accepted by them. In addition, she was concerned about how she and her family had dealt with her father's past affair, a shared secret. In EFT terms, this unfinished business with her father was marked by self-interruption of her anger and resentment leading to un-symbolized body discomfort and symptoms when around him. In relation to the boyfriend, she felt that her needs were unmet, while she always gave in to his wishes; for example, she wanted marriage, but for him it was not important. At work she was passive, unable to assert her rights. At the beginning of the therapy she was working, in the middle she was unemployed due to the end of her work contract, and at the end of therapy she had started a new job. By the time of the last sessions, she had decided to live with her boyfriend. Alice was one of two cases considered in a study of setbacks in assimilation (decreases of one or more APES stages from one passage to the next), where it was shown that most of her setbacks were attributable to the therapist's directing her attention to relatively unassimilated strands of the problem being discussed (Mendes et al., 2016).

Alice's therapist was 31-year-old woman with a PhD in clinical psychology, a university faculty member. At intake, she had had 8 years of experience as a therapist and 1 year of clinical practice in EFT but had been pursuing training in EFT for 4 years. As part of the clinical trial, she received weekly group supervision conducted by an experienced EFT therapist.

3.2. Treatment

The "Decentering and change in psychotherapy" study used an EFT treatment manual that specifies intervention strategies for depression (Greenberg, Rice, & Elliott, 1993; see also Elliott et al., 2004). EFT is an empirically supported humanistic therapy (Elliott et al., 2004; Greenberg & Watson 2006). It aims to change maladaptive emotional processing following five principles: awareness, emotional arousal, emotional regulation, emotional reflection and emotional transformation (Elliott et al., 2004). Markers that indicate maladaptive emotional processing are associated with specific strategies to access maladaptive core emotional schema and transform them into adaptive emotional responses and new meanings. In treating depression, the first step of the intervention is to access the core of depression, namely the perception of self as weak or bad, by the fear and shame emotional schema in order to activate, approach, tolerate, accept and transform these emotions (Greenberg & Watson, 2006).

In Alice's case, the initial phase of the treatment (sessions 1 to 5) focused on empathic exploration and validation of her main needs and concerns. In the middle phase (sessions 6 to 11) work was directed toward her main difficulties in current relationships, including her lack of

assertiveness with her boyfriend and her boss, her unfinished business with her father, and her difficulties in dealing with transitional unemployment. In accomplishing this, the therapist used two chair work and focusing exercises, following the EFT treatment manual (Greenberg et al., 1993; see also Elliott et al., 2004). The final phase (sessions 12 to 16) was focused on consolidating personal agency and working through unfinished business with her father.

3.3. Measures

3.3.1. Beck Depression Inventory-II (BDI-II). The BDI-II (Beck, Steer, & Brown, 1996) was adapted for a Portuguese population by Coelho, Martins, and Barros (2002). The BDI-II is a self-report inventory designed to assess the severity of depression symptoms. It is composed of 21 items, each scored from 0 to 3. Total scores below 13 indicate depressive symptoms within normal range, scores from 14 to 19 indicate mild to moderate levels of depression, scores from 20 to 28 indicate moderate to severe depression, and scores above 29 indicate a severe level of depression. The Cronbach's Alpha was 0.89 (Coelho et al., 2002).

3.3.2. Global Assessment of Functioning (GAF) Scale. The GAF (APA, 2000) assesses the psychological, social and occupational functioning. This scale describes the symptoms and functional severity according to 10 levels and scale points ranging from 1 to 100. Ratings until 50 indicate that the global level of functioning is severely affected. Ratings from 51 to 100 indicate moderate to good global levels of functioning.

3.3.3. Assimilation of Problematic Experiences Scale (APES). As described earlier, the APES (Caro Gabalda & Stiles, 2009; Stiles et al., 1991) rates the degree of assimilation of a problematic experience on a scale of 8 stages or levels (scored 0 to7; see Table 7).

3.3.4. Measure of Immersed and Distanced Speech (MIDS). The MIDS is an observational measure that assesses immersion and distancing in client speech in transcribed sessions. This measure seeks to apply the theoretical definition of immersion and distancing to people's speech (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009; Kross et al., 2005; Kross et al., 2012).

As shown in Table 8, the MIDS infers immersed speech from *what statements* and *attributive statements*; and distanced speech from *insight statements* and *closure statements*. When none of these is appropriate, the speech is classified as *other*.

The immersed categories aim to identify the egocentric point of view. They include client speech in which there is a concrete construction of the experience, namely "what happened" through what statements, and "what did I feel" through attributive statements. In these categories are include the description of events, original thoughts, behaviors, feelings or internal states about client or others as experienced in the first person. The distanced categories aim to identify the

observer point of view. They include client speech focused on explaining and exploring the experience through the integration of different aspects of the experience (insight statements) or on a broader stance based on past and current experiences (closure statements). Distanced categories include statements that characterize insight or closure regardless of adaptiveness of the content expressed. That is, the MIDS construes the immersed and distanced perspectives as processes that place the self closer to or further from the experience– as an observer, respectively, whether or not the content expressed is adaptive. For example, if the client is establishing relationships between different facets of the experience (feelings, cognitions and events, for example), the statement is considered as distancing (insight statements), even if the content is not representative of the reality.

The study about MIDS's validation is under preparation (Barbosa, Silva, Castro, Pinto-Gouveia, & Salgado, 2016). Preliminary results show a high internal consistency for both immersion (α = .95) and distancing (α = .91), as well as a good to strong interrater reliability (Hill & Lambert, 2004) for raters' pairs (Cohen´s Kappa ranged from .75 to .96).

3.4. Procedure

Selection of the case. Inclusion criteria for the "Decentering and change in Psychotherapy" study were: the presence of major depressive disorder (mild or moderate); a GAF scale (APA, 2000) higher than 50; and no psychotropic medication. The exclusion criteria were other psychological or psychiatric treatment: high risk of suicide; current or previous diagnosis of one of the following DSM-IV Axis I disorders: panic, substance abuse, psychosis, manic-depression, or eating disorder; or one of the following DSM-IV Axis II diagnoses: borderline, antisocial, or schizotypal. The inclusion and exclusion criteria were assessed by the Structural Clinical Interviews for the DSM-IV-TR I (First, Spitzer, Gibbon, & Williams, 2002) and II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), and the BDI-II for Portuguese population (Coelho et al. 2002).

Alice was randomly assigned to EFT and to her therapist, and she completed 16 weekly sessions plus 6 follow-up sessions at 1, 3, 6, 9, 12 and 18 months after concluding treatment. She was considered a good-outcome case, showing reliable and clinically significant change on the BDI-II scores according to the criteria proposed by Jacobson and Truax (1991). Alice's BDI-II scores decreased from 22 to 1 from pre- to post-therapy, ending below the cut-off score of 13 points, with a decrease exceeding the Reliable Change Index of 7.75 for Portuguese version of the BDI-II (Coelho et al., 2002). The treatment and the collection and processing of data followed the ethical principles and standards of the American Psychological Association and the Code of Ethics of Portuguese Psychologists. Alice gave her informed consent for participation in all aspects of this research. Her personal information was de-identified to protect her anonymity.

3.4.1. Ratings of assimilation and of immersion and distancing. Alice's 16 sessions were transcribed following guidelines proposed by Mergenthaler and Stinson (1992). The

transcripts were analyzed following three steps: a) identification of the problematic experience, b) rating the problematic experience according to APES, and c) rating of the problematic experience according to the MIDS. The APES and MIDS were applied by different pairs of judges; each pair was blind to the results obtained with the other scale.

The two APES raters were women aged 26 and 30, with a master degree and a PhD in clinical psychology, respectively. As training for rating assimilation, they read and discussed journal articles and the APES rating manual (Honos-Webb, Stiles, & Greenberg, 2003), which included descriptions of formulating dominant and problematic voices. They then applied the APES to several EFT sessions of until they reached the reliability criterion, which was an Intraclass Correlation Coefficient (ICC; Shrout & Fleiss, 1979) higher than.70 (considered high reliability by Hill & Lambert, 2004). A team member with experience applying the assimilation model conducted this training, clarifying the coding system, answering questions and supervising the coding of the training sessions.

The analysis of the immersion and distancing involved a different team, comprising a 29-year-old female PhD student and a 29 year old man with a Master's degree in clinical psychology. Initially, the raters had training in unitizing procedures, dividing speech into segments following guidelines described by Hill and O'Brien (1999). The raters applied the unitizing procedures to four practice sessions, reaching an agreement above 90%. Then, these raters received training for MIDS coding, which consisted of reading relevant articles and manuals as well as practicing the coding procedures independently, in an EFT case, in which they met the reliability criterion of Cohen's kappa >.75 (see Hill & Lambert, 2004).

3.4.1.1. ***Identification of the problematic experience.*** The raters who identified Alice's problematic experience were those who later rated the APES levels. They began by reading all of the Alice's sessions, identified the main clinical issues, and excerpted all text that concerned them. The raters considered, by consensual judgment, that Alice's central problematic experiences involved two themes - "difficulty in being assertive" and "feeling hurt in relation to her father". The "difficulty in being assertive" theme occurred with more frequency (73.6% of the therapeutic process). This theme referred to her constant fear of disappointing others (family, boyfriend, colleagues) and not asserting her needs and rights. The theme "hurt towards her father" (7% of the therapeutic process) related to unfinished business with her father; she had great difficulty dealing with this issue or expressing hurt. Both themes were formulated as involving the following dominant and problematic voices: The dominant voice (i.e., Alice's usual self) was described as "submissive." This voice involved client's fear of being rejected and abandoned, which led her to inhibit her expression of feelings and needs. It was expressed in a pervasive interpersonal pattern marked by passivity in significant relationships (mother, father, brother, boyfriend, friends) and work. The problematic voice was described as "assertive". It was associated with expectations of rejection whenever she gave voice to her needs and rights, particularly her need to be accepted and her right of decide her own life and of express her hurt in

relation to the father's behavior (for more details, see Mendes et al., 2016).

3.4.1.2. ***APES rating.*** First, the two raters independently divided the text that concerned each problematic experience into separate passages. A passage, the coding unit for the APES, was the stretch of client speech delimited by a change in the theme or by markers of changes in APES levels, as described in the rating manual (Honos-Webb et al., 2003). The APES raters identified 554 such passages in Alice's 16 sessions. Finally, the raters rated the passages independently according to the APES. The experienced assimilation researcher supervised the APES rating procedures. Disagreements were resolved by consensus between raters (see Hill et al., 2005). Interrater reliability of the independent ratings was ICC (2, 2) =.97l.

3.4.1.3. ***Analysis of immersion and distancing.*** The passages representing Alice's central problematic experiences previously identified by the two APES raters were highlighted in the transcripts (with different colors), and the highlighted transcripts (but not the APES ratings) of Alice's 16 sessions were provided to MIDS raters. The first step of the analysis of immersion and distancing was dividing these passages into small units (essentially sentences) following guidelines proposed by Hill and O'Brien (1999). This unitizing was done independently by the two raters, who obtained an agreement level of 94% on a total of 9072 MIDS units. Raters discussed all unitizing discrepancies and resolved them by consensus (see Hill et al., 2005). Next, the coders independently coded each unit according to the MIDS (see Table 8), recording the presence or absence of the 3 types of speech: *immersion, distancing* and *others.* Interrater reliability was strong (Cohen's kappa was .88; Hill & Lambert, 2004). The disagreements were resolved by discussion between raters (see Hill et al., 2005).

Table 8. Brief Description of the Measure of Immersed and Distanced Speech

Type of speech	Categories	Contents	Examples
Immersed	What statements	Client describes a specific chain of events.	"He yelled at me and treated me badly."
			"He told me to back off."
		Client describes specific and original thoughts or behaviors	"I went to my room and cried for a long time."
			"My work is worthless."
	Attributive statements	Client ascribes characteristics to self or others without explaining or providing reasons to them.	"He was mean."
			"I was kind of stupid."
		Client describes feelings or other internal states.	"I feel sad."
			"I feel happy."
			"I have a great pain and a permanent restlessness."
Distanced	Insight statements	Client describes the causes underlying the event, his or her feelings, behaviors and cognitions.	"He does not respect me because I never established any limits."
		Client establishes relations between behaviors, feelings or cognitions.	"Maybe I reacted that way because I felt he rejected me."
		Client expresses new awareness about own behaviors, feelings or cognitions.	"It may have been somehow irrational but now I better understand my motivation then."
	Closure statements	Client indicates he or she assesses a past experience from a broad perspective, taking into account past and current experiences to make sense of feelings and experiences.	"I look back and I see that suffering had to do with how I interpreted criticisms. Now I know that critical remarks can be constructive and it does not mean that others do not like me."
		Client establishes relations (contrasts or similitudes) between past and present behaviors, feelings or cognitions.	"Today I know that I'm valued by my father."
			"Today I barely hugged my father, whereas before we were like brothers"
		Client express present feelings or thoughts about past experience or situations	"I thought about how glad I am that part of my past is over."
			"I see my past as a difficult moment of my life that brought implications in what I am today."

3.4.2. Qualitative and quantitative analysis of the data. To test the linear hypothesis that immersion would decrease and distancing would increase across successful therapy, we analyzed the trends of the APES and the MIDS across sessions and the relation of the APES ratings to the MIDS codes across sessions. For each session, prevalence of immersed and distanced speech was calculated as the frequency of units coded in each type of speech divided by

the total of number of MIDS units in that session, and this was compared with the mean APES ratings of assimilation in that session. Simulation Modelling Analysis (SMA) was used to compare these variables. SMA uses a bootstrap sampling method to minimize the statistical problems generated in case-based time series studies, including autocorrelation and low numbers of observations (see Borckardt et al., 2008 for technical details).

To assess the assimilation model's suggestion that immersion should be predominant at APES stage 2, whereas distancing should be increasingly prominent at higher APES stages, we examined the relative frequencies of immersion and distancing in passages at each assimilation level independently of the session in which this occurred. APES passages often included several MIDS units (essentially sentences), so there were many fewer APES ratings (554) than MIDS codes (9072) in the theme-relevant passages. We compared the MIDS code of each unit with the APES rating of the passage that contained that unit. Thus, for each APES level, the immersion and distancing proportions were calculated as the number of units given each MIDS code (immersion, distancing, or others) in passages rated at that APES level divided by the total of number of MIDS units in passages rated that APES level. That is, the unit of analysis for the comparison was based on the number of MIDS units.

Additionally, we examined the extent to which immersion and distancing occurred in the same passages. Our interpretations in this study are illustrated by selected passages. This procedure was inspired by Morrow (2005) who argued that "Just as numbers contribute to the persuasive 'power' of a quantitative investigation, the actual words of participants are essential to persuade the reader that the interpretations of the researcher are in fact grounded in the lived experiences of the participants" (p. 256). Such examples are considered as fundamental in theory-building case studies (Stiles, 2005), to provide readers with psychological proximity with phenomena being studied, conveying their characteristics and appreciation of the client's experience.

4. Results

4.1. Immersion and Distancing Across Successful Therapy

Figure 4 shows the relative frequency of immersion and distancing and the mean APES rating achieved in each session. The mean APES level was between 2 and 3 in session 1, and it reached a mean level of nearly 5 in the last session, showing that the problematic experience progressed from unresolved to resolved. The Spearman correlation of the mean APES rating with session number was, $r_s(16) = .75$, $p < .001$. Immersion was higher than distancing except in sessions 14 and 16, in which distancing was higher. Immersion tended to decrease across sessions, $r_s(16) = .76$, $p = .003$, and distancing tended to increase, $r_s(16) = .64$, $p = .003$. There was a negative relationship between assimilation and immersion, $r_s(16) = -.69$, $p = .002$, and a positive relationship between assimilation and distancing, $r_s(16) = .79$, $p < .001$.

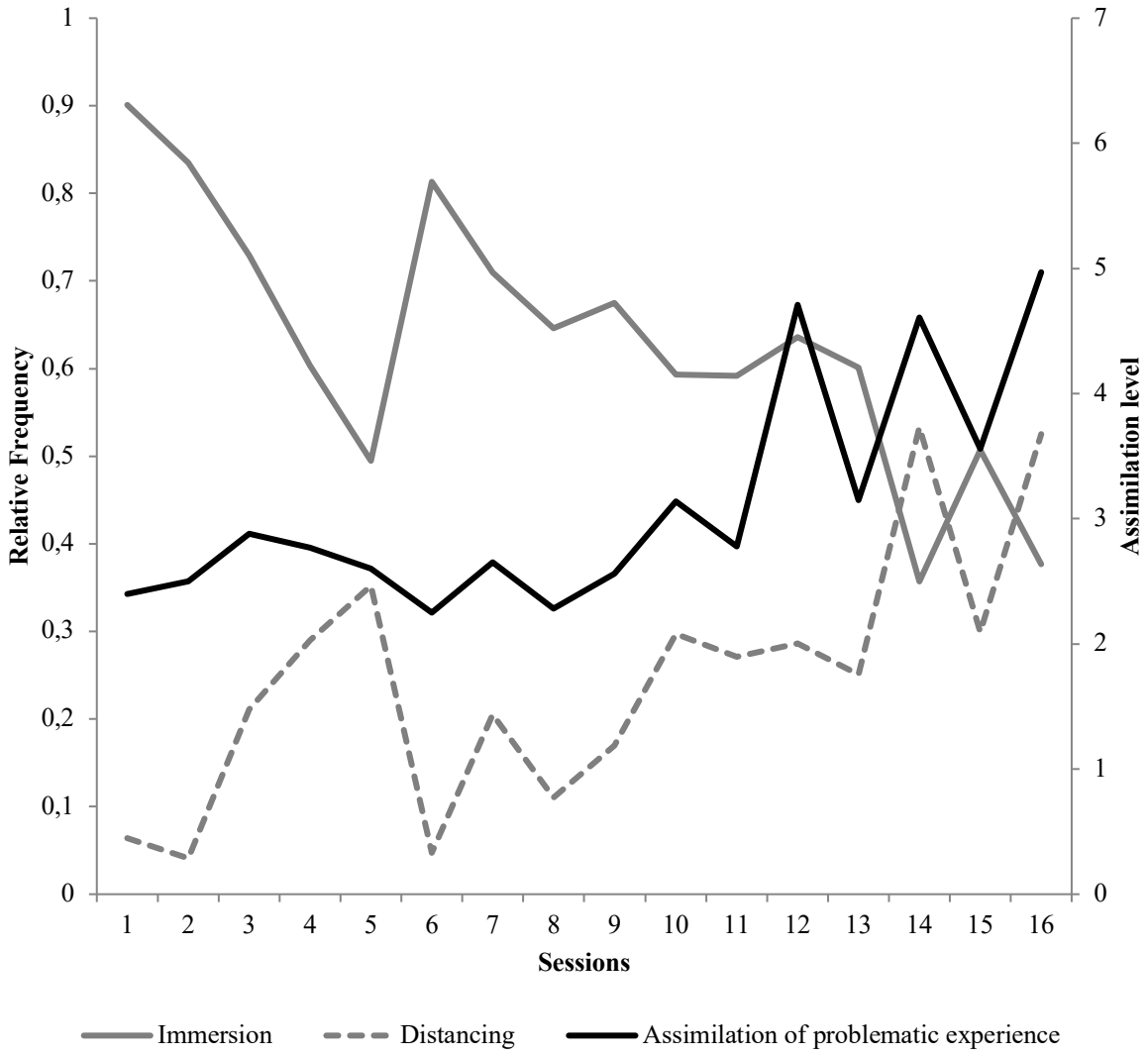

Figure 4. Immersion, distancing and assimilation across sessions

4.2. Immersion and Distancing at Different Assimilation Levels

Figure 5 shows the frequency of immersion and distancing in passages rated at each assimilation level independently of when the passage occurred. As suggested by the assimilation model, immersion was greatest (and distancing least) in passages rated at APES level 2 (vague awareness/emergence), where the problem was emerging and being confronted. Distancing exceeded immersion in passages rated at APES levels 4 (understanding/insight) and 6 (resourcefulness/ problem solution). Note that in passages rated at APES 1 (unwanted thoughts/avoidance), although immersion was predominant, distancing was greater than in passages rated at APES 2, consistent with some degree of avoidance. Note also that in passages rated at APES 5, immersion exceeded distancing; we address this unexpected observation in the Discussion section. APES levels 0 and 7 did not occur in Alice's transcripts.

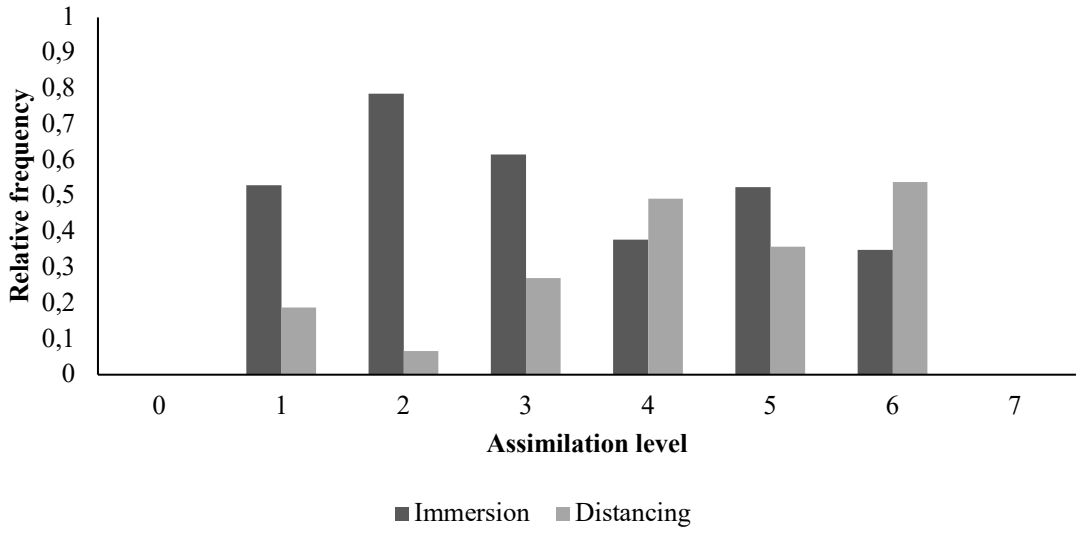

Figure 5. Immersion and distancing within each assimilation level

To convey the psychological meaning of these relations, we next illustrate how immersion and distancing appeared at each APES level. In the following excerpts, which were translated from Portuguese by the first author, text coded as immersion is shown in italics and text coded as distancing is underlined.

Level 1 - Unwanted thoughts/active avoidance. In the following examples, Alice avoided working on her unfinished business with her father. In the immersed perspective at this APES level, Alice focused on her avoidance of thinking about this issue, which seemed to stem from a fear of losing her ability to function in daily life.

> **Therapist**: Do you think that it is an experience that you would like to reflect on and work on here?
> **Alice**: *I don't know... I don't know...* [Immersion]
> **Therapist**: What is the meaning of "I don't know"? I'm curious (laughs).
> **Alice**: (laughs) *I don't know if I feel ready to talk about it.* [Immersion]
> **Therapist**: […] it is like: 'I have the feeling that the things are quiet right now and I am afraid of what will happen if I touch this box'. It is what happens inside you, right?
> **Alice**: *Yes, yes is exactly that.* [Immersion]
> **Therapist**: What are you afraid of?
> **Alice**: *I don't know how to deal with the whole situation, how to deal with my father… I don't feel good about this because when we're together, I'm more nervous, more anxious, more anguished…* [Immersion] (Session 6)

In the distanced perspective at APES level 1, Alice actually avoided the problematic experience, reflecting only on peripheral content of the experience with distancing language.

Therapist: [...] please explain to me a little better this problem, this difficulty. For me it seems that part of you agrees that to talk about this issue is the right thing to do, but another part of you does not accept that.
Alice: I'm aware that maybe to talk about it would be important for dealing with the relationship with my father, because it is a complicated relationship. Although I know this, and maybe he is also aware of it, we don't want to face the situation. [Distancing] (Session 6)

Level 2 - Vague awareness/emergence. The following examples also refer to the unfinished business with her father. In immersion at APES 2, Alice described uncomfortable thoughts and events, activating painful emotions associated with her experiences in a repeated and passive way. This example involved use of the empty chair technique.

Therapist: Do you remember the first time you controlled this anger?
Alice*: It was when I discovered that my father had someone else, because I wanted to tell him that I knew that, but I didn't.* [Immersion]
Therapist: Tell him here [in the empty chair] 'father I knew, I knew, I discovered'.
Alice: *Father I knew, I discovered and I could do nothing, I could not tell anyone.* [Immersion]
Therapist: And 'I felt' - what? Anger?
Alice: *Yes, anger*. [Immersion]
Therapist: More than that, right?
Alice: *I think I felt disgusted.* [Immersion]
Therapist: Ok. Tell him that.
Alice: *I felt disgust and anger.* [Immersion]
Therapist: 'How is it possible'?
Alice: *Yes, how is it possible?* [Immersion] (Session 15)

In distancing, which was very rare at APES 2 (see Figure 5), Alice observed the impact of the experience on her daily life. She reflected on her experience in a metaphoric way, exploring the problem (negative consequences) without concretizing it.

Alice: It's like those movies in which the father is our hero and then stops to be - - - it was what eventually happened. [Distancing]
Therapist: So tell him that.
Alice: Because everything that I thought, everything he made me feel like ´father is a good person and is there for me´... [Distancing]
Therapist: was lost.
Alice: …was lost, stopped, no longer exists. He remains always there but something was lost. [Distancing]
Therapist: Tell him what was lost, what he left, what he did.
Alice [still speaking to the therapist, not the empty chair]: Confidence, concept of family

and respect. [Distancing] (Session 15)

Level 3 - Problem statement/clarification. At this level, immersion and distancing occurred in a coordinated way, clarifying the problem. In the immersed perspective, Alice focused on illustrative episodes of the problem (what happened, what I thought, what I felt). In the distanced perspective, Alice observed and expressed the intentions, thoughts or feelings of herself and others that caused her suffering.

Alice: *On Sunday I went out with John and I arrived home at eleven o'clock. My parents were upset because I had not warned I would not dine at home [...] but I know that on Sunday my family does not dine [...] This situation made me criticize myself and think 'you are bad, you are being selfish, you only think about yourself, in your own well-being'.* [Immersion]
Therapist: What do selfish and bad people deserve?
Alice: They deserve - maybe I'm on the other side [distancing] (points to the other chair).
Therapist: Sit here.
Alice: (change chair)
Therapist: What did you do?
Alice: ...I did nothing wrong [...] in the same way that I should have called, they also could have called [...] [distancing]
Therapist: And what about 'you are bad, you are selfish'?
Alice: I'm not being selfish. Maybe my problem is not being selfish enough and not thinking a little more about me - what makes me happy... and thinking about what others will say or think, and if they will criticize my actions or not. [Distancing] (Session 10)

Level 4 - Understanding/insight. At this level, the change from immersion to distancing and distancing to immersion was more frequent. In immersion, Alice was not so focused on negative experiences that caused suffering. She described her own private experiences and experiences with other people that illustrated her problem. In distancing, Alice produced insights, establishing possible connections between the different experiences.

Alice: *I was watching an episode of Desperate Housewives* [...] *and one of the women had never felt pleasure during sexual intercourse. This episode showed the phase of her life in which it was established that, for women, sex was an obligation* [...] *so she did not enjoy it, she had no pleasure,* [immersion] and I looked at this and I thought that since my childhood I heard that the woman has to date, marry and have children... so, I associate the story of that episode to my life. [Distancing]
Therapist: So, you are talking about that critic voice
Alice: Yes, yes. It's closely linked to the education I had: 'It is not expected to be this way. What is expected is you to date, then marry and then have children'. [Distancing]
Therapist: Exactly.

Alice: and maybe what is expected for my life is too established in me, [distancing] *For example, I have male cousins from Lisbon and none of them is married […] but they always came on vacation and slept in my family's house with their girlfriends, which sometimes were different year after year. My parents never had any trouble about it* [immersion] […] I think this is the issue that sometimes really makes me stop, and feel sadder, more vulnerable. [Distancing] (Session 14)

Level 5 - Application/working through. In the immersed perspective at APES 5, Alice focused on events that illustrated a partial resolution of the problem. She described new actions, thoughts, and feelings that occurred in daily life. In the distanced perspective, Alice assessed the events, exploring the novelties and their impact in her life. In the following excerpt Alice talks about her decision of going on vacation with her boyfriend for the first time, and how it did not prevent her to job search.

Alice: [...] *I said 'I decided I'm going on vacation', I was very tired and after vacation I felt better, with energy* [...] *and I also took all documents that are need to apply for a job* [...] [immersion]
Therapist: Everything programmed.
Alice: *Yes everything programmed because if my curriculum became necessary, I would send it by e-mail or my parents would send it, so I thought, 'I did everything I could. If I really don't get the job, it was not for lack of effort'.* [Immersion]
Therapist: Mm-hm and so I can have peaceful vacation.
Alice: Because if I was not on vacation, I would continue to suffer and it just would make me worse […] [distancing]
Therapist: Mm-hm. How do you feel now after all this?
Alice: […] I feel the ideas are clearer, everything is much clearer. [Distancing] (Session 12)

Level 6 - Resourcefulness/problem solution. In immersion at APES 6, Alice described episodes and emotions associated with the problem resolution. In distancing speech, Alice reflected on how she was previously and how she is now, assuming a metacognitive stance. She offered an overview of how the changes occurred. Sometimes she started with a description of the change in her daily life, comparing the present with past behaviors or experiences. In this example, Alice started in immersed perspective, describing how her behavior was now different. Then, in distanced perspective, she compared her past and present experiences, describing the differences in daily life.

Therapist: What did people say? Who said it?
Alice: *My friends Mary and Susy. They say that I have a more positive attitude, more confident and that I don't have such difficulty in making decisions.* [Immersion]
Therapist: How does it feel to hear this from people who are close to you and know you

well?

Alice: *It's good, it's good. It's always nice to know that people have noticed differences, that I'm more positive, that I'm ok with myself* [immersion] […] now I start to think differently, I think 'they will accept if I do not go', but previously I did not think this was the right way, 'I have to go because if not, they will get upset with me' and I was afraid of the reactions of others, and now this doesn't happen. This is a way in which I have improved [...] [distancing]

Therapist: What happened with the fragile Alice, and with her fear?

Alice: The fear continues but it is a more positive fear; it's a part of us, it's a different fear. I do not feel the insecurity. I was an extremely insecure person in many aspects, and now I feel that I'm different, I'm a more secure person, more confident. [Distancing] (Session 14).

5. Discussion

Our observation that Alice's APES levels tended to increase across treatment supported the assimilation model's expectations for a good outcome case. Likewise, the observation that her psychological improvement was generally associated with a decrease in her relative frequency of immersion and increase in her relative frequency of distancing converges with the experimental studies that argued for the association of distancing with adaptive self-reflection on problematic experiences (Ayduk & Kross, 2010a, 2010b; Gruber et al., 2009; Kross & Ayduk, 2008, 2009; Kross et al., 2005; Verduyn et al., 2012) and for the association of immersion with negative psychopathologic states, such as depression (e.g., Ayduk & Kross, 2010a; Barbosa, Amendoeira et al., 2016; Barbosa et al., 2013; Barbosa, Silva, Pinto-Gouveia et al., 2016; Kross & Ayduk, 2009; Kross et al., 2005; Kross et al., 2012).

These findings could be seen as consistent with the suggestion that distancing is adaptive and immersion is harmful. However, the associations we observed do not demonstrate a causal direction, and some features of our results weigh against viewing immersion and distancing as causal. For one thing, immersion remained high throughout most of treatment, with the exception of the two final sessions. This result suggests that high immersion does not prevent improvement (cf. Barbosa, Amendoeira et al., 2016; Barbosa et al., 2013; Barbosa, Silva, Pinto-Gouveia et al., 2016). On the contrary, finding that substantial frequencies of immersion co-occurred with distancing at all assimilation levels suggest that immersion was also important in the therapeutic process. Indeed, immersion was more common than distancing at APES level 5, a stage of application and generalization of new understandings in daily life (Caro Gabalda & Stiles, 2009; Stiles et al., 1991). Thus, high immersion may not inevitably represent destructive rumination or negative processes as some authors have suggested (Ayduk & Kross, 2010a; Kross & Ayduk, 2009; Kross et al., 2005; Kross et al., 2012).

Finding that immersion was highest at APES level 2, as Alice was becoming aware of the problem, than at level 1, when she was avoiding it, is consistent with the assimilation model

suggestion that more immersion is associated with an adaptive (albeit painful) emergence of the problem, overcoming the avoidance (Varvin & Stiles, 1999). The EFT approach encourages immersion when emotions are being avoided, in order to activate and process them (Elliott et al., 2004). Finding that distancing predominated over immersion at APES level 4 (understanding/insight) and level 6 (resourcefulness/problem solution) suggests that distancing is associated with success in building meaning bridges and solving the problem. This converges with the suggestion that distancing is linked with reconstructing experience (Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009; Kross et al., 2005) and closure on problems (e.g., Kross et al., 2012).

Immersion and distancing may each play a role within each assimilation level. For example, in our illustration of APES level 1, Alice seemed to avoid confronting her unfinished business with her father. This involved immersion in her fear of losing functionality and also taking a distancing perspective on the central contents of the problematic experience. In this way, she avoided the painful emotions related with the problematic experience. Such avoidance may be considered as a form of emotional regulation (see Kennedy-Moore & Watson, 2001). However, it hinders access to aspects of the experience that are essential for problem resolution (e.g., Kashdan, Barrios, Forsyth, & Steger, 2006), suggesting that immersion and distancing used in this way are unproductive.

Finding the greatest relative frequency of immersion at APES levels 2 and 3, is consistent with the assimilation model's suggestion that an immersed perspective at these stages of the change process can reflect productive awareness (level 2) and clarification of the problem (level 3). Theoretically, in both the assimilation model and EFT, immersion is important for accessing the thoughts and powerful emotions (e.g. anger) associated with the problem. Immersion in episodes that illustrated the problematic experience (e.g. the episode in which Alice returned home late) served to focus on what happened and what Alice felt and thought. Immersion at an early or cathartic phase of therapy may reflect a need to confront and reveal painful feelings, which is consistent with the fever model's (Stiles, 1995) account of the benefits of self-disclosure. Later in the process, at APES level 4, the increase of distancing and decrease of immersion reflects work on assigning meaning to the experience. At this level Alice had insights moments, finding relations between different experiences (e.g., she found links between her education and her relationship with her boyfriend). Clients finding such links converges with the experimental suggestion that distancing is associated with the meaning making out of experience (Kross & Ayduk, 2011).

As shown in the passages illustrating APES levels 3 and 4, immersion and distancing seemed to occur in a more coordinated way in the middle stages, with frequent changes back and forth between them, yielding more adaptive and flexible views of the self and reality. This interaction between perspectives may have been facilitated by the reduced emotional threat of the problem at these levels, as compared to lower APES levels (Caro Gabalda & Stiles, 2009; Stiles et al., 2004). That is, at APES level 1 Alice was overwhelmed by the problematic experience, and

she avoided contact with the painful content. Then, as she achieved more emotional regulation, she was progressively able to reflect by alternating immersed and distanced perspective on central aspects of the problem in an integrative way (level 4).

The observation that Alice showed more immersion than distancing at APES level 5 (application/working through) was unexpected from both an assimilation model and an immersion/distancing perspective (see Figure 5). Taking in consideration that affect tends to be positive at level 5 (Caro Gabalda & Stiles, 2009), one possibility is that at this level, the immersion was in positive experiences, perhaps helping to sustain positive emotional states (Verduyn et al., 2012). Alternatively, the relatively higher frequency of immersion codes may be an artifact of the therapeutic situation. Because application of new understanding to daily life must be reported rather than achieved within the therapeutic hour, APES 5 ratings are given mainly for reports of events experienced outside therapy. Such narratives of life events tend to get immersed codes.

Our analysis has focused on client processes, but of course the therapist plays a role in the changes. EFT principles for treating depression indicate that in the early stages of treatment, therapists should attend to and validate clients' expressed feelings and current sense of self, establishing a collaborative focus on the presenting internal states (Greenberg & Watson, 2006). This therapist position is directly complementary with the client's immersed perspective. As client and therapist enact these reciprocal roles, clients become aware of their phenomenal experience and create a narrative that helps them to clarify their problem (Greenberg & Watson, 2006), which is congruent with therapeutic work at low assimilation levels (APES 2 - 3). At later stages of the treatment, EFT principles suggest that therapist promotes reflection on experience to create new meanings using therapeutic tasks like two chair work (Greenberg & Watson, 2006). These interventions are complementary with a distancing perspective, since they imply a differentiation of the self, allowing clients to observe the several parts of themselves and reflect about alternative ways to construe experience. As this happens, clients become able to make links among different contents of their experience and see alternative perspectives and solutions (Greenberg & Watson, 2006). This is consistent with therapeutic work at higher assimilation levels (APES 4 - 6). This progression could be seen in the interventions by Alice´s therapist, as described previously. Probably these evolving reciprocal roles in successful therapy are best understood as reflecting mutual influence, in which therapist both respond to and promote client immersion in poorly assimilated material and then, as the material is assimilated, both respond to and promote a more distancing perspective.

Depressed clients like Alice may tend to present in an immersed state, but clients with other disorders may have different requirements. For example, some studies of social phobia (Coles, Turk, Heimberg, & Fresco, 2001) and post-traumatic stress disorder (e.g., Berntsen, Willert, & Rubin, 2003), argue that client visualize anxiety memories from a persistent observer perspective, which may have an avoidance function, blocking adaptive confrontation of their experience. Perhaps in these situations distancing is associated with low assimilation of crucial

experiences at the beginning of the therapy (APES 1, avoidance), requiring therapeutic work to achieve immersion (APES 2).

6. Implications, Limitations and Future Research

This study can be considered as theory-building (Stiles, 2009) since its results directly addressed assimilation theory, and tentatively elaborated some aspects. The findings demonstrated a systematically changing pattern of immersion and distancing associated with rising APES levels in this good outcome case of EFT for depression. Showing that immersion was predominant in a good-outcome case is consistent with assimilation model expectations, though it challenges some immersion/distancing expectations. The observation that immersion and distancing seemed to alternate in systematic ways in the middle APES stages suggests a refinement in assimilation theory. Our observations also suggest a refinement of the immersion/distancing theory distinction between immersion in negative versus positive emotion, specifically distinguishing between immersion in problems (as in early APES stages) and immersion in narratives of solving problems (as at APES level 5).

Clinically, these observations could give therapists additional tools to identify the assimilation level of clients, giving information about what to expect and how to proceed. For example, deep immersion in problematic experiences may signal confrontation of problematic experiences at APES 2. Coordinated alternation between immersion and distancing (experiencing and observing) may signal coming to terms with the problem at APES 4. Research on cases presenting with other disorders and treated with other approaches is needed to assess and refine these suggestions.

As in any theory-building case study, the burden of generalization is borne by the theory; the observations are not meant to be generalized independently (Stiles, 2009). Any particular results could be specific to this particular case; however, a good theory must account for such distinctive details and may grow by accommodating them. Our results lend a small increment of confidence to the assimilation model's account of the interplay of immersion, distancing, cognition and emotion (Stiles, 2011), but further clinical cases will be important to support our interpretations.

7. References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR, 4th ed., Text Revision). Washington, DC: American Psychiatric Press, Inc.

Ayduk, Ö., & Kross, E. (2010a). Analyzing negative experiences without ruminating: The role of self-distancing in enabling adaptive self-reflection. *Social and Personality Psychology Compass, 4*, 841-854. doi: 10.1111/j.1751-9004.2010.00301.x

Ayduk, Ö., & Kross, E. (2010b). From a distance: Implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology, 98*, 809-829. doi: 10.1037/a0019205

Barbosa, E., Amendoeira, M., Bento, T., Teixeira, S., Pinto-Gouveia, J. P., & Salgado, J. (2016). *Immersion, distancing and emotional arousal: An intensive case study of a good outcome case of CBT.* Manuscript submitted for publication.

Barbosa, E., Lourenço, P., Amendoeira, M., Pinto-Gouveia, J. P., & Salgado, J. (2013, June). *Inmersión, distanciamiento y activación emocional en casos de éxito de terapia focalizada en la emoción y terapia cognitivo-conductual* [Immersion, distancing and emotional arousal in good outcome cases on emotion focused and cognitive behavioral therapy]. Paper presented at the VI Congresso Internacional de Psicologia Clínica, Santiago de Compostela, Spain. Retrieved from http://dmp.ismai.pt/2013-2014/Santiago.pdf

Barbosa, E., Silva, S., Castro, D., Pinto-Gouveia, J. P., & Salgado, J. (2016). *Development and validation of the Measure of Immersed and Distanced Speech.* Manuscript in preparation.

Barbosa, E., Silva, S., Pinto-Gouveia, J. P., & Salgado, J. (2016). *How and when the immersion and distancing are useful in emotion-focused therapy for depression*. Manuscript submitted for publication.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: The Psychological Corporation, Harcourt Brace & Company.

Berntsen, D., Willert, M., & Rubin, D. C. (2003). Splintered memories or vivid landmarks? Qualities and organization of traumatic memories with and without PTSD. *Applied Cognitive Psychology, 17*, 675–693.

Borckardt, J., Nash, M., Murphy, M., Moore, M., Shaw, D., & O'Neil, P. (2008). Clinical practice as natural laboratory for psychotherapy research. *American Psychologist, 63*, 77-95. doi: 10.1037/0003-066X.63.2.77

Caro Gabalda I., & Stiles, W. (2009). Retrocessos no contexto da terapia linguística de avaliação [Setbacks in the context of linguistic therapy of evaluation]. *Análise Psicológica, 27,* 199-212. doi: 10.14417/ap.205

Ciesla, J., & Roberts, J. (2007). Rumination, negative cognition, and their interactive effects on depressed mood. *Emotion, 7*, 555-565. doi: 10.1037/1528-3542.7.3.555

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive

symptoms among adolescents ascertained by the Beck Depression Inventory II. *European Psychiatry, 17*, 222-226. doi: 10.1016/S0924-9338(02)00663-6

Coles, M. E., Turk, C. L., Heimberg, R. G., & Fresco, D. (2001). Effects of varying levels of anxiety within social situations: Relationship to memory perspective and attributions in social phobia. *Behavior Research & Therapy, 39*, 651–665.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. (2004). *Learning emotion-focused therapy: The process-experiential approach to change.* Washington, DC: America Psychology Association.

First, M. B., Spitzer, R. L, Gibbon, M., & Williams, J. B.W. (2002). *Structured clinical interview for DSM-IV-TR Axis I disorders, research version (SCID-I-RV)*. (A. Costa Maia, Trans.). New York: Biometrics Research.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin L. S. (1997). *Structured clinical interview for DSM-IV Axis II personality disorders* (SCID-II) (J. Pinto-Gouveia, A. Matos, D. Rijo, P. Castilho, & M. Salvador, Trans.). Washington, DC: American Psychiatric Press, Inc.

Greenberg, L. S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by moment process*. New York: Guilford Press

Greenberg, L., & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.

Gruber, J., Harvey, A., & Johnson, S. (2009). Reflective and ruminative processing of positive emotional memories in bipolar disorder and healthy controls. *Behaviour Research and Therapy, 47*, 697-704. doi: 10.1016/j.brat.2009.05.005

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi: 10.1037/0022-0167.52.2.196

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84-136). Hoboken, NJ: John Wiley & Sons, Inc.

Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight and action*. Washington, DC: American Psychological Association.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35,* 23-33. doi: 10.1037/h0087682

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50*, 189-198. doi: 10.1037/0022-0167.50.2.189

Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12-19. doi: 10.1037/0022-006X.59.1.12

Kashdan T. B., Barrios V., Forsyth J. P., & Steger, M. F. (2006). Experiential avoidance as a

generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy, 44*, 1301-1320. doi:10.1016/j.brat.2005.10.003

Kennedy-Moore, E., & Watson, J. (2001). How and when does emotional expression help. *Review of General Psychology, 5*, 187-212. doi: 10.1037/1089-2680.5.3.187

Kross, E., & Ayduk, Ö. (2008). Facilitating adaptive emotional analysis: Distinguishing distanced-analysis of depressive experiences from immersed-analysis and distraction. *Personality and Social Psychology Bulletin, 34*, 924-938. doi: 10.1177/0146167208315938.

Kross, E., & Ayduk, Ö. (2009). Boundary conditions and buffering effects: Does depressive symptomology moderate the effectiveness of distanced-analysis for facilitating adaptive self-reflection?. *Journal of Research in Personality, 43,* 923-927. doi: 10.1016/j.jrp.2009.04.004

Kross, E., Ayduk, Ö. (2011). Making meaning out of negative experiences by self-distancing. *Current Directions in Psychological Science, 20*, 187-191. doi: 10.1177/0963721411408883

Kross, E., Ayduk, Ö., & Mischel, W. (2005). When asking ‘‘why’’ does not hurt: Distinguishing rumination from reflective processing of negative emotions. *American Psychological Society, 16*, 709-715. doi: 10.1177/0963721411408883

Kross, E., Gard, D., Deldin, P., Clifton, J., & Ayduk, Ö. (2012). “Asking why” from a distance: Its cognitive and emotional consequences for people with major depressive disorder. *Journal of Abnormal Psychology*, *121*, 559-569. doi: 10.1037/a0028808

Mendes, I., Rosa, C., Stiles, W. B., Caro Gabalda, I., Gomes, P., Basto, I., & Salgado, J. (2016). Setbacks in the process of assimilation of problematic experiences in two cases of emotion-focused therapy for depression. *Psychotherapy Research, 2,* 1-15. doi: 10.1080/10503307.2015.1136443.

Mergenthaler, E., & Stinson, C. (1992). Psychotherapy transcription standards. *Psychotherapy Research, 2,* 125-142. doi: 10.1080/10503309212331332904

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260. doi: 10.1037/0022-0167.52.2.250

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*, 467-482. doi: 10.1016/0010-0285(83)90016-6

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*, 400-424. doi: 10.1111/j.1745-6924.2008.00088.x

Robinson, J. A., & Swanson, K. K. (1993). Field and observer modes of remembering. *Memory, 1*, 169-184. doi: 10.1080/09658219308258230

Salgado, J. (2008). *Decentering and change: Grant project PTDC/PSI/PCL/103432/2008*.

Unpublished manuscript. FCT: Portuguese Foundation for Science and Technology.

Shrout, P. E., & Fliess, J. L. (1979). Intraclass correlations: Users in assessing rater reliability. *Psychological Bulletin, 86*, 420-428. doi: 10.1037/0033-2909.86.2.420

Stiles, W. B. (1995). Disclosure as a speech act: Is it therapeutic to disclose? In J. W. Pennebaker (Ed.), *Emotion, disclosure and health* (pp. 71-91).Washington, DC: American Psychological Association.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy, 5*, 9-22. doi: 10.14713/pcsp.v5i3.973

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384. doi: 10.1080/10503307.2011.582186

Stiles, W. B., Morrison, L. A., Haw, S. K., Harper, H., Shapiro, D. A., & Firth-Cozens, J. (1991). Longitudinal study of assimilation in exploratory psychotherapy. *Psychotherapy*, *28*, 195-206. doi: 10.1037/0033-3204.28.2.195

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans, & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Takagishi, Y., Sakata, M., & Kitamura, T. (2013). Influence of rumination and self-efficacy on depression in Japanese undergraduate nursing students. *Asian Journal of Social Psychology, 16*, 163-168. doi: 10.1111/ajsp.12000

Varvin, S., & Stiles, W. B. (1999). Emergence of severe traumatic experiences: An assimilation analysis of psychoanalytic therapy with a political refugee. *Psychotherapy Research, 9*, 381-404. doi:10.1080/10503309912331332821

Verduyn, P, Mechelen, I. V., Kross, E., Chezzi, C., & Bever, F. V. (2012). The relationship between self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion, 12*, 1248-1263. doi: 10.1037/a0028289

ESTUDO 4 – FLEXIBILITY BETWEEN IMMERSION AND DISTANCING: A DYNAMIC PATTERN THAT BENEFITS SYMPTOMATIC IMPROVEMENT IN DEPRESSION

Barbosa, E., Sousa, M., Pinto-Gouveia, & Salgado (2019). Flexibility between Immersion and Distancing: A Dynamic Pattern that Benefits Symptomatic Improvement in Depression. Manuscript submitted for publication.

1. Abstract

High levels of change are associated with transitions between immersion (first-person perspective) and distancing (third-person perspective), suggesting that a dynamic pattern between them may result in a more adaptive view of reality. This study aimed to assess if greater flexibility between these perspectives during clients´ reflection on negative experiences in the intermediate phase is associated with a reduction in depressive symptoms at the end of therapy. We analyzed the flexibility through frequency and magnitude of changes between immersion and distancing, in representative sessions of the intermediate phase of therapy in 17 cases with depression. The results showed that an increase in the frequency of changes predicted a decrease in depressive symptoms. Conversely, the magnitude of these transitions was negatively associated with those symptoms. Immersion and distancing seem to work as dynamic processes, and greater flexibility between them seems to bring an adaptive pattern associated with positive changes in depressive symptomatology.

Keywords: immersion, distancing, dynamic systems theory, depressive symptoms

2. Introduction

Distancing and immersion are two contrasting reflective perspectives that through which, a person may view his or her own personal experience. In immersion, the person adopts a first-person perspective, while in distancing, he or she reflects on personal events in a third-person, or observational, stance. Previous studies have found that a decrease in immersion and an increase in distancing at the end of psychotherapy were associated with good outcomes (e.g., Barbosa, Amendoeira et al., 2017; Barbosa, Silva, Pinto-Gouveia & Salgado, 2017; Couto et al., 2016). Up to now, these results have been interpreted as the consequence of a linear or progressive association between clinical improvement and the development of the clients' perspectives that are used to reflect on their experiences. In other words, throughout the treatment, the client becomes increasingly able to reflect less as "the self that experienced the event" (i.e., the immersed perspective, see Nigro & Neisser, 1983; Robinson & Swanson, 1993) and more able to reflect as "the self separate from their initial experiencing self" by adopting an observational stance (i.e., the distanced perspective, see again Nigro & Neisser, 1983; Robinson & Swanson, 1993). Thus, a linear movement from immersion to distancing is key to the success of psychotherapy.

A complementary view, however, is also worth considering. It is possible to argue that in cases with good outcomes, at a more detailed level, immersion and distancing are feeding each other in cyclical and dynamic ways, creating greater flexibility in the kind of perspective assumed. In other words, patients feel better when they gain the capacity to perform repetitive cycles between immersion and distancing. So, the person starts by being immersed in negative experiences but then switches to an observational distanced stance, which in turn creates a new immersed experience that feeds new forms of distancing, and so on. A recent deeper analysis of a case suggested precisely this more dynamic view by finding high levels of change to be associated with transitions between immersion and distancing in therapy (Barbosa et al., 2018). The evolutionary pattern of a client's perspective may therefore be nonlinear or unstable, or in other words, the change may involve periods of greater flexibility between the immersed and distanced perspectives. This means the therapeutic process can be described as a cycle in which the person becomes increasingly able to shift between immersion and distancing.

This assumption accords with dynamic systems theory, which argues that periods of instability, which are characterized by greater flexibility in the way these processes occur, require a new and more adaptive self-configuration to be achieved. Moreover, instability has been associated with psychotherapeutic change (Fisher, Newman, & Molenaar, 2011). On this basis, the present study intended to assess, for a clinical sample being treated for depression, whether more flexibility in the client's perspective about his or her experience is associated with better outcomes in depressive symptoms at the end of psychotherapy.

2.1. The Linear Pattern between Immersion and Distancing during Therapy for Depression

When making sense of their past personal experiences, people reflect on them according to an immersed or distanced perspective. In the immersed perspective, people live in the experience (Nigro & Neisser, 1983; Robinson & Swanson, 1993), reflecting on it with the same eyes through which they experienced the event (i.e., in the first person) (Ayduk & Kross, 2010b). People therefore focus on specific details of an experience (e.g., Kross, Ayduk, & Mischel, 2005; Kross, Gard, Deldin, Clifton, & Ayduk, 2012), and the current thoughts, feelings, and behaviors accord with those experienced in the past (McIsaac & Eich, 2004; Nigro & Neisser, 1983; Robinson & Swanson, 1993). An example account of an immersed perspective would be as follows: "We were having dinner when my father told me that I have to send more job applications because it will be very difficult for me to land a job. I just wanted to cry. I feel frustrated. No one believes in me and in my abilities."

In contrast, with the distanced perspective, the person adopts a different position regarding the experience, namely that of an observer (Nigro & Neisser, 1983; Robinson & Swanson, 1993), thus reflecting on it as a third person (Ayduk & Kross, 2010b). In this perspective, people have a broader vision of the experience, seeing themselves as if looking through someone else's eyes (Kross et al., 2012; Nigro & Neisser, 1983; Robinson & Swanson, 1993). People therefore focus more on explaining and exploring the feelings, thoughts, and behaviors, integrating them in a way of insight and closure (e.g., Kross et al., 2005; Kross et al., 2012). An example account of the same experience as above with a distanced perspective could be as follows: "My father is like this with everyone. He has to encourage us by pointing out what we have not accomplished and what we need to do, so I was using the fact that I still do not have a job as evidence that I am failing."

According to several experimental studies, these two perspectives of the self for recalling an experience have different implications for the way people feel (e.g., Ayduk & Kross, 2008; Kross et al., 2012; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008), perceive the experience (e.g., Ayduk & Kross, 2010b; Kross & Ayduk 2008, 2009), and behave (e.g., Mischkowski, Kross, & Bushman, 2012). These implications have piqued the interest of researchers and led to them studying these two phenomena in psychotherapy. Research thus far into immersion and distancing across the therapeutic process has also shown the potential benefits of these two perspectives when people with depression reflect on their negative experiences (Barbosa, Amendoeira et al., 2017; Barbosa et al., 2018; Barbosa, Silva, Pinto-Gouveia et al., 2017). Studies conducted with specific therapies, namely emotion-focused therapy (EFT, see Barbosa, Silva, Pinto-Gouveia et al., 2017; Barbosa et al., 2018) and cognitive-behavioral therapy (CBT, see Barbosa, Amendoeira et al., 2017), indicate that a decrease in immersion and an increase in distancing is a common evolutionary pattern over the therapeutic process in good outcome cases where people had been previously diagnosed with depression. In contrast, high levels of immersion and low levels of distancing throughout therapy characterized the prevalent

perspective patterns in poor outcome cases, showing that the perspective used to recall negative experiences across the therapeutic process remained stable (Barbosa, Silva, Pinto-Gouveia et al., 2017). Moreover, in these studies, the change in a client's perspective over the course of therapy, from more immersion to more distancing, was related to a reduction in depressive symptoms to non-clinical levels (Barbosa, Amendoeira et al., 2017, Barbosa, Silva, Pinto-Gouveia et al., 2017), as well as to a lower frequency of negative emotions and a higher frequency of positive emotions (Barbosa, Amendoeira et al., 2017). These findings suggest that a progressive increase in the use of distancing helps achieve therapeutic success, while in contrast, continuous and excessive immersion results in persistent clinical symptoms (Barbosa, Silva, Pinto-Gouveia et al., 2017) and negative emotions (Barbosa, Amendoeira et al., 2017). In fact, several experimental studies argue that distancing is an adaptive perspective when reflecting on negative experiences, since in this perspective, people see a "bigger picture" of these experiences (Ayduk & Kross, 2010b, p. 810), revealing several of their facets and consequently facilitating a comprehensive analysis, the construction of new meanings (Ayduk & Kross, 2010b; Kross & Ayduk, 2011; Kross et al., 2012), and the resolution of problems (e.g., Ayduk & Kross, 2008, 2010b). In contrast, from an immersed perspective, people have a smaller and more simplistic picture of the experience, so in attempt to make sense of it, they focus on the concrete and painful details of the experience, which then feeds ruminative cycles (Nolen-Hoeksema et al., 2008) and increases the intensity (Kross et al., 2014; Kross et al., 2012) and duration of the negative affect (Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012). Although such results associate immersion with psychopathological states, clinical studies argue that the negative effects of immersion only occur when immersion is used excessively and persistently (Barbosa, Silva, Pinto-Gouveia et al., 2017). When immersion is followed by greater distancing, however, it can have positive therapeutic effects, especially at the beginning of the therapy (Barbosa, Amendoeira et al., 2017; Barbosa, Silva, Pinto-Gouveia et al., 2017; Barbosa et al., 2018). More specifically, in a study with a sample of cases treated through EFT, the good outcome cases started the therapy with significantly higher levels of immersion than the poor outcome cases (Barbosa, Silva, Pinto-Gouveia et al., 2017). What is more, in these cases, immersion and distancing co-existed despite a significant increase in distancing over therapy, and overall, immersion remained a dominant perspective, even when symptoms dropped below the clinical threshold (Barbosa, Amendoeira et al., 2017; Barbosa, Silva, Pinto-Gouveia et al., 2017). Furthermore, empirical findings show that more immersion is needed to overcome avoidance and become aware of a problem, even if it implies a more negative affect (Barbosa et al., 2018). These findings support the existence of a progressive or linear evolutionary pattern regarding the client's perspective for experiences, one in which greater immersion is beneficial at the beginning of therapy as long as it is followed by a subsequent increase in distancing throughout the therapeutic process, because this is associated with best outcomes (Barbosa, Amendoeira et al., 2017; Barbosa, Silva, Pinto-Gouveia et al., 2017) and a resolution of the problematic experience (Barbosa et al., 2018). However, these studies analyzed the global data obtained in therapeutic sessions to study the global level of

distancing and immersion in the sessions, but they did not consider the potential dynamics between these two processes. This requires a more fine-grained analysis of the dynamics of these phenomena as they happen over time in a session.

2.2. The Dynamic Pattern between Immersion and Distancing in Therapy for Depression

A recent, more detailed study about the relationship between immersion/distancing and levels of change in therapy showed coordinated and frequent transitions between immersion and distancing to lead to higher levels of change (Barbosa et al., 2018). For example, in this case, at level 6 of change (on a scale ranging from 0 [avoidance of the experience] to 7 [mastery of the problem]), an immersed perspective occurred while the client described her new behavior in daily life regarding her problem, followed by a distanced perspective in which the client observed and compared these behaviors with regards to those that occurred in the past. Therefore, immersion and distancing can occur in a dynamic way that seems to be associated with "more adaptive and flexible views of the self and reality" (Barbosa et al., 2018, p. 325). In fact, there is empirical evidence to show that change within psychotherapeutic processes occurs in discontinuous and nonlinear ways (e.g., Gumz, 2010; Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007).

Dynamic systems theory argues that instability promotes the destabilization or loosening of problematic patterns (Hayes et al., 2007). Problematic patterns refer to a rigid and stable self-organization, one that is characterized by restricted and inflexible patterns of thoughts, feelings, and behaviors that make it difficult for the individual to deal with new situations and to construct new and more adaptive meanings for an experience. This stable configuration of the self across time increases the vulnerability to psychopathology (Fisher et al., 2011). Depression is an example of the absence of flexibility in such self-organization. People with depression experience events as undifferentiated, seeing the world in the present and in the future as empty, hopeless, and unpleasant. In addition, in these people, the negative emotional state and/or an inability to derive pleasure from the environment remains stable at different situations (Abramson, Metalsky, & Alloy, 1989; Fresco, Williams, & Nugent, 2006). Flexibility is needed to break the problematic state of a maladaptive and rigid stability of the self (Fresco et al., 2006; Kashdan & Rottenberg, 2010; Moore & Fresco, 2007). Increasing flexibility requires instability in the personal system, in which critical fluctuations occur (Ebner-Priemer, Kleindienst, Trull, & Stabenow, 2009; Hayes et al., 2007; Schiepek, 2009; Schiepek & Strunk, 2010; Schiepek, Tominschek, & Heinzel, 2014). In therapy, flexibility is promoted through therapeutic work, since therapeutic interventions facilitate the gradual creation and assimilation of new inputs into the self, which then leads the system to a chaotic and unstable state (Fisher et al., 2011).

Moreover, several studies have shown an association between destabilization and better therapeutic outcomes (e.g., Gumz et al., 2010; Hayes et al., 2007; Schiepek et al., 2014). Following the destabilization of the system, a more adaptive configuration of the self is achieved by returning to a state of homeostasis or stability (Fisher et al., 2011). For example, clinical

symptoms are expected to decrease gradually throughout the therapeutic process, reaching significant clinical improvements by the end of treatment (Schiepek et al., 2014). However, before the symptoms stabilize at non-clinical levels, several studies have found fluctuations in clinical symptoms during treatment, and these have been associated with therapeutic change (e.g., Ebner-Priemer et al., 2009; Gumz et al., 2010; Schiepek, 2009; Schiepek & Strunk, 2010; Schiepek et al., 2014).

In line with these findings, we expected that periods of flexibility between perspectives (i.e., dynamic transitions between immersion and distancing), when re-experiencing and observing the negative experience, may create a positive impact on the rigid way that the self reflects on it. Thus, we hypothesize that the change pattern characterized by the decrease in immersion and increase in distancing may represent a more macroscopic view of a more dynamic microscopic model of transition between the immersed and distanced perspectives, which is associated with a positive clinical change. Specifically, more flexibility in the reflection on the negative experience, as characterized by the ability to move more easily from one perspective to another, may lead to an effective improvement in depressive symptoms.

2.3. Purpose and Aims of the Present Study

We analyzed immersion and distancing moment-by-moment in a clinical sample with depression in order to assess how the level of flexibility in the clients' reflection patterns for negative experiences, during the working phase of the therapy, was related to the clinical symptoms at the end of treatment. We used the frequency and magnitude of the changes between immersion and distancing, which in turn allowed assessment of the nonstationary phenomena in short time-series (Ebner-Priemer et al., 2009; von Neumann, Kent, Bellinson, & Hart, 1941) as measures of flexibility. We expect a positive relationship between frequency and improvement in depressive symptoms and a negative relationship between magnitude and improvement in depressive symptoms. Furthermore, should the results confirm this hypothesis, it is also our aim to illustrate how the flexibility between immersion and distancing emerged in clients' speech, presenting excerpts from two clinical cases in the sample in order to exemplify high and low flexibility.

3. Method

3.1. Clients

This study included 17 clients, comprising 14 women (82%) and 3 men (18%) aged between 20 and 48 years, $M = 33.06$, $SD = 9.48$. Nine clients were single, five were married, and three were divorced. Just one client completed the 6th grade, one the 9th grade, five the 12th grade, and ten had higher education. Nine clients were professionally active, nine were unemployed, two were students, and one was a student worker. These clients were part of a sample of a randomized clinical trial (RCT) entitled "Decentering and change in psychotherapy – ISMAI Depression

Study" (Salgado, 2014). This RCT aimed to compare the clinical efficacy of EFT and CBT for clients diagnosed with depressive disorders. All participants met the following inclusion criteria: (a) diagnosed with a major depressive disorder; (b) not taking medication; and (c) a global assessment of functioning score higher than 50. The exclusion criteria were (a) a high risk of suicide; (b) currently receiving other treatment for depression; (c) current or previous diagnosis of one of a number of DSM-IV Axis I Disorders – namely panic, substance abuse, psychosis, bipolar, eating disorder – or one of a number of DSM-IV Axis II Disorders – namely borderline, antisocial, narcissistic, or schizotypal. For the assessment of these criteria, the Structural Clinical Interview was used to assess the DSM-IV-TR I (First, Spitzer, Gibbon, & Williams, 2002) and II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997), as well as the Beck Depression Inventory-II (BDI-II) for the Portuguese population (Coelho, Martins, & Barros, 2002). The therapeutic modality was randomly assigned to each client. Both EFT and CBT comprised 16 weekly sessions of psychotherapy, which were video recorded. The 17 clients who participated in the present study were randomly selected from the 50 clients who completed all 16 sessions. Ten clients were treated through EFT, while seven clients were treated through CBT. There were no significant differences regarding clients' demographic variables between the EFT and CBT groups, namely with respect to gender, $\chi^2(1) = 2.55$, $p = .110$, age, $U = 34.00$, $p = .922$, civil status, $\chi^2(2) = 1.036$, $p = .596$, education level, $U = 29.50$, $p = .542$, and professional occupation, $\chi^2(3) = 3.56$, $p = .313$. All participants signed an informed consent form authorizing the analysis of their data for scientific publication. This document stated the purposes and procedures of the RCT, and in particular, provided information about the anonymization of their personal data in order to ensure the confidentiality.

3.2. Therapists

This sample received therapy from a total of ten therapists, each of which treated 1–3 clients in this study. The EFT group comprised five therapists (three females and two males aged between 31 and 45 years, $M = 35.4$, $SD = 4.57$. These therapists had 1–20 years of clinical experience and 1–4 years of experience in the EFT therapeutic model. The CBT group comprised five female therapists (aged 27–37 years, $M = 31.6$, $SD = 3.56$). They had 2–12 years of clinical experience and 1–12 years of clinical experience in the CBT therapeutic model. Both groups received six months of training (80 hours) in the protocol of the respective therapeutic modality, as well as weekly supervision.

3.3. Therapy

As stated previously, the clients in our sample were treated through EFT or CBT, following the intervention protocols used in the ISMAI Depression Study (Salgado et al., 2010). The EFT protocol was based on the work of Greenberg and Watson (2006) and Elliott, Watson, Goldman and Greenberg (2004) on EFT intervention for depression. According to this protocol, and to EFT principles, the therapists encourage clients to access their maladaptive emotional

schemes and through emotional processing, transform them into more congruent and adaptive ones. With emotional processing, EFT helps clients to be able to create new meanings, as well as more adaptive emotional responses, that are more compatible with their needs.

The CBT protocol was based on the protocol for depression described by Beck, Rush, Shaw and Emery (1979). According to this protocol, and to CBT principles, clinical problems are caused and maintained by dysfunctional interpretations of reality that have negative consequences in the way people feel and behave, leading to negative behavioral patterns that exclude a satisfactory life. CBT aims to change dysfunctional beliefs and behaviors, in order to change emotional states, by creating alternative beliefs and thoughts more oriented toward adaptive views about an experience, as well as by providing clients with tools for problem-solving, behavioral activation, and self-control (Beck, 2011; Beck et al., 1979).

3.4. Measures

3.4.1. BDI-II. This study used the BDI-II (adapted for the Portuguese population) of Coelho et al. (2002) based on that of Beck, Steer, & Brown (1996). This self-reported questionnaire allows the measurement of the severity of depressive symptoms. The questionnaire comprises 21 items scored on a Likert scale ranging from 0 to 3. The total score therefore ranges from 0 to 63, with a total score over 13 indicating that depression symptoms are clinically significant. More specifically, scores of 14–19 represent mild-to-moderate levels of depression, scores of 20–28 represent moderate-to-severe depression, and a score of 29 or more represents a severe level of depression. The Cronbach's alpha was calculated to assess the internal consistency of the questionnaire in this study and was found to be .89. The Portuguese versions of the BDI-II's obtained psychometric qualities that were congruent with the original version (Coelho et al., 2002).

3.4.2. Measure of immersed and distanced speech (MIDS). The MIDS is an observational measure that assesses immersed and distanced perspectives by analyzing the client's speech in the transcribed sessions. Based on theoretical definition and prior research on immersion and distancing (e.g., Ayduk & Kross, 2010b; Kross & Ayduk, 2008, 2009; Kross et al., 2005; Kross et al., 2012; Nigro & Neisser, 1983; Robinson & Swanson, 1993), MIDS classifies the client's speech as immersed or distanced according to five mutually exclusive categories. The "*what statements"* and *"attributive statements"* are the immersed speech categories, and they allow the identification of the first-person perspective. These statements focus on describing "*what happened/what did I think*" (*what statements*) or "*how did I feel*" (*attributive statements*) in the experience and are characterized by the presence of details of events, thoughts, feelings, and behaviors as they happened in the situation experienced by the client. The "*insight statements"* and "*closure statements"* comprise the distanced speech categories, and they allow the identification of the observer perspective. These statements focus

on explaining and/or exploring the experience and are characterized by the exploration and integration of several particularities of the experience (*insight statements*) or an overall view about the experience that also considers present and past experiences (*closure statements*). When an identification of these categories is not possible, the speech is classified as "*other statements*".

It should be noted that MIDS aims to identify the immersed or distanced perspective by considering the contents of statements that according to empirical data, show the egocentric or the observer perspective independently of the adaptive character of that content. For example, when the client reflects about the experience while showing a connection between thoughts, feelings, and behaviors (*insight statements*) or making conclusions about the experience while taking into account current and past experiences (*closure statements*), that statement is classified as distanced speech, even if the content itself is biased or dysfunctional.

The preliminary results for the psychometric qualities of MIDS indicated a Cronbach's Alpha of .95 for immersion and 0.91 for distancing, with the interrater reliability for the coders' pairs ranging from .75 to .96 (Barbosa, Silva, Castro, Pinto-Gouveia, & Salgado, 2017). These results show a high internal consistency for immersion and distancing, as well as a good-to-strong interrater reliability for the coders' pairs (Hill & Lambert, 2004).

3.5. Procedures

In this study, we selected sessions 4, 8, 12, and 16 of the 17 cases. The sessions 4, 8 and 12 were selected because they are representative of the intermediate/working phase of therapy. This is in line with the intervention protocols used in the ISMAI depression study, which considers the intermediate phase of therapy from session 4 to session 12, inclusive (Beck et al., 1979; Elliott et al., 2004; Greenberg & Watson, 2006), as well as with other studies that use specific sessions to represent this phase of the therapy (e.g., Goldman, Greenberg, & Pos, 2005; Hill, 2009).

The sessions 4, 8 and 12 were analyzed in all cases in order to assess the flexibility between immersion and distancing. For this purpose, these sessions were previously transcribed verbatim according to the guidelines suggested by Mergenthaler and Stinson (1992). Then, for each session, we identified the excerpts corresponding to the main negative experience that the client brought to the therapy. This was needed to ensure that we captured immersion and distancing only when the client was reflecting on negative experiences (negative material). Moreover, prior relevant studies into immersion and distancing in therapy, on which this study is based, used the same procedure (e.g., Barbosa, Amendoeira et al., 2017; Barbosa, Silva, Pinto-Gouveia et al., 2017, Barbosa et al., 2018). The excerpts identified with this negative experience were later analyzed for immersion and distancing using MIDS. After identifying the moments of immersion and distancing, the flexibility between these perspectives was calculated using the measures of flexibility described in this study. Session 16, as the final session, was analyzed in order to identify the depressive symptoms at the end of treatment.

In summary, this study involved the identification of the main negative experience in

each case, an analysis of immersed and distanced perspectives in the reflection of that experience, an analysis of the flexibility in the shift from one perspective to another, and finally, an assessment of depressive symptomatology. These procedures are further described in more detail below.

3.5.1. Identification of the main negative experience in each case. This task was performed by a team of 12 judges: one PhD clinical psychologist, two PhD students, and nine master's degree students studying clinical and health psychology. One of the judges had clinical experience in EFT and two in CBT. Initially, the judges were involved in a training phase, which comprised (1) reading and discussing relevant journal articles about the identification of negative and problematic experiences in psychotherapy (e.g., Brinegar, Salvi, Stiles, & Greenberg, 2006; Honos-Webb, Stiles, & Greenberg, 2003; Stiles, Meshot, Anderson, & Sloan, 1992); and (2) practicing, using the therapeutic sessions, identifying the negative experience that was previously identified by trained judges. For this training phase, the judges had weekly two-hour meetings over two months. These judges then analyzed the cases included in the present study, with each being analyzed by a team of two judges. The judges with greater experience in this procedure supervised the remaining judges. The judges of each team independently read five transcript sessions in order to construct a clinical perception of the case and list the main clinical issues. Following this procedure, the judges discussed and together elaborated on the clinical formulation of the case and, by consensus, identified the main negative experience by taking into account its clinical relevance and the time consumed by it during the therapeutic sessions. Next, for sessions 4, 8 and 12 of each case, the excerpts where the negative experience manifested were identified and delimited jointly by the two judges. In all cases, the negative experience in each session occupied more than 70% of the client's speech (ranging from 72% to 93%).

3.5.2. Analysis of immersion and distancing. All the cases were analyzed in terms of immersion and distancing for sessions 4, 8, and 12 by a team of nine coders: one PhD student and eight master's degree students in clinical and health psychology. One of these had clinical experience in EFT and one in CBT. None of these coders belonged to the teams of judges who had previously identified the negative experience. The analysis of the immersion and distancing perspectives involved two phases: (1) the training phase for the use of MIDS and (2) the application phase of this coding system to the excerpts pertaining to the negative experience. In this first phase, the coders read and discussed relevant articles about immersion and distancing and the MIDS procedure manual, as well as practicing this coding system in the therapeutic sessions. This phase ended when the coders achieved a satisfactory Cohen's kappa (Cohen's kappa $\geq .75$, see Hill & Lambert, 2004). This phase lasted about three months. In the second phase, the excerpts related to the negative experience were analyzed in terms of immersion and distancing using MIDS. In each case, this procedure was performed independently by a team of two coders. The team member with the most experience in applying MIDS supervised the coding

procedures in all cases. The coding procedures comprised an analysis of the presence of the different categories of immersed and distanced speech in the excerpts previously identified with the negative experience. The stretches of the speech in which the coders could not identify either of these categories were classified as *other*. Considering the number of words per session coded as *other,* only 3.2% of speech fell into this category on average. A particular stretch of the speech of a given category was delimited by the presence of contents that characterize that category. When these contents were no longer identified, the coders considered it the end of that particular stretch. The end of a stretch could also be triggered by the end of the excerpt representing the negative experience or by the introduction of contents belonging to another category. Any disagreements were discussed by the coders and the expert rater and resolved through consensus (see Hill et al., 2005). The Cohen's kappa average for all pairs of coders combined was .81, individually ranging from .70 to .96, indicating good to strong inter-rater reliabilities, respectively (Hill & Lambert, 2004).

3.5.3. Analysis of flexibility. The flexibility was analyzed for the sessions representative of the intermediate phase of therapy (sessions 4, 8, and 12). These sessions were assessed moment-by-moment (i.e., in each moment of immersed speech and in each moment of distanced speech). We considered a moment of immersed speech the stretch of the text in which the immersion categories were identified. The beginning of a moment of immersed speech corresponded to the moment when an immersion category was identified, and ended when the distanced speech category emerged. Whenever two categories of immersed speech were identified consecutively, this was regarded as a single moment of immersion speech. A similar procedure was adopted for distanced speech. The flexibility was then computed using two measures: (1) the frequency of switching, from one moment to another, between immersion and distancing speech and (2) the magnitude of those moments. Specifically, the frequency of change corresponded to the number of transitions between immersion and distancing speech per session. To assess the magnitude, we counted the number of words for each moment as a way to calculate the extent of this moment, and then we used the *mean square successive difference* (MSSD) proposed by von Neumann et al. (1941). This measure allowed the calculation of the magnitude in terms of both variability and temporal dependency over time, since it assesses the changes from one moment to the next (successive changes) instead of just an entire period. MSSD is the average of the squared difference between successive observations at moments between *i*-1 and *i*. The MSSD for a time series of *n* measurement moments is calculated using the following mathematical formula:

$$\mathrm{MSSD} = \frac{1}{N-1}\sum_{i=1}^{N-1}(x_{i+1} - x_i)^2.$$

When calculating the magnitude of the consecutive changes from immersion to distancing through MDDS, the instability in the reflection pattern of the negative experience is quantified. A pattern with a higher magnitude shows stronger ups and downs over time (i.e., larger shifts from one moment to the next), which means that clients spent more time in each moment, indicating a lesser ability to switch perspective (i.e., more stable in the type of perspective adopted). In contrast, a pattern with lower magnitude shows weak ups and downs over time (i.e., short shifts from one moment to the next), which means that clients move more quickly between the perspectives (i.e., more unstable in the type of perspective adopted). In this sense, the high number of changes and the low magnitude of the transitions between immersion and distancing indicate frequent and fast transitions between perspectives, meaning greater flexibility.

3.5.4. Assessment of depressive symptomatology. The 17 clients of the present study completed the BDI-II at the end of the treatment (session 16).

3.5.5. Data analysis. Considering the number of participants in the EFT group (n=10) and CBT group (n=7), as well as the total number of participants in this study (N=17), a statistical analysis points to the use of nonparametric tests. However, we used a strategy of presenting the results with their equivalent parametric tests whenever the data respected the normality and homogeneity principles proposed by Marôco (2011), since these tests are more robust (Marôco, 2011; Fife-Schaw, 2006). Regarding the normality and homogeneity principles, we tested if the dependent variable had a normal distribution using the Kolmogorov-Smirnov test and if population variances were homogeneous using the Levene test (Marôco, 2011).

Initially, we compared the therapies by testing the differences between the EFT and CBT groups with regards to the dependent variables under study in order to establish the viability of combining the two samples into a single one (Field, 2009). Next, we tested the relationship between the measures of flexibility (frequency and magnitude of changes between immersion and distancing) in the intermediate phase of therapy with the depressive symptoms at the end of treatment.

In order to illustrate the results obtained regarding flexibility in the transition between the two perspectives, we selected two cases of low and high flexibility. Representative excerpts of these phenomena are presented in order to illustrate how they manifested in these clients' speech.

4. Results

4.1. Preliminary Analyses

No significant differences were found between the EFT and CBT groups in terms of either the number of changes (frequency) between immersion and distancing, t (15) = -.07, p= .944, d = -.29, or in the magnitude of those changes, U = 31.00, p = .696, r = -.09, in the

intermediate phase of therapy. Given the lack of significant differences between these two samples, we decided to combine them into a single sample for the following analyses.

4.2. Flexibility between Immersion and Distancing and its Relationship with Depressive Symptoms

Descriptive analysis of the flexibility measures during the intermediate phase of therapy showed that frequency ranged from 18 to 75 (M = 41.1; SD = 15.58) and magnitude from 26205.97 to 2945569.6 (M = 378166.61; SD = 719185.95). Depressive symptoms at the end of treatment ranged from 0 to 29 (M = 10.64; SD = 9.33).

The statistical analysis indicated significant relationships between the flexibility measures in the intermediate phase and the depressive symptoms at the end of the treatment. Concerning the frequency of the changes between immersion and distancing, we performed an analysis of the residues values and multicollinearity, and this showed that the data respected the assumption of executing a linear regression model. The regression model was significant and explained 34% of the variance in the BDI-II values at the end of the treatment, F (1, 15) = 9.33, p = .008, R^2 adj = .34. Specifically, an increase in the frequency of changes between the two perspectives in the intermediate phase of therapy predicted a decrease in the depressive symptoms at the end of treatment, β = -.62, SE = 7.56; t (15) = -3.05, p = .008. Concerning the magnitude of these changes, a significant negative moderated correlation, ± .30> r_s > ± .70, p < .05 (Cronk, 2006) between this flexibility measure and the depressive symptoms was observed, r_s (17) = -.56, p = .019. Specifically, a decrease in the magnitude of these changes between the two perspectives in the intermediate phase of the therapy was associated with better outcomes in terms of depressive symptoms at the end of treatment.

Since this finding is somewhat new to this field, we decided to complement this analysis with some contrasting clinical vignettes in order to better illustrate how flexibility may vary in clinical sessions. The following vignettes were extracted from two cases, one with low flexibility (transitions characterized by lower frequency and higher magnitude) and the other with high flexibility (transitions characterized by higher frequency and lower magnitude) between immersion and distancing when talking about negative experiences during the therapeutic conversation. “Anna’s” case (a fictitious name) is an example of low flexibility between the two perspectives. The transitions between perspectives were characterized by an average frequency of 18 and a magnitude of 425912.87 per session in the intermediate phase of the therapy. This subject presented a BDI-II score of 16 at the end of treatment. In turn, “Sandra’s” case (again a fictitious name) is an example of high flexibility between the two perspectives. The transitions between perspectives were characterized by an average frequency of 51 and a magnitude of 96149.39 per session in the intermediate phase of therapy. This subject presented a BDI-II score of 6 at the end of treatment. Figures 6 and 7 show how the transitions occurred moment-by-moment in Anna’s and Sandra’s cases, respectively. Stronger ups and downs over time can be observed in Anna’s case when compared with Sandra’s case (i.e., there were moments in which

Anna retained a perspective for a long period of time, especially for the immersed perspective). Conversely, Sandra visibly presented more changes between perspectives and weaker ups and downs over time, remaining in each perspective for less time, showing how she moved faster between them. In Sandra's case, there was less discrepancy in terms of the time spent in each perspective moment-by-moment than in Anna's case (see the tendency lines in Figures 6 and 7).

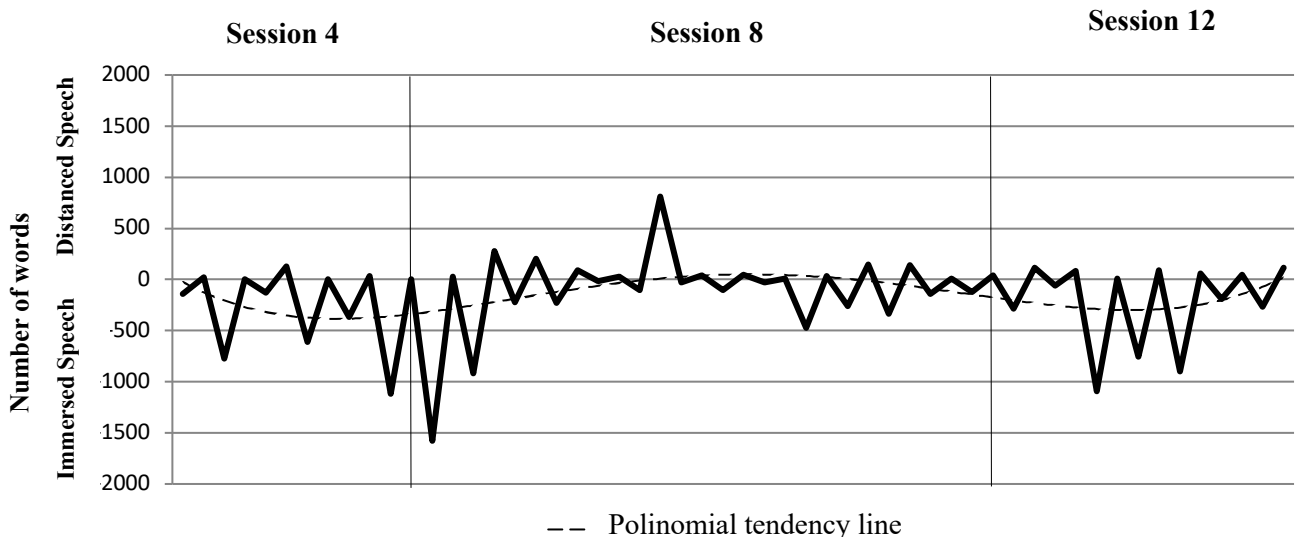

Figure 6. Transition between immersion and distancing in Anna's case

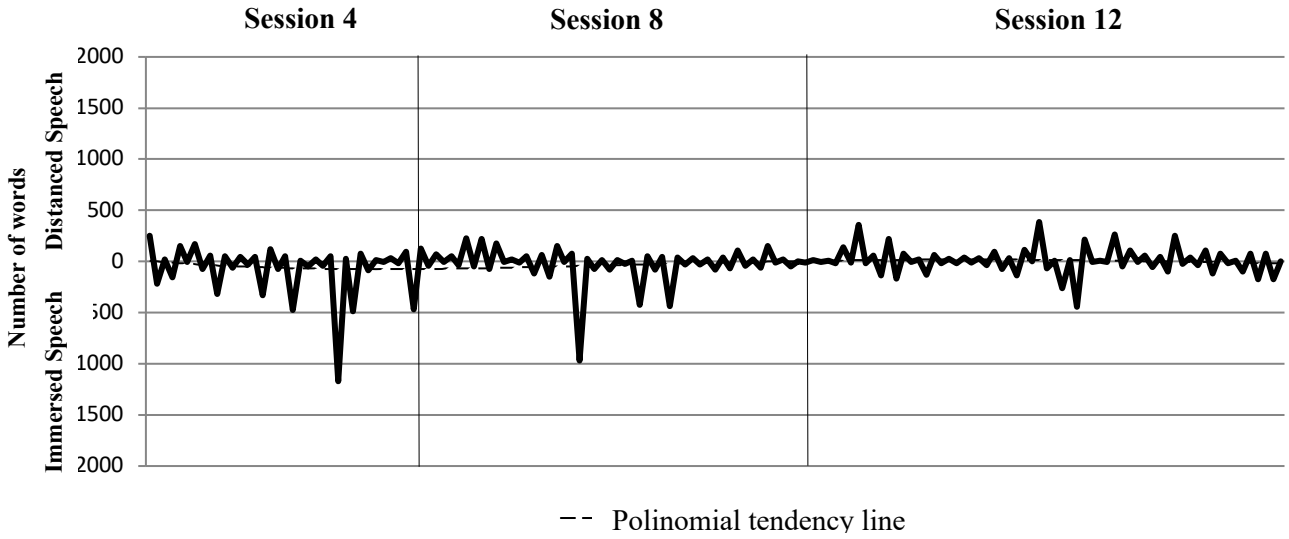

Figure 7. Transition between immersion and distancing in Sandra's case

In the following, excerpt paragraphs are presented from Anna's and Sandra's cases to give

a better understanding of the psychological meaning of high or low flexibility between the immersed and distanced perspective. The text that is representative of the immersed perspective is expressed in italics, while the text that is representative of the distanced perspective is underlined.

In both cases, negative experiences were associated with problems in the relationships with their respective husbands. Anna felt rejected by her husband. Throughout the process, her husband leaves home and later returns. In the excerpt below, the client talks about her husband's return.

> **Anna**: *He texted me, "Hello, good morning. I've been going crazy looking for answers to my life. I know that I have hurt you a lot and that I disappointed you and our daughters. It's with my heart crying that I ask for forgiveness. I also know that I cannot be happy away from you and our daughters. I would like to try to unite the family once again, but I feel we all have to do things differently, mainly I. If you allow, I would like to return to our home. I am willing to be a different and a better man. I just need to heal my lacerated soul. kisses, I love you very much." I was speechless… I answered that if it was his will, we were willing to receive him with open arms. I did not contact him. On Wednesday, he appeared at home. Meanwhile, he brought things a little bit each day and he came home definitely. However, I am not very excited because I do not see great changes. It's all the same, the same routines. He arrives at eight o'clock for dinner, goes to the couch, and if I tell him something, he says that he doesn´t want to do anything. If I ask him some kind of more intimate question, he answers "You and your difficult questions. Leave me in my corner." Why did he come home? I still have not had the courage to ask him, but I want to ask him, "What did you really come for?"*
>
> **Therapist**: You did not have the courage to ask him this?
>
> **Anna**: *No, I did not have the courage. I thought I was going to be a little annoying. I don't know ... I did not have the courage.* I wonder if I created too many expectations. No one changes from one day to another, as is evident. Aha, I also could not expect him to come home a completely transformed man, the super-loving man that he never was...I also cannot wait for this. And then the days went by and I was appeasing what I had here inside, because I'm more lucid about things. I confess that I do this, but I'm not as blind as before: for me the solution to my life involved living with him, knowing he was home. Now, I don't think in the same way.
>
> **Therapist**: Okay, what solutions do you have for your life?
>
> **Anna**: Aha, I already see with good eyes that he leaves home, and I live alone with the girls. It was something that tormented me before but now no longer.
>
> **Therapist**: What is different?
>
> **Anna**: I think that I'm more rational, more lucid, more... that time during which I was alone showed me that I have abilities or skills that maybe I thought I did not have to control the stuff… that perception on many occasions is part of the problem and not part of the solution for the problem…It's a bit like this…*but it hurts a lot because I think that a relationship cannot be one day at a time, and I think I've lived for a long time on a razor's edge. I never know very well what I can count… It was so many years together. I built a family, and it was not worth it. I feel defeated. I do not know what else to do. His*

coldness hurt...I just feel like crying. It's confusing for the girls. They don't know what to do. (The client then tells of another episode in which her husband rejects her.) (Session 8)

In turn, Sandra felt devalued by her husband. Sandra and her husband worked for a long time together. The excerpt from Sandra's case refers to moments when she feels incapable of maintaining her professional relationship with her husband.

Sandra: *Francisco [husband, fictitious name] does not admit failures at work, but when we are working together and I fail, he gets very upset, screams, and almost insults me, and I do not really like this character he has. I'm offended, very hurt…* but you know, I think that I need this Francisco because I did not want an irresponsible person with me without knowing how to do things. He gives me security. *He worries that if there is a deadline to do something, if there is something to buy, if there is an important thing to do, if it is necessary to call someone to solve some problem. I do not have this autonomy. I trust him in all these things.*
Therapist: We spoke in the previous session that we sometimes think we do not have the skills to do certain things, but we never really try to do them.
Sandra: That's right. I never had to do these things. He is the leader at work.
Therapist: He's the leader at work and in other contexts, especially for household chores, in taking care of children?
Sandra: I am the leader at home. I do not see him in this role.
Therapist: Why do you think this happens?
Sandra: Because I do everything for him, or at least I used to do everything for him, he did not have to make an effort. *There was no need for him to come home and ask me for a pair of socks, because I knew he needed a pair of socks. He did not have to ask me, for example, where the napkins are, because I knew he was going to sit at the table and would need a napkin.*
Therapist: You are saying that when we do not practice, we accommodate the situation. Last week we talked about the new things in which you are more autonomous at work.
Sandra: I'm less afraid. I have more confidence in me... In fact, I'm very insecure. I know I am, but lately I risk a little more.
Therapist: And when you do take a risk, how do you feel?
Sandra: *A good feeling.*
Therapist: Mm-hmm
Sandra: If I do not risk, I do not know what the result is.
Therapist: Mm-hmm, what you are telling me is that when we do not take risks, we avoid bad things, but we also avoid good things.
Sandra: How can I know what the result is?... I'm not so passive...the things I'm saying are not said by me, aha, but it's more those who surrounds me.
Therapist: Mm-hmm, exactly, you told me of your children...
Sandra: Yes, my children are my best critics. *(She then tells of a situation where she took the initiative to solve a situation at work and the children praised her.)* (Session 8)

As we can see from these excerpts, Anna describes the events in detail, focusing on the negative feelings that these moments provoke (immersion). The moments of distancing are interrupted by the description of her suffering that was caused by her husband's rejection (immersion). Sandra, on the other hand, moves more rapidly between the description of the experience (immersion) and a reflection of this experience from another angle (distancing), constructing new meanings and reinforcing them with examples of her own experience (immersion).

5. Discussion

The results of this study show that greater flexibility between immersion and distancing in the intermediate phase of therapy predicts better outcomes for depressive symptoms at the end of treatment. This finding supports our initial hypothesis regarding the potential of transitions between perspectives to affect symptomatic improvement when people with depression reflect on a negative experience in therapy. Specifically, the increase in the frequency of changes between the two perspectives in the intermediate phase of therapy predicts a decrease in depressive symptoms at the end of treatment, indicating that is important for a client to learn to shift frequently from one perspective to the other, alternating between a view of the negative experience through a first-person perspective to more reflective one through a third-person perspective as many times as possible. Moreover, a decrease in magnitude for those changes was also associated with a decrease in depressive symptoms at the end of treatment. Although the available data does not allow a more robust statistical analysis, the moments of therapy in which the magnitude of changes and depressive symptoms were assessed indicates the direction of this association (Marôco, 2011).

In this sense, fast transitions between immersion and distancing seem to be helpful in the working phase for further symptomatic improvement, emphasizing the importance of the clients spending shorter periods in each perspective. In short, in people diagnosed with depression, frequent and fast transitions between immersion and distancing in the working phase of the therapeutic process seem to be an adaptive way of reflecting on the negative experience that has the potential effect of improving depressive symptoms. With this finding, we support the existence of a discontinuous or nonlinear pattern in a client's reflection on an experience, and this seems to be independent of the therapeutic approach (EFT or CBT). In other words, the discontinuous pattern seems to be common rather than specific to the type of therapy. This is coherent with dynamic systems theory, which argues that changes in psychotherapy occur in discontinuous and nonlinear ways (e.g., Gumz, 2010; Hayes et al., 2007) and flexibility is needed to break the problematic and rigid self-configuration (Fresco et al., 2006; Kashdan & Rottenberg, 2010; Moore & Fresco, 2007). Depression is associated with problematic patterns characterized by a rigid and stable self-organization. This problematic pattern in turn maintains the depressive

symptomatology (Fisher et al., 2011). In fact, previous studies have shown that depressive people tend to reflect according to an immersed perspective (e.g., Barbosa, Amendoeira et al., 2017; Barbosa et al., 2018; Couto et al., 2016; Kross & Ayduk, 2009; Kross, Davidson, & Ochsner, 2009; Kross et al., 2012), and while this pattern remains stable, it may hinder any symptomatic improvement (Barbosa, Silva, Pinto-Gouveia et al., 2017).

The focus on a negative experience, according to an immersed perspective, tends to promote ruminative cycles, which are common in people with depression, preventing the construction of new meanings (e.g., Ayduk & Kross, 2010a; Kross et al., 2012) and increasing the intensity (Kross et al., 2014; Kross et al., 2012) and duration of the negative affect (Verduyn et al., 2012). In contrast, the distanced perspective has been considered as a mechanism to fight against rumination (e.g., Ayduk & Kross, 2010a; Kross et al., 2012), and it is associated with lower intensity (Kross et al., 2014; Kross et al., 2012) and shorter duration (Verduyn et al., 2012) of the affect. Based on these studies and dynamic systems theory (e.g., Ebner-Priemer et al., 2009; Hayes et al., 2007; Schiepek, 2009; Schiepek & Strunk, 2010; Schiepek et al., 2014), we believe that an increase in the flexibility between immersion and distancing in people with depression involves an instability in the personal system for the reflection on a negative experience, thus creating fluctuations between perspectives that break with the rigid and maladaptive patterns that are mainly characterized by the immersed perspective.

The transition from an immersed to a distanced perspective may prevent rumination cycles and the exacerbation of a negative affect, helping the client to see other facets of the experience. However, our results also suggest the importance of the transition from distancing to immersion. In accordance with dynamic systems theory, constant returns to a previous position is expected until a more significant change occurs (Fisher et al., 2011), as happened with other processes that have been already studied (e.g., Basto et al., 2018; Fisher et al., 2014). However, the findings of this study regarding the frequency and magnitude of the transitions also apply to moving from distancing to immersion. In other words, in order to improve depressive symptomatology in our sample, these transitions should be frequent and of a low magnitude, which suggest there are benefits to spending just a little time in a distanced perspective before returning to immersion. This suggestion agrees with a previous study that showed that the poor outcome cases began with a higher distancing from the negative experience than the good outcome cases, suggesting that reflecting through a distanced perspective is not always useful (Barbosa, Silva, Pinto-Gouveia et al., 2017). In addition, an in-depth study of a clinical case with depression showed that avoidance was associated with greater levels of distancing and that immersion seemed an essential perspective to overcome avoidance and become aware of a problem (Barbosa et al., 2018).

Sometimes, when attempting to avoid the suffering that results from a negative experience, people avoid any involvement with that experience, instead observing and representing it in a superficial way. In other words, they reflect only on the peripheral content, and this prevents any adaptive contact with the negative experience (e.g., Barbosa et al., 2018;

Foa & Kozak, 1986). A reflection of the negative and painful content of an experience from an immersed perspective may be useful when this happens, because it is making them more aware. The same seems to happen with the positive contents of a problematic experience, because, as with negative content, immersion tends to reinforce/activate them (Kross et al., 2014) and make the subject aware (Barbosa et al., 2018). In summary, in depression, we believe that the flexibility between immersion and distancing may prevent or break rumination patterns from resulting over long periods in the immersed perspective, and it may also promote contact with new points of view about an experience without the avoidance that results from maladaptive distancing. Greater flexibility between perspectives probably enables reciprocal influences between them, promoting change in the way people cognitively represent an experience and exhibit better emotional regulation. This accords with a previous study that argues that immersion and distancing may work as coordinated processes in psychotherapeutic change, thus allowing a more adaptive vision of reality (Barbosa et al., 2018).

6. Conclusion, Clinical Applications, Limitations, and Further Studies

In conclusion, our findings support the hypothesis that a decrease in immersion and an increase in distancing being associated with symptomatic change may just be an overview of a more dynamic model of transition between the immersed and distanced perspectives. In depression specifically, greater flexibility between these perspectives when a client reflects on a negative experience in the intermediate phase of therapy seems to take the form of an adaptive pattern that effects changes in depressive symptomatology by the end of treatment. These observations may provide important clinical indications for therapeutic intervention. Specifically, the intermediate phase of therapy seems to be a phase in which the therapist should be aware of the manner in which the client reflects on negative experiences. Fast and frequent transitions between re-experiencing the experience and observing it in this phase may be a sign of therapeutic progress. It may therefore be useful to apply therapeutic strategies to promote the transition between these two perspectives in order to foster greater flexibility in the reflection of an experience. While encouraging a distanced perspective in depression should be important in order to break rigid reflection patterns for an experience, immersion also seems to play a role in reconstructing the experience. The immersed and distanced perspectives may not be opposing forces but rather related processes that can work in a coordinated and productive way.

Our results should be read with caution, however, due to the small size and the specificity of our sample, thus preventing more robust statistical analyses that would make the findings more representative and generalizable. Research in cases diagnosed with other disorders and treated with other therapeutic approaches is needed to assess and refine our results, as well as studies that

support the suggestions addressed throughout the discussion. Moreover, since our results are congruent with dynamic systems theory regarding the importance of flexibility in the intermediate phase of therapy, it would be interesting to explore the evolution of transitions between immersion and distancing in the remaining phases in order to establish if their evolution occurs as expected according to this model (e.g., Fisher et al., 2011). In particular, we would see if it evolves from a more rigid pattern characterized mainly by the immersed perspective in the initial phase into a more flexible pattern in the intermediate phase and later back into to a less flexible pattern that is characterized by greater moments of distancing in the final phase of the treatment.

7. References

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory based subtype of depression. *Psychological Review, 96,* 358−372. doi: 10.1037/0033-295X.96.2.358

Ayduk, Ö., & Kross, E. (2008). Enhancing the pace of recovery, self-distanced analysis of negative experiences reduces blood pressure reactivity. *Psychological Science, 19*, 229-231. doi: 10.1111/j.1467-9280.2008.02073.x

Ayduk. Ö., & Kross, E. (2010a). Analyzing negative experiences without ruminating: The role of self-distancing in enabling adaptive self-reflection. *Social and Personality Psychology Compass, 4*, 841-854. doi:10.1111/j.1751-9004.2010.00301.x

Ayduk, Ö., & Kross, E. (2010b). From a distance: Implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology, 98*, 809-829. doi:10.1037/a0019205

Barbosa, E., Amendoeira, M., Ferreira, T., Teixeira, A. S., Pinto-Gouveia, J., & Salgado, J. (2017). Immersion and distancing across the therapeutic process: Relationship to symptoms and emotional arousal. *Research in Psychotherapy: Psychopathology, Process and Outcome*, *20*(2), 110-121. doi:10.4081/ripppo.2017.258

Barbosa, E., Couto, A. B., Basto, I., Stiles, W. B., Pinto-Gouveia, J., & Salgado., J. (2018). Immersion and distancing during assimilation of problematic experiences in a good-outcome case of emotion-focused therapy. *Psychotherapy Research*, *2,* 313-327. doi:10.1080/10503307.2016.1211347

Barbosa, E., Silva, S., Castro, D., Pinto-Gouveia, J., & Salgado, J. (2017). *Development and validation of the Measure of Immersed and Distanced Speech.* Manuscript in preparation.

Barbosa, E., Silva, S., Pinto-Gouveia, J., & Salgado, J. (2017). How and when immersion and distancing are useful in emotion focused therapy for depression. *Psychotherapy Research,* 1-15. doi:10.1080/10503307.2017.1411626.

Basto, I., Stiles, B., Bento, T., Pinheiro, P., Mendes, I., Rijo, D., & Salgado, J. (2018). Fluctuation in the assimilation of problematic experiences: A case study of dynamic systems analysis. *Frontiers in Psychology.* doi:10.3389/fpsyg.2018.01119

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II (BDI-II)*. San Antonio, TX: Psychological Corporation.

Beck, J. S. (2011). *Cognitive behavior therapy: Basic and beyond* (2nd ed.). New York: The Guilford Press.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180. doi:10.1037/0022-0167.53.2.165

Coelho, R., Martins, A., & Barros, H. (2002). Clinical profiles relating gender and depressive symptoms among adolescents ascertained by the Beck Depression Inventory-II. *European Psychiatry, 17*, 222-226. doi:10.1016/S0924-9338(02)00663-6

Couto, A. B., Barbosa, E., Silva, S., Bento, T., Teixeira, A. S., Salgado, J., & Cunha, C. (2016). Client's immersed and distanced speech and therapist's interventions in emotion-focused therapy for depression: an intensive analysis of a case study. *Research in Psychotherapy: Psychopathology, Process and Outcome, 19*(2), 136-149. doi:10.4081/ripppo.2016.205

Cronk, B. C. (2006). *How to use SPSS: A step-by-step guide to analysis and interpretation* (4th ed.). Glendale, CA: Pyrczak Publishing.

Ebner-Priemer, U. W., Eid, M., Kleindienst, N., Trull, T. J., & Stabenow, S. (2009). Analytic strategies for understanding affective (in)stability and other dynamic processes in psychopathology. *Journal of Abnormal Psychology, 118*, 195–202.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion focused therapy: The process-experiential approach to change.* Washington, D.C.: America Psychology Association.

Field, A. P. (2009). *Discovering statistics using SPSS* (3rd ed.). London, UK: Sage Publication Ltd.

Fife-Schaw, C. (2006). Levels of measurement. In G. M. Breakwell, S. Hammond, C. Fife-Schaw, & J. A. Smith (Eds), *Research methods in psychology* (3rd Ed.). London: Sage.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II).* (J. Pinto-Gouveia, A. Matos, D. Rijo, P Castilho, & M. Salvador, Trans.). Washington, D.C.: American Psychiatric Press, Inc.

First, M. B., Spitzer, R. L, Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version (SCID-I-RV)*. (A. Costa Maia, Trans.). New York: Biometrics Research.

Fisher, A. J., Newman, M. G., & Molenaar, P. C. M. (2011). A quantitative method for the analysis of nomothetic relationships between idiographic structures: Dynamic patterns create attractor states for sustained posttreatment change. *Journal of Consulting and Clinical Psychology, 79*(4), 552-563.

Foa, E. B., & Kozak, M. J. (1986). *Emotional processing of fear*: *Exposure to corrective information*. *Psychological Bulletin, 99*(1), 20-35.

Fresco, D. A., Williams, N. L., & Nugent, N. (2006). Flexibility and negative affect: Examining the associations of explanatory flexibility and coping flexibility to each other and to depression and anxiety. *Cognitive Therapy and Research, 30*, 201−210. doi:10.1007/s10608-006-9019-8

Goldman, R. N, Greenberg, L. S, & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15(3),* 248-260. doi:10.1080/10503300512331385188

Greenberg, L. S., & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington, D. C.: American Psychological Association.

Gumz, A., Kastner, D, Geyer, M., Wutzler, U., Villmann, T., & Brahler, E. (2010). Instability and discontinuous change in the experience of therapeutic interaction: An extended single-case study of psychodynamic therapy processes. *Psychotherapy Research, 20*, 398-412. doi: 10.1080/10503300903551021

Hayes, A., M., Laurenceau, J., Feldman, G., Strauss, J., & Cardaciotto, L. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27*, 715-723. doi:10.1016/j.cpr.2007.01.008

Hill, C. E. (2009). *Helping skills: Facilitating exploration, insight, and action* (3rd ed.). Washington, DC: American Psychological Association.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi:0.1037/0022-0167.52.2.196

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 84-136). Hoboken, New Jersey: Wiley.

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50*, 189-198. doi:10.1037/0022-0167.50.2.189

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review, 30*, 865–878. doi:10.1016/j.cpr.2010.03.001

Kross, E., & Ayduk, Ö. (2008). Facilitating adaptive emotional analysis: Distinguishing distanced-analysis of depressive experiences from immersed-analysis and distraction. *Personality and Social Psychology Bulletin, 34*, 924-938. doi:10.1177/0146167208315938

Kross, E., & Ayduk, Ö. (2009). Boundary conditions and buffering effects: Does depressive symptomology moderate the effectiveness of self-distancing for facilitating adaptive emotional analysis? *Journal of Research in Personality, 43,* 923-927. doi:10.1016/j.jrp.2009.04.004

Kross, E., & Ayduk, Ö. (2011). Making meaning out of negative experiences by self-distancing. *Current Directions in Psychological Science, 20*, 187-191. doi:10.1177/0963721411408883

Kross, E., Ayduk, Ö., & Mischel, W. (2005).When asking ''why'' does not hurt: Distinguishing rumination from reflective processing of negative emotions. *American Psychological Society, 16*, 709-715. doi:10.1177/0963721411408883

Kross, E., Bruehlman-Senecal, E., Park, J., Burson, A., Dougherty, A., Shablack, H., … Ayduk, O. (2014). Self-talk as a regulatory mechanism: How you do it matters. *Journal of Personality and Social Psychology, 106*, 304–324. doi:10.1037/a0035173

Kross, E., Davidson, M., Weber, J., & Ochsner, K. (2009). Coping with emotions past: The neural bases of regulating affect associated with negative autobiographical memories. *Biological Psychiatry, 65*, 361-366. doi:10.1016/j.biopsych.2008.10.019

Kross, E., Gard, D., Deldin, P., Clifton, J., & Ayduk, Ö. (2012). "Asking why" from a distance: Its cognitive and emotional consequences for people with major depressive disorder. *Journal of Abnormal Psychology*, *121*, 559-569. doi:10.1037/a0028808

Marôco J. (2011). *Análise estatística com o SPSS Statistics.* (5ª ed). Pero Pinheiro: ReportNumber.

McIsaac, H. K., & Eich, E. (2004). Vantage point in traumatic memory. *Psychological Science, 15*, 248-253. doi:10.1111/j.0956-7976.2004.00660.x

Mergenthaler, E., & Stinson, C. (1992). Psychotherapy transcription standards. *Psychotherapy Research, 2,* 125-142. doi:10.1080/10503309212331332904

Mischkowski, D., Kross, E., & Bushman, B. J. (2012). Flies on the wall are less aggressive: Self-distancing "in the heat of the moment" reduces aggressive thoughts, angry feelings and aggressive behavior. *Journal of Experimental Social Psychology, 48,* 1187-1191. doi:10.1016/j.jesp.2012.03.012

Moore, M. T., & Fresco, D. M. (2007). Depressive realism: A meta-analytic review. *Clinical Psychology Review 32*, 496–509. Doi: 10.1016/j.cpr.2012.05.004

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*, 467-482. doi:10.1016/0010-0285(83)90016-6

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*, 400-424. doi:10.1111/j.1745-6924.2008.00088.x

Robinson, J. A., & Swanson, K. K. (1993). Field and observer modes of remembering. *Memory, 1*, 169-184. doi:10.1080/09658219308258230

Salgado, J. (2014). *ISMAI depression project: Results of a comparative clinical trial of EFT and CBT.* Paper presented at 45th International Annual Meeting of Society for Psychotherapy Research, Copenhagen, Denmark.

Salgado, J., Meira, L., Santos, A., Cunha, C., Bento, T., Almeida, C., … Pinheiro, P. (2010). Protocolo clínico.

Schiepek (2009). Complexity and nonlinear dynamics in psychotherapy. *European Review, 17*, 331-356. doi:10.1017/S1062798709000763

Schiepek, G., & Strunk, G. (2010). The identification of critical fluctuations and phase transitions in short term and coarse-grained time series – A method for the real-time monitoring of human change processes. *Biological Cybernetics, 102,* 197-207. doi:10.1007/s00422-009-0362-1.

Schiepek, G., Tominschek, I., & Heinzel, S. (2014). Self-organization in psychotherapy: Testing the synergetic model of change. *Frontiers in Psychology, 5*, 1-14. doi: 10.3389/fpsyg.2014.01089

Stiles, W. B., Meshot, C. M., Anderson, T. M., & Sloan, W. W. (1992). Assimilation of

problematic experiences: The case of John Jones. *Psychotherapy Research, 2,* 81-101. doi:10.1037/0033-3204.38.4.462

Verduyn, P, Mechelen, I. V., Kross, E., Chezzi, C., & Bever, F. V. (2012). The relationship between self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion, 12*, 1248-1263. doi:10.1037/a0028289

von Neumann, J., Kent, R. H., Bellinson, H. R., & Hart, B. I. (1941). The mean square successive difference. *The Annals of Mathematical Statistics, 12,* 153–162.

Conclusão

1. Discussão Integrada dos Principais Resultados da Presente Dissertação

A presente dissertação teve como objetivo primordial clarificar o papel da imersão e do distanciamento em psicoterapia. Este objetivo decorreu das dúvidas existentes quanto aos efeitos de cada uma destas perspetivas neste tipo de contexto. Sabendo do potencial da imersão/distanciamento para o desenvolvimento, manutenção e recuperação de estados psicopatológicos (e.g., Ayduk & Kross, 2010b; Gross, 2007; Kross, 2009; Kross & Ayduk, 2008), estudos nesta área são particularmente importantes para conhecer as condições em que estas perspetivas podem ser benéficas no tratamento psicológico. A investigação prévia na área não se enquadra completamente nas necessidades e características de um processo terapêutico, quer em termos de procedimentos metodológicos envolvidos, quer em termos de avaliação da eficácia destas perspetivas. Sendo assim, foram realizados os quatro estudos apresentados ao longo desta dissertação, através dos quais se procurou testar uma visão mais flexível e longitudinal sobre estes fenómenos, enquadrando-se na investigação de processo-resultado em contexto psicoterapêutico. A investigação de processo-resultado defende que a forma de compreender como a psicoterapia é eficaz implica o estudo dos fenómenos ou processos que promovem melhores resultados terapêuticos e mudança clínica (Llewelyn et al., 2016). Assim, estudos sobre imersão e distanciamento no âmbito da investigação de processo-resultado mostraram-se úteis no sentido de conhecer se estas perspetivas estão envolvidas na mudança psicoterapêutica, contribuindo com conhecimento para aprimorar a qualidade da prática clínica.

Os estudos presentes nesta dissertação incidiram sobre o tratamento da perturbação depressiva major, uma perturbação incapacitante e com elevada prevalência a nível mundial (WHO, 2018), merecendo, por isso, a atenção clínica e científica a fim de melhorar a eficácia dos seus tratamentos. Além disso, é das problemáticas mais vulneráveis ao afeto negativo e à ruminação (Ciesla & Roberts, 2007; Nolen-Hoeksema et al., 2008; Takagishi et al., 2013), sendo esperado que o distanciamento, em oposição à imersão, seja benéfico na melhoria desta condição clínica (Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen- Hoeksema, 2011). Seguindo as conclusões retiradas dos estudos anteriores, estas perspetivas são opostas e independentes, levando a resultados contrastantes (e.g., Kross & Ayduk, 2008, Kross, 2009). Neste sentido, aumentar o distanciamento na reflexão de experiências negativas seria vantajoso para a diminuição da ativação emocional de emoções negativas e consequente bem-estar (e.g., Kross et al., 2014; Verduyn et al., 2012), bem como para a criação de novos significados e reconstrução dessas experiências (e.g., Ayduk & Kross, 2008, 2010b). Pelo contrário, a imersão poderia ser motivadora de maior ruminação (e.g., Ayduk & Kross, 2010a; Kross, Ayduk, &

Mischel, 2005), ativação de emoções negativas e consequente mal-estar (Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012), mantendo ou potenciando o estado psicopatológico (Brosschot et al., 2006; Bushman, 2002; Nolen-Hoeksema et al., 2008). Estes resultados sugerem que incentivar o distanciamento e evitar a imersão serão estratégias úteis no tratamento psicológico.

Globalmente, os estudos elaborados no âmbito desta dissertação parecem corroborar os resultados anteriores quanto à importância do aumento do distanciamento para mudança e bem-estar. Contudo, em psicoterapia, isso não invalida o papel positivo da imersão na mudança clínica, nomeadamente no tratamento da depressão. Aliás, alguns resultados apontam para desvantagens do distanciamento em determinadas circunstâncias do processo terapêutico. Uma ação coordenada e integrada destes fenómenos parece ser vantajosa para a mudança clínica, o que se contrapõe a uma visão destas perspetivas como opostas e independentes. Estas considerações serão de seguida discutidas e integradas dentro de dois grandes temas que julgamos caracterizar os resultados dos estudos desta dissertação, nomeadamente o padrão de evolução da imersão e do distanciamento associado à mudança clínica; e a imersão e o distanciamento como mecanismos coordenados e dinâmicos envolvidos no processo de mudança terapêutica.

1.1. Padrão de evolução da imersão e do distanciamento associado à mudança clínica

Esta tese representa um esforço pioneiro sistemático em explorar, empiricamente e num formato longitudinal, a imersão e o distanciamento em psicoterapia. Este tipo de metodologia proporcionou alguma clareza sobre a forma como cada perspetiva pode manifestar-se durante o tratamento da depressão e sobre a sua relação com a mudança clínica. Um dos resultados mais relevantes diz respeito ao padrão comum de evolução da imersão e do distanciamento encontrado nos casos de sucesso analisados (estudos 1, 2 e 3), nomeadamente a diminuição da imersão e o aumento do distanciamento ao longo do processo psicoterapêutico, sugerindo uma transição progressiva de maior imersão, dominante sobretudo na fase inicial, para maior distanciamento, mais frequentemente observado na fase final do processo. Esta tendência revelou-se transversal aos dois modelos de intervenção estudados: na terapia cognitivo-comportamental (estudo 1) e na terapia focada nas emoções (estudos 2 e 3). Embora o estudo 1 seja apenas um estudo de caso, estes resultados lançam a possibilidade desta evolução ser um padrão comum de mudança, independentemente do modelo terapêutico aplicado. A relação positiva entre o padrão de evolução referido e a diminuição dos sintomas (estudos 1 e 2) é consistente com os estudos prévios quanto aos benefícios do distanciamento, em oposição à imersão, para o alívio sintomatológico (Ayduk & Kross, 2008, 2010b; Kross & Ayduk, 2008; Kross et al., 2005, 2012; Verduyn et al., 2012). Contudo, também de acordo com os estudos 1 e 2, para que o sucesso terapêutico ocorra a diminuição da imersão e o aumento do distanciamento ao longo do processo deverão ser significativos, i.e., a pessoa deverá apresentar uma marcada mudança no padrão de reflexão da experiência, passando de uma perspetiva imersa para um aumento substancial da perspetiva distanciada. Aliás, o estudo 2 mostrou que a mudança na perspetiva estava relacionada

positivamente com a mudança dos sintomas depressivos em terapia focada nas emoções. Esta observação sugere que, quanto maior for a mudança na perspetiva (de imersa para mais distanciada), mais efetiva é a mudança em termos sintomatológicos. Os casos de insucesso analisados (estudo 2), embora tenham manifestado a mesma tendência que os casos de sucesso (diminuição da imersão e aumento do distanciamento), apresentaram tal tendência de forma ligeira, ou seja, uma alteração não significativa em termos estatísticos. Tais casos tiveram, assim, um padrão mais estável na reflexão da experiência pessoal problemática, caracterizado por elevada imersão e baixo distanciamento ao longo de todo o processo. Sendo assim, e tendo por base os resultados dos estudos 1 e 2 sobre a associação das perspetivas com a severidade dos sintomas, bem como a literatura quanto aos efeitos da imersão nos sintomas depressivos (e.g., Kross & Ayduk, 2009), sai reforçada a tese de que a imersão contínua está associada a uma ativação persistente dos sintomas, mantendo-se o estado psicopatológico e potenciando-se, portanto, o insucesso terapêutico.

Globalmente, os resultados até agora discutidos são coerentes com os estudos experimentais/laboratoriais quanto à associação entre imersão e estados psicopatológicos ou negativos, como a depressão (e.g., Kross & Ayduk, 2009; Kross et al., 2009; Kross et al., 2012), e quanto aos efeitos positivos em mudar da perspetiva imersa para a perspetiva distanciada (Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen- Hoeksema, 2011) ao longo do processo terapêutico neste tipo de perturbação. Simultaneamente apoiam duas das hipóteses lançadas no início desta tese, nomeadamente: (1) o excessivo foco na experiência negativa a partir de uma perspetiva imersa está associado ao insucesso e compromete o resultado terapêutico; bem como (2) existe uma associação entre aumento da reflexão da experiência segundo uma perspetiva distanciada e o sucesso terapêutico.

A atribuição da imersão a estados negativos e do distanciamento a estados de maior bem-estar psicológico em psicoterapia para a depressão é reforçada com os resultados do estudo 1 referentes à ativação emocional. De facto, tal como era expectável, o estudo 1 revelou uma relação positiva entre imersão e a ativação emocional de emoções negativas e entre o distanciamento e a ativação emocional de emoções positivas, sendo coerente com a visão de que, face a experiências negativas, a imersão potencia a ativação emocional de conteúdo negativo (e.g., Kross, 2009; Kross & Ayduk, 2009; Kross et al., 2012; Wisco & Nolen- Hoeksema, 2011), enquanto o distanciamento alimenta estados mais positivos. Tendo em consideração os padrões de reflexão da experiência obtidos nos casos de insucesso e nos casos de sucesso (estudo 2), a excessiva e contínua imersão poderá ativar o afeto negativo para níveis extremamente dolorosos, alimentando círculos de ruminação e sofrimento (Ayduk & Kross, 2010a; Kross et al., 2005). Do ponto de vista clínico, faz sentido admitir que o aumento do distanciamento é útil na promoção de uma maior capacidade de regulação emocional quando ativado material afetivamente negativo. Isto é coerente com as modalidades terapêuticas que estiveram na base dos estudos desta dissertação quando estas usam estratégias que sugerem distanciamento com vista a obter um melhor controlo emocional. Por exemplo, a observação do problema de modo mais afastado (na

gíria desta terapia, criar "uma distância de trabalho"), tal como é sugerido pela tarefa "limpar o espaço" em terapia focada nas emoções (Elliott et al., 2004); ou a reavaliação cognitiva, no sentido de mudar o significado criado em situações negativas, tal como é sugerido na "reestruturação cognitiva" em terapia cognitivo-comportamental (Beck, 1970). Portanto, os resultados parecem apoiar a premissa de que o aumento da perspetiva distanciada pode funcionar como um mecanismo eficaz na redução da ativação de emoções negativas (e.g., Kross et al., 2014; Verduyn et al., 2012), ou seja, o distanciamento como promotor de maior controlo emocional.

Os benefícios do distanciamento foram também encontrados na integração e resolução da experiência problemática. Especificamente, o padrão de evolução, caracterizado pela diminuição da imersão e aumento do distanciamento ao longo do processo terapêutico, revelou estar associado ao aumento dos níveis de assimilação da experiência negativa no caso de sucesso analisado no estudo 3. Mais uma vez, esta observação é coerente com os estudos que consideram o distanciamento como uma perspetiva importante na reconstrução da experiência negativa (Ayduk & Kross, 2010b; Kross & Ayduk, 2011; Kross et al., 2012).

Em suma, a interpretação dos resultados dos estudos desenvolvidos no âmbito desta dissertação, tendo por base a relação de cada uma das perspetivas com a sintomatologia depressiva, ativação emocional, e integração e resolução de experiências problemáticas, sugerem que a elevada imersão e o baixo distanciamento podem ser prejudiciais pela sua associação a estados depressivos, sofrimento emocional e problemas não resolvidos em psicoterapia para a depressão. Sendo assim, aumentar a reflexão sobre a experiência problemática do ponto de vista do observador pode ser benéfico pela sua associação a uma maior integração da experiência, maior capacidade de regulação emocional e bem-estar. Estas conclusões vão ao encontro da visão do distanciamento como uma perspetiva adaptativa na reflexão de experiências negativas (e.g., Ayduk & Kross, 2010b; Etzel, 2017; Kross & Ayduk, 2011; Kross et al., 2012). Numa ótica dos estudos experimentais/laboratoriais, estes seriam dados suficientes para considerar a imersão como uma perspetiva desadaptativa. Contudo, esta leitura, embora aparentemente seja coerente com as observações realizadas, parece ser demasiado redutora e simplista no que concerne ao papel da imersão em psicoterapia. Mais concretamente, existem outras observações que sugerem que a imersão pode ser um elemento importante no processo de mudança.

Em primeiro lugar, a imersão foi, de um modo global, a perspetiva dominante mesmo nos casos de sucesso (estudos 1, 2 e 3), mostrando que a sua elevada frequência não impede resultados terapêuticos favoráveis. O domínio da imersão ao longo das diferentes fases do tratamento leva a considerar a hipótese de que a imersão é o tipo de perspetiva mais solicitada em terapia. Os/as clientes necessitam de partilhar com o/a terapeuta/a a visão pessoal sobre a experiência (pensamentos, sentimentos, comportamentos, eventos) de forma a contextualizar e fornecer a sua perceção sobre a realidade. Sendo assim, este tipo de perspetiva pode exigir mais tempo em terapia do que o distanciamento.

Em segundo lugar, mesmo quando a imersão era a perspetiva dominante, ou seja, continuava elevada quando comparada com a perspetiva distanciada, nalgumas sessões terapêuticas os sintomas apresentaram níveis subclínicos (estudos 1 e 2). Estes resultados revelam que, mesmo com elevada imersão, é possível apresentar níveis sintomatológicos satisfatórios e progredir favoravelmente em psicoterapia. Aliás, no caso analisado no estudo 3, frequências substanciais de imersão coocorreram com o distanciamento em todos os níveis de mudança terapêutica, sendo mesmo a perspetiva mais elevada num dos últimos níveis de mudança, nomeadamente no nível 5 em que o afeto tende a ser positivo (numa escala de 0 a 7). Estas observações indicam que elevada imersão pode não representar um mecanismo negativo associado a estados psicológicos desfavoráveis, mesmo na depressão; pelo contrário, pode ser indicador de progresso terapêutico, dependendo do estado de mudança em que o/a cliente se encontra.

Em terceiro lugar, um outro resultado curioso, que também aponta no sentido da importância da imersão no processo de mudança, foi a presença de maior frequência de distanciamento na primeira sessão no grupo de insucesso do que no grupo de sucesso (estudo 2). Este resultado sugere que mais distanciamento no início da terapia não é necessariamente um preditor de bom resultado terapêutico. Pelo contrário, estes dados, sendo lidos à luz da importância do envolvimento e ativação emocional em terapia (e.g., Fosha, 2000; Greenberg, 2002; Samoilov & Goldfried, 2000), sugerem que, sobretudo numa fase inicial, refletir sobre experiências pessoais problemáticas a partir de uma perspetiva imersa pode ser uma parte importante do processo terapêutico. O estudo 3 apoia este pressuposto ao revelar que a imersão foi inferior ao distanciamento no nível 1 de mudança (evitamento da experiência) e mais elevada do que o distanciamento no nível 2 (consciência do problema) e 3 (clarificação do problema) no caso analisado. Especificamente, maior distanciamento, numa fase precoce de mudança, poderá estar associado a processos de evitamento prejudiciais para o progresso terapêutico; enquanto a elevada imersão, embora envolva estados dolorosos (níveis 1 e 2 associados a afeto negativo), parece ser um mecanismo adaptativo associado à superação do evitamento da experiência negativa e à emergência e clarificação do problema na consciência.

Neste sentido, assumimos a imersão simultaneamente como uma perspetiva associada ao sofrimento psicológico, mas também como parte do processo de promoção do bem-estar. Aliás, no estudo 1, a elevada imersão apresentada, bem como a elevada frequência de emoções negativas, sobretudo na fase inicial da terapia, não foram impeditivas do sucesso terapêutico. Portanto, tudo indica que devemos ter cuidado quando associamos a imersão e as emoções negativas a estados problemáticos em psicoterapia, porque podem funcionar como uma importante ferramenta para o tratamento, fazendo parte do processo de mudança. Estes pressupostos estão em linha com os modelos de intervenção que estiveram na base desta dissertação.

Em terapia focada nas emoções, o início do tratamento passa por incentivar o/a cliente a contactar com os seus estados emocionais desadaptativos e que causam sofrimento, de modo a

ativá-los, tornando-os conscientes para posteriormente serem processados e transformados. O contacto com esses estados pode ser feito a partir de uma reflexão focada nos seus sentimentos, estados físicos e perceção de si mesmo/a, o mais aproximadamente possível da sua experiência, o que sugere uma perspetiva imersa sobre essa mesma experiência (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006). Por sua vez, na terapia cognitivo-comportamental, um dos primeiros passos do tratamento passa por solicitar ao/à cliente a descrição dos eventos dolorosos tal como foram percebidos por si na altura em que ocorreram, ou seja, na perspetiva de primeira pessoa. Desta forma, é possível aceder a pensamentos disfuncionais, com o objetivo de os tornar conscientes, o que é fundamental para a posterior criação de visões alternativas mais realistas sobre a experiência (e.g., Beck, 1970, 1979; Young, Rygh, Weinberger, & Beck, 2014).

Sendo assim, os resultados dos estudos desta dissertação, apoiados nos modelos teóricos subjacentes (e.g., Beck, 1970; Elliott et al., 2004), bem como na literatura sobre a importância da ativação emocional (e.g., Elliott et al., 2013; Greenberg et al., 1993; Pennebaker & Graybeal, 2001; Smyth, 1998; Wilson & Gilbert, 2008), apoiam a possibilidade da imersão ser promotora de envolvimento emocional com conteúdos mentais geradores de respostas afetivas negativas, tornando o problema consciente e claro para a posterior criação de novos significados. Considerando estes achados juntamente com os padrões de evolução de imersão e distanciamento que distinguem os casos de sucesso e os de insucesso (estudo 2) e o predomínio do distanciamento em detrimento da imersão no nível 4 de mudança do modelo de assimilação (nível de emergência de novos significados – estudo 3), a imersão parece ser útil em terapia desde que seja seguida do aumento substancial do distanciamento. Caso contrário, a imersão será excessiva e contínua, podendo ser sinal de falta de progresso terapêutico.

Embora os resultados desta dissertação necessitem de mais apoio empírico, estes sustentam a hipótese de que a imersão tem efeitos terapêuticos positivos, mais precisamente quando não ocorre de forma contínua e indefinida. O/A cliente pode começar por expressar o material negativo a partir de uma perspetiva imersa, promovendo o aumento da consciencialização e o contacto com os afetos envolvidos nos problemas em decurso. Esse contacto mais sustentado com tais conteúdos poderá progressivamente diminuir evitamentos automáticos e aumentar a capacidade de lidar com os conteúdos envolvidos. Se tal acontecer, é legítimo esperar-se que isto torne o/a cliente cada vez mais capaz de refletir sobre esse material de forma distanciada, potenciando-se a criação de novos significados. Esta possibilidade é coerente com dados empíricos que mostram que o contacto com a experiência negativa na perspetiva de primeira pessoa permite aceder, tolerar e aceitar essa mesma experiência, facilitando a emergência de significados alternativos (Greenberg, 2004). Também é provável que o progressivo aumento do distanciamento favoreça o controlo emocional sobre a experiência potencialmente dolorosa, impedindo que a imersão se manifeste de forma descontrolada e persistente. Esta possibilidade é coerente com os estudos experimentais/laboratoriais (e.g., Kross et al., 2014; Verduyn, Mechelen, Kross, Chezzi, & Bever, 2012), bem como com os modelos

terapêuticos envolvidos nesta dissertação (e.g., Beck, 1970; Greenberg & Watson, 2006) no que concerne aos benefícios do distanciamento na regulação emocional.

O benefício do aumento do distanciamento no tratamento da depressão parece ser inegável, e, de acordo com o estudo 1, este aumento poderá ser mais favorável da fase inicial para a intermédia. Apesar deste resultado dever ser lido com cuidado, por derivar apenas de um estudo de caso, é consistente com diferentes modelos terapêuticos, pois a fase intermédia tende a ser a fase de trabalho, em que as técnicas que exigem maior desafio à experiência problemática são aplicadas e, por isso, uma perspetiva mais abrangente e distanciada pode ser exigida (e.g., Beck, 1970; Greenberg & Watson, 2006). No caso da terapia cognitivo-comportamental para a depressão (terapia subjacente no estudo referido), da fase inicial para a fase intermédia várias técnicas cognitivas são normalmente aplicadas no sentido de incentivar o/a cliente a adotar uma nova perceção sobre a realidade. Por exemplo, estratégias de reestruturação cognitiva são frequentemente usadas neste período, desafiando pensamentos automáticos associados a um ponto de vista de primeira pessoa. Para tal, o/a terapeuta auxilia o/a cliente no desafio desses pensamentos a partir do distanciamento da própria crença, com o objetivo de obter uma perceção mais abrangente e, por isso, mais rica que permita a criação de novos significados, mais ajustados à realidade (Beck, 1970; Ma & Teasdale, 2004). Na terapia focada nas emoções (terapia subjacente aos estudos 2 e 3), também são aplicadas estratégias, sobretudo na fase intermédia da terapia, que são consistentes com o uso da perspetiva distanciada. Por exemplo, de acordo com os princípios deste modelo terapêutico, nesta fase da terapia é comum o/a terapeuta facilitar a criação de novos significados sobre a experiência a partir do exercício de trabalho de cadeiras. Esta tarefa implica a diferenciação do *Self* no sentido do/a cliente observar as diversas partes de si mesmo/a (Greenberg & Watson, 2006), o que é coerente com a perspetiva distanciada (Nigro & Neisser, 1983; Robinson & Swanson, 1993).

Em síntese, os estudos realizados no âmbito desta dissertação, nomeadamente os estudos 1, 2 e 3, sugerem que um padrão de evolução, caracterizado por maior imersão inicial e posterior aumento substancial do distanciamento ao longo da terapia, corresponde a um progresso favorável no tratamento da depressão, associado à mudança clínica. Esta evolução parece envolver uma ação coordenada entre as perspetivas, na medida em que uma está mais associada a envolvimento emocional e consciencialização do problema (imersão), mais comum no início da terapia, e a outra a uma fase posterior de observação, análise e criação de novos significados (distanciamento).

1.2. Imersão e distanciamento como mecanismos coordenados e dinâmicos envolvidos no processo de mudança terapêutica

Nos estudos 3 e 4 foram realizadas análises a um nível mais detalhado que permitiram observar que a imersão e o distanciamento podem atuar de forma coordenada e dinâmica no processo de mudança terapêutica. Em particular, o estudo 3 usou o modelo de assimilação de experiências problemáticas como modelo desenvolvimental de mudança em psicoterapia,

procurando perceber a associação destas perspetivas aos diferentes níveis de mudança. Embora o distanciamento, inversamente à imersão, se tenha revelado positivamente associado ao aumento dos níveis de assimilação – sugerindo que a mudança está associada a uma evolução linear de imersão para distanciamento com o avançar da terapia –, a análise destas perspetivas dentro de cada nível de mudança demonstrou um padrão de imersão e distanciamento que se modificou sistematicamente à medida que houve progressão para níveis mais elevados. Estes resultados sugerem que, a um nível mais micro, a evolução das perspetivas ao longo da mudança pode ser descontínua. Alguns dos dados que mostram esta descontinuidade já foram apresentados e debatidos no ponto anterior quando foi mencionado o facto de, em níveis mais precoces de mudança, ser encontrado mais distanciamento do que imersão associado a processos de evitamento (nível 1), e o aumento da imersão poder superar esse evitamento, bem como facilitar a consciência (nível 2) e clarificação do problema (nível 3). Adicionalmente, este estudo mostrou que maiores frequências de distanciamento do que de imersão poderão ser necessárias na compreensão e *insight* sobre diferentes facetas do problema (nível 4). Novamente, maior frequência de imersão poderá ser útil na aplicação das novas compreensões no sentido de resolver o problema (nível 5). Posteriormente, maior distanciamento parece ser necessário para a resolução efetiva do problema (nível 6). Estes resultados sugerem importantes reflexões quanto ao papel da imersão e do distanciamento em psicoterapia, sendo estas de seguida discutidas em 5 pontos distintos:

(1) A imersão e o distanciamento poderão estar ambos associados a evitamento.

Embora o evitamento permita um alívio imediato, restituindo o nível de funcionalidade (e.g., Gross, 2007; Kennedy-Moore & Watson, 2001), a médio-longo prazo pode trazer consequências devastadoras, pois impede a resolução efetiva do problema (Kashdan et al., 2006), e potencia a preocupação sobre o mesmo e a persistência de crenças desajustadas à realidade (e.g., Akbari & Khanipour, 2018), estando, muitas vezes, na base do desenvolvimento e manutenção de estados psicopatológicos (Gross, 2007; Moroz & Dunkley, 2019). Sendo assim, a imersão e o distanciamento podem manifestar-se como mecanismos prejudicais quando usados como forma de evitar o contacto emocional com a experiência que causa sofrimento. Este estudo, pela presença de distanciamento e imersão no nível 1 de mudança (evitamento), apoia a literatura sobre a relação entre o distanciamento e o evitamento (e.g., McIsaac & Eich 2004), mas acrescenta ainda que também a imersão pode estar associada a este processo. No caso analisado, o evitamento manifestou-se na imersão quando a cliente se focou no medo em explorar um dos seus principais problemas, evitando envolver-se em conteúdos mais centrais. No distanciamento ocorreu pela reflexão apenas periférica de conteúdos ligados à experiência, impedindo o envolvimento emocional. Em conjunto, a imersão e o distanciamento parecem ter contribuído para o evitamento.

(2) A imersão surge associada à superação do evitamento inicial nos níveis 2 e 3 de assimilação.

As elevadas frequências de imersão encontradas nos níveis 2 e 3 de mudança sugerem que esta perspetiva pode ser útil para aceder a pensamentos e a emoções associados ao problema e que causam sofrimento (consciencialização do problema – nível 2), sendo que o seu foco e expressão pode favorecer uma melhor definição do problema (clarificação do problema – nível 3). Simultaneamente, os benefícios do aumento da imersão estendem-se à superação do evitamento. Isto leva a considerar que, numa fase precoce de mudança, a imersão deverá ser elevada para provocar o envolvimento emocional necessário. Portanto, fomentar a imersão, em detrimento do distanciamento poderá ser útil.

(3) O aumento do distanciamento surge ligado a uma nova compreensão de si e dos problemas.

Numa fase posterior do processo, o aumento do distanciamento e a diminuição da imersão aparecem associados à atribuição de significado à experiência (compreensão/*insight* – nível 4), fundamental para o equilíbrio emocional (afeto neutro) e homeostasia do *Self* (Basto et al., 2017; Stiles, 2011; Stiles, Osatuke, Glick, Mackay, 2004) – resultado também coerente com os estudos que associam o distanciamento à regulação emocional (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012) e à reconstrução da experiência (e.g., Etzel, 2017; Kross et al., 2012).

(4) A passagem dessa nova compreensão para esforços práticos de resolução do problema corresponde a um aumento da imersão.

Num nível posterior, o aumento da imersão sobre o distanciamento poderá ser útil na aplicação das novas compreensões como primeiros esforços para a resolução do problema (aplicação/trabalho sobre o problema – nível 5). O predomínio da imersão num nível elevado de assimilação, adicionado ao facto do nível 5 ser caracterizado pela emergência de maior afeto positivo, não era um resultado expectável, quer tendo em conta o modelo de assimilação (Caro Gabalda & Stiles, 2009; Stiles, 2011; Stiles et al. 1991), quer os estudos que associam a imersão ao afeto negativo (e.g., Kross et al., 2014; Kross et al., 2012; Verduyn et al., 2012). De acordo com o caso analisado, neste nível, a perspetiva imersa manifestou-se pela descrição de ações, pensamentos e sentimentos que ocorreram diariamente, ilustrativos da parcial resolução do problema. Neste sentido, uma possibilidade explicativa deste fenómeno é que, neste nível, a imersão ocorreu sobre facetas positivas da experiência, podendo ter sustentado estados emocionais positivos (Verduyn et al., 2012). Uma outra hipótese é que a aplicação das novas compreensões da vida diária é alcançada fora da terapia e em terapia é solicitado que ela seja relatada a partir da sua descrição, implicando uma perspetiva imersa. Contudo, isto não parece invalidar a importância da imersão em terapia, pois a expressão de novas conquistas permite sistematizar e integrar as mudanças alcançadas (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011).

(5) A resolução do problema clínico surge associada a maior distanciamento.

Posteriormente, uma reflexão sobretudo distanciada poderá ser benéfica para a efetiva resolução do problema, compreendendo as diferenças entre o passado e o presente e o processo

nele envolvido. Isto é convergente com os estudos experimentais/laboratoriais que associam o distanciamento à resolução de problemas (e.g., Ayduk & Kross, 2008, 2010b).

Portanto, o estudo 3 oferece indicações sobre como a imersão e o distanciamento podem estar envolvidos em diferentes etapas do processo de mudança terapêutica. Os resultados obtidos sugerem a existência de um padrão irregular, caracterizado por oscilações no predomínio de cada perspetiva com o progresso para níveis de mudança mais elevados. Estas observações revelam evidência empírica de que (1) também a imersão pode estar associada a diferentes níveis de mudança, mesmo nos níveis mais avançados (e.g., nível 5); (2) ambas as perspetivas podem exercer papéis importantes para a mudança psicoterapêutica; (3) embora cada perspetiva seja divergente na sua associação ao nível de mudança, podem convergir no sentido da mudança, exercendo papéis complementares. Aliás, a partir do nível 3, foram detetadas transições frequentes e coordenadas entre imersão e distanciamento dentro de cada nível de mudança, gerando visões mais adaptativas da realidade. Por exemplo, no nível 4, a cliente em estudo descreveu diferentes experiências que ilustravam o seu problema a partir de uma perspetiva imersa, e estabeleceu possíveis ligações entre essas experiências a partir de uma perspetiva distanciada. Foi neste nível que foram detetadas transições mais frequentes que, coincidentemente, é o nível a partir do qual se distinguem os casos de sucesso dos de insucesso (Brinegar et al., 2008). Mais precisamente, os estudos que se enquadram dentro do modelo de assimilação de experiências problemáticas têm mostrado que os casos de sucesso terapêutico progridem para níveis mais elevados do que os de insucesso terapêutico (nível 4 ou superior). Portanto, em conjunto, os resultados sugerem que imersão e o distanciamento podem atuar de forma coordenada e dinâmica em terapia, e isso é favorável ao sucesso terapêutico.

Esta premissa é apoiada pelo estudo 4, mostrando que maior flexibilidade entre perspetivas, caracterizada por transições frequentes e rápidas entre imersão e distanciamento, na fase intermédia da terapia, esteve associada negativamente aos sintomas depressivos no final do tratamento, independentemente da abordagem terapêutica aplicada (terapia cognitivo-comportamental ou terapia focada nas emoções). Mais concretamente, o aumento da frequência das mudanças entre perspetivas numa fase intermédia da terapia prediz a diminuição dos sintomas depressivos alcançado no término do processo. Assim, a capacidade em alternar frequentemente entre refletir sobre a experiência numa perspetiva imersa para uma perspetiva distanciada poderá ser útil para o progresso favorável da sintomatologia. Além disso, os resultados parecem apontar para a importância dos/as clientes diagnosticados/as com depressão, numa fase intermédia, despenderem curtos períodos de tempo em cada perspetiva à medida que refletem sobre a sua experiência problemática, o que pressupõe um padrão flexível e, por isso, dinâmico de funcionamento destas perspetivas.

A depressão é caracterizada por padrões rígidos que contribuem para manter a sintomatologia (Ciesla & Roberts, 2007; Nolen-Hoeksema et al., 2008; Takagishi et al., 2013). A teoria dos sistemas dinâmicos, por seu turno, defende a importância da flexibilidade para quebrar padrões rígidos de configuração do *Self* (Fisher et al., 2011) e este estudo vai na mesma direção,

ao mostrar que o aumento da flexibilidade entre imersão e distanciamento gera flutuações na forma como a pessoa perspetiva a experiência, flutuações essas que quebram com padrões rígidos e desadaptativos. Assim, rápidas e frequentes transições entre imersão e distanciamento na fase intermédia do processo terapêutico parecem representar uma forma adaptativa de reflexão da experiência problemática na depressão. Aliás, tendo em consideração os resultados associados aos casos de insucesso com depressão, nomeadamente um padrão contínuo e estável sobretudo de imersão (estudo 2), bem como a associação do distanciamento a estados de evitamento (estudo 3), um padrão flexível entre perspetivas pode impedir ou quebrar processos negativos provenientes de longos períodos de imersão, bem como processos de evitamento resultantes de períodos de distanciamento desadaptativo. Repetidos ciclos de imersão e distanciamento poderão ser necessários para obter uma melhor regulação emocional e promover a mudança na forma como a pessoa representa cognitivamente a experiência, contribuindo para um maior bem-estar. Teoricamente, ciclos repetidos alimentam a produção de mais ciclos (Gonçalves et al., 2011; Mergenthaler, 2000). Portanto, possivelmente, maior flexibilidade entre perspetivas promove influências recíprocas, aumentando a capacidade em transitar de uma perspetiva para a outra e, consecutivamente, alimentando novos ciclos de imersão e distanciamento. Por outras palavras, a pessoa começa por refletir a partir de uma perspetiva imersa, mas, entretanto, muda de perspetiva, adotando uma posição de observador, o que cria uma nova reflexão imersa que, por sua vez, alimenta novas formas de distanciamento, e assim por diante. Isto é análogo ao que é proposto pelo modelo de ciclos terapêuticos, que defende que o envolvimento emocional e a abstração podem ocorrer de forma conexa, ou seja, o/a cliente é capaz de expressar-se emocionalmente e seguidamente elaborar sobre o conteúdo expressado, criando *insight* (Mergenthaler, 1996, 2000).

Sumariamente, o padrão linear de evolução associado ao sucesso terapêutico, caracterizado por maior imersão inicial seguida do aumento substancial de distanciamento (estudos 1 e 2), parece representar uma visão global de um modelo irregular de transição entre imersão e distanciamento, para alcançar uma reflexão mais adaptativa e estável. Estas considerações vão ao encontro da teoria dos sistemas dinâmicos que defende que maior flexibilidade permite a destabilização do sistema pessoal, fundamental para posterior configuração mais adaptativa e estável do *Self* (Fisher et al., 2011) e mudança clínica (e.g., Gumz et al., 2010; Hayes et al., 2007). Esta visão sobre a imersão e o distanciamento apoia também a hipótese de que estas perspetivas podem não atuar de forma oposta e independente em psicoterapia. Pelo contrário, há evidências de que a imersão e o distanciamento podem funcionar como mecanismos coordenados e dinâmicos na mudança psicoterapêutica (estudos 3 e 4).

2. Limitações e Estudos Futuros

Os estudos realizados no âmbito desta dissertação apresentam um conjunto de limitações que condicionam a interpretação dos resultados alcançados, bem como a generalização dos mesmos.

Uma das principais limitações prende-se com o tamanho e características das amostras recolhidas. Foram utilizados estudos de caso e estudos com amostras pequenas (n=6 e n=17). O reduzido número de casos analisados deve-se essencialmente a constrangimentos no processo de codificação de imersão e distanciamento, bem como de outras variáveis usadas, como a assimilação de experiências problemáticas (estudo 3). O processo de codificação destas medidas é bastante moroso, pois implica várias fases (e.g., estudo, treino e aplicação da medida) e está dependente do acordo inter-juízes. O tempo despendido em cada caso dificulta a constituição de uma amostra substancial, sendo comum encontrar amostras pequenas em estudos que englobam este tipo de procedimentos (e.g., Basto, Stiles, Rijo, & Salgado, 2017; Mendes et al., 2016). Contudo, a opção por este tipo de medidas prende-se com a possibilidade de aceder a microprocessos do/a cliente em contexto psicoterapêutico, aumentando a riqueza e a profundidade das observações obtidas. Os estudos de caso seguiram esta abordagem mais minuciosa, pelo que os resultados devem ser lidos para o caso específico analisado, não sendo generalizáveis. No entanto, isso não retira a importância deste tipo de estudos, dado que as observações alcançadas numa análise exaustiva de casos clínicos podem ser acomodadas à teoria existente, o que favorece o seu aperfeiçoamento (e.g., Stiles, 2007, 2015).

Relativamente às características da amostra, é de salientar que os casos recolhidos foram acompanhados no âmbito de um ensaio clínico, nomeadamente o *Estudo de depressão do ISMAI* (Salgado, 2014), o que, embora tenha sido vantajoso para a elaboração dos estudos aqui apresentados, tornam a amostra restrita no que respeita às características sociodemográficas e motivação para o processo, e também homogénea no que respeita ao diagnóstico (e.g., perturbação depressiva major). Apesar de ser nosso objetivo focar os estudos especificamente no tratamento da depressão dada a pertinência político-social envolvida, coloca-se a questão: será que outro tipo de perturbação exigiria uma evolução diferente em termos de imersão e distanciamento ao longo do processo de mudança psicoterapêutica? Clientes com depressão tendem a refletir a partir de uma perspetiva imersa (Kross & Ayduk, 2009; Kross et al., 2009; Kross et al., 2012) e isso foi reforçado pelos estudos desta dissertação. Contudo, outras perturbações podem partir de uma perspetiva diferente. Face a estas limitações, prevê-se fundamental, em investigações futuras, replicar os estudos com amostras maiores e mais heterogéneas, isto é, que abranjam outro tipo de perturbação e população clínica proveniente de um contexto real de atendimento (e.g., contextos de prática de rotina). Desta forma será possível aumentar a validade ecológica dos nossos resultados e perceber se são representativos e generalizáveis à população geral e a diferentes psicopatologias.

A elaboração de estudos com amostras maiores permite o uso de análises estatísticas mais exigentes e, consequentemente, resultados mais robustos. Embora tenham sido precavidas algumas situações, como o uso do *Simulation Modelling Analysis* como forma de minimizar os problemas estatísticos gerados em estudos de séries temporais (autocorrelação e baixo número de observações), os resultados dos estudos desta dissertação devem ser lidos com precaução. Por exemplo, a natureza correlacional dos resultados é uma questão sensível, pois não permite atribuir

uma causa direta e, por este motivo, é necessário considerar mais do que uma explicação. É o caso da relação encontrada entre imersão/distanciamento e os sintomas, pois existem duas possíveis formas de interpretação dos resultados: (1) por um lado, é possível que mudanças na perspetiva possam promover mudanças na severidade dos sintomas depressivos e, nesta lógica, a manutenção da perspetiva imersa resulta na manutenção dos sintomas e consequente condição psicopatológica; (2) alternativamente, a mudança na severidade dos sintomas depressivos pode provocar mudanças na perspetiva adotada durante a reflexão da experiência negativa. O mesmo pode ser considerado no caso da ativação emocional: (1) por um lado, o aumento da imersão pode gerar ativação emocional de emoções negativas e o aumento do distanciamento a ativação emocional de emoções positivas; (2) por outro lado, o aumento das emoções negativas pode levar a uma reflexão imersa sobre a experiência negativa e o aumento das emoções positivas pode facilitar uma reflexão distanciada sobre a mesma. Portanto, importa clarificar estas questões com mais estudos que usem amostras substancialmente maiores.

Dada a complexidade na aplicação das medidas de processo, como a MIDS, antevê-se dificuldades na constituição de amostras com elevado número de participantes. Por esta razão, atualmente está a ser validada uma nova medida, baseada na MIDS, que permite a identificação da imersão e do distanciamento a partir do discurso transcrito de uma forma computorizada (Sousa et al., 2017). O objetivo deste método é tornar a codificação mais rápida, mantendo o rigor científico na identificação das perspetivas. Uma outra solução, que poderá também contornar o constrangimento relativo à morosidade da aplicação da MIDS e, adicionalmente, ultrapassar a questão da existência de transcrições, é a elaboração de uma medida observacional.

Uma outra questão metodológica a notar nos estudos desta dissertação, é facto de um dos juízes envolvidos na análise qualitativa dos dados ter tido conhecimento dos resultados clínicos dos casos analisados. Isto pode ser visto como uma limitação pelo potencial enviesamento dos resultados obtidos. No entanto, reduzimos esse potencial efeito através de dois procedimentos: tendo sempre um/a segundo/a juiz/juíza cego/a aos resultados; os/as dois/duas juízes/as envolvidos/as em cada caso analisado codificaram 100% do material. Acrescenta-se, ainda, que os valores kappa de Cohen também revelaram um acordo satisfatório, o que credibiliza o processo de codificação.

No que respeita a eventuais investigações futuras, um outro aspeto a considerar é o efeito da terapia e do/a terapeuta na perspetiva adotada pelo/a cliente. Em relação à terapia, os estudos desta dissertação procuraram informar mais sobre a questão da transversalidade dos resultados encontrados, a partir da análise da imersão e do distanciamento em duas modalidades terapêuticas contrastantes (terapia cognitivo-comportamental e terapia focada nas emoções). Embora o padrão de evolução encontrado seja similar (e.g., estudo 1 e estudos 2/3), provavelmente o tempo gasto em cada perspetiva é diferente. Esta questão poderá ser dissipada em estudos futuros envolvendo estas e outras modalidades terapêuticas.

Em relação ao/à terapeuta, a contribuição dele/dela na perspetiva adotada pelo/a cliente julga-se pertinente para a prática clínica. Ao longo da elaboração desta dissertação, esta questão

de investigação foi sendo explorada num outro estudo. Esse estudo não foi incluído neste trabalho, uma vez que foi liderado por uma outra investigadora. Os resultados do referido estudo sugerem implicações do/a terapeuta na perspetiva do/a cliente, em particular na flexibilidade do seu discurso ao evidenciar diferentes tipos de competências do/a terapeuta que acompanharam a alternância entre os dois tipos de perspetivas no/a cliente (Couto et al., 2016). Tendo por base o estudo 4, que apontou para a flexibilidade entre perspetivas no/a cliente como importante para a mudança clínica, estudos que sustentem os resultados encontrados e clarifiquem esta relação são pertinentes, no sentido em que estas informações podem ser usadas na formação dos/as profissionais, sendo úteis para melhorar a prática e a eficácia terapêutica.

Ainda no que respeita à flexibilidade entre perspetivas, consideramos também pertinente explorar a evolução das transições entre imersão e distanciamento na fase inicial e final da terapia, com o objetivo de verificar se, também nestas fases, a imersão e o distanciamento se mostram coerentes com o modelo dos sistemas dinâmicos. Mais concretamente, testar a existência de um padrão de reflexão rígido, caracterizado pelo predomínio da perspetiva imersa na fase inicial da terapia, evoluindo para maior flexibilidade entre imersão e distanciamento na fase intermédia e, culminando num padrão de reflexão mais estável, caracterizado pelo predomínio da perspetiva distanciada na fase final da terapia (Fisher et al., 2011).

3. Implicações para a Prática Clínica

A presente dissertação salienta a importância da perspetiva adotada na reflexão de experiências pessoais problemáticas ao longo do tratamento da depressão. A sua relação com a mudança psicoterapêutica parece indicar que as perspetivas imersa e distanciada têm um papel relevante em psicoterapia, sugerindo implicações para a prática clínica. Ao elucidar sobre quando e como estas perspetivas podem ser úteis e prejudiciais em contexto terapêutico, este trabalho evidencia que ambas as perspetivas podem ser usadas em prol da mudança ou poderão servir de mecanismos que mantêm o estado psicopatológico. Por isso, julgamos que quando e como estas perspetivas se manifestam ao longo do processo terapêutico devem ser alvo de atenção clínica. Conhecer como cada uma delas pode atuar de forma produtiva/não produtiva poderá ajudar o/a terapeuta a orientar a sua intervenção no sentido de promover a perspetiva que melhor de adequa à fase do processo em que o/a cliente se encontra, aumentando assim a probabilidade de eficácia do tratamento.

Vários aspetos dos resultados alcançados nesta dissertação podem ser apontados a este nível. Um deles prende-se com o padrão de evolução das perspetivas imersa e distanciada que se revelou associado à mudança, quer no que respeita à assimilação de experiências problemáticas, quer à mudança sintomatológica e emocional. Neste sentido, poderá ser favorável para o sucesso terapêutico, o/a terapeuta ajudar o/a cliente no desenvolvimento de um padrão de evolução caracterizado por maior imersão inicial e posterior aumento do distanciamento. A presença de um padrão estável, marcado sobretudo pela perspetiva imersa ao longo do processo, pode sinalizar que o/a cliente não está a progredir favoravelmente, beneficiando de técnicas promotoras de

distanciamento. O contrário também pode acontecer, ou seja, a presença de elevado distanciamento no início da terapia, em que o/a cliente se foca em conteúdos periféricos da experiência, pode ser sinal de evitamento. Fomentar a perspetiva imersa poderá ser uma ação terapêutica útil no alcance de níveis de mudança superiores.

Um outro aspeto refere-se à importância da flexibilidade entre perspetivas na fase intermédia da terapia para o resultado final em termos de sintomas depressivos. Assim, a atenção do/a terapeuta dada a este fenómeno parece relevante. Poderá ser vantajoso o uso de estratégias que fomentem transições frequentes e rápidas entre imersão e distanciamento na fase intermédia da terapia, de modo a promover maior flexibilidade na reflexão da experiência problemática.

Tendo por base as implicações para a prática clínica até agora abordadas, estas parecem fundamentar, em primeira instância, a importância de o/a terapeuta ser capaz de identificar a perspetiva usada pelo/a cliente. A elaboração e validação de uma medida de autorrelato preenchida pelo/a cliente, que permita avaliar em cada sessão este fenómeno, poderá ser uma solução rápida e prática de aceder às perspetivas. Do mesmo modo, a elaboração e validação de uma medida preenchida pelo/a terapeuta poderá ser importante. Aliás, a conjugação das duas medidas pode ser interessante, fornecendo informação sobre a perceção dos diferentes intervenientes sobre o mesmo fenómeno. Estas medidas permitiriam obter o nível de imersão/distanciamento global. Contudo, também poderá ser vantajoso conseguir perceber no momento (in loco) quando o/a cliente está a refletir segundo uma perspetiva imersa e distanciada. Este processo seria facilitado com a elaboração de um conjunto de indicadores, ou seja, sinais ou pistas observáveis, que caracterizam cada uma das perspetivas.

Obviamente que será necessário conhecer de forma mais clara quais as estratégias que melhor se adequam à promoção de cada uma das perspetivas, tendo em conta o nível de mudança e fase do processo terapêutico em que o/a cliente se encontra. Portanto, poderá ser um passo importante na melhoria da prática clínica no tratamento da depressão incentivar os/as terapeutas a prestar atenção à perspetiva usada na reflexão de experiências problemáticas, criando ferramentas que os/as ajudem na identificação de cada perspetiva e na devolução de respostas adequadas ao desenvolvimento positivo das mesmas ao longo da terapia. Este passo pode ser útil no sentido de fomentar o processo de mudança e bem-estar clínico.

4. Conclusões e Considerações Finais

A presente dissertação salienta a importância da imersão e do distanciamento no processo de mudança psicoterapêutica na depressão, contribuindo para ampliar a compreensão sobre os processos promotores da eficácia neste contexto. Em conjunto, os resultados dos diferentes estudos tornam legítimo extrair a possibilidade de um modelo representativo da imersão e do distanciamento no sucesso terapêutico de clientes diagnosticados/as com depressão. Um padrão marcado por mais imersão na fase inicial da terapia, seguido de maior flexibilidade entre perspetivas, sobretudo na fase intermédia, acompanhado do aumento substancial do distanciamento, poderá ser um modelo desenvolvimental útil pela sua associação à mudança

clínica e emocional. Este modelo assume a imersão e o distanciamento como mecanismos coordenados e dinâmicos, integrados no processo de mudança. Neste sentido, acreditamos que refletir sobre a experiência pessoal problemática de forma adaptativa, não é apenas um resultado, mas sim um processo complexo entre a perspetiva imersa e distanciada que decorre ao longo do tratamento psicoterapêutico.

Seguindo esta linha de raciocínio, salientam-se algumas considerações acerca da importância de cada uma das perspetivas de acordo com o momento do processo terapêutico em que se manifestam, as quais refletem as principais conclusões desta dissertação: (1) a imersão sobre experiências negativas numa fase inicial da terapia pode ser entendida como um movimento no sentido da mudança, mesmo que isso não implique elevados níveis de bem-estar; (2) parece ser importante o aumento significativo do distanciamento a partir desta fase, uma vez que a imersão elevada de forma contínua e indefinida torna-se excessiva e prejudicial. Assim, a diminuição da imersão poderá ser considerada como um processo esperado, mas não propriamente negativo. Por sua vez, o aumento do distanciamento poderá ser útil e favorável à criação de novos significados; (3) o papel positivo da imersão poderá estender-se também a uma fase de mudança mais tardia, nomeadamente quando o/a cliente reflete sobre a aplicação das novas compreensões no sentido de resolver o problema; (4) o desenvolvimento de uma reflexão mais distanciada poderá ser útil para a resolução efetiva do problema numa fase final do processo terapêutico. Contudo, isto não significa que elevado distanciamento em psicoterapia seja produtivo, pois mais distanciamento numa fase inicial pode representar evitamento da experiência dolorosa; (5) a flexibilidade entre perspetivas numa fase intermédia poderá constituir um momento-chave para a mudança psicoterapêutica. Este fenómeno, sendo transversal aos modelos teóricos subjacentes a esta dissertação, sugere que a flexibilidade entre perspetivas é um processo abrangente que traduz mudanças na forma como a pessoa reflete sobre a sua experiência, quebrando padrões rígidos e inflexíveis, e isso está diretamente associado ao bem-estar atingido no final do tratamento. Neste sentido, o processo de evolução das perspetivas quando analisadas a um nível mais detalhado é descontínuo e instável, sugerindo um processo dinâmico como visão complementar ao movimento linear de imersão para distanciamento.

Numa apreciação global desta dissertação, existem ainda outros aspetos que se julgam relevantes considerar. Em primeiro lugar, é de realçar a importância da elaboração da MIDS, permitindo a observação longitudinal das variáveis em estudo.

Em segundo lugar, este trabalho não se restringe à avaliação de mudança ao nível de sintomatologia de uma determinada categoria de diagnóstico. Foi usado, por exemplo, o modelo de assimilação que permite avaliar o funcionamento global (cognitivo, emocional e comportamental) em relação a uma experiência negativa (Caro Gabalda & Stiles, 2009; Stiles, 2011; Stiles et al. 1991) e, por isso, os resultados tornam-se mais próximos e coerentes com a complexidade da mudança em psicoterapia e funcionamento humano.

Por último, ainda que devam ser consideradas algumas limitações, esta dissertação constitui o primeiro esforço em estudar a imersão e o distanciamento de forma sistemática em

psicoterapia, adotando uma perspetiva longitudinal e integradora sobre estes fenómenos. Esta abordagem permitiu obter resultados que reforçam a teoria existente, mas também outros resultados que sugerem novas leituras sobre o potencial de cada perspetiva e das perspetivas em conjunto, nomeadamente na mudança sintomatológica e emocional e na assimilação de experiências problemáticas. Assim, este trabalho constitui um pequeno incremento no reforço, mas também no refinamento da teoria existente. Além disso, acreditamos que o seu contributo se estenda a nível clínico, pelas indicações obtidas sobre quando e como a imersão e o distanciamento podem ser úteis/prejudiciais em psicoterapia para a depressão. Acreditamos que estas informações merecem atenção clínica por parte dos/as terapeutas, pois podem constituir uma ferramenta importante no sentido de promover a perspetiva que melhor se adequa à fase em que o/a cliente se encontra e, consequentemente, facilitar a mudança e fomentar a eficácia terapêutica.

Referências Bibliográficas[5]

Akbari, M., & Khanipour, H. (2018). The transdiagnostic model of worry: The mediating role of experiential avoidance. *Personality and Individual Differences, 135*, 166-172. doi:10.1016/j.paid.2018.07.011

Ayduk. Ö., & Kross, E. (2010a). Analyzing negative experiences without ruminating: The role of self-distancing in enabling adaptive self-reflection. *Social and Personality Psychology Compass, 4*, 841-854. doi:10.1111/j.1751-9004.2010.00301.x

Ayduk, Ö., & Kross, E. (2010b). From a distance: Implications of spontaneous self-distancing for adaptive self-reflection. *Journal of Personality and Social Psychology, 98*, 809-829. doi:10.1037/a0019205

Ayduk, Ö., & Kross, E. (2009). Asking 'why' from a distance facilitates emotional processing: A reanalysis of Wimalaweera and Moulds (2008). *Behaviour Research and Therapy, 47*, 88-92. doi:10.1016/j.brat.2008.06.014

Ayduk, Ö., & Kross, E. (2008). Enhancing the pace of recovery, self-distanced analysis of negative experiences reduces blood pressure reactivity. *Psychological Science, 19*, 229-231. doi:10.1111/j.1467-9280.2008.02073.x

Bar-Anan, Y., Liberman, N., & Trope, Y. (2006). The association between psychological distance and construal level: Evidence from an implicit association test. *Journal of Experimental Psychology: General, 135*(4), 609-622. doi:10.1037/0096-3445.135.4.609

Barbosa, E., Silva, S., Castro, D., Pinto-Gouveia, J., & Salgado, J. (2017). *Development and validation of the measure of immersed and distanced speech.* Manuscript in preparation.

Basto, I., Pinheiro, P., Stiles, W. B., Rijo, D., & Salgado, J. (2017). Changes in symptom intensity and emotion valence during the process of assimilation of a problematic experience: A quantitative study of a good outcome case in CBT. *Psychotherapy Research, 27*, 437-449. doi:10.1080/10503307.2015.1119325

Basto, I. M., Stiles, W. B., Rijo, D., & Salgado, J. (2018). Does assimilation of problematic experiences predict a decrease in symptom intensity? *Clinical Psychology & Psychotherapy, 25*(1), 76-84. doi:10.1002/cpp.2130

Beck, A. T. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy,* 1, 184-200. doi:10.1016/S0005-7894(70)80030-2

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

[5] Nesta secção são apresentados os trabalhos citados ao longo da introdução e conclusão desta dissertação. Os trabalhos citados em cada estudo estão apresentados na lista de referências correspondente.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II (BDI-II)*. San Antonio, TX: Psychological Corporation.

Berman, M. G., Peltier, S., Nee, D. E., Kross, E., Deldin, P. J., & Jonides, J. (2011). Depression, rumination and the default network. *Social Cognitive and Affective Neuroscience, 6,* 548-555. doi:10.1093/scan/nsq080

Bernstein, A., Hadash, Y., Lichtash, Y., Tanay, G., Shepherd, K., & Fresco, D. (2015). Decentering and related constructs: A critical review and meta-cognitive processes model. *Perspectives on Psychological Science, 10*(5), 599-617. doi:10.1177/1745691615594577

Berntsen, D., Willert, M., & Rubin, D. C. (2003). Splintered memories or vivid landmarks? Qualities and organization of traumatic memories with and without PTSD. *Applied Cognitive Psychology, 17*, 675–693. doi:10.1002/acp.894

Bonanno, G. A., Keltner, D., Holen, A., & Horowitz, M. J. (1995). When avoiding unpleasant emotions might not be such a bad thing: Verbal-autonomic response dissociation and midlife conjugal bereavement. *Journal of Personality and Social Psychology, 69*, 975-989. doi:0022-3514/95/S3.00

Brinegar, M. G., Salvi, L. M., & Stiles, W. B., (2008). The case of Lisa and the assimilation model: The interrelatedness of problematic voices. *Psychotherapy Research, 18*, 657-666. doi:10.1080/10503300802183694.

Brosschot, J. F., Gerin, W., & Thayer, J. F. (2006). The perseverative cognition hypothesis: A review of worry, prolonged stress-related physiological activation, and health. *Journal of Psychosomatic Research, 60*, 113-124. doi:10.1016/j.jpsychores.2005.06.074

Bushman, B. J. (2002). Does venting anger feed or extinguish the flame? Catharsis, rumination, distraction, anger, and aggressive responding. *Society for Personality and Social Psychology, 28*, 724-731. doi:10.1177/0146167202289002

Bushman, B. J., Bonacci, A. M., Pedersen, W. C., Vasquez, E. A., & Miller, N. (2005). Chewing on it can chew you up: Effects of rumination on triggered displaced aggression. *Journal of Personality and Social Psychology, 88*(6)*,* 969–983. doi:10.1037/0022-3514.88.6.969

Caro Gabalda, I. (2011). El cambio terapéutico a través del modelo de asimilación: Su aplicación en la terapia lingüística de evaluación. *Revista de Psicopatología y Psicología Clínica, 16*, 169-188. doi:10.5944/rppc.vol.16.num.3.2011.10360

Caro Gabalda, I., & Stiles, W. (2009). Retrocessos no contexto da terapia linguística de avaliação. *Análise Psicológica, 27,* 199-212. doi:10.14417/ap.205

Caro Gabalda, I., Stiles, W. B., & Pérez Ruiz, S. (2016). Therapist activities preceding setbacks in the assimilation process. *Psychotherapy Research, 26*, 653-664. doi:10.1080/10503307.2015.1104422

Carryer, J. R., & Greenberg, L. S. (2010). Optimal levels of emotional arousal in Experiential Therapy of depression. *Journal of Counseling and Clinical Psychology, 75(2),* 190-199. doi:10.1037/a0018401

Ciesla, J., & Roberts, J. (2007). Rumination, negative cognition, and their interactive effects on depressed mood. *Emotion, 7*, 555-565. doi:10.1037/1528-3542.7.3.555

Clark, D. A., & Beck, A. T. (2010). Cognitive theory and therapy of anxiety and depression: Convergence with neurobiological findings. *Trends in Cognitive Science, 14*, 418-424. doi:10.1016/j.tics.2010.06.007

Clark, D. A., & Beck, A. T. (2010). *Cognitive therapy of anxiety disorders science and practice*. New York: Guilford Press.

Coles, M. E., Turk, C. L., Heimberg, R. G., & Fresco, D. (2001). Effects of varying levels of anxiety within social situations: Relationship to memory perspective and attributions in social phobia. *Behavior Research & Therapy, 39*, 651–665. doi:10.1016/S0005-7967(00)00035-8

Couto, A. B., Barbosa, E., Silva, S., Bento, T., Teixeira, A. S., Salgado, J., & Cunha, C. (2016). Client's immersed and distanced speech and therapist's interventions in emotion-focused therapy for depression: An intensive analysis of a case study. *Research in Psychotherapy: Psychopathology, Process and Outcome, 19*(2), 136-149. doi:10.4081/ripppo.2016.205

Denson, T. F., Spanovic, M., & Miller, N. (2009). Cognitive appraisals and emotions predict cortisol and immune responses: A meta-analysis of acute laboratory social stressors and emotion inductions. *Psychological Bulletin, 135*(6), 823–853. doi:10.1037/a0016909

Dimaggio, G., Carcione, A., Nicolò, G., Conti, L., Fiore, D., Pedone, R., ..., Semerari, A. (2009). Impaired decentration in personality disorder: A series of single cases analysed with the Metacognition Assessment Scale. *Clinical Psychology and Psychotherapy, 16*, 450-462. doi:10.1002/cpp.619

Dimaggio, G., & Lysaker, P. H. (2015). Metacognition and mentalizing in the psychotherapy of patients with psychosis and personality disorders. *Journal of Clinical Psychology: In Session, 71*(12), 117-124. doi:10.1002/jclp.22147

Dorfel, D., Lamke, J. P., Hummel, F., Wagner, U., Erk, S., & Walter, H. (2014). Common and differential neural networks of emotion regulation by detachment, reinterpretation, distraction, and expressive suppression: A comparative fMRI investigation. *NeuroImage, 101,* 298–309. doi:10.1016/j.neuroimage.2014.06.051.

Duckworth, A. L., Gendler, T. S., & Gross, J. J. (2016). Situational strategies for self-control. *Perspectives on Psychological Science, 11,* 35-55. doi:10.1177/1745691615623247

Elliott, R., Greenberg, L. S., Watson, J., Timulak, L., & Freire, E. (2013). Research on humanistic-experiential psychotherapies. In M. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (pp. 495-538). New Jersey: John Wiley & Sons, Inc.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion focused therapy: The process-experiential approach to change.* Washington, D.C.: America Psychology Association.

Espejo, E. P., Gorlick, A., & Castriotta, N. (2017). Changes in threat-related cognitions and experiential avoidance in group-based transdiagnostic CBT for anxiety disorders. *Journal of Anxiety Disorders, 46,* 65-71. doi:10.1016/j.janxdis.2016.06.006

Etzel, L. (2017). Self-distancing as a mechanism for processing negative emotional experiences. *Yale Review of Undergraduate Research in Psychology.* Retrieved from https://cpb-us-w2.wpmucdn.com/campuspress.yale.edu/dist/a/1215/files/2017/06/Lena-2gemnhw.pdf

Fisher, A. J., Newman, M. G., & Molenaar, P. C. M. (2011). A quantitative method for the analysis of nomothetic relationships between idiographic structures: Dynamic patterns create attractor states for sustained posttreatment change. *Journal of Consulting and Clinical Psychology, 79*(4), 552-563. doi:10.1037/a0024069.

Foa, E. B., & Kozak, M. J. (1986). *Emotional processing of fear: Exposure to corrective information. Psychological Bulletin, 99*(1)*,* 20-35. doi:10.1037/0033-2909.99.1.20

Fosha, D. (2000). *The transforming power of affect: A model of accelerated change.* New York: Basic Books.

Fresco, D., Moore, M., Van Dulmen, M., Segal, Z., Ma, S., Teasdale, J., & Williams, J. M. (2007). Initial psychometric properties of the experiences questionnaire: Validation of a self-report measure of decentering. *Behavior Therapy, 38*(3), 234-246. doi:10.1016/j.beth.2006.08.003

Fujita, K., Trope, Y., Liberman, N., & Levin-Sagi, M. (2006). Construal levels and selfcontrol. *Journal of Personality and Social Psychology, 90(3),* 351–367. doi:10.1037/0022-3514.90.3.351

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapies and the nature of "innovative moments" in the construction of change. *Journal of Constructive Psychology, 22*, 1-23. doi:10.1080/10720530802500748

Gonçalves, M. M., & Ribeiro, A.P. (2012). Therapeutic change, innovative moments and the reconceptualization of the self: A dialogical account. *International Journal of Dialogical Science*, *6*, 81-98.

Gonçalves, M. M., Ribeiro, A., Mendes, I., Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research, 21*(5)*,* 497–509. doi:10.1080/ 10503307.2011.560207

Gotlib, I. H., & Joormann, J. (2010). Cognition and depression: Current status and future directions. *Annual Review of Clinical Psychology, 6*, 285–312. doi:0.1146/annurev.clinpsy.121208.131305

Gray, M. A., & Stiles, W. B. (2011). Employing a case study in building an assimilation theory account of generalized anxiety disorder and its treatment with cognitive-behavioral therapy. *Pragmatic Case Studies in Psychotherapy, 7*, 529–557. doi:10.14713/pcsp.v7i4.1115

Greenberg, L. S. (2002). *Emotion-Focused Therapy: Coaching clients to work through their feelings*. Washington: America Psychology Association.

Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical Psychology and Psychotherapy, 11*, 3-16. doi:10.1002/cpp.388

Greenberg, L. S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by moment process*. New York: Guilford Press.

Greenberg, L. S., & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington, D.C.: American Psychological Association.

Gross, J. J. (2015). Emotion regulation: Current status and future prospects. *Psychological Inquiry, 26*, 1-26. doi:10.1080/1047840X.2014.940781

Gross, J. J. (2013*). Handbook of emotion regulation* (2nd Ed.). New York: Guilford Press.

Gross, J. J. (*2007*). *Handbook of emotion regulation*. New York: Guilford Press.

Gross, J. J. (1998). Antecedent-and response-focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Social Psychology, 74*(1), 224–237. doi:10.1037/0022-3514.74.1.224

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348–362. doi:10.1037/0022-3514.85.2.348

Grossmann, I., & Kross, E. (2010). The impact of culture on adaptive versus maladaptive self-reflection. *Psychological Science, 21*, 1150-1157. doi:10.1177/0956797610376655

Gumz, A., Kastner, D, Geyer, M., Wutzler, U., Villmann, T., & Brahler, E. (2010). Instability and discontinuous change in the experience of therapeutic interaction: An extended single-case study of psychodynamic therapy processes. *Psychotherapy Research, 20*, 398-412. doi:10.1080/10503300903551021

Hardy G., & Llewelyn, S. (2015) Introduction to psychotherapy process research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 183–196). New York: Springer-Verlag.

Hayes, A., M., Laurenceau, J., Feldman, G., Strauss, J., & Cardaciotto, L. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27*, 715-723. doi:10.1037/0022-006X.75.3.409

Hayes-Skelton, S., & Graham, J. (2012). *Decentering as a common link among mindfulness, cognitive reappraisal, and social anxiety*. *Behavioural and Cognitive Psychotherapy, 41*(3)*,* 317-328. *doi:10.1017/S1352465812000902*

Heinzel, S., Tominschek, I., & Schiepek, G. (2014). Dynamic patterns in psychotherapy: Discontinuous changes and critical instabilities during the treatment of obsessive-compulsive disorder. *Nonlinear Dynamics, Psychology, and Life Sciences, 18*, 155–176.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi:0.1037/0022-0167.52.2.196

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change - 5th Edition* (pp. 84-136). Hoboken, New Jersey: Wiley.

Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight and action*. Washington, DC: American Psychological Association.

Hofmann, S. G., & Otto, M. W. (2008). *Cognitive-behavior therapy for social anxiety disorder: Evidence-based and disorder-specific treatment techniques.* New York: Routledge/Taylor & Francis Group.

Honos-Webb, L., Lani, J. A., & Stiles, W. B. (1999). Discovering markers of assimilation stages: The fear of losing control marker. *Journal of Clinical Psychology, 55,* 1441–1452. doi:10.1002/(SICI)1097-4679(199912)55:123.0.CO;2-K

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35,* 23-33. doi:10.1037/h0087682

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50*, 189-198. doi:10.1037/0022-0167.50.2.189

Honos-Webb, L., Surko, M., Stiles, W. B., & Greenberg, L S. (1999). Assimilation of voices in psychotherapy: The case of Jan. *Journal of Counseling Psychology, 46,* 448–460. doi:10.1037/0022-0167.46.4.448

Huang, Y., Chen, S., & Tseng, H. (2019). Attachment avoidance and fearful prosodic emotion recognition predict depression maintenance. *Psychiatry Research, 272*, 649–654. doi:10.1016/j.psychres.2018.12.119

Ingram, R. E., & Hollon, S. D. (1986). Cognitive therapy for depression from an information processing perspective. In R. E. Ingram (Ed.), *Information processing approaches to clinical psychology* (pp. 255– 281). San Diego, CA: Academic Press.

Kashdan T. B., Barrios V., Forsyth J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy, 44*, 1301-1320. doi:10.1016/j.brat.2005.10.003

Kashdan, T. B., Goodman, F. R., Machell, K. A., Kleiman, E. M., Monfort, S. S., Ciarrochi, J., & Nezlek, J. B. (2014). A contextual approach to experiential avoidance and social anxiety: Evidence from an experimental interaction and daily interactions of people with social anxiety disorder. *Emotion, 14*(4), 769-781. doi:10.1037/a0035935

Kennedy-Moore, E., & Watson, J. (2001). How and when does emotional expression help. *Review of General Psychology, 5*, 187-212. doi:10.1037/1089-2680.5.3.187

Knobloch, L. M. Endres, L. M., Stiles, W. B., & Silberschatz, G. (2001). Convergence and divergence of themes in successful psychotherapy: An assimilation analysis. *Psychotherapy, 38*, 31-39. doi:31-39.10.1037/0033-3204.38.1.31

Koenigsberg, H. W., Fan, J., Ochsner, K. N., Liu, X., Guise, K. G., Pizzarello, S., … Siever, L. J. (2009). Neural correlates of the use of psychological distancing to regulate responses to negative social cues: A study of patients with borderline personality disorder. *Biological Psychiatry, 66*(9), 854–863. doi:10.1016/j.biopsych.2009.06.010.

Koenigsberg, H. W., Fan, J., Ochsner, K. N., Liu, X., Guise, K., Pizzarello, S., … Siever, L. J. (2010). Neural correlates of using distancing to regulate emotional responses to social situations. *Neuropsychologia, 48*(6), 1813–1822. doi:10.1016/j.neuropsychologia.2010.03.002

Kross, E., & Ayduk O. (2017). Self-distancing: Theory, research, and current directions. *Advances in Experimental Social Psychology, 55*, 81-136. doi:10.1016/bs.aesp.2016.10.002

Kross, E., & Ayduk, Ö. (2011). Making meaning out of negative experiences by self-distancing. *Current Directions in Psychological Science, 20*, 187-191. doi:10.1177/0963721411408883

Kross, E., & Ayduk, Ö. (2009). Boundary conditions and buffering effects: Does depressive symptomology moderate the effectiveness of self-distancing for facilitating adaptive emotional analysis? *Journal of Research in Personality, 43,* 923-927. doi:10.1016/j.jrp.2009.04.004

Kross, E., & Ayduk, Ö. (2008). Facilitating adaptive emotional analysis: Distinguishing distanced-analysis of depressive experiences from immersed-analysis and distraction. *Personality and Social Psychology Bulletin, 34*, 924-938. doi:10.1177/0146167208315938

Kross, E., Ayduk, Ö., & Mischel, W. (2005). When asking ‘‘why’’ does not hurt: Distinguishing rumination from reflective processing of negative emotions. *American Psychological Society, 16*, 709-715. doi:10.1177/0963721411408883

Kross, E., Bruehlman-Senecal, E., Park, J., Burson, A., Dougherty, A., Shablack, H., … Ayduk, O. (2014). Self-talk as a regulatory mechanism: How you do it matters. *Journal of Personality and Social Psychology, 106*, 304–324. doi:10.1037/a0035173

Kross, E., Davidson, M., Weber, J., & Ochsner, K. (2009). Coping with emotions past: The neural bases of regulating affect associated with negative autobiographical memories. *Biological Psychiatry, 65*, 361-366. doi:10.1016/j.biopsych.2008.10.019

Kross, E., Gard, D., Deldin, P., Clifton, J., & Ayduk, Ö. (2012). “Asking why” from a distance: Its cognitive and emotional consequences for people with major depressive disorder. *Journal of Abnormal Psychology*, *121*, 559-569. doi:10.1037/a0028808

Kuyken, W., & Moulds, M. L. (2009). Remembering as an observer: How is autobiographical memory retrieval vantage perspective linked to depression? *Memory, 17,* 624–634. doi:0.1080/09658210902984526

Lench, H. C., Bench, S. W., & Davis, E. L. (2015). Distraction from emotional information reduces biased judgements. *Cognition and Emotion, 30*(4), 638-653. doi:10.1080/02699931.2015.1020767.

Liberman, N., & Trope, Y. (2008). The psychology of transcending the here and now. Sc*ience, 322*(5905), 1201–1205. doi:10.1126/science.1161958.

Llewelyn, S., Macdonald, J., & Aafjes-van Doorn, K. (2016). Process–outcome studies. In J. C. Norcross, G. R. VandenBos, D. K. Freedheim, & B. O. Olatunji (Eds.), *APA handbooks in psychology. APA handbook of clinical psychology: Theory and research* (pp. 451-463). Washington, DC: American Psychological Association.

Ma, S. H., & Teasdale, J. D. (2004) Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology, 72*, 31-40. doi:10.1037/0022-006X.72.1.31

McIsaac, H. K., & Eich, E. (2004). Vantage point in traumatic memory. *Psychological Science, 15*, 248-253. doi:10.1111/j.0956-7976.2004.00660.x

McIsaac, H. K., & Eich, E. (2002). Vantage point in episodic memory. *Psychonomic Bulletin & Review, 9*(1)*,* 146–150. doi:10.3758/BF03196271

Mendes, I., Rosa, C., Stiles, W., Caro Gabalda, I., Gomes, P., Basto, I., & Salgado, J. (2016) Setbacks in the process of assimilation of problematic experiences in two cases of emotion focused therapy for depression. *Psychotherapy Research, 26*(6)*,* 638-652. doi:10.1080/10503307.2015.1136443

Mergenthaler, E. (1996). Emotion-abstraction patterns in verbatim protocols: A new way of describing psychotherapeutic processes. *Journal of Consulting and Clinical Psychology, 64* (6)*,* 1306-1318. doi:10.1037/0022-006X.64.6.1306

Mergenthaler, E. (2000). The therapeutic cycles model in psychotherapy research: Theory, measurement and clinical application*. Ricerche sui Gruppi, 10*, 34-40.

Mischel, W., & Ayduk, O. (2004). Willpower in a cognitive-affective processing system: The dynamics of delay of gratification. In R. Baumeister & K. Vohs (Eds.), *Handbook of selfregulation research: Research, theory, and applications* (pp. 99–129). New York: Guilford.

Mischkowski, D., Kross, E., & Bushman, B. J. (2012). Flies on the wall are less aggressive: Self-distancing "in the heat of the moment" reduces aggressive thoughts, angry feelings and aggressive behavior. *Journal of Experimental Social Psychology, 48,* 1187-1191. doi:10.1016/j.jesp.2012.03.012

Mkrtchian, A., Aylward, J., Dayan, P., Roiser, J. P., & Robinson, O. J. (2017). Modeling avoidance in mood and anxiety disorders using reinforcement learning. *Biological Psychiatry*, *82*(7)*,* 532-539. doi:10.1016/j.biopsych.2017.01.017

Moroz, M., & Dunkley, D. M. (2019). Self-critical perfectionism, experiential avoidance, and depressive and anxious symptoms over two years: A three-wave longitudinal study. *Behaviour Research and Therapy, 112*, 18–27. doi:10.1016/j.brat.2018.11.006

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260. doi:10.1037/0022-0167.52.2.250

Moulds, M. L, Kandris, E., & Williams, A. D. (2007). The impact of rumination on memory for self-referent material. *Memory, 15*(8)*,* 814-821. doi:10.1080/09658210701725831

Nigro, G., & Neisser, U. (1983). Point of view in personal memories. *Cognitive Psychology, 15*, 467-482. doi:10.1016/0010-0285(83)90016-6

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*, 569-582. doi:10.1037/0021-843X.100.4.569

Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science, 3*, 400-424. doi:10.1111/j.1745-6924.2008.00088.x

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology, 67,* 143-154. doi:10.1002/jclp.20758

Osatuke, K., Glick, M. J., Stiles, W. B., Greenberg, L. S., Shapiro, D. A., & Barkham, M. (2005). Temporal patterns of improvement in client-centered therapy and cognitive-behaviour therapy. *Counselling Psychology Quarterly, 18,* 95-108. doi:10.1080/09515070500136900

Park, J., Ayduk, O., & Kross, E. (2016). Stepping back to move forward: Expressive writing promotes self-distancing. *Emotion, 16*(3)*,* 349364. doi:10.1037/emo0000121

Park, J., Ayduk, O., O'Donnell, L., Chun, J., Gruber, J., Kamali, M., … Kross, E. (2014). Regulating the high: Cognitive and neural processes underlying positive emotion regulation in bipolar I disorder. *Clinical Psychological Science, 2*(6)*,* 661–674. doi:10.1177/2167702614527580.

Pascual-Leone, A. (2009). Dynamic emotional processing in experiential therapy: Two steps forward, one step back. *Journal of Consulting and Clinical Psychology, 77*(1), 113-126. doi:10.1037/a0014488

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why "the only way out is through". *Journal of Consulting and Clinical Psychology, 75*, 875-887. doi:10.1037/0022-006X.75.6.875

Payne, L. A., Ellard, K. K., Farchione, T. J., Fairholme, C. P., & Barlow, D. H. (2014). Emotional disorders: A unified transdiagnostic protocol. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 237-274). New York: Guilford Press.

Pennebaker, J. W., & Chung, C. K. (2007). *Expressive writing, emotional upheavals, and health. Handbook of Health Psychology*. New York: Oxford University Press.

Pennebaker, J. W., & Graybeal, A. (2001). Patterns of natural language use: Disclosure, personality, and social integration. *Current Directions in Psychological Science, 10(3)*, 90–93. doi:10.1111/1467-8721.00123

Penner, L. A., Guevarra, D. A., Harper, F. W., Taub, J., Phipps, S., Albrecht, T. L., & Kross, E. (2016). Self-distancing buffers high trait anxious pediatric cancer caregivers against short-and longer-term distress. *Clinical Psychological Science, 4,* 629–640. doi:10.1177/2167702615602864.

Ray, R. D., Wilhelm, F. H., & Gross, J. J. (2008). All in the mind's eye? Anger, rumination and reappraisal. *Journal of Personality and Social Psychology, 94*(1), 133-145. doi:10.1037/0022-3514.94.1.133.

Ressler, K. J., & Mayberg, H. S. (2007). Targeting abnormal neural circuits in mood and anxiety disorders: From the laboratory to the clinic. *Nature Neuroscience, 10*(9), 1116–1124. doi:10.1038/nn1944

Ribeiro, A. P., Bento, T., Salgado, J., Stiles, W. B., & Gonçalves, M. M. (2011). A dynamic look at narrative change in psychotherapy: A case-study tracking innovative moments and protonarratives using state-space grids. *Psychotherapy Research*, *21*, 34-69. doi:10.1080/10503307.2010.504241

Ribeiro, A. P., Braga, C., Stiles, W. B., Teixeira, P., Gonçalves, M. M., & Ribeiro, E. (2016). Therapist interventions and client ambivalence in two cases of narrative therapy for depression. *Psychotherapy Research, 26,* 681-693. doi:10.1080/10503307.2016.1197439

Ribeiro, E., Cunha, C., Teixeira, A. S., Stiles, W. B., Pires, N., Santos, B., … Salgado, J. (2016). Therapeutic collaboration and the assimilation of problematic experiences in emotion-focused therapy for depression: Comparison of two cases. *Psychotherapy Research, 26*, 665-680. doi:10.1080/10503307.2016.1208853

Robinson, J. A., & Swanson, K. K. (1993). Field and observer modes of remembering. *Memory, 1*, 169-184. doi:10.1080/09658219308258230

Rodríguez-Cano, E., Sarró, S., Monté, G. C., Maristany, T., Salvador, R., McKenna, P. J., & Pomarol-Clotet, E. (2014). Evidence for structural and functional abnormality in the subgenual anterior cingulate cortex in major depressive disorder. *Psychological Medicine, 44*(15), 3263-3273. doi:10.1017/S0033291714000841

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rusting, C. L., & Nolen-Hoeksema, S. (1998). Regulating responses to anger: Effects of rumination and distraction on angry mood. *Journal of Personality and Social Psychology, 74*(3)*,* 790–803. doi:10.1037/0022-3514.74.3.790

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy*. Lanham, MD: Jason Aronson.

Salgado, J. (2014). *ISMAI depression project: Results of a comparative clinical trial of EFT and CBT.* Paper presented at 45th International Annual Meeting of Society for Psychotherapy Research, Copenhagen, Denmark.

Samoilov, A., & Goldfried, M. R. (2000). Role of emotion in cognitive-behavior therapy. *Clinical Psychology: Science and Practice, 7,* 373-385. doi:10.1093/clipsy.7.4.373

Schartau, P. E., Dalgleish, T., & Dunn, B. D. (2009). Seeing the bigger picture: Training in perspective broadening reduces self-reported affect and psychophysiological response to distressing films and autobiographical memories. *Journal of Abnormal Psychology, 118*(1), 15–27. doi:10.1037/a001290

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression (2nd Edition)*. New York: The Guilford Press.

Smyth, J. M. (1998). Written emotional expression: Effect sizes, outcome types, and moderating variables. *Journal of Consulting and Clinical Psychology, 66,* 175-184. doi:10.1037/0022-006X.66.1.174

Smith, J. M., & Alloy, L. B. (2009). A roadmap to rumination: A review of the definition, assessment, and conceptualization of this multifaceted construct. *Clinical Psychology Review, 29*(2), 116–128. doi:0.1016/j.cpr.2008.10.003

Smith M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore, MD: John Hopkins University Press.

Soderberg, C. K., Callahan, S. P., Kochersberger, A. O., Amit, E., & Ledgerwood, A. (2015). The effects of psychological distance on abstraction: Two meta-analyses. *Psychological Bulletin*, *41*(3), 525-48. doi:10.1037/bul0000005

Sousa, M., Ferreira, T., Barbosa, E., Madureira, S., Lemos, L., & Oliveira, D. (2017, July). *Development of a computerized measure of experiential immersion and distancing.* Paper presented at the 15th European Congress of Psychology, Amsterdam, The Netherlands.

Stiles, W. B. (2015). Theory-building, enriching, and fact gathering: Alternative purposes of psychotherapy research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 159–180). New York: Springer-Verlag.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384. doi:10.1080/10503307.2011.582186

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research, 7,* 122-127. doi:10.1080/14733140701356742

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21. doi:10.1080/10503309912331332561

Stiles, W. B. (1995). Disclosure as a speech act: Is it therapeutic to disclose? In J. W. Pennebaker (Ed.), *Emotion, disclosure and health* (pp. 71-91). Washington, DC: American Psychological Association.

Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27*, 411–420. doi:10.1037/0033-3204.27.3.411

Stiles, W. B., Morrison, L. A., Haw, S. K., Harper, H., Shapiro, D. A., & Firth-Cozens, J. (1991). Longitudinal study of assimilation in exploratory psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 28*, 195–206. doi:10.1037/0033-3204.28.2.195

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans &

G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Tagini, A., & Raffone, A. (2010). The 'I' and the 'Me' in self-referential awareness: A neurocognitive hypothesis. *Cognitive Processing, 11*(1), 9-20. doi:10.1007/s10339-009-0336-1

Takagishi, Y., Sakata, M., & Kitamura, T. (2013). Influence of rumination and self-efficacy on depression in Japanese undergraduate nursing students. *Asian Journal of Social Psychology, 16*, 163-168. doi:10.1111/ajsp.12000

Teasdale, J. D., Moore, R. G., Hayhurst, H., Pope, M., Williams, S., & Segal, Z. V. (2002). Metacognitive awareness and prevention of relapse in depression: Empirical evidence. *Journal of Consulting and Clinical Psychology, 70*(2), 275-287. doi:10.1037//0022-006X.70.2.275

Trope, Y., & Liberman, N. (2010). Construal-level theory of psychological distance. *Psychological Review, 117*(2), 440–463. doi:10.1037/a0018963

Trope, Y., & Liberman, N. (2003). Temporal construal. *Psychological Review, 110*(3), 403-421. doi:10.1037/0033-295X.110.3.403

Vago, D., & Silbersweig, D. (2012). Self-awareness, self-regulation, and self-transcendence (S-ART): A framework for understanding the neurobiological mechanisms of mindfulness. *Frontiers in Human Neuroscience*, *6,* 1-30. doi:10.3389/fnhum.2012.00296

Verduyn, P, Mechelen, I. V., Kross, E., Chezzi, C., & Bever, F. V. (2012). The relationship between self-distancing and the duration of negative and positive emotional experiences in daily life. *Emotion, 12*, 1248-1263. doi:10.1037/a0028289

Wells, A. (2000). *Emotional disorders and metacognition: Innovative cognitive therapy.* New York: *John Wiley & Sons Ltd*.

Wilson, T. D., & Gilbert, D. T. (2008). Explaining away a model of affective adaptation. *Perspectives on Psychological Science, 3*, 370-386. doi:10.1111/j.1745-6924.2008.00085.x

Wisco, B. E., Marx, B. P., Sloan, D. M., Gorman, K. R., Kulish, A. L., & Pineles, S. L. (2015). Self-distancing from trauma memories reduces physiological but not subjective emotional reactivity among veterans with posttraumatic stress disorder. *Clinical Psychological Science, 3*(6), 956–963. doi:10.1177/2167702614560745.

Wisco, B. E., & Nolen-Hoeksema, S. (2011). Effect of visual perspective on memory and interpretation in dysphoria. *Behaviour Research and Therapy, 49*, 406–412. doi:10.1016/j.brat.2011.03.012.

World Health Organization. (2018, March 22). A report retrieved from https://www.who.int/news-room/fact-sheets/detail/depression

Young, J. E., Rygh, J. L., Weinberger, A. D., & Beck, A. T. (2014). Cognitive therapy for depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 275-331). New York: Guilford Press