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Processo de Mudança em Psicoterapia: Validação Empírica do Modelo de Assimilação de Experiências Problemáticas

Tese de doutoramento em Psicologia, especialidade em Psicologia Clínica, orientada pelo Professor Doutor João Salgado e pelo Professor Doutor Daniel Rijo e apresentada à Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra

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Título

Processo de Mudança em Psicoterapia:

Validação Empírica do Modelo de Assimilação de Experiências Problemáticas

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The curious paradox is that when I accept myself as I am, then I can change.

(Carl Rogers, 1995, p. 17, in Becoming a Person: A Therapist's View of Psychotherapy)

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Resumo

Introdução: Ao longo dos anos, a investigação tem confirmado, de forma sistemática, a eficácia da psicoterapia no tratamento de diferentes perturbações psicológicas e emocionais. Sistematicamente diferentes estudos parecem apoiar a perspetiva que as diferentes modalidades psicoterapêuticas possuem eficácias semelhantes. No entanto, apesar de parecer ser consistente a perspetiva que a psicoterapia é um tratamento eficaz, pouco ainda se conhece sobre os mecanismos ou processos que a tornam eficaz. O facto de a investigação prévia sugerir a existência de eficácia similar entre os diferentes modelos psicoterapêuticos parece apoiar a perspetiva de que são os fatores ou processos comuns que influenciam a mudança clínica. No entanto, esta perspetiva não é consensual, principalmente porque os diferentes modelos psicoterapêuticos têm focos de intervenção distintos. Neste sentido, parece ser importante esclarecer qual o contributo dos fatores específicos para a mudança clínica. Neste sentido, no estudo 1 da presente dissertação foi efetuada uma revisão da literatura com o objetivo de (1) sintetizar quais os processos de mudança em psicoterapia e (2) analisar qual o papel dos processos específicos nessa mudança.

O Modelo de Assimilação das Experiências Problemáticas propõe uma explicação integrativa e transteórica sobre a mudança psicológica ao longo da terapia. Para este modelo, a mudança psicológica ocorre através de um processo gradual de integração e assimilação de experiências problemáticas previamente ignoradas ou evitadas. Apesar de estudos de caso prévios sugerirem a existência de uma associação entre a assimilação e o resultado terapêutico, urge consolidar empiricamente esses resultados em amostras maiores, com o objetivo de validar a perspetiva teórica do Modelo de Assimilação sobre a mudança clínica. Assim, no estudo 2 da presente dissertação (1) explorou-se a relação, teoricamente expectável, mas ainda com fraca evidência empírica, entre o aumento da assimilação e a diminuição da sintomatologia ao longo das 16 sessões de terapia. No sentido de ampliar os resultados obtidos elaborou-se o estudo 3 que teve como objetivo verificar (1) se o aumento da assimilação prediz a diminuição da sintomatologia clínica, ou, se pelo contrário, (2) a diminuição da sintomatologia clínica prediz o aumento na assimilação de experiências problemáticas.

Uma das características mais relevantes do processo de assimilação de experiências problemáticas ao longo da terapia é instabilidade existente no seu progresso. Estudos prévios tiverem como objetivo caracterizar este processo, mas pouco ainda se conhece sobre qual a relação da instabilidade no progresso da assimilação com a mudança sintomática. Assim, no estudo 4 e 5 tentamos esclarecer essa relação. O estudo 4 teve como objetivo explorar a relação da instabilidade no processo de assimilação (1) com o progresso na assimilação e (2) com a evolução dos sintomas clínicos, enquanto o estudo 5 visou esclarecer a sua associação (3) ampliar os resultados obtidos no estudo 4, verificando como a instabilidade no progresso de assimilação se relaciona com a mudança sintomática sessão a sessão em dois casos contrastantes.

Em suma, o objetivo primordial da presente tese foi ampliar o conhecimento existente relativamente aos processos promotores da eficácia terapêutica, nomeadamente, na sua relação com a mudança subsequente nos problemas, sintomas ou funcionamento dos clientes.

Metodologia: No primeiro estudo da presente dissertação foi efetuada uma revisão da literatura sobre a investigação prévia relativa aos processos de mudança em psicoterapia. Nos estudos subsequentes utilizou-se metodologia de investigação mista, sendo a presente dissertação constituída por três estudos de caso e um estudo de amostra, todos longitudinais. A amostra utilizada na presente dissertação foi recolhida de um ensaio clínico que teve como objetivo comparar a eficácia da Terapia Focada nas Emoções e a Terapia-Cognitivo-Comportamental, no tratamento da depressão ligeira a moderada.

Resultados: A revisão da literatura efetuada no estudo 1 apoia a perspetiva de que tanto os processos ou fatores específicos como os comuns têm um papel mediador na promoção da mudança terapêutica. No entanto, não foi possível confirmar a associação entre os fatores específicos e as terapias que supostamente os suscitam. Isto reforça ainda mais a necessidade de se estudarem modelos transteóricos, como o modelo de assimilação. No estudo 2, os resultados sugeriram uma associação entre maior assimilação das experiências problemáticas e menor intensidade dos sintomas clínicos. Relativamente ao estudo 3, os resultados permitiram verificar que a assimilação foi um

melhor preditor da mudança sintomática do que o inverso. Os resultados do estudo 4 e 5 validaram a perspetiva de que o processo de assimilação se caracteriza por instabilidade, no entanto, não confirmaram a relação entre a instabilidade no processo da assimilação e o resultado terapêutico.

Conclusões: De uma forma geral, os resultados da presente dissertação apoiam a perspetiva de que a mudança terapêutica ocorre através de processos psicológicos abrangentes e complexos. Especificamente, a presente dissertação apoia empiricamente a importância do papel da assimilação das experiências problemáticas no processo de mudança, contribuindo para aumentar a compreensão sobre os processos promotores da eficácia terapêutica. As implicações para a investigação em psicoterapia e para a prática clínica foram discutidas.

Palavras-chave: Psicoterapia; investigação de processo-resultado; modelo de assimilação de experiências problemáticas; depressão; processo de mudança clínica; instabilidade.

Abstract

Introduction: Over the last decades, research has consistently established the efficacy of psychotherapy in the treatment of different psychological disorders, however far less is known about the mechanisms and processes that make it effective. While some studies support the hypothesis that processes (or factors) common to different psychotherapies explain clinical change, others advocate the contribution of the specific factors of each therapeutic approach. In this sense, the first study encompassed a revision of the literature aiming (1) to synthesize the processes of change in psychotherapy and (2) to clarify the role of the specific processes in such change.

The assimilation of problematic experiences model proposes an integrative and transtheoretical explanation for the therapeutic change process. To this model, psychological change occurs through a process of integrating problematic experiences that were previously ignored or avoided and that needed to be gradually assimilated by the client. Although previous case studies seem to suggest the existence of an association between assimilation and therapeutic success, it is crucial to consolidate these findings in larger samples in order to validate the theoretical claim of the assimilation model about the therapeutic change process. Thus, in study 2 (1) the theoretically expected relation between the increase in assimilation and the decrease of clinical symptoms was explored across 16 sessions of therapy in a case study. To amplify the results obtained in study 2, study 3 was developed aiming to verify (1) whether increasing assimilation predicted the decrease of clinical symptoms, or if (2) decreasing clinical symptoms predicted increases in assimilation.

One of the most relevant features of the assimilation change process is the instability in its progress. Previous studies aimed to describe and explore this process; however, little is still known about the relationship of instability in the assimilation progress and therapeutic outcome. Study 4 aimed to explore how instability in the assimilation process relates to (1) the progress of assimilation of problematic experiences and with (2) the evolution of clinical symptoms. Study 5 aimed to broaden the obtained results exploring how instability in the assimilation progress relates to the therapeutic outcome, session-to-session, in two contrasting cases.

In this sense, the primary aim of this thesis was to broaden the existing knowledge regarding the processes promoting therapeutic efficacy, in particular, its assotiation with subsequent changes in the client's problems, symptoms or functioning.

Methodology: A revision of literature was carried out in study 1 focusing in the current state of research on the mechanisms of change in psychotherapy. In the subsequent studies, a mixed research methodology was used resulting in three case studies and a sample study, all longitudinal. The sample used in this dissertation was collected from a clinical trial aiming to compare the efficacy of Emotion Focused Therapy and Cognitive-Behavioral Therapy in the treatment of mild to moderate depression.

Results: The revision of literature carried out in study one seems to support the assumption that common and specific processes have a mediator role in promoting therapeutic change. However, it was not possible to confirm the association between the specific factors and the therapeutic modalities that intentionally promote them. In study 2, the results suggested a negative association between the assimilation of problematic experiences and the intensity of clinical symptoms. Regarding study 3, the results allowed to verify that assimilation progress was a better predictor of the decrease in the intensity of clinical symptoms than the inverse. The results of study 4 and 5 supported the assumption that the assimilation process is inherently instable, however, these did not confirm the relation between instability in the assimilation process and therapeutic outcome.

Conclusions: Overall, the results from the present dissertation seem to support the assumption that therapeutic change occurs through comprehensive and complex psychological processes. More specifically, this dissertation contributed to empirically validate the theoretical expectation about the assimilation of problematic experiences being a key process for psychological change. In this sense, the results of this dissertation helped to understand a little more about the processes that may promote therapeutic efficacy. Implications for the field of psychotherapy research and for clinical practice were discussed.

Key words: Psychotherapy, process-outcome research; assimilation of problematic experiences model; depression; therapeutic change process; instability.

CAPÍTULO I: ENQUADRAMENTO TEÓRICO

1. Investigação de processo-resultado em psicoterapia

A investigação em psicoterapia, numa tentativa de ser reconhecida pela comunidade científica pelo seu rigor metodológico e científico, tem tentado reproduzir o modelo médico de investigação. Na medicina o principal objetivo de investigação é averiguar quais os tratamentos mais eficazes no tratamento de doenças específicas. O foco da investigação em psicoterapia tem sido similar, ou seja, tem procurado verificar quais os tratamentos/terapias mais eficazes no tratamento de diferentes perturbações psicológicas. Ao longo dos anos, diferentes estudos têm obtido a mesma resposta: a psicoterapia é eficaz no tratamento de diferentes perturbações psiquiátricas, e este resultado parece ser transversal aos diferentes modelos psicoterapêuticos existentes (McAleavey & Castonguay, 2014). Braun, Gregor e Tran (2013) efetuaram uma meta-análise de estudos comparativos da eficácia de diferentes psicoterapias no tratamento da depressão e verificaram que, de uma forma geral, os tratamentos são eficazes, independentemente do modelo psicoterapêutico utilizado.

No entanto, apesar de muitos estudos apoiarem e validarem, de forma clara, a eficácia de diferentes formas de psicoterapia no tratamento das mais variadas psicopatologias, na realidade, ainda pouco sabemos sobre os processos ou mecanismos pelos quais a mudança ocorre em psicoterapia (Pos, Greenberg, Goldman, & Korman, 2003; Kazdin, 2009). A investigação de processo-resultado em psicoterapia surge como forma de colmatar esta fragilidade, sendo o seu objetivo perceber de que forma o cliente, o terapeuta e a interação na díade origina a mudança terapêutica (Llewelyn, Macdonald, & Doorn, 2016). O "processo" refere-se a qualquer fenómeno, característica ou situação que ocorra durante a psicoterapia, ou que esteja relacionado com as sessões terapêuticas (Hill & Lambert, 2004). De uma forma mais específica, pode ser definido como fenómeno clínico em que é expectável que ocorra alguma mudança significativa por parte do cliente (Hardy & Llewelyn, 2015). Estes fenómenos podem ser cognitivos, afetivos, comportamentais e podem estar associados ao terapeuta, ao cliente, à relação entre ambos, ou ao contexto (Llewelyn et al., 2016). O resultado clínico diz respeito a algo na condição do cliente que possa ser definido como sendo uma consequência do processo terapêutico,

ou seja, que ocorre devido ao trabalho terapêutico, durante a terapia ou no final da mesma, como por exemplo, a diminuição da sintomatologia clínica (Gelo & Manzo, 2015). Assim sendo, o objetivo da investigação de processo-resultado em psicoterapia é perceber como ocorrem os processos de mudança do cliente (dentro e/ou fora das sessões) e de que forma a terapia influencia essa transformação em termos de resultado clínico (Hardy & Llewelyn, 2015). Tal como Crist-Cristoph e colaboradores (2013, p. 299) referem "*a investigação de processo-resultado explora os eventos que ocorrem nas sessões terapêuticas, ou os construtos relacionados com a mudança nas sessões ou entre sessões e a sua associação com a mudança subsequente nos problemas, sintomas ou funcionamento*". Existem 4 objetivos fundamentais na investigação de processo resultado em psicoterapia (Hardy & Llewelyn, 2015). O primeiro objetivo, e o fundamental, está relacionado com perceber quais os mecanismos psicoterapêuticos e quais os processos inerentes ao cliente que facilitam a mudança clínica. Ou seja, perceber quais os ingredientes inerentes ao processo terapêutico que fazem com que este seja eficaz (Hardy & Llewelyn, 2015). Apesar de existirem um vasto número de estudos de eficácia em psicoterapia, os estudos de processo-resultado são menos frequentes, ocupando um papel secundário no panorama geral de investigação em psicoterapia (Llewelyn et al., 2016). Por exemplo, em relação à terapia cognitivo-comportamental, uma grande quantidade de estudos empíricos validam a sua eficácia, mas poucos se debruçam sobre quais as estratégias e processos promotores da mudança. O segundo objetivo é melhorar a prática clínica, ou seja, esclarecer quais os aspetos da terapia que funcionam melhor, permitindo desenvolver e disseminar a sua utilização. O terceiro objetivo está relacionado com o desenvolvimento de teorias que possam sustentar a prática clínica. Interligando os três objetivos anteriores, o quarto objetivo está relacionado com apoiar o treino efetivo de terapeutas. "*Assim, a investigação de processo pretende permitir que os terapeutas encontrem formas mais eficazes de intervir, com o objetivo de aumentar a qualidade dos tratamentos e assegurar que as teorias que alicerçam as abordagens estudadas são, efetivamente, suportadas pela evidência empírica*" (Hardy & Llewelyn, 2015, p.185).

Tal como referido acima, a psicoterapia parece ser eficaz no tratamento de diferentes perturbações psicológicas (Smith & Glass, 1977). De forma sistemática, os estudos parecem confirmar o denominado "veridicto do pássaro Dodo": diferentes

modelos psicoterapêuticos têm resultados equivalentes em termos de eficácia, em diferentes perturbações psicológicas (McAleavey & Castonguay, 2014). Tal parece indicar que os ingredientes comuns aos diferentes modelos terapêuticos são fatores fundamentais para promover a mudança clínica. O modelo dos fatores comuns mais amplamente divulgado foi proposto por Frank e Frank (1991) e identifica 4 fatores: (1) relação terapêutica que promova a confiança entre terapeuta e cliente; (2) ”mito” ou racional terapêutico adequado ao contexto, (3) aceitação do “mito” tanto pelo terapeuta como pelo cliente; e (4) “ritual” que promova a participação ativa do terapeuta e do cliente e que seja fundamentado na crença da eficácia do tratamento (e.g., estabelecer objetivos e desenvolver tarefas terapêuticas consistentes). Entre os fatores comuns, a aliança terapêutica foi um dos mais estudados, estando consolidado o seu papel preponderante na mudança terapêutica (Crist-Cristophe, Gibbons, & Mukberjee, 2013). Diferentes estudos confirmam a sua influência na mudança sintomática, caracterizando-a como um processo transversal e comum aos diferentes modelos psicoterapêuticos.

No entanto, apesar da evidência empírica apontar para eficácia similar entre os diferentes modelos psicoterapêuticos, uma vez que esses utilizam estratégias terapêuticas específicas, não deveriam existem diferentes processos ou fatores específicos que expliquem a mudança nesses modelos? Poucos são os estudos que tentaram verificar esta premissa da existência de fatores específicos, mesmo em terapias com ampla validação empírica, como é a Terapia-Cognitivo-Comportamental (Basto & Salgado, 2014). Os estudos que se debruçaram sobre o papel dos fatores específicos para a mudança terapêutica parecem sugerir que estes possam funcionar como mediadores da mudança sintomática (Basto & Salgado, 2014). No entanto, não confirmam a sua especificidade em relação às terapias que especificamente os promovem. Alternativamente, a mudança terapêutica parece ser fomentada pela combinação ou simbiose entre fatores comuns e fatores específicos (McAleavey & Castonguay, 2014), ou seja, os fatores comuns são fundamentais para providenciar um tratamento eficaz e, no entanto, os fatores específicos também possuem um papel importante na promoção de mudança psicológica (Budge & Wampold, 2015). Isto parece sugerir que a questão principal na investigação em psicoterapia não é sobre quais são os fatores que com maior poder explicativo da mudança, i.e., os fatores comuns ou os específicos, mas assumir que ambos desempenham

um papel importante e tentar compreender mais aprofundadamente o contributo de cada um destes fatores para a mudança terapêutica.

2. Modelo de Assimilação de Experiências Problemáticas

O Modelo de Assimilação das Experiências Problemáticas propõe uma explicação integrativa e transteórica sobre a mudança psicológica ao longo do processo terapêutico (Stiles, 2002; Stiles, 2011; Stiles et al., 1990; 1991; Stiles, Shankland, Wright, & Field, 1997) Para o modelo de assimilação, a mudança psicológica ocorre através de um processo de integração de experiências problemáticas previamente ignoradas ou evitadas e que necessitam de ser gradualmente assimiladas pelo cliente (Brinegar, Salvi, Stiles, & Greenberg, 2006; Stiles, 2002, 2011; Stiles et al., 1990). Stiles e colaboradores (1990), os autores deste modelo, sugerem que a assimilação de experiências problemáticas funciona como um mecanismo de mudança transversal a vários modelos terapêuticos e que contempla diferentes fenómenos, tais como processos cognitivos, emocionais ou comportamentais. À semelhança de outros modelos transteóricos, o Modelo de Assimilação das Experiências Problemáticas propõe-se a explicar a mudança clínica como ocorrendo através de um processo composto por uma série de etapas desenvolvimentais pelas quais o cliente deve passar no sentido de conseguir resolver a problemática que o trouxe à terapia (Newman & Beail, 2002). Assim sendo, define-se como um modelo integrativo, que se sustenta em construtos de modelos teóricos diversos, tais como, modelos psicodinâmicos, experienciais, cognitivo-comportamentais, e do desenvolvimento humano.

Numa primeira versão do modelo, Stiles e colaboradores (1990) propuseram que a mudança clínica significativa ocorria num processo de reconhecimento, reformulação, compreensão e resolução de experiências problemáticas pelo cliente, através de uma sequência desenvolvimental gradual e regular (Stiles et al., 1990). Nesta primeira versão do modelo, um dos conceitos fundamentais é a noção de esquema, desenvolvido a partir do conceito utilizado pelas teorias desenvolvimentais e cognitivas (Rumelhart & Norman, 1978). Para os autores das referidas teorias o conceito de esquema refere-se à existência de uma estrutura ou padrão organizado de ideias e formas de pensar onde se vão integrando e organizando as diferentes experiências vividas ao longo da vida. Por outras palavras, os esquemas são estruturas onde se organizam constelações de experiências que modelam a forma como percecionamos o mundo, e por consequência, agimos sobre o

mesmo. Assim, para Stiles e colaboradores (1990), ao longo da nossa vida, diferentes experiências vão sendo vividas e, consequentemente, acomodadas ou assimiladas nos nossos esquemas. No entanto, por vezes surgem experiências que, por serem incongruentes ou inconsistentes com os esquemas pré-existentes, não são apropriadas nem assimiladas convenientemente. Stiles e colaboradores (1990) definiram estas experiências como problemáticas. Por norma, representam situações problemáticas (e.g., situações de perda, rejeições, trauma), por serem discrepantes dos esquemas previamente formados. Estas experiências são perspetivadas como incompreensíveis ou como não "sendo parte de mim". Tal como os autores referem: "*Essas experiências, egodistónicas ou incompatíveis geralmente envolvem autopercepções (por exemplo, observações sobre os próprios sentimentos ou comportamentos) ou percepções da relação do eu com outros significativos que são discrepantes do esquema atual e não podem ser assimilados*" (Stiles et al., 1990, p. 412). Por este motivo, quando as experiências problemáticas surgem na consciência geram sofrimento psicológico e estão geralmente na base de quadros de psicopatologia (Stiles, 1990). O surgimento destas experiências problemáticas associa-se também a sensações de confusão, exprimindo a existência de conflito ou desconexão interna. Assim, devido ao seu carácter egodistónico e à carga emocional negativa que normalmente acarretam, estas experiências são evitadas e mantidas fora da consciência. Contudo, muito provavelmente as experiências problemáticas representam situações importantes, que precisam de ser apropriadas para servirem como recurso a ser utilizado em situações futuras. Assim sendo, a sua assimilação é o passo necessário para recuperar o sentido de coerência interna e por consequência, retomar o bem-estar psicológico. Para o modelo de assimilação (Stiles, 1990), os conceitos de assimilação e acomodação, retirados dos pressupostos da teoria do desenvolvimento cognitivo de Piaget (Piaget, 1962, 1970) são elementos fundamentais no processo mudança clínica. A assimilação refere-se ao processo de integração de novas experiências no esquema pré-existente, ou seja, estas novas experiências passam a fazer parte da estrutura de conexões de experiências prévias que se encontram organizadas no esquema. Para que tal aconteça, estas experiências são modificadas de forma a se tornarem "compatíveis" com o esquema prévio. Complementarmente ao processo de assimilação, ocorre o processo de acomodação que implica a modificação, tanto dos esquemas prévios como das

experiências problemáticas. Durante a terapia, estes dois processos ocorrem em simultâneo e de forma indissociável. Desta forma, através da relação terapêutica e num contexto seguro, a experiência problemática é trazida à consciência, clarificada, compreendida e, posteriormente integrada, favorecendo a redução do mal-estar psicológico e o retornar a um funcionamento adaptativo.

Anos mais tarde, Stiles e colaboradores (Honos-Webb & Stiles, 1998; Stiles, 1997, 1999a, 1999b) reformularam o modelo, efetuando algumas alterações conceptuais que integrassem uma perspetiva mais dialógica e dinâmica do funcionamento intrapsíquico (Stiles, 2011). Assim sendo, numa segunda versão do modelo de assimilação, o *self* é conceptualizado como sendo composto por múltiplas vozes (Dimmagio & Stiles, 2007). Estas vozes representam, metaforicamente, as experiências que fomos tendo ao longo da nossa vida e que, segundo esta perspetiva, funcionam como agentes ativos que interagem entre si, formando uma estrutura estável e organizada denominada de comunidade de vozes (Honos-Webb & Stiles, 1998; Honos-Webb, Surko, Stiles & Greenberg, 1999). Tal como supracitado, as vozes que compõem o *self* representam traços de experiências prévias e são reativadas sempre que experiências atuais se assemelham a experiências prévias (Osatuke et al., 2005). Por exemplo, se a minha experiência atual for a de estar desempregado/a, provavelmente, a voz que será reativada, estará relacionada com a minha experiência prévia de desemprego, o que me permitirá saber que recursos utilizar para fazer face à minha situação atual (e.g., como devo elaborar o meu currículo, onde devo procurar emprego, etc.). Como é possível verificar através do exemplo fornecido, estas vozes funcionam como recursos importantes, visto que promovem a conexão entre experiências passadas e situações atuais, permitindo assim utilizar o conhecimento passado como uma ferramenta para lidar com as experiências do dia-a-dia. Em suma, sempre que no presente lidamos com uma situação de vida específica (como por exemplo, escalar uma montanha), a voz conectada com a experiência similar do passado assume um papel mais dominante na comunidade, permitindo ao *self* lidar com a situação presente de uma forma mais adaptativa e congruente com a sua vivência (Caro Gabalda, 2014; Caro Gabalda & Stiles, 2009). Novas experiências são representadas por novas vozes que precisam de ser assimiladas e integradas na comunidade de vozes (Osatuke et al., 2011). De uma forma geral, este processo ocorre de uma forma “suave” sempre que as novas

vozes são compatíveis com a comunidade e não representam uma ameaça para a sua estrutura (Mosher & Stiles, 2009). Contudo, tal como na versão prévia do modelo acima descrita (Stiles, 1990), a estabilidade desta estrutura pode ser ameaçada por vozes incompatíveis (Caro Gabalda, 2013). Estas vozes são denominadas de vozes problemáticas (Honos-Webb & Stiles, 1998). As vozes problemáticas representam experiências que são incongruentes com experiências prévias e que podem ter origem em eventos de vida difíceis ou desafiantes. Quando, em paralelo com a emergência de uma voz problemática, o *self* é composto por uma comunidade de vozes estruturalmente mais rígida e inflexível (ou seja, as mesmas vozes assumem, frequentemente papeis dominantes na estrutura) a probabilidade de existência de conflito entre a voz problemática e as vozes dominantes da comunidade aumenta (Stiles, Osatuke, Glick & Mackay, 2004). O conflito resulta do confronto entre a voz problemática que tenta ser ouvida e a comunidade de vozes que tenta ignorar e evitar esta voz, com o intuito de manter a sua estabilidade (Caro Gabalda, 2014; Osatuke et al., 2011). No entanto, tal como já havida sido referido na versão prévia deste modelo (Stiles, 1990), ignorar vozes problemáticas implica negligenciar experiências que contêm em si importantes recursos para o *self*. Mais ainda, quando as mesmas vozes assumem frequentemente e indiscriminadamente papéis dominantes na comunidade, isso normalmente implica uma maior dificuldade do *self* em se adaptar a situações de vida novas ou/e mais desafiantes. Neste sentido, a existência de uma comunidade de vozes estruturalmente mais rígida, o evitamento de vozes consideradas problemáticas e o consequente conflito entre as vozes dominantes da comunidade e as vozes problemáticas, poderão promover o aparecimento de quadros clínicos.

Para fomentar a mudança clínica, a psicoterapia deverá promover a conexão entre a voz problemática e a voz dominante, permitindo que ocorra um diálogo entre elas e um possível entendimento (Honos-Webb & Stiles, 1998; Stiles, 1997, 1999a, 1999b). Para os autores do modelo de assimilação, o entendimento mútuo entre vozes ocorre através da criação de pontes de significado que contribuirão para uma gradual integração da voz problemática no *self* (Honos-Webb et al., 1999; Stiles & Brinegar, 2007). Construir "pontes de significado" entre a voz problemática e a voz dominante implica a utilização de significados comuns que permitam formar uma ligação semiótica, favorecendo a

gradual integração na comunidade de vozes de experiências previamente rejeitadas (Stiles, 2011). Assim sendo, a criação de pontes de significado entre vozes parece ser um processo fundamental para a assimilação de experiências problemáticas no *self*, i.e., para a mudança terapêutica. Este processo gradual de mudança pode ser avaliado através da aplicação da Escala de Assimilação de Experiências Problemáticas (APES; Caro Gabalda & Stiles, 2009; Stiles, 1999; Stiles et al. 1991) ao conteúdo das sessões de psicoterapia (Tabela 1). A escala descreve oito níveis sequenciais para avaliar as mudanças existentes na relação entre a voz problemática e as vozes dominantes da comunidade. As referidas mudanças podem compreender desde da dissociação da experiência problemática, no nível 0, até à integração completa da voz problemática na comunidade de vozes, no nível 7. O contacto, conflito e compreensão progressiva entre vozes ao longo do processo de assimilação tem implicações emocionais para o indivíduo. Por outras palavras, o encontro entre vozes dissonantes gera conflito e deste conflito podem emergir diferentes experiências emocionais.

Tabela 1

Escala de Assimilação de Experiências Problemáticas (retirado de Caro Gabalda & Stiles, 2009)

Resumo da Escala de Assimilação de Experiências Problemáticas (EAEP)

Estádio	Descrição
0. Evitamento	O conteúdo não está formado; o cliente não está consciente do problema. O desconforto pode ser mínimo, reflectindo o evitamento bem sucedido.
1. Pensamentos indesejáveis	O conteúdo é pensamentos desconfortáveis. O cliente prefere não pensar neles; os tópicos são sugeridos pelo terapeuta ou por circunstâncias externas. A emoção é frequentemente mais saliente do que o conteúdo e envolve fortes pensamentos negativos – ansiedade, medo, raiva, tristeza.
2. Consciência vaga/emergência	O cliente reconhece a experiência problemática e descreve pensamentos desconfortáveis associados, mas não consegue formular o problema claramente. A emoção inclui dor psicológica aguda ou pânico associado a pensamentos e experiências.
3. Colocação do problema/clarificação	O conteúdo inclui a colocação clara de um problema – algo que pode ser trabalhado. A emoção é negativa mas pode ser gerida, não há pânico.
4. Compreensão/insight	A experiência problemática é colocada em forma de esquema, formulada, compreendida com estabelecimento de ligações claras. A emoção pode ser mista, com reconhecimentos desagradáveis, mas também com curiosidade e por vezes com agradável surpresa.
5. Aplicação/elaboração	A compreensão é utilizada para se trabalhar um problema; existem esforços específicos para a resolução do problema. O cliente pode descrever a consideração de alternativas ou a selecção sistemática de percursos de acção. O tom emocional é positivo, trabalhar e optimista.
6. Solução do problema	O cliente atinge a solução para um problema específico. A emoção é positiva, o cliente está satisfeito, orgulhoso da sua realização. À medida que o problema diminui a emoção torna-se mais neutral.
7. Domínio	O cliente usa de forma bem sucedida as soluções em novas situações; esta generalização é em grande medida automática e não saliente. A emoção é neutra (ou seja, já não se trata de algo acerca do qual sentir excitação).

A figura 1 ilustra a valência emocional teoricamente associados a cada nível de assimilação, representados como "feeling level" (Stiles et al., 1991; Osatuke et al., 2004; Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). A valência emocional é produto da atenção/saliência dada à voz problemática (*salience of experience*) e do potencial emocional da própria experiência (*valence of experience*). Assim sendo, em níveis iniciais de assimilação (nível de assimilação 0 e 1), o potencial emocional negativo é maior, o que implica que menor atenção será dada à voz problemática. O evitamento da voz problemática parece resultar na presença de afeto negativo, mas pouco prevalente e pouco intenso. Quanto maior for a atenção dada à voz problemática, mais consciente esta se torna (nível de assimilação 2), o que se reflete na presença de afeto negativo mais prevalente e intenso. Quando o indivíduo foca a sua atenção na voz problemática de forma intencional, esta começa a ganhar força e consegue comunicar com maior clareza com a comunidade de vozes (nível de assimilação 3). Neste nível de assimilação, ainda se verifica a existência de afeto negativo, mas esse torna-se mais fácil de gerir para o individuo. Quando a voz problemática inicia o processo de integração na comunidade de vozes (nível de assimilação 4), o seu potencial emocional começa a transformar-se de negativo para positivo. Neste nível, o afeto torna-se misto, ou seja, verificam-se episódios de afeto positivo e de afeto negativo, associados a *insights* ou novas compreensões do problema, que podem estar associadas a surpresas positivas ou, por outro lado, a descobertas negativas. A progressiva integração da voz problemática na comunidade de vozes permitirá ao individuo introduzir mudanças na sua vida (nível de assimilação 5 e 6), e progressivamente aumentar o potencial positivo da experiência, o que trará implicações emocionais positivas que se refletirão numa maior prevalência e intensidade de afetos positivos. Finalmente, quando a voz problemática estiver completamente integrada na comunidade de vozes (nível 7 de assimilação), menor atenção é dada à experiência, visto que esta já faz parte da forma usual de funcionamento do indivíduo, o que se reflete em afeto neutro, ou seja, positivo, mas pouco prevalente e pouco intenso. Um estudo prévio apoiou esta premissa teórica do modelo de assimilação (Mackay, Barkham, Stiles & Goldfried, 2002) sendo, no entanto, necessária maior evidência empírica para esclarecer a relação entre o nível de assimilação e o tipo e intensidade de emoções mais dominantes. Tal confirmação permitirá validar um importante pressuposto

do modelo de assimilação, ou seja, que a assimilação progressiva das experiências emocionais conduz a alterações na expêriencia emocional do cliente. Confirmar este pressuposto será um contributo importante para apoiar a perpetiva sobre a mudança terapêutica que nos sugere que "*the only way out is troughout*" (Pascual-Leone, & Greenberg, 2007). Ou seja, que entrar em contato com emoções mais negativas é um dos passos mais importantes para a mudança terapêutica e para a resolução de experiência problemáticas previamente evitadas (Varvin & Stiles, 1999).

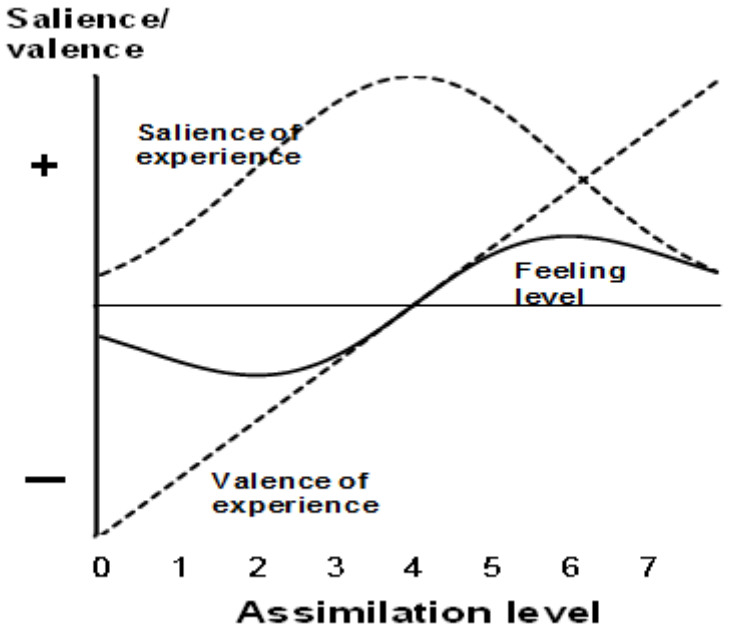

Figura 1. Relação teórica entre a atenção/saliência e potencial emocional da experiência problemática com a valência emocional específica de cada nível de assimilação de experiências problemáticas: 0 = warded off; 1 = avoided; 2 = emerging; 3 = recognized; 4 = understood; 5 = applied; 6 = solved; 7 = mastered.

2.1. Investigação sobre o Modelo de Assimilação das Experiências Problemáticas

2.1.1. Assimilação de experiências problemáticas e resultado terapêutico

Ao longo das últimas décadas são inúmeros os estudos empíricos que permitiram consolidar as premissas teóricas defendidas pelo modelo de Assimilação, nomeadamente no que diz respeito à relevância da assimilação para o processo de mudança terapêutica (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; Osatuke et al, 2007; Ribeiro, Braga, et al., 2016; Ribeiro, Cunha, et al., 2016). Uma parte significativa da referida investigação privilegiou a utilização de estudos de caso e metodologia qualitativa, os denominados de "*theory building case studies*" (Stiles, Hill, & Elliott, 2015). Tal como Stiles (2007) refere, a psicoterapia revela-se um contexto altamente rico e privilegiado de acesso à experiência humana. Apesar deste facto, a maior parte dos estudos em psicoterapia utiliza grandes amostras e privilegia a utilização de metodologias quantitativas de análise de dados, que pouca informação fornecem sobre e como ocorre a mudança momento-a-momento. Segundo o autor, dever-se-iam privilegiar estudos que facilitem uma maior compreensão sobre os processos cognitivos, emocionais e interpessoais altamente complexos que ocorrem em psicoterapia e que permitam enriquecer a teoria e prática clínica. Desta forma, a prática clínica ao ser analisada, acumulada e publicada em formatos de estudos de caso, pode informar a teoria e explicar os fenómenos que ainda carecem de entendimento. Nos "*theory building case studies*", o objetivo é, portanto, verificar como as observações efetuadas se coadunam com a teoria, corroborando-a, ou pelo contrário, sugerindo novas elaborações ou modificações à mesma, promovendo o seu refinamento (Stiles, 2015).

Os estudos de caso previamente desenvolvidos dentro do Modelo de Assimilação das Experiências Problemáticas sugerem que os casos de sucesso terapêutico, avaliados através de medidas de sintomatologia clínica, progridem até níveis elevados de assimilação (nível 4 ou superiores da APES) ao longo do processo terapêutico (Brinegar, Salvi, & Stiles, 2008; Caro Gabalda, 2006, 2011; Field, Barkham, Shapiro, & Stiles, 1994;

Gray & Stiles, 2011; Honos-Webb, Stiles, & Greenberg, 2003; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb et al., 1999; Knobloch, Endres, Stiles, & Silberschatz 2001; Leiman & Stiles 2001; Mosher, Goldsmith, Stiles, & Greenberg, 2008; Osatuke, et al., 2005; Osatuke et al, 2007). Assim, os diferentes estudos parecem indicar que, ao longo da terapia, as vozes problemáticas vão sendo assimiladas de forma gradual e progressiva até à sua integração completa no *self*. Este processo parece ser transversal a diferentes diagnósticos, tais como: perturbação depressiva (Barbosa, Couto, Basto & Salgado, 2018; Brinegar et al., 2008; Caro Gabalda, 2003; Field et al., 1994; Gonçalves et al.,2014; Honos-Webb, Stiles & Greenberg, 2003; Honos-Webb et al., 1998; Honos-Webb et al., 1999; Meystre, Kramer, Despland, & Rotten, 2017; Mosher et al., 2008; Osatuke et al.,2007; Stiles, et al., 2006); perturbações de ansiedade (Caro Gabalda, 2006, 2008; Penttinen, Wahlström, & Hartikainen, 2017; Stiles, Meshot, Anderson, & Sloan Jr., 1992); perturbação dissociativa da personalidade (Humphreys, Rubin, Knudson & Stiles, 2005); demências (Lishman, Cheston, & Smithson, 2016; Snow, Cheston, & Smart, 2016; Watkins, Cheston, Jones, & Gilliard, 2006); Perturbação de sintomas somáticos (Reid & Osatuke, 2006); perturbação borderline da personalidade (Kramer, Meystre, Imesch, & Kolly, 2016; Osatuke & Stiles, 2006); perturbação de *stress* pós-traumático (Varvin & Stiles, 1999); esquizofrenia (Osatuke et al., 2011). A evidência empírica acumulada pelos diferentes estudos parece também apoiar a premissa de que, para além de trans-diagnóstico, o processo de assimilação de experiências problemáticas ocorre de forma trans-teórica, i.e., é independente do modelo terapêutico usado, tal como observado pelos resultados similares encontrados nas seguintes abordagens: Terapia Cognitivo-Comportamental (Goodridge & Hardy, 2007; Osatuke, et al., 2005, 2007; Stiles et al, 1997); Terapia Focada nas Emoções (Brinegar et al., 2008; Honos-Webb et al., 2003; Honos-Webb, et al., 1998; Honos-Webb et al., 1998; Honos-Webb et al., 1999; Leiman & Stiles, 2001; Brinegar, Salvi, Stiles, & Greenberg, 2006); Terapia Centrada no Cliente (Osatuke, et al., 2005; Mosher et al., 2008; Brinegar et al., 2006; Stiles et al., 1997); Terapia Psicodinâmica (Field et al., 1994; Heaton, Hill, Hess, Leotta, & Hoffman, 1998; Knobloch et al., 2001; Stiles et al. 2007; Varvin & Stiles, 1999); Terapia Linguística de Avaliação (Caro Gabalda, 2003; 2006; 2009; 2011); Terapia de Grupo (Penttinen & Wahström, 2013; Penttinen et al., 2017); Terapia familiar (Laitila & Aaltonen, 1998);

Terapia de casal (Shielke et al., 2011); e até em Psicofarmacoterapia (Osatuke et al., 2011). Assim, a generalidade dos estudos parece indicar que, em diferentes modelos psicoterapêuticos, a mudança está associada à integração, ao longo da terapia, de experiências previamente evitadas e que os casos de sucesso atingem níveis mais elevados de assimilação, nomeadamente, acima do nível 4 da APES (Detert et al., 2006). Esse nível de formulação de uma nova compreensão sobre o problema ou experiência problemática, tem, portanto, sido identificado como um ponto de viragem no processo de assimilação (Caro Gabalda & Stiles, 2009). Os casos de insucesso, apesar de também progredirem em termos de assimilação, não alcançam níveis de assimilação tão elevados (Detert et al, 2006), pelo menos de uma forma sistemática (Caro Gabalda, 2014). Não obstante o processo de assimilação parecer ser transversal aos modelos psicoterapêuticos, importa salientar que não apresenta um progresso igual em todas as abordagens.

Assim, os resultados dos diferentes estudos empíricos são consensuais em apoiar a premissa de que a mudança psicoterapêutica se encontra associada à assimilação de experiências problemáticas. Mais especificamente, parece existir uma relação entre o progresso dos clientes ao longo dos níveis de assimilação e a gradual diminuição da sintomatologia clínica, nomeadamente após a clarificação e compreensão da experiência problemática (nível 4 da APES; Detert et al., 2006). No entanto, tal como referido anteriormente, a maior parte dos estudos efetuados são estudos de caso. Parece existir, portanto, necessidade de maior suporte empírico para validação do modelo, nomeadamente através do estudo de amostras clínicas (Halsteed, 1996). A escassez de estudos de amostra tem como principal justificação a morosidade do processo de codificação, já que envolve a observação de sessões, a identificação dos problemas/vozes problemáticas e a codificação de acordo com a APES por pelo menos dois codificadores (Detert, et al., 2006). O estudo de Detert e colaboradores (2006) tentou colmatar esta necessidade através da análise de uma amostra de oito casos clínicos de sucesso e insucesso em terapia Cognitivo-Comportamental e Psicodinâmica-Interpessoal. Os resultados desta investigação parecem corroborar as premissas do modelo de assimilação, visto que os casos de sucesso atingiram níveis de assimilação mais elevados do que os casos de insucesso. No entanto, este estudo apresenta limitações à generalização dos seus resultados: (1) a amostra tem um N reduzido (6 casos); (2) protocolo terapêutico muito

breve (duas sessões de intervenção e uma follow-up), não refletindo a forma de tratamento da maioria dos protocolos clínicos utilizados em psicoterapia. (Detert et al., 2006). No mesmo sentido, um estudo mais recente (Meystre et al., 2017) propôs-se analisar as diferenças entre casos de sucesso e insucesso no progresso da assimilação de experiências problemáticas. Para tal, utilizou 6 casos clínicos diagnosticados com depressão, que receberam 12 sessões de psicoterapia psicodinâmica. Os resultados deste estudo apenas validaram parcialmente os pressupostos do modelo de assimilação. Verificou-se que, dos 3 casos de sucesso, apenas 2 alcançaram níveis de assimilação iguais a 4. Em relação ao progresso da assimilação do início para o fim da terapia, não se verificaram diferenças significativas entre o grupo de sucesso e o grupo de insucesso. Os autores desse estudo sugeriram que os resultados poderiam estar relacionados com a utilização de uma amostra pequena (Meystre et al., 2017). Assim sendo, parece existir questões importantes que permanecem sem resposta: qual a relação entre a assimilação e o resultado terapêutico? Será a assimilação capaz de promover a diminuição na sintomatologia clínica momento a momento? Se esta hipótese se verificar empiricamente, isto pode significar que a diminuição da sintomatologia clínica pode ser potenciada, em parte, pela capacidade do cliente em assimilar a sua experiência problemática. Temos, contudo, que considerar também o cenário inverso. Ou seja, será que é a diminuição dos sintomas clínicos que prediz o aumento nos níveis de assimilação? Caso este último resultado se verifique, isto pode sugerir que o processo de assimilação pode não funcionar como um fator promotor de mudança, mas configurar-se como um resultado dessa mesma mudança. Neste seguimento, parece importante ampliar os resultados produzidos pelos estudos anteriores analisando uma amostra maior, com protocolos clínicos mais amplos, que permitam perceber, de forma longitudinal, qual a relação entre estas variáveis (assimilação e sintomatologia clínica). Perceber qual o papel da assimilação na mudança psicoterapeuta pode trazer implicações importantes para a prática clínica, nomeadamente para o treino de terapeutas. Caso se confirme a relação teoricamente prevista entre a assimilação e a diminuição de sintomas clínicos, poderá ser importante formar terapeutas no sentido de identificar o nível de assimilação em que o cliente se encontra e adequar a intervenção às necessidades do cliente com o objetivo de promover a gradual integração das experiências e assim, apoiar uma mudança clínica efetiva e sustentada.

2.2. Instabilidade no processo de Assimilação de Experiências Problemáticas

Apesar dos estudos supracitados sugerirem que os casos de sucesso terapêutico alcançam, gradualmente, níveis de assimilação mais elevados, quando observamos o processo de assimilação de forma mais próxima, podemos constatar a existência de um padrão irregular e diversos avanços e recuos na sua progressão ao longo das sessões. Estes movimentos foram denominados de retrocessos (em inglês *setbacks*; Caro Gabalda & Stiles, 2013). Um retrocesso é definido como um retorno de um nível de assimilação mais elevado para um nível de assimilação mais baixo (Caro Gabalda & Stiles, 2013). Estudos prévios verificaram que os retrocessos ocorrem de forma transversal em diferentes terapias, o que parece indicar que se trata de uma característica essencial do processo de assimilação (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al. 2006; Knobloch, et al., 2001; Goodrigde & Hardy, 2009; Osatuke et al., 2005).

Têm sido propostas diferentes interpretações para o papel dos retrocessos na mudança em psicoterapia. Usualmente, os problemas que os clientes trazem à terapia encontram-se organizados, ou são compostos, por diferentes subtemas ou assuntos (Mendes et al., 2016). Desta forma, uma explicação possível é que os retrocessos podem estar associados a uma mudança de um tópico ou assunto que se encontra num nível de assimilação mais elevado para outro que se encontra num nível mais baixo de assimilação. Se pensarmos em termos da conceptualização de vozes do modelo de assimilação, cada voz encontra-se interligada a outras vozes, ou sub-vozes, representativas de diferentes facetas da mesma experiência ou de experiências similares. O facto de focarmos a nossa atenção num aspeto, ou sub-voz, do mesmo problema, poderá ter implicações para as outras partes do problema, por estarem relacionadas entre si (Caro Gabalda & Stiles, 2013). Estudos anteriores classificaram os retrocessos distinguindo 3 categorias: (1) exceder a zona de desenvolvimento proximal, (2) metáfora do equilíbrio; e (3) mudança espontânea (Mendes et al., 2016). O conceito de (1) exceder a zona de desenvolvimento proximal (Leiman & Stiles, 2001) foi desenvolvido a partir do conceito proposto por Vygotsky (1978) e refere-se à diferença entre o nível de assimilação que o cliente conseguirá alcançar por si e o nível de assimilação que o cliente poderá alcançar com o apoio do terapeuta. É importante referir que os limites desta zona de desenvolvimento

podem mudar ao longo da terapia e de acordo com os problemas. Por vezes, se o terapeuta "puxar" o cliente acima da sua zona de desenvolvimento proximal, ou seja, se o terapeuta dirigir o cliente para um nível de assimilação em que esse sinta que é demasiado arriscado permanecer, ou para o qual não se sinta preparado, o cliente rapidamente pode retornar a um nível inferior, criando um retrocesso no progresso da assimilação (Caro Gabalda, 2006; Leiman & Stiles, 2001; Mendes et al., 2016; Osatuke et al., 2005). A (2) metáfora do equilíbrio refere-se a uma estratégia utilizada pelo terapeuta, cujo objetivo é focar a atenção do cliente numa vertente do problema que se encontra menos assimilada. Este movimento também propicia o aparecimento de retrocessos no progresso da assimilação (Mendes et al., 2016). Por fim, (3) a mudança espontânea ocorre quando o cliente espontaneamente, i.e., sem que se identifique uma associação à intervenção direta ou indireta do terapeuta, se movimenta de um nível de assimilação superior para um nível de assimilação inferior (Mendes et al., 2016).

Os estudos prévios parecem sugerir que os retrocessos, ao invés de serem um fenómeno indesejado, poderão ser um passo importante no progresso da assimilação de experiências problemáticas (Caro Gabalda, 2006; Mendes et al., 2016). No entanto, ainda não é claro se a existência de um padrão de assimilação mais irregular, nomeadamente com retrocessos mais frequentes e amplos, se encontra associado a melhores resultados terapêuticos.

3. Presente estudo

A investigação em psicoterapia, tal como supracitado, tem tido como principal enfoque verificar qual a eficácia das diferentes terapias no tratamento de perturbações emocionais e psicológicas. No entanto, apesar de parecer ser consensual a assunção de que a psicoterapia é, de uma forma geral, eficaz, pouco se conhece sobre os processos pelos quais ocorre a mudança clínica nos clientes. Devido ao facto de inúmeros estudos confirmarem o princípio da equivalência de eficácia das diferentes terapias (Wampold et al., 1997; Braun et al., 2013), diversos autores privilegiam o papel dos fatores comuns na promoção da mudança clínica. No entanto, se utilizarmos diferentes terapias com diferentes hipóteses explicativas sobre o processo de mudança e, consequentemente, estratégias diferentes, seria de esperar que, pelo menos parte do processo de mudança, pudesse ser explicado por processos específicos, dependendo do modelo psicoterapêutico que estiver a ser utilizado. Ou seja, se as terapias cognitivas utilizam estratégias específicas para promover mudança de processos ou fatores cognitivos, enquanto as terapias experienciais recorrem a estratégias para facilitar a transformação emocional, seria expetável que diferentes terapias promovessem maior mudança em processos específicos. Assim sendo, o primeiro estudo desta dissertação teve como propósitos: (1) efetuar uma breve síntese do estado atual da investigação sobre os processos de mudança em psicoterapia; e (2) perceber o que a investigação prévia nos diz em relação ao papel dos fatores específicos para a promoção de mudança clínica.

O modelo de assimilação das experiências problemáticas apresenta-se como uma teoria abrangente e transteórica relativamente à forma como explica o processo de mudança terapêutica. A assimilação de experiências problemáticas, além de permitir perceber o processo de mudança através de uma perspetiva desenvolvimental, caracteriza-se como sendo um processo complexo, mas abrangente, na sua essência, visto que contempla a interligação entre fatores cognitivos, emocionais, interpessoais e comportamentais, na promoção da mudança. Diferentes estudos de caso parecem validar o pressuposto de que a mudança terapêutica ocorre através de um processo gradual de integração das experiências no *self* e que os casos de sucesso atingem níveis de assimilação superiores aos casos de insucesso. No entanto, poucos são os estudos que

utilizam metodologias de análise de dados que permitam verificar qual a relação entre a assimilação e a sintomatologia clínica ao longo do processo terapêutico (e.g., sessão a sessão). Perceber, longitudinalmente, como é a relação entre a assimilação das experiências problemáticas e a sintomatologia clínica poderá contribuir para uma maior compreensão sobre o processo de mudança terapêutica. Assim, o segundo estudo desta dissertação teve como objetivo analisar a relação entre o progresso na assimilação de experiências problemáticas e a evolução da sintomatologia clínica e da ativação emocional. Através de um estudo intensivo de um caso de sucesso em terapia cognitivo-comportamental, diagnosticado com depressão, (1) explorou-se a relação, teoricamente expectável, mas ainda com fraca evidência empírica, entre o aumento da assimilação e a diminuição da sintomatologia clínica ao longo das 16 sessões de terapia. Pretendeu-se também explorar empiricamente de que forma a experiência emocional do caso clínico analisado se adequa à curva teórica do afeto apresentada na figura 1.

Tal como foi referido, dentro do modelo de assimilação, são escassos os estudos que utilizam amostras clínicas, em grande parte devido à morosidade inerente ao processo de codificação com a APES. Os escassos estudos que existem apresentam algumas limitações, nomeadamente no que se refere: (1) ao tamanho da amostra; (2) à estrutura do protocolo de intervenção utilizado; e (3) às análises de dados efetuadas. Todos estes factos dificultam a possibilidade de verificar se existe uma relação de predição entre as variáveis, ou seja, se a assimilação de experiências problemáticas contribui para a diminuição da sintomatologia clínica, ou se, pelo contrário, a diminuição da sintomatologia clínica contribui para um aumento na assimilação de experiências problemáticas. O terceiro estudo surge como uma tentativa de dar resposta a estas questões. Nesse sentido, foi analisada a relação entre o progresso da assimilação e a evolução da sintomatologia clínica, em 22 casos diagnosticados com depressão ligeira a moderada. Mais concretamente, pretendeu-se verificar se existia uma relação de predição entre as variáveis e qual a direção dessa predição, ou seja, (1) se o aumento da assimilação prediz a diminuição da sintomatologia clínica, ou, se pelo contrário, (2) a diminuição da sintomatologia clínica prediz o aumento na assimilação de experiências problemáticas. Esta análise foi efetuada longitudinalmente com o intuito de verificar se a relação preditiva entre as variáveis ocorria ao longo do processo terapêutico.

A assimilação de experiências problemáticas ao longo da terapia parece ser composta por diferentes avanços e recuos no seu progresso, ou seja, por retrocessos. Vários estudos qualitativos têm tentado compreender este fenómeno, principalmente através da identificação e caraterização deste processo (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch et al., 2001; Goodrigde & Hardy, 2009; Osatuke et al., 2005). No entanto, pouco se sabe sobre a forma como este fenómeno contribui para o resultado terapêutico. Assim, partindo do pressuposto apoiado pela Teoria dos Sistemas Dinâmicos de que instabilidade é um fator relevante para a mudança terapêutica, o quarto estudo desta dissertação teve como objetivo explorar de que forma a instabilidade no processo de assimilação se relaciona com: (1) o progresso da assimilação de experiências problemáticas e com (2) a evolução dos sintomas clínicos. Como forma de medir quantitativamente a instabilidade na assimilação, mais concretamente ao nível da frequência e amplitude dos retrocessos, utilizou-se uma medida de flutuação (Schiepek & Strunk, 2010). Este estudo teve como amostra um caso de sucesso de depressão em Terapia Focada nas Emoções.

Por fim, em continuidade com os propósitos referidos para o quarto estudo desta dissertação, surgiu a pertinência de desenvolver um quinto estudo. Este pretendeu analisar longitudinalmente o progresso da assimilação, da instabilidade no progresso da assimilação e a evolução dos sintomas clínicos. Desta forma, pretendeu-se verificar como a instabilidade no progresso de assimilação se relaciona com o resultado terapêutico sessão-a-sessão. Para medir a instabilidade de assimilação foi utilizada a medida de flutuação acima referida (Schiepek & Strunk, 2010). Este estudo foi baseado na análise de dois casos contrastantes: um caso de sucesso e um caso de insucesso de depressão em Terapia Focada nas Emoções.

CAPÍTULO II: ESTUDOS EMPÍRICOS

ESTUDO 1: La investigación sobre el proceso de cambio en psicoterapia y los diferentes enfoques terapéuticos: un análisis de los mecanismos cognitivos y emocionales

Basto, I., & Salgado, J. (2014). La investigacion sobre el proceso de cambio en psicoterapia y los diferentes enfoques terapêuticos: un analisis de los mecanismos cognitivos y emocionales. *Revista de Psicoterapia, 25 (99)*, 31-47.

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Resumen

Actualmente, la investigación sobre la efectividad de los diferentes tipos de psicoterapia demuestra que la psicoterapia funciona para distintos tipos de trastornos. Sin embargo, todavía hay varios problemas que siguen sin resolverse, por ejemplo, los casos que no responden al tratamiento así como casos de deterioro. Con esta finalidad, es necesario complementar la investigación de eficacia con estudios de proceso (investigación de proceso y proceso-resultado). Así este trabajo tiene como objetivos: efectuar una breve síntesis del estado actual de la investigación sobre los mecanismos de cambio (emocionales y cognitivos) en la psicoterapia; y analizar cómo la investigación del proceso de cambio se ha articulado con los modelos teóricos. El análisis de los diferentes estudios parece validar empíricamente el papel mediador de diferentes mecanismos en la promoción del cambio terapéutico. Sin embargo, parece ser más difícil confirmar la especificidad de los mecanismos a las terapias que los suscitan especificamente. Se discutirá las implicaciones de estos resultados para investigaciones futuras sobre el cambio terapéutico.

Palabras Clave: psicoterapia; cambio terapéutico; investigación proceso-resultado; mecanismos de cambio.

Abstract

Currently, research on the effectiveness of different types of psychotherapy shows that psychotherapy works for different types of disorders. However, there are still several issues that remain to be solved, for example, cases that do not respond to treatment, as well as cases of deterioration. For this purpose, it is necessary to complement research about the effectiveness of therapy with process studies (process and process-outcome research). So this paper aims to: make a brief summary of the current state of research on the mechanisms of change (emotional and cognitive) in psychotherapy; analyze how process research has been articulated with theoretical models. The analysis of different studies seems to empirically validate the role of mediation that several mechanisms seem to have in promoting therapeutic change. However, it seems more difficult to confirm the hypothesis that these mechanisms are specific to therapies that intentionally promote them. The implications of these results for future research on therapeutic change will be discussed.

Keywords: psychotherapy; therapeutic change process; process-outcome research; change mechanisms

La investigación sobre el proceso de cambio en psicoterapia y los diferentes enfoques terapéuticos: un análisis de los mecanismos cognitivos y emocionales

Recientemente se celebró los 50 años de la publicación en la revista Psychotherapy de la famosa polémica entre Hans Jurgen Eysenck y Hans Herrman Strupp, sobre la supuesta ineficacia de las psicoterapias psicodinámicas (Eysenck, 1964; Strupp, 1964). En ese momento, permanecía en el aire la duda sobre la validez y la solidez de los tratamientos psicológicos. Hoy, después de estos años, el escenario es, en algunos aspectos, mucho más claro. La psicoterapia funciona, llegando a revelar tamaños del efecto muy elevados. En el estudio de la efectividad de los diferentes tipos de psicoterapia para distintos tipos de disturbios, la lista de tratamientos apoyados empíricamente no ha dejado de aumentar (APA, 2012). Todavía hay más y más tratamientos para cada trastorno existente. Por ejemplo, la división 12 de la APA sostiene que la depresión tiene ahora 13 tratamientos con apoyo empírico. Estudios sobre la relación costo-beneficio de la psicoterapia también han revelado que esta presenta claras ventajas económicas en comparación con otros tratamientos (Dobson et al., 2008).

Sin embargo, todavía hay varios problemas y desafíos, teóricos y prácticos, en el campo de la investigación en psicoterapia. Aunque la eficacia está probada, es todavía evidente que hay tasas relevantes de no respuesta al tratamiento, así como casos de deterioro (Barlow, 2010), siendo nuestra comprensión de estos fenómenos escasa. Por otra parte, no siempre los resultados son sostenidos en el tiempo. Por ejemplo, uno de los mayores desafíos que aún pone en el tratamiento de la depresión es encontrar procedimientos efectivos para la prevención de la recaída (Kuyken et al., 2008).

Probablemente, estos desafíos serán mejor revelados si tenemos una idea más clara sobre cómo funcionan en concreto las terapias. Con este fin, la investigación sobre el resultado (investigación de resultado) necesita ser complementada con la investigación de proceso (investigación de proceso y proceso-resultado). Aquí viene el primer propósito de este trabajo: una breve síntesis del estado actual de la investigación sobre los procesos de cambio en la psicoterapia.

Un segundo propósito de este trabajo es analizar cómo la investigación del proceso de cambio se ha articulado con los modelos teóricos que informan las terapias. Lo

hacemos a partir del análisis de dos tipos específicos de cambio (cambios emocionales y cognitivos), que servirán como indicadores del estado actual de la investigación en este campo. Sabemos que dejamos fuera de nuestro análisis otros tipos de cambio también relevantes (por ejemplo, cambios en el comportamiento o cambios interpersonales), pero para proceder al análisis deseado estos dos tipos son suficientes para ilustrar el estado actual de la investigación.

Nos interesa, particularmente, explorar en este artículo, si los resultados obtenidos por cada tratamiento son debido a los procesos y mecanismos de cambio que supuestamente ese tratamiento promueve. En general se asume que teóricamente cada forma de psicoterapia, a través de sus procesos y técnicas específicas, activa los mecanismos de cambio específicos y coherentes con el modelo. Por ejemplo, dentro de la terapia cognitiva, la reestructuración cognitiva producirá una modificación de los esquemas cognitivos; o bien, en la terapia focalizada en la emoción, la exploración empática de emociones secundarias conduce a la expresión y la conciencia de emociones primarias más nucleares. Por lo tanto, se estipula una relación lineal entre las técnicas y los mecanismos de cambio. Sin embargo, podemos preguntarnos acerca de esta relación lineal.

Por ejemplo, ¿En qué medida el cambio cognitivo es generado por las técnicas y los procesos cognitivos? O ¿en qué medida los cambios emocionales son generados por las técnicas experienciales?

Una breve introducción a la investigación sobre el proceso de cambio en psicoterapia

Aunque en la actualidad existen varios estudios que apoyan y validan claramente diversas formas de psicoterapia como eficaces en el tratamiento de diversas psicopatologías, en realidad, poco se sabe sobre los procesos o mecanismos por los cuales se produce el cambio en psicoterapia. Como dice provocativamente Kazdin (2009): “Podría decirse que la pregunta más urgente es cómo la terapia conduce a un cambio. En la actualidad, no sabemos las razones, aunque se han propuesto muchas ideas” (p. 418).

Por lo tanto, continúa sin respuesta la pregunta sobre cómo la psicoterapia funciona realmente (Greenberg, Goldman, y Korman, 2003).

Varios estudios sobre el cambio en la psicoterapia intentan responder a esta pregunta analizando los procesos involucrados en el éxito terapéutico. Hay un acuerdo en llamar a la investigación sobre los eventos ocurridos durante la psicoterapia como "investigación de proceso". Cuando el proceso de análisis se asocia con los resultados obtenidos en la terapia, se denomina "investigación de proceso-resultado" (Hill, 1993). Sin embargo, la mera asociación de ciertos acontecimientos en la terapia y los resultados, aunque puede apoyar empíricamente una terapia determinada, no garantiza una lectura que permitirá comprender el proceso de desarrollo del cambio. En este sentido, Greenberg (1986) propuso que las investigaciones que tratan de describir dicho proceso de transformación deben denominarse de "investigación del proceso de cambio".

En el campo de convenciones terminológicas, a menudo se hace una distinción entre "procesos de cambio," y "mecanismos de cambio" (Crits-Cristoph, Gibbons, y Mukberjee, 2013). Los procesos se refieren a hechos relacionales entre cliente y terapeuta, directos o indirectos, con impacto causal en el resultado, por ejemplo, la aplicación de la técnica de reestructuración cognitiva, la utilización de una técnica de silla vacía, rellenar un diario, etc. Los mecanismos se refieren a cambios en el cliente con impacto causal en el resultado, e.g., cambio de los pensamientos automáticos disfuncionales, cambio del procesamiento emocional, etc.

Dentro de la investigación del proceso, hay una división entre los estudios que tratan de analizar los factores comunes a las distintas formas de psicoterapia y aquellos que se centran en los factores específicos del cambio en cada terapia. La primera se centra en el análisis de los factores transversales, transteóricos, de cualquier forma de psicoterapia. Los estudios que se centran en factores específicos enfocan su análisis en los "ingredientes" específicos de cada modalidad terapéutica y su posible contribución para el resultado.

Sin ser exhaustivos, podemos señalar como ejemplos de estudios de los factores comunes los estudios sobre la relación terapéutica (por ejemplo, la alianza terapéutica; estudios sobre empatía), estudios sobre el cambio del *self* (por ejemplo, asimilación de

experiencias problemáticas; Caro, 2012; Stiles, 2012; procesos dialógicos, Leiman, 2002) y los estudios sobre el cambio narrativo (Angus, 2012; Gonçalves et al., 2009). Los estudios sobre los procesos específicos son, sin embargo, más frecuentes. Además, parece existir una resistencia en adoptar un enfoque centrado en factores comunes, quizás por ser percibido como una amenaza para la viabilidad y diferenciación de muchos modelos. A priori, dentro de los estudios sobre los procesos de cambio específico en cada tratamiento, podría haber tantos tipos de estudios como tipos de terapia existen, es decir, cientos, sino miles. Sin embargo, en nuestro estudio, nos proponemos organizar este territorio de una manera más simple, en 4 categorías generales de procesos o mecanismos: cognitivo, emocional, conductual e interpersonal. Estas cuatro categorías principales de procesos serán también "familias" de terapias: terapias cognitivas, experienciales, conductuales y psicodinámicas. Este sistema de clasificación está lejos de ser perfecto y respetar la diversidad enorme en el campo, pero nos permite adoptar, al menos, una perspectiva más organizada.

A continuación haremos un breve resumen del estado actual de la investigación sobre los procesos de cambio en psicoterapia, más específicamente sobre los mecanismos cognitivos y emocionales.

Estudios sobre mecanismos cognitivos

En cuanto a los mecanismos cognitivos, Beck et al. (1979) definieron un modelo cognitivo que entiende la psicopatología como asociada a los procesos y contenidos cognitivos desadaptativos, más probables en individuos que han desarrollado a lo largo de su vida esquemas cognitivos depresivos o negativos. Estos esquemas cognitivos siguen "dormidos" durante toda la vida, hasta que un evento en particular los activa. Cuando se activan, estos esquemas cognitivos negativos sesgan el procesamiento cognitivo el cual influye, a su vez, en el contenido cognitivo (como pensamientos automáticos y actitudes disfuncionales; Dozois et al., 2009) o que fomenta la aparición de trastornos psicológicos (por ejemplo, depresión). Por lo tanto, tenemos diferentes niveles de profundidad con respecto a los mecanismos cognitivos. En un nivel más profundo tenemos los esquemas

cognitivos que, no sólo están conectados al almacenamiento, organización y estructuración de la forma en cómo se procesa la información, sino que también influyen los contenidos cognitivos (Dozois & Beck, 2008). A un nivel más superficial existen los productos cognitivos, que son los que son más accesibles a las personas y que pueden tomar la forma de pensamientos automáticos o actitudes disfuncionales (Dozois et al., 2009).

Como ya hemos mencionado, aunque sabemos que la terapia es efectiva para producir cambio, a saber, por ejemplo en la depresión, no entendemos claramente cual es el proceso implicado. Con respecto a la terapia cognitivo-conductual, a pesar de ser un tratamiento empíricamente validado en diferentes tipos de psicopatología, no existen estudios confirmando empíricamente qué mecanismos cognitivos median en el cambio (Garratt, Ingram, Sawalani, y Rand, 2007). Hay varias propuestas teóricas que ofrecen una conceptualización del cambio especificando los mediadores cognitivos. Uno de estos modelos de cambio sugiere que para que se produzca el cambio terapéutico deben existir modificaciones estructurales en los esquemas cognitivos negativos (Garratt, Ingram, Sawalani, y Rand, 2007). Por otra parte, otros autores proponen que no existen cambios estructurales, sino una desactivación del esquema cognitivo durante el proceso terapéutico (Ingram y Hollon, 1986). Finalmente, existe un modelo de cambio cognitivo que propone que la terapia no cambia el esquema cognitivo, pero apoya el cliente en la creación de esquemas compensatorios que ayudan en situaciones difíciles (Garratt, Ingram, Sawalani, y Rand, 2007; Hollon et al., 1990). A pesar de que los diferentes modelos sostienen que el elemento central del cambio es el esquema cognitivo (un proceso cognitivo profundo), la mayoría de los estudios sobre los mecanismos de cambio cognitivo se centran en las cogniciones más superficiales tales como pensamientos automáticos y actitudes disfuncionales. Ello es debido a que es difícil acceder a los esquemas cognitivos, al contrario de lo que ocurre con las cogniciones más superficiales.

Así pues examinaremos las revisiones de la literatura sobre los mecanismos de cambio cognitivo, así como los meta-análisis que se han producido en los últimos 15 años. Nuestro análisis esta dividido por el tipo de enfoque de los estudios: (1) focalizados en mecanismos cognitivos más superficiales, como pensamientos automáticos o actitudes

disfuncionales, y (2) centrados en cogniciones más profundas como los esquemas cognitivos. También se tendrá en consideración los estudios que examinan la influencia de la mediación cognitiva en el proceso de cambio de los síntomas durante el proceso terapéutico y su especificidad en las terapias cognitivo-conductuales.

Con respecto a los estudios sobre mecanismos cognitivos más superficiales y su influencia en el cambio sintomático, nos apoyamos en una revisión de la literatura (Garratt, Ingram, Sawalani, y Rand, 2007) que informa sobre los resultados de 31 estudios sobre el tratamiento de la depresión. En términos generales, los diversos estudios confirman que la terapia cognitivo-conductual afecta el cambio en los mecanismos cognitivos, que a su vez permiten una disminución de la sintomatología clínica depresiva. Por ejemplo, en el estudio realizado por Kwon y Owei (2003), con 35 clientes de terapia cognitiva verificaron que una disminución de pensamientos automáticos en una etapa inicial del proceso terapéutico se relacionaba con la disminución de síntomas depresivos al final del proceso terapéutico.

Kuyken (2004), en un estudio que se realizó en terapia cognitiva con una muestra de 122 personas, encontró que los cambios en la desesperanza en etapas iniciales del proceso terapéutico predijeron una mejora en la sintomatología al final del proceso, con independencia del nivel inicial de síntomas depresivos. Tang y DeRubeis (1999) en un estudio de 61 pacientes en terapia cognitiva-conductual encontraron que los cambios cognitivos significativos ocurridos durante la sesión precedieron a las reducciones repentinas en el nivel de síntomas depresivos. Tang et al. (2005) replicaron el mismo estudio (pero con una muestra de Terapia Cognitivo-Conductual parcial, Terapia Cognitivo-conductual y Terapia Conductual), obteniendo resultados similares. Como se puede ver en estos estudios, parece haber evidencia a favor de que los mecanismos cognitivos están relacionados con e influyen en los síntomas y el resultado terapéutico.

Con respecto a los estudios sobre mecanismos cognitivos profundos, los esquemas cognitivos, los estudios son más escasos debido a la dificultad en la medición de la variable en cuestión. Sin embargo, los resultados de las investigaciones realizadas permiten apoyar empíricamente los supuestos teóricos relacionados con el papel de

esquemas cognitivos en la vulnerabilidad y el mantenimiento de estados depresivos (Dozois et al. 2009).

Seeds y Dozois (2010) han analizado la estabilidad de la organización de los esquemas cognitivos, a través de la comparación de los resultados en dos momentos con 1 año de distancia. Verificaron la existencia de una estabilidad de moderada a alta en los patrones de organización de los esquemas cognitivos. Analizaron también la relación de estos esquemas cognitivos con una mayor vulnerabilidad a la depresión, después de la ocurrencia de eventos negativos en la vida. Confirmaron que los esquemas cognitivos organizados de forma más rígida alrededor de contenido negativo se asociaron con una mayor ocurrencia de sintomatología depresiva después de acontecimientos negativos. Lo mismo ocurrió en relación con esquemas cognitivos organizados de forma difusa alrededor del contenido positivo interpersonal.

También se han realizado estudios con la intención de verificar cómo el uso de estrategias compensatorias tien un impacto en la reducción sintomatológica. Estrategias compensatorias derivan de esquemas compensatorios e son habilidades promovidas pela terapia cognitiva con objetivo de compensar el esquema cognitivo disfuncional e ayudar a ultrapasar situaciones de vida difíciles que conducirían a la depresión (Hollon et al., 1990). Hablando en términos generales, los diversos estudios (Barber y DeRubeis 2001; Connoly, Gibbons et al., 2009; Strunk, DeRubeis, Chiu, y Alvarez, 2007;) han encontrado una asociación entre los niveles más elevados de utilización de estrategias compensatorias y el cambio clínicamente significativo, así como con una disminución en la probabilidad de recaída.

Existen algunos estudios sobre la cuestión de si los resultados obtenidos por la terapia cognitivo-conductual son debido a los procesos y mecanismos de cambio supuestamente activados. En ellos se comparan las terapias cognitivas con otros tratamientos, incluyendo la psicofarmacología, con respecto a la presencia de diferentes mecanismos cognitivos y su impacto en la reducción de los síntomas.

Los resultados de estudios previos (DeRubeis et al. 1990; Fava, Bless, Otto, Pava, y Rosenbaum, 1994; McKnight, Nelson-Gray, y Barnhill, 1992; Stravynski et al., 1994; Whisman, Miller, Norman, y Keitner, 1991;) confirmaron la existencia de una asociación

significativa entre un cambio en los mecanismos cognitivos y la reducción de los síntomas. Sin embargo, hay pocos estudios que pueden aclarar el papel específico de la terapia cognitiva en la promoción de una transformación del procesamiento cognitivo, puesto que, de una forma general, no se encuentran diferencias significativas entre el grupo de terapia cognitiva-conductual y la psicofarmacoterapia, con respecto a los cambios en el procesamiento cognitivo (Garratt, Ingram, Sawalani, y Rand, 2007).

Teasdale et al. (2001) compararon dos condiciones diferentes de tratamiento: una que combinaba terapia cognitiva, medicación y manejo clínico, y otra que incluía manejo clínico y medicación, pero no terapia cognitiva. Los autores no encontraron diferencias significativas entre los dos grupos, ni en las medidas relativas a los mecanismos cognitivos, ni en las medidas relativas a la sintomatología depresiva. Por otra parte, sí que encontraron diferencias entre los grupos en la forma de rellenar los cuestionarios sobre medidas cognitivas, siendo el grupo sin terapia cognitiva el que puntuaba de forma significativa con valores más extremos, hecho que se mantuvo durante todo el proceso. En cambio, el grupo de terapia cognitivo-conductual disminuyó significativamente el número de puntuaciones extremas en los cuestionarios a lo largo del proceso terapéutico. Encontraron también que, después de la eliminación de los abandonos (casos que se retiraron antes de las 8 semanas), el grupo de terapia cognitiva tenía menos recaídas y promovió, en gran medida, un cambio en ciertos tipos de errores de pensamiento (e.g., pensamiento de tipo absolutista/dicotómico).

Beevers y Miler (2004) compararon grupos con diferentes condiciones: un grupo de medicación, un grupo de medicación más terapia familiar, un grupo de medicación y terapia cognitiva-conductual y, finalmente, un grupo de medicación más terapia cognitiva-conductual y terapia familiar. No se encontraron diferencias significativas entre ninguno de los grupos, en las diversas medidas relativas a la sintomatología y los mecanismos cognitivos.

En una serie de estudios, Segal et al. (1999, 2006) encontraron resultados distintos de los anteriormente mencionados. Los autores elaboraron un estudio que analizó cómo un estado de depresión temporal influye en la aparición de actitudes disfuncionales en grupos que previamente habían sido tratados por depresión, con terapia cognitiva-

conductual y con farmacoterapia, y compararon los resultados de ambos grupos. Verificaron que, en ambos grupos, cuando estaban en uno estado de ánimo normal, no presentaban, de una forma significativa, actitudes disfuncionales. Sin embargo, cuando se indujo un estado depresivo, el grupo tratado con psicofarmacoterapia demostró mayor reactividad cognitiva, presentando un número significativamente mayor de actitudes disfuncionales. También se verificó que esta reactividad cognitiva era predictiva de futuras recaídas.

Dozois et al (2009) elaboraron un estudio que comparó un grupo de terapia cognitiva y farmacoterapia, con un grupo de farmacoterapia con respecto a los mecanismos cognitivos (superficiales y profundos) y la sintomatología depresiva. En contraste con estudios previos, encontró resultados que, en parte, apoyan la idea que el cambio en la terapia cognitiva se produce, mediante la modificación de los esquemas cognitivos. En relación a los mecanismos cognitivos superficiales, ambos grupos mostraron una disminución significativa de los síntomas depresivos y una disminución significativa de los pensamientos automáticos y actitudes disfuncionales. Sin embargo, en respecto a los mecanismos cognitivos más profundos, los esquemas cognitivos, sólo existieron cambios significativos en el grupo de terapia cognitiva más farmacoterapia.

Cuando hablamos de la asociación entre la utilización de las estrategias compensatorias y la terapia cognitiva, estudios comparativos con otros tratamientos, no han confirmado la existencia de una asociación positiva entre los niveles más elevados de utilización de estrategias compensatorias y la terapia cognitiva (Connoly-Gibbons et al., 2009).

En resumen, los diversos estudios demuestran que una modificación en los mecanismos cognitivos (pensamientos automáticos, actitudes disfuncionales, esquemas cognitivas o estrategias compensatorios) tiene impacto en la reducción de los síntomas. Sin embargo, pocos son los estudios que son capaces de probar y confirmar la hipótesis de que existe una relación de causa y efecto entre las dos variables. Además, la gran mayoría de los estudios comparativos con otros tratamientos, por ejemplo, farmacoterapia, no son capaces de confirmar la hipótesis de que la terapia cognitiva tiene mayor capacidad para promover cambios cognitivos que otros tratamientos. Varias

cuestiones metodológicas pueden haber contribuido a esta situación, a saber: el uso de muestras reducidas que no tienen poder estadístico suficiente para producir diferencias significativas entre grupos; la falta de un grupo de control en los diferentes estudios, que permitiría comparar el impacto real del tratamiento vs el no tratamiento; por último, en la mayoría de los estudios no se controla la existencia del cambio sintomatológico previo al cambio cognitivo, lo cual reduce la posibilidad de confirmar el efecto mediador de los mecanismos cognitivos en el cambio terapéutico (Crits-Cristoph, Gibbons, y Mukberjee, 2013).

Estudios sobre mecanismos emocionales

Con respecto a los mecanismos emocionales, son varios los estudios que analizan cómo las emociones influyen en el cambio terapéutico. En primer lugar, vamos a presentar estudios relativos a la activación emocional y después estudios cuyo enfoque es el procesamiento emocional. Aunque se puede argumentar que la activación emocional es parte del procesamiento emocional, existen varios estudios sobre este mecanismo más específico, por lo que nos pareció importante realizar esta división. Los estudios que se presentan seguida continuación sobre la activación emocional están basados en una revisión de la literatura sobre el papel de las emociones en el proceso terapéutico de Greenberg y Pascual-Leone (2006). También se presentarán estudios más recientes sobre la activación emocional, pero, en general, los resultados son convergentes.

Con respecto a los mecanismos emocionales presentes en terapia, la activación emocional parece ser un primer paso, cuando el foco de la intervención son las emociones. Traer a la conciencia la experiencia emocional permite el trabajo terapéutico posterior con emociones descubiertas (Greenberg y Pascual-Leone, 2006). Para superar la evitación y permitir la activación emocional es necesaria la exposición a experiencias evitadas. Diversos estudios en terapia conductual (Foa, Riggs, Massie, y Yarczower, 1995; Jaycox, Foa, y Morral, 1998) en clientes con trastornos por estrés postraumático, encontraron que la activación emocional del miedo en conjunto con el recuento de los eventos traumáticos durante la primera exposición y con una disminución progresiva del malestar sentido

durante las exposiciones durante el proceso terapéutico, funcionaron como predictores del éxito terapéutico. Otro estudio llevado a cabo con los clientes con trastorno por estrés postraumático (Foa, Aparejos, Massie, y Yarczower, 1995) encontró que la activación emocional (medida a través de la expresión facial) durante la narración de eventos traumáticos era esencial para permitir el acceso a la “estructura del miedo" que, a la postre, promueve el éxito terapéutico. Un metaanálisis sobre la eficacia de diferentes terapias en el tratamiento del trastorno por estrés postraumático (Foa, Rothbaum, y Furr, 2003) concluye que la terapia de exposición (sin ser combinada con otras terapias) es la más eficaz en el tratamiento de este trastorno.

En cambio, los estudios llevados a cabo con terapias experienciales indican que la activación emocional, por sí sola, no es suficiente para promover el cambio terapéutico, siendo necesaria una combinación con la integración cognitiva de la propia experiencia emocional. Un estudio (Warwar y Greenberg, 2000) en una muestra de clientes en terapia focalizada en la emoción para la depresión parece confirmar estos resultados, al tiempo que verifica que la activación emocional en conjunción con la reflexión sobre las emociones activadas en la fase intermedia del proceso terapéutico fueron predictores del éxito terapéutico. Otro estudio (Warwar, 2003) analizó la relación entre la emoción exprimida e la emoción experenciada (esta última requiere interpretación cognitiva de la emoción) e el resultado terapéutico. Se verificó que las dúas variables en conjunto fueron mejores predictores del resultado terapéutico, que cuando analizadas solas. Finalmente, un estudio (Missirlan, Toukmanian, Warwar, y Greenberg, 2005) realizado sobre una muestra de 32 clientes en terapia focalizada en la emoción para la depresión verificó que la activación emocional en conjunción con el procesamiento perceptivo son mejores predictores de éxito terapéutico que cualquiera de las variables solas. Los resultados de estos estudios parecen indicar que, no solo es importante la activación de emociones pero también la consciencia e reflexión sobre las mismas. Carryer y Greenberg (2010) realizaron un estudio para determinar la relación entre el tiempo pasado en la expresión de emociones intensas (activación emocional significativa) y el éxito terapéutico. Utilizaron una muestra de 32 clientes en terapia focalizada en la emoción. Los resultados del estudio indicaron que el éxito terapéutico estaba asociado con cantidades moderadas de activación emocional intensa (aproximadamente 25% del tiempo de la terapia, en la

fase intermedia y de la fase final). Por lo tanto, parece importante no sólo que el cliente alcance niveles elevados de activación emocional, sino también cuánto tiempo se mantiene en niveles de activación emocional intensa.

Estés estudios parecen indicar que, a pesar de que la activación emocional desempeñe un papel muy importante para el proceso terapéutico, por sí sola no parece ser suficientemente eficaz, siendo necesaria una integración cognitiva de la propia experiencia emocional para facilitar el proceso de cambio. O contrario puede también ocurrir, para existir una integración cognitiva apropiada y completa de la experiencia emocional que está siendo trabajada en la terapia, es necesaria la activación eficaz de las emociones agregadas a esa experiencia. Además, durante el proceso terapéutico parece haber una frecuencia ideal (ni demasiado alta ni demasiado baja) de tiempo en la expresión de emociones.

Sobre el estudio de los mecanismos emocionales y el cambio terapéutico, diferentes estudios se centraron en el procesamiento emocional. El procesamiento emocional se define como el proceso mediante el cual se accede a los estados emocionales, se fijan temporalmente en la conciencia de la persona y se transforman en experiencias emocionales más adaptativas y claramente conectadas con las necesidades reales del individuo (Baker et al., 2012). En relación a cómo se produce, un estudio fue diseñado (Pascual-Leone y Greenberg, 2007) para mostrar cómo se lleva a cabo, momento a momento, el procesamiento emocional. Este estudio propone un modelo teórico con las diferentes fases o pasos de la ocurrencia del procesamiento emocional relacionado con el cambio, el cual fue empíricamente validó en una muestra de 34 clientes. En una etapa inicial del procesamiento emocional, el modelo propone la existencia de emociones indiferenciadas o no procesadas, tales como el malestar general, la rabia agresiva, lo miedo y la vergüenza. Posteriormente y como un paso principal para el cambio, se refiere a la interconexión entre una mayor conciencia de la autoevaluación negativa de sí mismo con las necesidades del *self* que anteriormente no eran conscientes. Finalmente, el acceso a las emociones como la rabia asertiva, la angustia, el dolor y el auto-apaciguamiento parecen ser pasos más avanzados de procesamiento emocional (Pascual-Leone y Greenberg, 2007).

Varios estudios también analizaron cuál es la relación del procesamiento emocional y el cambio terapéutico, especialmente en terapias experienciales que centran su intervención en la exploración y procesamiento de las experiencias emocionales del cliente. Un estudio (Pos, Greenberg, Goldman, y Korman, 2003) realizado con 34 clientes en terapia focalizada en la emoción tuvo como objetivo examinar la relación entre el procesamiento emocional (inicial y tardío) con los síntomas generales, la autoestima y los problemas interpersonales. Se constató, en primer lugar, que el procesamiento emocional mejoró significativamente a lo largo de la terapia y que este aumento producía mejoras sintomáticas. Además, se comprobó que el procesamiento emocional inicial fue mediado por el procesamiento emocional tardío (Pos, Greenberg, Goldman, y Korman, 2003). Esto parece indicar que iniciar la terapia con una buena capacidad de procesamiento emocional no es un factor muy importante para el resultado terapéutico, pero lo que parece importante es aumentar esta capacidad a lo largo del proceso terapéutico.

Del mismo modo, otro estudio (Pos, Greenberg, y Warwar, 2009) analizó cómo el procesamiento emocional y la alianza terapéutica, en diferentes etapas de la terapia (inicial, intermedia y final), se relacionan con los resultados terapéuticos (sintomatología depresiva y general, autoestima y problemas interpersonales). Para este estudio se utilizó una muestra de 74 clientes en terapia experiencial breve. Como en el estudio anterior, el procesamiento emocional aumentó significativamente durante el proceso terapéutico. Lo mismo ocurrió con la alianza terapéutica. También se constató que el procesamiento emocional de la fase intermedia fue el mejor predictor del resultado terapéutico con respecto a los síntomas (depresivos y generales) y el procesamiento emocional de la fase final fue el mejor predictor con respecto a la autoestima. También se constató que la alianza terapéutica influía directamente en el procesamiento emocional e indirectamente en los resultados terapéuticos, durante la etapa intermedia y final de la terapia. Un estudio más reciente (Malin y Pos, 2014) destinado a comprobar cómo la empatía expresada por el terapeuta, en la fase inicial del tratamiento, influye en la alianza terapéutica, en el procesamiento emocional (en la fase intermedia de la terapia) y en la sintomatología depresiva (en la fase final de la terapia). Con este fin, se utilizó una muestra de 30 clientes en terapia experiencial breve para la depresión. Se encontró que tanto la alianza terapéutica, como el procesamiento emocional influyeron directamente en los resultados

terapéuticos (sintomatología depresiva en las etapas finales). La empatía había influenciado estos dos mecanismos (alianza y procesamiento emocional) directamente e indirectamente en los resultados terapéuticos.

Aunque una proporción significativa de los estudios sobre procesamiento emocional utilizaron muestras de terapias experienciales, también se realizaron estudios en otras terapias cuyo foco terapéutico no es cambiar la experiencia emocional, sino más bien, los mecanismos cognitivos, como por ejemplo la terapia cognitivo-conductual. A través del análisis de estos estudios podremos verificar si la modificación de los mecanismos emocionales es más significativa en las terapias experienciales. Esto podría ayudar a confirmar la posible existencia de una relación de causa-efecto entre las estrategias experienciales y la modificación de los mecanismos emocionales. Castonguay et al. (1996) realizaron un estudio para analizar cómo dos variables comunes a otras terapias (la alianza terapéutica y el procesamiento emocional) y una variable específica de la terapia cognitiva-conductual (las distorsiones cognitivas) influían en el resultado terapéutico. El estudio se realizó sobre una muestra de clientes con depresión tratados con terapia cognitivo-conductual con y sin medicación. Se observó que el aumento de la alianza terapéutica y del procesamiento emocional predecían la mejora sintomática, mientras la disminución de las distorsiones cognitivos no anticipaba la disminución de síntomas. Watson y Bedard (2006) compararon los niveles de procesamiento emocional de 40 casos de éxito y fracaso en terapia cognitivo-conductual y terapia experiencial. Los resultados ayudaron a demostrar que: (1) en ambos tratamientos el procesamiento emocional aumentó a lo largo de la terapia, de forma más significativa en la fase intermedia del proceso terapéutico; (2) que el grupo de éxito en ambos tratamientos obtuvo niveles de procesamiento emocional significativamente superiores en comparación con el grupo de peores resultados; y (3) que los clientes de terapia cognitivo-conductual llegaron a niveles de procesamiento emocional inferiores en comparación con el grupo de la terapia experiencial. Otro estudio posterior (Baker et al., 2012) comparó los niveles de procesamiento emocional de un grupo de clientes en terapia cognitivo-conductual con un grupo de individuos no clínicos. En la evaluación inicial, se encontró que los niveles de procesamiento emocional del grupo clínico fueron significativamente

más bajos que el grupo no clínico. Sin embargo, al final de la terapia, el grupo clínico había alcanzado niveles de procesamiento emocional próximos a los del grupo no clínico.

A pesar de que los diferentes estudios parecen confirmar la importancia de los mecanismos emocionales en al cambio terapéutico, los estudios contienen algunas limitaciones metodológicas que merece la pena señalar. En particular, gran parte de los estudios contaban con muestras reducidas y/o carecían de grupos control. Además, muchos estudios no tenían un control sobre las posibles mejoras en la variable de resultado, antes de medir la variable de proceso. Tales limitaciones dificultan la generalización de los resultados y dificultan la confirmación de la relación entre los mecanismos emocionales y el cambio terapéutico (Crist-Cristophe, Gibbons, y Mukberjee, 2013). Además son escasos los estudios que comparan las terapias experienciales con otros tratamientos (como la farmacoterapia) con respecto a los mecanismos emocionales. Esto dificulta la posibilidad de confirmar que el cambio en los mecanismos emocionales es más significativo en las terapias experienciales, lo cual apoyarían la idea de que transformación emocional es promovida, de forma más significativa, por el arsenal técnico y estratégico de dichas psicoterapias.

Sin embargo, a pesar de estas limitaciones, los diferentes estudios son unánimes en afirmar que el procesamiento emocional es un mecanismo clave que influye en el proceso de cambio en la terapia. Además, esta relación no parece ser específica de terapias cuyo enfoque es la experiencia emocional, como por ejemplo la terapia focalizada en la emoción, sino que también existen en las terapias que se centran en estrategias interrelacionadas con mecanismos cognitivos, como la terapia cognitivo-conductual.

Implicaciones para investigaciones futuras sobre el cambio en la terapia

Después de analizar los resultados de los diferentes estudios sobre los mecanismos emocionales y cognitivos, comprobamos que, en su mayor parte, los estudios validan el papel mediador de dichos mecanismos en la promoción del cambio terapéutico. Sin embargo, no confirman su especificidad al tipo de terapia concreta que supuesta y teóricamente los suscitan. De hecho, parece que el cambio se produce de forma simultánea

en diferentes mecanismos, emocionales y cognitivos, incluso cuando no hay estrategias terapéuticas que se dirigen específicamente a cada uno de estos mecanismos, como por ejemplo el tratamiento farmacológico. En efecto, los resultados de los estudios comparativos entre diferentes formas de psicoterapia y la farmacoterapia son sorprendentes, puesto que se producen cambios en los mecanismos emocionales y cognitivos, incluso cuando no se utilizan estrategias que tienen como objetivo su cambio. De hecho, el cambio fisiológico promovido por los psicofármacos también parecen tener un efecto, no sólo en los síntomas, sino también en los mecanismos cognitivos y emocionales. Aunque también es cierto que, como ha sido indicado más arriba, la inexistencia de diferencias entre los distintos tipos de tratamientos con respecto a la especificidad de los mecanismos de cambio, puede deberse de las limitaciones metodológicas de una parte significativa de los estudios (Crist-Cristophe, Gibbons, y Mukberjee, 2013). Los estudios con muestras reducidas pueden producir resultados menos claros, puesto que las diferencias que podrían ser significativas en una muestra más grande dejan de ser cuando tenemos una muestra más pequeña. Así, la inexistencia de diferencias significativas entre los diferentes tipos de tratamiento, puede explicarse por la utilización de muestras reducidas que no tienen poder estadístico suficiente para producir diferencias significativas entre los grupos.

No obstante, las limitaciones metodológicas pueden no ser la única explicación para la inexistencia de diferencias significativas entre los diferentes tipos de tratamiento en relación a los procesos psicológicos o mecanismos estudiados. De hecho, nos parece que los diferentes estudios se basan en un modelo teórico lineal o restrictivo sobre el cambio terapéutico y sobre la propia estructura psíquica. En otras palabras, el modelo psicológico y, a su vez, el modelo de cambio terapéutico utilizado por los diferentes estudios están basados en una lógica atomista y lineal, que intenta reducir de una manera simplista fenómenos y estructuras altamente complejos. Por lo tanto, nos parece que para poder entender mejor cómo se produce el cambio terapéutico será necesario adoptar un modelo más complejo del funcionamiento humano, que toma en cuenta los diferentes mecanismos psicológicos (cogniciones, emociones, procesos bioquímicos y fisiológicos, comportamientos) como fenómenos interconectados en un todo que se auto-organiza mediante los inputs del mundo que lo rodea (Feixas, 2003; Procter, 2009). Por lo tanto,

será más fácil de entender cómo las estrategias dirigidas a fomentar cambios en un proceso específico (por ejemplo comportamiento), producen cambios sustanciales en otros procesos o mecanismos psicológicos y fisiológicos. Así, cuando se toma una perspectiva de la estructura psíquica como un conjunto de procesos interconectados, con un funcionamiento sincrónico, pero también con influencias diacrónicas, y que se auto-organiza en un todo, es imposible disociar los diversos mecanismos a nivel de su funcionamiento. De esta manera, nos parece importante alcanzar un modelo de cambio terapéutico más integrador y configurado en esta perspectiva sobre los diferentes procesos como interconectados e inseparables. Nos parece que, una aproximación basada en esta visión permitiría lograr una comprensión más clara acerca de lo que sucede durante la terapia y entender qué hace que sea eficaz en la promoción del cambio y el bienestar. Es evidente que las limitaciones metodológicas, particularmente con respecto a la observación y medición de fenómenos tan complejos como los descritos, son, sin duda, un obstáculo difícil de sortear, pero al mismo tiempo un reto que parece ser importante afrontar en el futuro, con el fin de producir una comprensión más clara de los fenómenos y procesos que promueven el éxito terapéutico.

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ESTUDO 2: Changes in symptom intensity and emotion valence during the process of assimilation of a problematic experience: A quantitative study of a good outcome case of cognitive-behavioral therapy

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

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Abstract

The assimilation model describes the change process in psychotherapy. In this study we analyzed the relation of assimilation with changes in symptom intensity, measured session by session, and changes in emotional valence, measured for each emotional episode, in the case of a 33-year-old woman treated for depression with cognitive-behavioral therapy. Results showed the theoretically expected negative relation between assimilation of the client's main concerns and symptom intensity, and the relation between assimilation levels and emotional valence corresponded closely to the assimilation model's theoretical feelings curve. The results show how emotions work as markers of the client's current assimilation level, which could help the therapist adjust the intervention, moment by moment, to the client's needs.

Keywords: assimilation model; change process; cognitive-behavioral therapy; depression; symptom decrease; emotional valence

Introduction

The Assimilation Model (Stiles, 2001; Stiles et al., 1990) is a theory about the process of change in psychotherapy. This model explains change as a gradual integration of problematic experiences into the self in a regular sequence of stages (Stiles et al., 1990). Associated with this assimilation sequence is a distinctive pattern of affective changes (Stiles, Osatuke, Glick, & Mackay, 2004).

Previous case studies (Honos-Webb et al., 1998, 1999; Stiles, 2006; Stiles et al., 1991) as well as group comparisons (Detert et al., 2006) have confirmed that good-outcome cases tend to achieve higher levels of assimilation than poor-outcome cases. We extended this by quantitatively and longitudinally examining two processes that are theoretically associated with the assimilation of problematic experiences: changes in symptom intensity and changes in emotion valence (Stiles et al., 2004). We studied these processes session by session in a good-outcome case of cognitive-behavioral therapy (CBT).

The process of assimilation in psychotherapy

In the Assimilation Model the self is seen as multivocal, composed of several, sometimes contradictory internal voices (Honos-Webb & Stiles, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles, 1999). Each voice is composed of traces left by previous experiences (Stiles, 2011). The multiple voices interact with each other forming an organized structure, a community of voices that comprises the person's usual self (Honos-Webb & Stiles, 1998). The voices are agentic entities that function as psychological resources – activated and used as required in each new situation. When the situation resembles that in which particular voices were formed, these voices are activated and step forward, bringing to bear the relevant past experiences on the present situation (Detert et al., 2006; Stiles, 2011).

Some voices, however, jeopardize the stability of the community. These problematic voices represent experiences that are incompatible with the usual self (e.g., traumatic incidents, destructive relationships, threatening or painful situations). Although all voices, including problematic voices, try to be heard when relevant circumstances

arise, in the case of problematic voices, the incompatibility leads to rejection, avoidance, or dissociation of this voice. The emergence of such a problematic voice in consciousness causes a painful internal conflict between voices (Honos-Webb & Stiles, 1998). On the other hand, when problematic voices are dissociated or avoided, important experiences are disregard and valuable resources are unavailable. Clinically significant problems tend to occur when the self-community of voices becomes restrictive or inflexible, and the same voices assume over and over again a dominant role (Stiles, 1999).

Psychotherapy promotes integration of problematic voices into the self-community by the creation of links between them (Honos-Webb, Surko, Stiles, & Greenberg, 1999). This ongoing process involves the development of a common language between voices, that is, the creation of meaning bridges – signs (words, gestures, images, etc.), that have similar meaning to both voices. The gradual emergence of meaning bridges permits dialogue and mutual understanding between the conflicting parts (Stiles, 2011). Building meaning bridges between the dominant voices of the community and non-dominant, problematic voices is the core of the therapeutic assimilation process; it is the mechanism of integration of previously disregarded voices into the self-community of voices (Stiles, 2011).

The assimilation of problematic voices seems to involve a developmental process, which can be assessed using the Assimilation of Problematic Experiences Scale (APES; Caro Gabalda & Stiles, 2009; Stiles, 1999; Stiles et al., 1991). As shown in Table 1, the APES tracks the assimilation of the problematic experience through eight levels or stages, numbered 0 to 7, which describe the changing relation of the problematic experience to the dominant self (0 = Warded off/Dissociation; 1 = Unwanted thoughts/ Active avoidance; 2 = Vague awareness/Emergence; Level 3 = Problem statement/Clarification; 4 = Understanding/Insight; 5 = Application/Working through; 6 = Resourcefulness/ Problem solution; 7 = Integration/ Mastery). Clients may enter therapy at any level, and any progress through the sequence may be considered as improvement.

Table 1

Assimilation of Problematic Experiences Scale (adapted from Caro Gabalda & Stiles, 2009)

APES 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, proud of accomplishment.
7.Integration/ Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

A series of case studies has supported the assimilation model's contention that the process of change follows a common sequence approximated by the APES in a variety of therapies. These include Emotion Focused Therapy (Brinegar, Salvi, Stiles, & Greenberg, 2006), Client-Centered Therapy (Brinegar, Salvi, Stiles, & Greenberg, 2006; Osatuke et al., 2005), Psychodynamic Therapy (Knobloch, Endres, Stiles, & Silberschatz, 2001), Linguistic Therapy of Evaluation (Caro Gabalda, 2007), couple therapy (Schielke et al., 2011), and family therapy (Laitila & Aaltonen, 1998), as well as CBT (Gray & Stiles, 2011).

Studies have illuminated a few distinctive aspects of the assimilation process in different therapies. For example, in one study clients with well formulated problems had relatively better results in CBT than in a psychodynamic-interpersonal therapy (Stiles et al., 1997). Plausibly, CBT focuses on problematic experiences that are clearly formulated and thus work better for problems at intermediate and higher levels of assimilation, whereas psychodynamic strategies emphasize problems that aren't yet formulated (Honos-Webb & Stiles, 2002).

The relation between assimilation and improvement

The assimilation model proposes that development toward higher levels of assimilation is associated with psychological improvement, including a decrease in symptomatology, as assessed with conventional symptom intensity scales (Stiles, 2006). This link has been shown empirically in numerous case studies (Stiles, 2001; see also citations in previous section) as well as in group comparisons (Detert et al., 2006). Studies of poor-outcome cases have shown how assimilation failed to progress to high levels (i.e., to APES ≥ 4; Honos-Webb, Stiles, Greenberg, & Goldman, 1998).

At a fine-grained level, progress measured by the APES is typically irregular. Setbacks in the assimilation process, defined as movement from a higher APES level to a lower one in successive passages, are common in all therapies that have been studied (e.g., Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch et al., 2001). Rather than representing something undesirable, setbacks, so defined, usually involve a subtle shift of topics, from a more assimilated to a less assimilated strand of a problem (Caro Gabalda & Stiles, 2013). Setbacks in cognitive therapies often seem to reflect active and directive therapeutic strategies used push the person to the limits of their comfort zone or to redirect attention to a new aspect of the problem. This yields an irregular progression through the APES: a sawtooth pattern with brief, rapid advances followed by setbacks within a broader pattern of APES progress (Caro Gabalda & Stiles, 2013). By contrast, in experiential therapies, progress seems more steady, with slower advances and smaller setbacks (Osatuke et al., 2005).

Feelings and Assimilation

The assimilation process – the conflict and progressive understanding between voices described by the APES – involves powerful emotional forces. Theoretically, each level of assimilation is associated with a specific valence and intensity of feelings (Detert, et al., 2006; Stiles et al., 1991; Stiles, Osatuke et al., 2004). Of course, feelings vary in many ways besides salience and valence; arguably, each feeling is unique, reflecting the circumstances and content. However, the theoretical relation of these two aspects of feelings to assimilation level is interestingly systematic, as represented graphically in Figure 1. The S-shaped feelings curve represents the characteristic level of feeling at each assimilation level, in which "The client moves from being oblivious, to experiencing the content as acutely painful, then as less distressing, merely puzzling, then understood, and finally as confidently mastered" (Stiles et al., 1990, p. 411).

Theoretically, the feelings level is the product of the salience of the experience and its potential valence. The normal curve appearing in figure 1 represents the salience or amount of attention paid to the experience. At low assimilation levels (APES 0 and 1) the experience is avoided, and at the highest level (APES 7) the experience is fully integrated and therefore unremarkable, so at these levels the salience is low. In the middle phase of the assimilation progress (from APES 3 to 5), when the experience is being clarified, understood and applied, salience is high. The ascending diagonal line represents the potential valence of a direct encounter with a particular problematic experience: negative at lower levels of assimilation, and positive at higher levels of assimilation. The feelings curve is obtainable mathematically by multiplying the salience and valence curves (Stiles at al., 2004, p. 97).

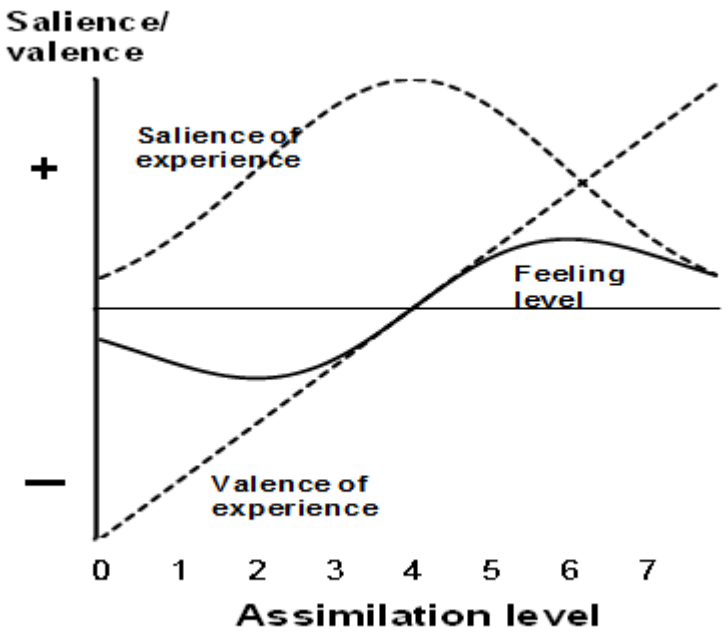

Figure 1. Theoretical relations of salience and valence of a problematic experience with specific feelings level at each stage of the Assimilation of Problematic Experiences Scale (APES): 0 = warded off; 1 = avoided; 2 = emerging; 3 = recognized; 4 = understood; 5 = applied; 6 = solved; 7 = mastered.

Psychologically, the feelings curve represents the client's reportable emotional experience that characterizes each assimilation level. To illustrate, consider a client who has lost a loved one (problematic experience). When the loss is at APES level 0 or 1, he avoids thinking about his loved one or about the event. Although the experience has a very negative potential, negative feelings are less strong because the client is not attending to it. At APES level 2, the client gains awareness of his loss and negative feelings emerge powerfully. At APES level 3, as the client clearly understands that he misses his loved one, his full attention is given to this experience; negative feelings are present but in a manageable way. For instance the client is able to go to the cemetery or talk about the deceased. At APES level 4, the client is able to understand that, although his loved one will always be missed, he can move on with his life. This entails mixture of positive and negative feeling; the client may feel pain for knowing that his loved one will never be

back in his life and, at the same time tranquility for knowing that he can move on. At APES level 5 the client starts to put the new understating into practice. For example, he is now able to resume activities he had stopped after the traumatic event. At APES level 6 the client is able to overcome his loss and recover his life. At APES 5 and 6 the client may have positive emotions, such as a sense of achievement and renewed enthusiasm for life. At APES level 7, the problematic experience is fully integrated. Although the client still misses his loved one, feelings tend to become more neutral, since this experience progressively has less impact in the client's life. Early work comparing APES ratings with sentence-by-sentence coding of affect was consistent with this account (Mackay et al., 2002).

The feelings curve helps to explain the interesting observation by Detert et al. (2006) that APES level 4 (insight/new understanding) seemed to represent a cutoff between conventionally-defined good and poor outcome cases. That is, the good outcome cases, defined in terms of achieving low scores on symptom intensity measures, reached at least level 4, whereas poor outcome cases reached at most level 3 (Detert et al., 2006). The feelings curve describes a nonlinear relation between assimilation and emotional suffering, which is presumably a large component of symptom intensity. Increasing assimilation may even entail an increase in distress across low (0-2) APES levels. Likewise, at high (6-7) APES levels, positive feelings may be level or decreasing (see Figure 1). Between levels 2 and 6, however, distress should decline, and level 4 (insight/understanding) is in the center of this range. Thus, Detert et al.'s cut point at level 4 represents the theoretical center of the segment in which increases in assimilation are associated with decreases in distress. It is also the point at which the feelings curve passes from negative feeling to positive feeling (see Figure 1).

Research design and purpose

In this study we analyzed the progress of assimilation in a successful CBT clinical case, along with measures of symptom intensity and measures of emotional arousal during sessions. This allowed us to assess the theoretical expectations that symptom intensity would decrease as assimilation of core problems increased and that emotion expression

would conform to the theoretical feelings curve (Figure 1). Insofar as this was a theory-building study, we were interested in how our observations conformed to the theory or suggested elaborations or modifications, recognizing that any generalization proceeds from the theory, not from the results of this particular case (Stiles, 2015).

Method

Client

Laura (a pseudonym) was a 33-year old Portuguese woman, married and mother of one child. She participated in the ISMAI Depression Study (Salgado et al., 2010), a randomized clinical trial that compared the efficacy of Emotion Focused Therapy and CBT in clients diagnosed with mild or moderate Major Depressive Disorder. She was considered to be a good outcome case based on her scores on standard symptom intensity measures.

The inclusion criteria for the ISMAI Depression Study were: being diagnosed with Major Depression Disorder; Global Assessment of Functioning (GAF)>50; and not being medicated. The exclusion criteria were: currently on medication or another form of treatment; or currently or previously diagnosed with one of the following DSM–IV Axis I disorders: panic, substance abuse, psychotic, bipolar, or eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or at high risk of suicide. The assessment was conducted by a clinician, a psychologist with 10 years of clinical experience. Laura met criteria for inclusion in the study after being diagnosed with moderate major depressive disorder assessed using the Structural Clinical Interview for the DSM-IV-TR (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002). She was randomly assigned to the CBT treatment. Laura received her treatment in the psychotherapeutic lab at Maia University Institute (ISMAI), Portugal, by a trained cognitive behavioral therapist, for 16 weekly sessions.

Laura's main concerns were related to her professional situation and her body image. She was having difficulties coping with the negative experience of having quit her job for health reasons and being unemployed since then (1 year previously). When Laura

came to therapy, she was feeling depressed, tired, insecure, and low in self-esteem, which intensified her sense of guilt and failure. Her appetite and weight had increased, which contributed to her body-image issues. During the therapeutic process a conflict with her mother emerged. Laura's had not felt accepted and loved during her childhood, and at the beginning of therapy she complained about a critical and demanding relationship with her mother.

From the initial to the final phase of therapy, there was a significant decrease in symptomatology and an increase in her well-being, assessed by self-report questionnaires. The self-report questionnaires presented in Table 2 were all used to assess the evolution of symptoms and therapeutic outcome but in this study only BDI-II and OQ-10 were used for comparison with assimilation.

Table 2

Pre-test, post-test and follow-up scores from Laura

Questionnaires	**Pre-test**	**Last Session**	**Follow-up (1 year)**
BDI-II	31	0	0
OQ-45.2	94	17	18
HDRS	8	0	N/A
OQ-10	25	4	1

Laura improved in self-esteem and self-image which allowed her to invest in new professional goals. The therapeutic improvements were maintained 1 year after the end of treatment.

Therapy

The intervention used in Laura's case was based on a CBT protocol for depression proposed by Beck and collaborators (Beck, Rush, Shaw, & Emery, 1997) and adapted within the ISMAI Depression Study (Salgado et al., 2010). CBT theory suggests that maladaptive emotions or behaviors proceed not from reality but errors in the processing of information about reality and that these errors originate in dysfunctional beliefs. The cognitive-behavior therapist and client collaborate first to determine which dysfunctional

beliefs are sustaining the problem, then to change environmental factors contributing to the problem, and then, through cognitive-restructuring, to challenge the dysfunctional beliefs in order to create more adaptive ways of thinking, and consequently, more positive emotions and adaptive behaviors. From an assimilation model perspective, dysfunctional beliefs may be grounded in dominant rigid voices that bias the processing of information, leading to automatic thoughts. The more adaptive ways of thinking may be considered as new meaning bridges that encompass the previously problematic voices, turning them from problems into resources. These meaning bridges and the subsequent integration of the problematic voice into the community of voices promotes a change in the core maladaptive beliefs, transforming them into more adaptive and flexible views of the self and reality.

Symptom intensity measures

Beck Depression Inventory (BDI).

The BDI-II (translated into Portuguese from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002) is a 21-item self-report inventory designed to measure the intensity of cognitive, affective and somatic depressive symptoms. Items are scored from 0 to 3, so total scores can range from 0 to 63. Higher scores indicate greater severity of depressive symptomatology. The cut-off point for Portuguese population separating minimal from mild depressive depression is 13. The Cronbach's Alpha was .89 (Coelho, Martins, & Barros, 2002). The results obtained in the Portuguese validation of BDI-II were congruent with the ones obtained in the American population (Coelho, Martins, & Barros, 2002).

Outcome Questionnaire-10 (OQ-10).

The OQ-10 (Lambert, Finch, Okiishi, Burlingame, McKelvey, & Reisinger 1998) is a 10-item self-report inventory designed to assess psychotherapy outcome. Each item is scored on a scale ranging from 0 to 4 (total scored from 0 to 40). Higher scores indicate poorer mental health functionality.

The total score of the English version of the OQ-10 has a reported internal consistency (Cronbach's Alpha) of .88 (Seelert, 1997) and a test–retest reliability of .62 over a 3-weeks interval (Lambert et al., 2005).

Based on the ISMAI Depression Study sample (*N*=64; Salgado et al., 2010), we found that the internal consistency (Cronbach's Alpha) of the total score of the Portuguese OQ-10 ranged from .63 to .92 and the test-retest reliability that was of .74 over a 1-week interval. Following the procedures of Lambert and collaborators (2005), we found that the concurrent validity of the OQ-10 total score, as compared with the BDI-II was .82. Also following the Lambert et al. (2005) procedures, we assessed construct validity using a t-test for correlated samples, testing the hypothesis that symptoms decreased with therapy. A significant improvement, $t(48) = 10.72$, $p<.001$, was found from session 1 to 16, indicating good construct validity.

Process measures

Assimilation of Problematic Experiences Scale (Caro Gabalda & Stiles, 2009; Stiles et al., 1991).

The APES was used to assess the levels of assimilation of the problematic experiences (described earlier; see Table 1).

Client Emotional Arousal Scale–III (CEAS-III; Warwar & Greenberg, 1999).

The CEAS-III assesses the quality and intensity of client emotions, classifying the emotion category (pain/hurt; sadness; hopelessness/helplessness; loneliness; anger/resentment; contempt/disgust; fear/anxiety; shame/guilt; anger and sadness; love; joy/excitement; pride and anger; contentment/calm/relief; pride/selfconfidence.) and the arousal level (i.e., intensity of that emotion). The arousal level is measure throughout a 7-point scale. Modal and peak expressed arousal are rated in each segment selected. The modal rating specifies the client's global level of expressed arousal in the selected segment. The peak rating indicates the highest level of expressed arousal in that specific segment (Greenberg, Auszra, & Herrmann, 2007). This is assessed through the evaluation

of client's vocal and body expressions. Warwar and Greenberg (2000) described interrater reliability coefficients of .70 for modal and of .73 for peak arousal ratings.

Procedure

Outcome measurement

The BDI-II was administered immediately before sessions 1, 4, 8, 12 and 16. The OQ-10 was administered immediately before all 16 sessions.

Process measurement

Assimilation analysis. The therapeutic sessions were transcribed according to the procedures of Mergenthaler and Stinson (1992). Then, using the transcripts, the analysis of the case according to APES followed procedures used in previous studies (e.g., Honos-Webb, Stiles, & Greenberg, 2003; Stiles et al., 1991; Stiles & Angus, 2001). The 2 raters who did the APES ratings were a PhD student and a research assistant with a Master's degree in clinical psychology. Both had had previous experience in the assimilation model and supervised experience in CBT. Training lasted approximately four months, during which raters met every week for 2 hours. The first part of training involved reading and discussing journal articles and previous rating manuals. Then, raters were given sessions to rate, initially together with an expert rater, and then independently to establish reliability. These practice ratings were compared with ratings of those sessions by an expert judge to assess reliability. Discrepancies were discussed in meetings of the raters and an expert judge and resolved by consensus. The coders were considered to be reliable and able to start coding the case when interrater reliability between each other and in comparison with the expert judge ratings reached ICC [2,1] ≥ .60.

Following procedures described by Stiles and Angus (2001), first, all sessions were read by both raters and the recurring issues were identified. Then, by consensual judgment the most relevant themes were selected based on their clinical relevancy (high proportion of time spent in therapeutic sessions), and the non-dominant (problematic) and dominant voices were identified and characterized. In Laura's case, a single theme was

selected because it was the focal problem across the entire therapeutic process. We characterized this theme as "perfectionism" since it represented the high demanding standards Laura imposed to herself in different intra- and interpersonal contexts, including her body image, her occupational performance and her relationship with mother. Since these standards were so difficult to achieve, Laura frequently felt she was failing, and this contributed to her feeling depressed. Laura's dominant voices could be characterized as saying, in various ways, "I must be perfect." The non-dominant (problematic) voices that emerged in various intra- and interpersonal contexts could be characterized as saying "I am failing." The sense she was a failure (problematic voice) collided with her dominant voice of perfectionism: whereas the dominant voice required Laura to be perfect in all situations; the problematic voice appeared to point out Laura's failures in a variety of intra- and interpersonal contexts.

Based on multiple readings and process notes, the raters identified excerpts in the transcripts where the perfectionism theme appeared. Then, the raters independently coded the excerpts according to the APES, identifying APES passages and the assimilation levels. The unit of analysis for the APES ratings was the passage (Honos-Webb, Stiles, & Greenberg, 2003). The raters coded a new passage every time there was a change on a topic, in the assimilation marker (see Honos-Webb, Lani, & Stiles, 1999) or in the assimilation level (Honos-Webb et al., 2003). Disagreements were resolved by consensus between judges (see Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). The interrater reliability (before consensus discussions) calculated using the Intraclass Correlation Coefficient, ICC [2,1], which gives the average reliability between raters (Shrout & Fleiss, 1979), was high (ICC [2,1] = .93). The reliability between coders was calculated on 100% of the material.

We found 629 passages representing the theme perfectionism in Laura's therapy. These were distributed irregularly throughout the 16 sessions; however every session included at least 22 passages.

CEAS-III. CEAS-III coding followed the two-part procedure used in previous studies (Missirlan, Toukmanian, Warwar, & Greenberg, 2005). First, each client emotional episode was identified. Second, in each emotional episode, the client's primary emotion was coded for its intensity (modal and peak emotional arousal) and its valence

(positive or negative; Warwar & Greenberg, 1999). For our valence ratings, negative emotions included: pain/hurt; sadness; hopelessness/ helplessness; loneliness; anger/resentment; contempt/disgust; fear/anxiety; shame/guilt; anger and sadness. Positive emotions included: love; joy/excitement; contentment/calm/ relief; pride/self-confidence; and pride and anger. Note that we considered anger associated with pride as a positive emotion because we viewed it as an adaptive or assertive anger, a very important emotion in the therapeutic change process (Pascual-Leone & Greenberg, 2007), particularly in cases where clients have difficulty in expressing their needs or state their rights.

For emotional intensity, each emotional episode was rated in terms of modal and peak emotional arousal.

The CEAS-III raters included three PhD students and one Master's student in clinical psychology, all with clinical experience and three with supervised experience in CBT. The four raters were divided into two pairs to optimize resources. Three of the raters applied only the CEAS-III. The fourth rater applied both the APES and CEAS-III (this rater coded 38% of the CEAS-III material). This person completed the APES rating before beginning CEAS-III coding. The previous knowledge this rater had of the APES coding could have influenced the CEAS-III results. To prevent and diminish this possible bias, the main rater, who was unaware of the APES rating, supervised all the CEAS-III codification.

CEAS-III training lasted approximately 2 months (weekly meetings of two hours). Raters first read and discussed journal articles. Then, they viewed videotapes of therapeutic sessions and discussed the presence of each emotional episode, its category and intensity. Afterwards, independently, raters coded the same sessions in order to establish reliability. Raters discussed any discrepancy that appeared and disagreements were resolved by consensus. When raters mastered the coding of the CEAS-III they were given the sessions to code. For that they had to achieve a good inter rater reliability (Cohen's $\kappa \geq .75$)

The unit of analysis was the Emotional Episode (EE) (Greenberg & Korman, 1993), which is a segment of psychotherapy where the client indicates having experienced

an emotion (emotional response or action tendency) in a specific situation. In order to code a complete EE segment, it is necessary to observe a new emotional response or a change in the theme of the client's discourse. The EE segments were selected from the 629 passages that deal with the main problem/theme. Each group of 2 raters identified the EEs within the passages they rated by inter-rater consensus.

Next the two raters independently coded each emotional episode within their assigned passages, categorizing its valence (positive or negative) for comparison with the feelings curve. They also rated the level of emotional intensity (arousal) in each emotional episode. For that, in each emotional episode they rated a modal and a peak expressed emotional arousal. There was a high agreement (Cohen's $\kappa = .911$) in the categorization of emotional valence. There was also a good agreement for modal emotional arousal rating (ICC [2,2] = .763) and very good agreement for peak emotional arousal rating (ICC [2,2] = .826). Disagreements were resolved by consensus. We computed the total frequency of EEs and the frequencies of positive and negative EEs. Then, we calculated the proportion of positive and of negative EEs of the total EEs, in each session. After that, we calculated the CEAS-III valence index in each session by subtracting the proportion of negative EEs in that session from the proportion of positive EEs. The possible range of the valence index was thus +1.00 to -1.00. In Laura's 629 passages, we identified 179 EEs (range: 5 to 21 per session); the valence index ranged from.-1 to. 1 across Laura's 16 sessions.

Results

We first summarize our qualitative assimilation analysis of Laura's therapy and then report the quantitative results of comparing APES levels to symptom intensity and emotional arousal and valence across sessions.

Assimilation of the problematic voice during therapy

Laura's voices of failure emerged particularly in three contexts: 1) thoughts and events associated with future professional performance and fear of disappointing other's expectations; 2) negative body image, after a significant increase in her weight; 3)

relationship with her mother (specifically, Laura felt that her mother didn't care about her and that she lacked assertiveness toward her mother). Figure 2 plots the assimilation of this problematic theme across the 629 APES-rated passages in Laura's therapy organized into three phases. There was a clear trend toward higher assimilation as treatment proceeded, though there were many setbacks to lower levels along the way. In the initial phase of therapy (sessions 1 to 4) we observed mostly lower APES levels: APES level 2 was coded for 57.6% of the passages in the initial phase. This prevalence of lower APES levels implies that the problematic experiences were not yet understood or formulated.

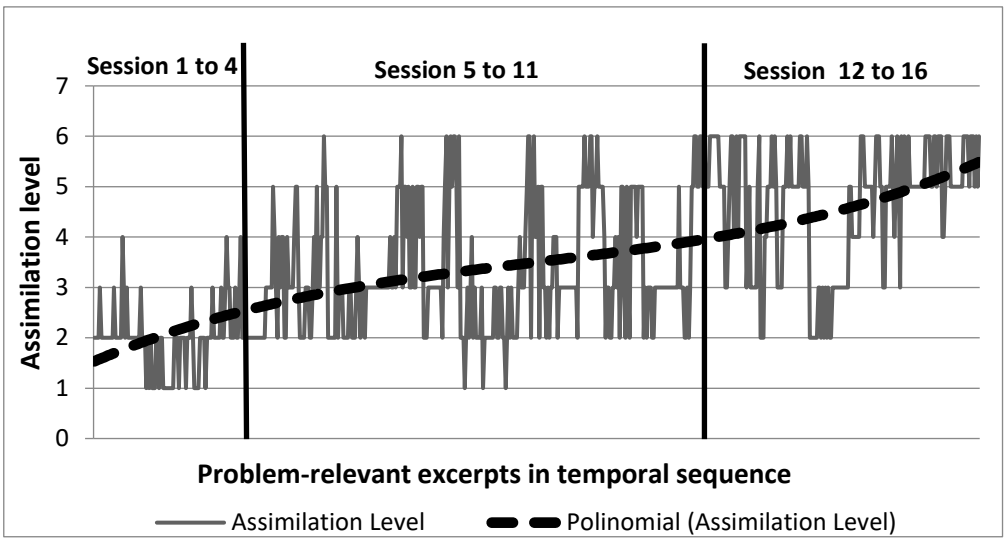

Figure 2. Assimilation process throughout sessions (629 passages).

Note: Polynomial (Assimilation Level) = Polynomial trendline of the assimilation evolution throughout therapeutic process ($y = 3E\text{-}08x^3 - 3E\text{-}05x^2 + .0121x + 1.5195$).

The following excerpt illustrates how a dominant voice appeared early in the therapeutic process:

Laura: 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? (APES level 2, session 3)

The following excerpt illustrates how the emergence of a problematic voice created discomfort and acute psychological pain or panic:

Laura: 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 so bad, I can’t see myself, it’s very hard to see myself in the mirror. (APES level 2, Session 2)

In the middle phase of therapy (sessions 5 to 11), the problematic voices achieved intermediate levels of assimilation: APES level 3 was coded for 38.9% of the passages in the middle phase. This implies that the problematic experiences became clearly formulated and there was a movement towards a new understanding (APES level 4 accounted for 8.4% of the passages in the middle phase). Negative feelings were still present but in a manageable way. The following excerpt illustrates the problematic voice at APES level 3:

Therapist: interesting… we fear the worst and but it’s even difficult to conceive what is worst

Laura: yes

Therapist: (laugh) interesting

Laura: it is the fear of failure and not being capable… not only… if I fail what is the problem? I don’t know… but I'm afraid to fail. (APES level 3; session 9)

A new understanding, coded as APES level 4, is illustrated by the following excerpt (the text in boldface seemed to represent a meaning bridge between the dominant voice and the problematic voice). There was a mixture of positive and negative feelings connected to the discovery of new understandings or insights:

Laura: But, it wasn’t so bad**. I realized that, even when I fail, I can do it**.

Therapist: You won’t explode.

Laura: Right. **It doesn’t mean that everything will go back. Therefore I am getting used to it and I realized that I go slowly** [referring to her efforts in losing weight]. (APES level 4; Session 8)

In the final phase of therapy (sessions 12 to 16) Laura achieved higher levels of assimilation, as her new understanding was used to work on the problem (APES level 5 was coded for 39.7% of the passages in the final phase), and describing resolution of the problem (APES level 6 was 26.6 % of the passages in the final phase).

Problem-solving efforts at APES level 5, where feelings are mainly positive and the tone is optimistic, are illustrated in the following excerpt:

Laura: I think that now the test is not very important to me because I am well aware that in this type of course the test is not very complicated, is it? It is not a test, is it? I am sure it's something simple and is based in what they taught us.

Therapist: mm-hm.

Laura: Therefore, I feel a bit comfortable with that. (APES Level 5; Session 12)

The resolution of the problem, at APES Level 6, characterized by positive feelings and a feeling of accomplishment is illustrated in this excerpt:

Laura: but now I don't feel that "I have to be perfect anymore, that I have to do everything right". (APES level 6; session 16)

Assimilation and Symptom Intensity

To compare assimilation level with the intensity of depressive symptoms measured by the BDI-II, we computed the mean assimilation level scored in each session (i.e., based on varying numbers of excerpts). Figure 3 shows that, across sessions, assimilation level tended to increase whereas depressive symptoms decreased, consistent with the expected negative relation between these two variables. To statistically assess the relation between these two variables we used the Simulation Modelling Analysis Software (SMA; Borckardt, 2006) developed to deal with statistical problems generated by case-based time series studies. The Spearman rho correlation, computed on the basis of the SMA bootstrap sampling method showed a significant negative association between assimilation and BDI-II scores (Rho = -.97, p = .003).

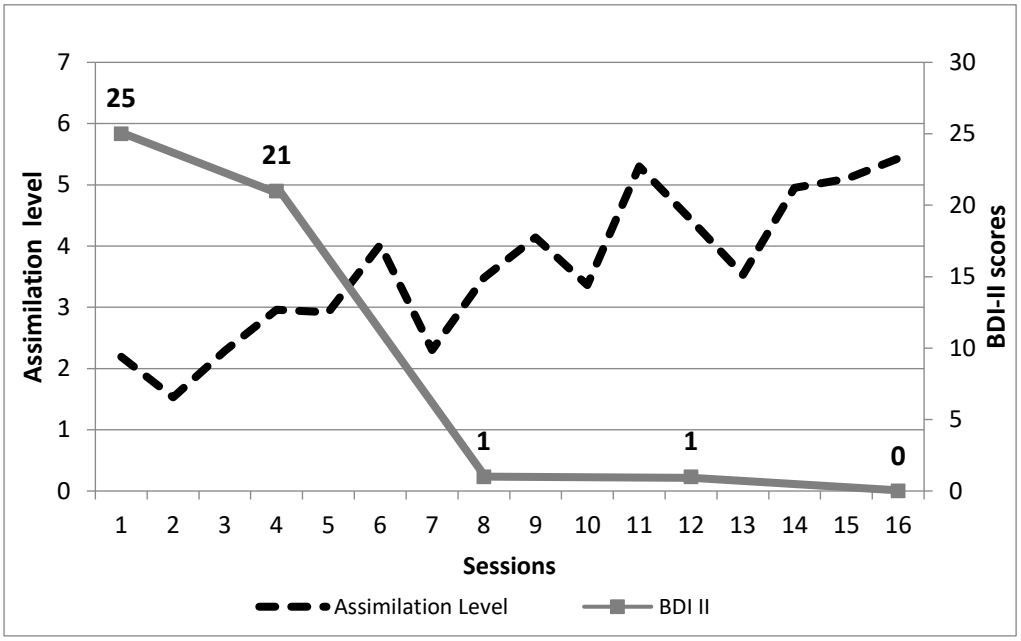

Figure 3. Comparison of assimilation with depressive symptoms measured by the Beck Depression Inventory - II (BDI-II).

Similarly, Figure 4 shows that APES level tended to increase while the OQ-10 scores, tended to decrease, signaling an improvement in mental health functionality. The Spearman rho correlation, computed on the basis of the SMA bootstrap sampling method showed a significant negative association between assimilation and OQ-10 scores (rho= -.77; p<.01).

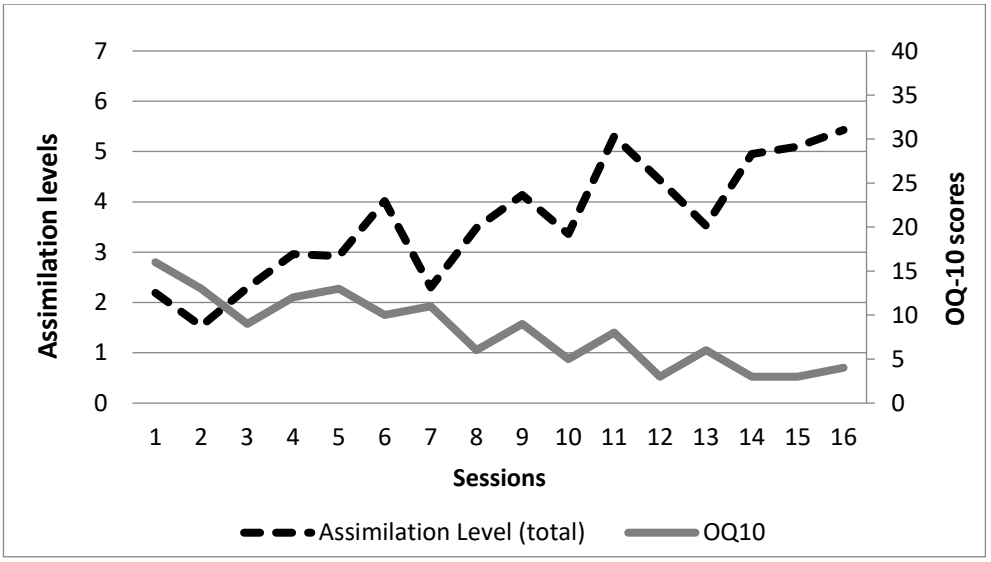

Figure 4. Comparative results between assimilation level and mental health functionality measured by the Outcome Questionnaire (OQ-10).

Assimilation and Feelings

Emotional intensity and assimilation. Laura's valence ratings showed marked changes as measured by the CEAS-III. However her absolute emotional intensity remained at about the same low level across sessions (in terms of modal and peak emotional arousal ratings), seemingly reflecting a stable client characteristic. That is, throughout her treatment, Laura was able to acknowledge and describe her emotional state but the arousal was mild in her voice and body. That is, it was possible to reliably distinguish positive and negative emotional episodes, but their absolute intensity was very similar.

Emotional valence and assimilation. We calculated the CEAS-III valence index as the proportion of negative EEs in each session subtracted from the proportion of positive EEs in that session. Figure 5 shows the evolution of the assimilation and this global valence index across Laura's 16 sessions.

Both the APES and the CEAS-III valence index had lower values in the initial phase of the therapeutic process and higher values at the final phase. Spearman rho correlation analysis found a significant positive association between assimilation and the valence of Laura's emotional arousal across sessions (rho= .64; p<.01). That is, across

Laura's 16 sessions, as the APES increased or decreased, the CEAS-III valence index also tended to increase or decrease. There was, however, an exception to this mirroring. Between session 1 and 2, assimilation decreased while the CEAS-III valence index increased.

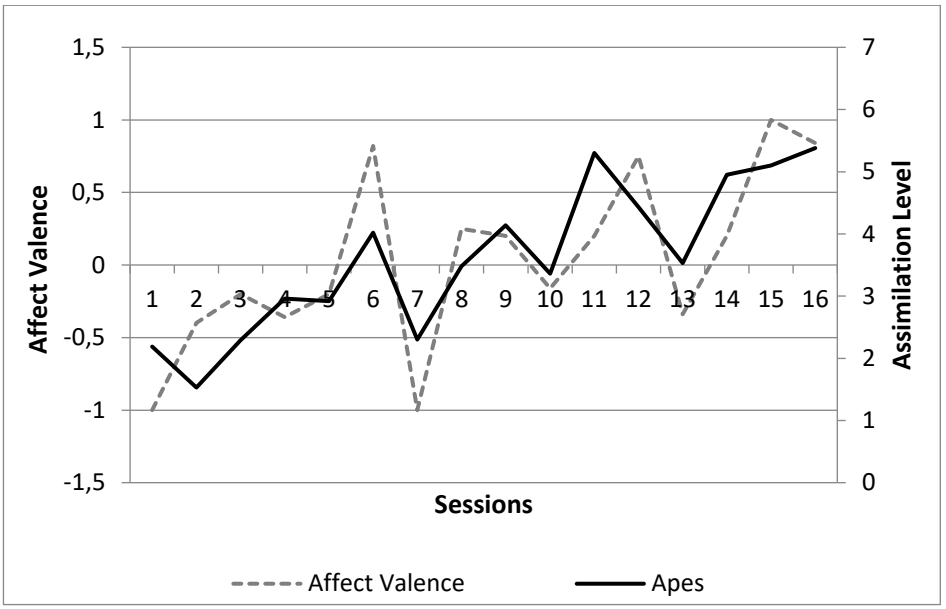

Figure 5. Evolution of assimilation and CEAS-III valence index throughout the 16 sessions.

Figure 6 shows the CEAS-III valence index (the proportion of positive EEs minus the proportion of negative EEs) as a function of assimilation level (i.e., aggregated without regard to session number). The plot clearly resembled the theoretical curve predicted by the assimilation model. That is, the valence of Laura's EEs at each APES level showed a recognizable correspondence with that suggested by the theoretical feelings curve. There were negative feelings at APES level 1 and even slightly more negative at APES level 2. At APES level 3 the CEAS-III valence index was less negative than in the lower APES levels (1 and 2). At APES 4 the client’s CEAS-III valence index was positive. At APES levels 5 and 6, there were progressively more positive feelings.

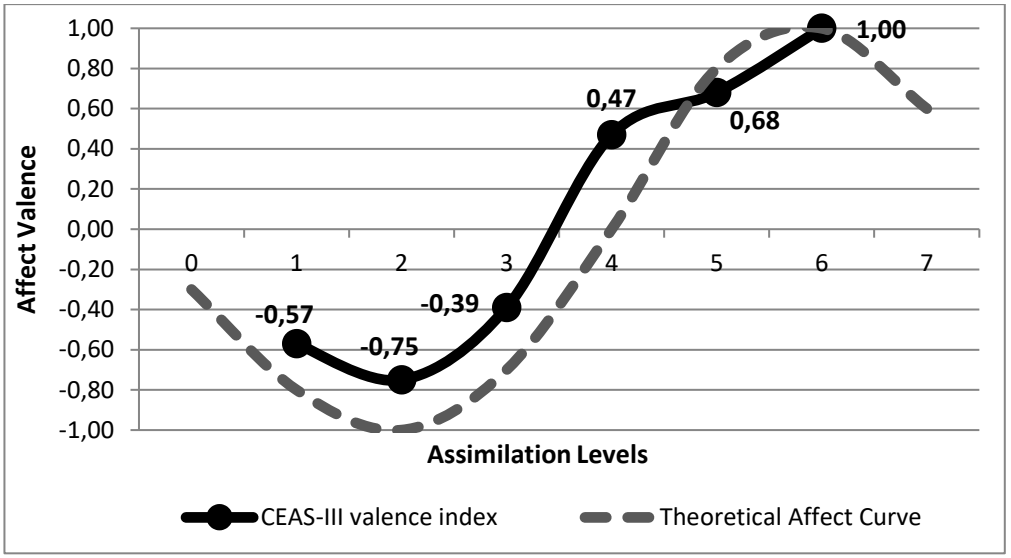

Figure 6. Relation between the CEAS-III valence index within each assimilation level and the theoretical feelings curve.

Discussion

The evolution of Laura's case followed the expected pattern of assimilation in a good outcome case of CBT. The assimilation was lower in the initial phase of therapy, reaching intermediate levels in the middle phase and achieving higher levels of assimilation in the final phase. Passages rated at APES level 4 and higher occurred in the middle to the final phases of therapy as predicted for good outcome cases and replicating observations by Detert et al. (2006).

Although Laura showed the expected increase in assimilation levels from the initial to the final phase of therapy, the evolution followed an irregular pattern, with many brief setbacks (see Figure 2). Previous studies indicated that such setbacks are common in the assimilation process of good outcome cases in cognitive therapies (Caro Gabalda, 2007; Caro Gabalda & Stiles, 2009, 2013). Caro Gabalda (2007) pointed out that in cognitive therapies the therapist has an active role, pushing the client to higher levels of assimilation. However, when the therapeutic work pushes beyond the client's current comfort zone along the APES continuum, setbacks tend to appear, and this seemed to occur in Laura's case. However, across her 16 sessions, the setbacks became

progressively less severe, consistent with the interpretation that Laura was progressively assimilating the problematic voice.

The association of the assimilation of problematic voices into the self-community of voices with the significant decrease in the depression (BDI-II) and improvement of general mental health (OQ-10) lends further empirical support to the contention that assimilation of problematic experiences promotes good outcome. Our results converge with those of previous case studies (e.g., Honos-Webb, Stiles, et al., 1998; Honos-Webb et al., 1999; Knobloch et al., 2001; Varvin & Stiles, 1999) in associating assimilation of problematic experiences with symptomatic improvement. However, those previous studies did not analyze this relation longitudinally. By tracking both assimilation and symptom intensity across sessions, the current study supports the contention in greater detail. For instance, Laura's BDI scores improved substantially from session 4 to session 8. (Figure 3). Although we cannot say exactly when this improvement occurred, we can see that it corresponded to substantial assimilation progress from session 4 to 8.

Laura's progress across sessions 4-8 was not smooth, however. Laura achieved APES level 4 at session 6, decreased to APES level 2 at session 7 and then increased again to APES level 4 at session 8. This could be a reflection of shifting attention among different strands/aspects of the problem. That is, some, aspects of Laura's problematic theme evolved more rapidly than others in assimilation terms (Caro Gabalda & Stiles, 2013). During the therapeutic process, the therapist may explicitly focus on strands of the problem that are not yet understood and integrated. This could help to promote a more complete integration of the problematic experience but may also produce temporary setback. This sort of process may explain how the irregular assimilation pattern co-occurs with a significant decrease in the BDI-II (Caro Gabalda & Stiles, 2013).

The relation between assimilation and feelings aggregated across sessions, as shown in Figure 6, corresponded fairly closely with the theoretical feelings curve (Figure 1; Stiles et al., 2004). Laura's feelings were negative as she avoided her problematic sense of failure (APES level 1), but they were even more negative when she confronted it (APES level 2). When she clearly understood the problematic voice (APES level 3), negative feelings were less, and when the problematic voice progressively became

integrated (APES levels 4, 5, and 6), positive feelings were correspondingly higher, following this progression.

Because Laura began with problems at low APES levels and was a good outcome case, we were able to assess the feeling curve across most of the APES range (APES 1-APES 6; see Figure 6). In a poor outcome case we could probably observe only the lower part of the curve, insofar as poor-outcome cases are less likely to reach higher assimilation levels (APES ≥ 4). The dip in feelings from APES 1 to APES 2 (Figure 6) is consistent with the theoretical suggestion (and clinical lore) that for cases starting at lower levels of assimilation (0 or 1) it may be an important step to experience more negative emotions in order to contact and then assimilate the problematic experience.

Thus, generally, these results are in agreement with Varvin and Stiles's (1999) suggestion that one important step in the resolution of avoided problems is an immersion in negative feelings – feeling worse before feeling better. However, it is important to notice that in Laura's case "feeling worse" did not entail a significant increase of symptom intensity as measured by the BDI-II or OQ-10. Although the CEAS-III measured valence of arousal passage-by-passage, whereas the BDI-II and OQ-10 measured symptom intensity only session-by-session, limiting our ability to assess this correspondence.

Stiles et al. (2004) suggested that APES level 4 should be associated with a neutral valence, involving a mix of unpleasant recognitions and pleasant surprises. In Laura's case, however, APES level 4 was associated with a higher proportion of positive than negative feelings (Figure 6). Finding relatively more positive emotions associated with APES 4 than expected suggests that reaching an understanding with the problematic voice, and achieving sustainable meaning-bridges was associated with an earlier than expected improvement in Laura's well-being.

The lack of variation in the intensity of emotion was somewhat surprising. We had expected that intensity would increase across therapy, particularly when Laura's problematic experience was emerging at APES level 2 and 3. Perhaps Laura's style of expression didn't show variations in intensity. In any case, this didn't seem to adversely impact the development of the case, as Laura was able to connect, understand and integrate her problematic experience.

Conclusion

This study supported important theoretical tenets of the assimilation model, including the association of assimilation progress with declining symptoms intensity across the therapeutic process and the theoretically predicted relation between assimilation level and feelings. Of course, this was single case study and any of its particular results could be specific to this particular case. The strength of the study is its detailed consistency with theory. Analyzing further clinical cases will be important to support our interpretations.

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ESTUDO 3: Does assimilation of problematic experiences predict a decrease in symptom intensity?

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Abstract

The assimilation model describes therapeutic change as an integration of experiences that had previously been problematic, distressing, avoided, or warded off. This study assessed whether assimilation was associated with treatment outcome in a sample of psychotherapeutic treatments for depression. Further, it assessed the direction of the association – whether increasing assimilation predicted decreases in symptom intensity or decreasing symptom intensity predicted increases in assimilation. **Method:** Participants were 22 clients with mild to moderate depression drawn from a clinical trial comparing cognitive-behavior therapy with emotion-focused therapy. The direction of prediction between assimilation progress and changes in self-reported symptom intensity was assessed. **Results:** The assimilation progress was shown to be a better predictor of decreases in symptom intensity than the reverse. **Conclusion:** The results supported the assimilation model's suggestion that assimilation progress promotes decreases in symptom intensity in the treatment of clients with major depressive disorder.

Keywords: assimilation model; symptom intensity; depression; change process.

Introduction

The assimilation model proposes that therapeutic improvement occurs through the gradual assimilation of experiences that had previously been problematic, distressing, avoided, or warded off (Stiles, 2002; 2011; Stiles et al., 1990). Intensive case studies have linked increases in assimilation with decreases in symptom intensity (e.g., Basto, Pinheiro, Stiles, Rijo & Salgado, 2016; Caro Gabalda, 2011) as has one small-sample study (N = 8; Detert, Llewelyn, Hardy, Barkham & Stiles, 2006). However, more empirical evidence is necessary to consolidate the suggestion that therapeutic change occurs through a process of assimilation of problematic experiences. Our study aimed to assess the relation and analyse the direction of prediction between assimilation progress and changes in self-reported symptom intensity. To do this, we assessed assimilation and symptomatic improvement longitudinally in a sample of 22 cases drawn from a clinical trial (Salgado, 2014) of Emotion Focused Therapy (EFT) and Cognitive Behavioral Therapy (CBT).

The Assimilation Model

The assimilation model is a theory of psychological change. It is not a treatment approach but seeks to explain the process of change in any treatment. It suggests that people's experiences leave traces that are active and agentic, so when the traces are reactivated, people's actions as well as their thoughts draw on the original experiences (Stiles, 2011). When a current experience resembles something that happened in the past, the traces of the past experience can emerge and serve as resources to help the person adapt to the current context. Assimilation authors often describe constellations of these traces by using the voice metaphor (Honos-Webb & Stiles, 1998; Osatuke et al., 2005; Stiles et al., 2006). When an internal voice is addressed by circumstances, it emerges and can act and speak.

Theoretically, the self can be described as composed of multiple internal voices that are organized into a structure called a community of voices (Stiles, 2011). Normally, the community accepts new experiences and integrates them smoothly. However, voices representing problematic experiences (e.g., traumatic incidents, destructive relationships,

threatening or painful situations) are incompatible with the community. When such a problematic voice is addressed by circumstances, it tries to respond since it represents experiences that are relevant to current circumstances and hence potentially important to the self (Osatuke & Stiles, 2006). The clash between the community and the problematic voice generates dysphoric affect – painful feelings and psychological suffering – which tends to suppress or distort the problematic voice (Stiles, Osatuke, Glick, & Mackay, 2004). In effect, to maintain its stability, the community tries to avoid or reject the problematic experience (Honos-Webb & Stiles, 2002), while circumstances address the experience, forcing it into awareness.

From a psychological point of view, this conflict of the self with problematic voices produces clinical problems like depression (Stiles, 1999; Stiles et al., 2004). The return to a state of well-being may be achieved by the assimilation of the problematic voices into the community, which can be facilitated by psychotherapy (Gonçalves et al., 2013; Honos-Webb & Stiles, 2002). By talking with the therapist, the community can make contact with the problematic voice. Gradually, the problematic voice gains strength and is able to state its side more clearly, which allows a dialogue between voices and the construction of meaning bridges (Stiles, 2011). Meaning bridges are signs (words, gestures, images, etc) that represent common understandings between voices. Theoretically, by building meaning bridges the problematic voice comes to be accepted and integrated into the community; that is, the formerly problematic experience becomes smoothly accessible and available as a resource within the community. Although the model's name emphasizes the assimilation (integrative) aspect of successful psychotherapy, this always also involves accommodation (change) within both voices (Stiles, 2011).

The assimilation of problematic experiences is a developmental process and can be assessed by ratings of session dialogue on the assimilation of problematic experiences scale (APES; Table 1; Caro Gabalda & Stiles, 2009; Stiles, 2002; Stiles et al., 1991). The APES is a continuum anchored by eight levels, from APES 0, where the experience is warded off, to APES 7 where the experience is fully integrated (see Table 1).

Table 1

Assimilation of problematic experiences scale (adapted from Caro Gabalda & Stiles, 2009)

APES 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, proud of accomplishment.
7.Integration/ Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

Relation of Assimilation to Therapy Outcome

A series of intensive case studies of assimilation progress in different therapeutic models has shown that good outcome clients, as assessed by standard symptom intensity measures, progress towards high APES levels across their sessions (e.g., 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; Osatuke et al, 2007; Ribeiro, Braga, et al., 2016; Ribeiro, Cunha, et al., 2016). For example, in a study of one good outcome client, Basto et al. (2016) found a strong negative correlation across 16 sessions of CBT between APES

level and symptom intensity. In poor outcome clients, on the other hand, APES levels remain lower, either stagnating across sessions or progressing only to middle APES levels (Caro Gabalda, 2006, 2011; Honos-Webb, Stiles, Greenberg & Goldman, 1998).

Theoretically (Stiles et al., 2004; Basto et al., 2017), across the range of APES 2 (vague awareness/emergence) to APES 6 (resourcefulness/problem solution) assimilation progress should yield monotonically decreasing scores on symptom intensity inventories, reflecting declining emotional distress (APES 2 to 4, as the problem is formulated and clarified) followed by increasing pride or elation (APES 4 to 6, as the problem is understood, worked through, and solved). Most short-term therapies work primarily within this range of APES levels, leading to our expectation of a negative statistical relation between APES levels and symptom intensity in this study.

At the extremes, theoretical expectations are different. At very low APES levels (APES 0 to 2), assimilation progress is expected to be associated with increasing distress, as the client moves from warding off the problematic experience (APES 0) to facing it directly (APES 2). At very high levels, APES 6 to 7, there may be declining elation as successfully dealing with formerly problematic issue becomes routine (Stiles et al., 2004; Basto et al., 2017).

At APES 4 (insight/understanding; see Table 1), the client's feeling tone crosses the theoretical line from predominantly negative to predominantly positive affect with respect to that particular problematic experience. In the case study research, achievement of APES 4, has distinguished good- from poor-outcome clients as assessed by standard symptom intensity measures. Good-outcome clients have consistently reached and sustained levels of APES 4 or higher with respect to their main problematic experiences, whereas poor-outcome clients have remained below APES 4 except for a few brief passages. Likewise, in Detert et al.'s (2006) contrasting groups study of a very brief therapy for mild depression (two weekly sessions plus a follow-up session three months later), all 4 good outcome clients (as assessed with the Beck Depression Inventory) achieved at least APES level 4, whereas all 4 poor outcome clients' main problems remained below that level.

Applying the APES is a time-consuming and labor-intensive task, requiring detailed familiarity with the content of the client's problems and progress, and few

investigators have had the resources to apply it to more than a few cases at a time. To our knowledge, the Detert et al. (2006), study, at N=8, is the largest previous comparison of APES-rated assimilation progress with standard self-report measures of symptom intensity, so our study, though still modest at N=22, addresses a need for larger samples.

Aims of this study

We sought to assess the theoretical suggestion that assimilation progress is associated with positive treatment outcome. We also addressed the expected direction of prediction: that increasing assimilation should predict decreases in symptom intensity better than declining symptom intensity predicts increases in assimilation.

We assessed the relation of assimilation progress to changes in symptom intensity in a sample of 22 clients with mild to moderate depression selected from a clinical trial comparing CBT and EFT. However, treatment approach was not a focus of this study, and we did not expect the APES-outcome relation to differ across approaches.

Method

Clients

The 22 clients in the present study were randomly selected from the 50 clients who completed therapy in the ISMAI Depression Study (Salgado, 2014) a randomized clinical trial comparing the efficacy of EFT and CBT. The inclusion criteria for the ISMAI trial were being diagnosed with Major Depression Disorder and having at least a moderate level of symptoms on the Global Assessment of Functioning Scale (APA, 2000). The exclusion criteria were currently being on medication or another form of treatment or having been diagnosed with one of the following DSM–IV Axis I disorders: panic, substance abuse, psychotic, bipolar, or eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or at high risk of suicide. The assessment was conducted using the Structural Clinical Interview for the

DSM-IV-TR (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002). After being admitted into the clinical trial, the clients were randomly assigned to CBT or EFT. Then, each client was randomly assigned to a therapist. In the ISMAI project, both EFT and CBT conditions included 16 to 18 sessions (Salgado, 2014).

The 22 randomly selected clients in our study included 12 EFT clients and 10 CBT clients. Eighteen (82%) of the clients were women and four (18%) were men. All clients were Portuguese. The clients were aged between 20 and 50 years old (M=34.55; SD=8.68). Twelve clients were single, eight were married, and 3 were divorced. All clients had completed at least the 6th grade; 12 clients were professionally active, 8 were unemployed and 3 were students.

Therapists

In this sample, drawn from the ISMAI project, there were 5 EFT therapists and 5 CBT therapists, each of whom saw from 1 to 3 of the 22 clients in our sample. The EFT therapists included 3 females and 2 males with ages between 30 and 45. All were psychologists with 1 to 20 years of clinical experience and 1 to 4 years of experience in the EFT therapeutic model. The CBT therapists were all female, with ages between 27 and 37. Two were PhD students in psychology with clinical practice and three were psychologists. They had 2 to 12 years of clinical experience and 1 to 12 years of experience in the CBT therapeutic model. Therapists in both groups received six months of training in the specific therapeutic protocol used in the ISMAI study, and subsequently had weekly supervision sessions.

Therapy

The EFT intervention was based on a protocol for depression described by Greenberg and Watson (2006) and Elliott and collaborators (Elliott, Watson, Goldman, & Greenberg, 2004). EFT is an empirically validated humanistic therapy (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson 2006). The aim of EFT interventions is to access and change maladaptive emotional processing, transforming the core emotional schemas into more congruent and adaptive ones. The therapist facilitates the emergence

of new emotional responses, more congruent with the individual needs (Greenberg & Watson, 2006).

The CBT intervention was based on a protocol for depression proposed by Beck and collaborators (Beck, Rush, Shaw, & Emery, 1997) and adapted within the ISMAI Depression Study (Salgado et al., 2010). CBT is a semi-structured directive therapeutic model that views clinical problems as a consequence of errors in the processing of information about reality. Together, the CBT therapist and the client seek to challenge and progressively change dysfunctional beliefs and maladaptive schemas and promote more adaptive beliefs and thoughts and consequently more positive emotions and adaptive behaviors.

Measures

BDI-II.

The BDI-II (translated into Portuguese from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002) is a questionnaire designed to measure depressive symptoms. It is composed by 21 items scored from 0 to 3 (ranging from 0 to 23). Higher scores indicate the presence of severe depressive symptoms. For the Portuguese population scores below 13 are considered to be in the normal range. The Cronbach's Alpha was .89 (Coelho et al., 2002). In the present sample (N=22), the internal consistency of the BDI-II total score was .884 (Cronbach's Alpha), and the test-retest reliability was .749 over a 1-week interval.

Outcome Questionnaire-10 (OQ-10).

The OQ-10 (Lambert et al., 1998) is a questionnaire designed to assess psychotherapeutic outcome. It is composed by 10 items, each score on a 0 to 4 scale. The total score can range from 0 to 40, where lower values represent good health functionality and higher scores psychological distress. The OQ-10 has a reported internal consistency (Cronbach's Alpha) of .88 (Seelert, 1997) and a test–retest reliability of .62 over a 3-week interval (Lambert, Finch, Okiishi, & Burlingame, 2005). Based on the ISMAI Depression Study sample (*N*=64; Salgado, 2014), we found that the internal consistency of the total

score of the Portuguese OQ-10 was of .88 (Cronbach's Alpha) and the test-retest reliability was of .74 over a 1-week interval. Based on the present sample (n=22), we found that the internal consistency of the total score OQ-10 was .87 (Cronbach's Alpha) and the test-retest reliability was .76 over a 1-week interval.

Assimilation of Problematic Experiences Scale.

As summarized in Table 1, the APES (Caro Gabalda & Stiles, 2009; Stiles et al., 1991) describes the evolution of the relation of a problematic experience (or voice) to the self (dominant community of voices) using a sequence of eight stages, numbered 0 to 7, ranging from warded off (i.e. muted or dissociated) to mastery (i.e. fully integrated and no longer a problem, serving as a resource in new situations). The APES is considered as a continuum, and intermediate ratings (e.g., 2.3, 4.6) are allowed.

Procedure

Assessment of symptom intensity

Clients completed the BDI-II at the beginning and end of treatment. To assess changes in symptom intensity across sessions, the OQ-10 was administered immediately before each session.

Assimilation Analysis.

Sessions 1, 4, 8, 12 and the last session (usually session 16) of every case were transcribed following specifications by Mergenthaler and Stinson (1992). The transcribed sessions were analyzed according to the APES following procedures described previously (Honos-Webb et al., 2003; Stiles et al., 1991, 1992; Stiles & Angus, 2001).

The assimilation analysis was conducted by a team of 15 raters: one was a PhD clinical psychologist, two were PhD students and 12 were master's degree students in clinical psychology. Three of the raters had had clinical experience (two in CBT and one in EFT) and previous experience using the assimilation model. Each case was rated by a team of two raters. The first author of this paper served as a rater and also supervised the rating procedure.

Training for rating assimilation lasted approximately two months, which included

independent reading and practice along with weekly two-hour meetings. First, articles about the assimilation model and manuals describing the rating procedures were read and discussed. Then, sessions that had been previously rated were given to each rater to rate, first in a group and then independently to assess the interrater reliability. Doubts were discussed in the weekly meetings. The coders began coding for the study when they reached an interrater reliability (for a single rater), based on the Intraclass Correlation Coefficient (ICC [2, 1]) ≥ .60 (Cicchetti, 1994).

After raters had reached the reliability criterion, they were each given transcripts of five sessions (normally sessions 1, 4, 8, 12, 16) of one case to identify the main themes and rate them with the APES. First, sessions were read by each rater independently. A list of the main recurrent issues was compiled by each rater and then discussed in pairs. Then, by consensus, the main themes and the problematic and the dominant voices were identified. The themes were selected as the most clinically relevant for that specific client (based mainly on time spent across sessions).

After the themes and voices were identified, raters selected excerpts from the transcripts where the main themes appeared. The APES was then applied independently by each rater to all selected excerpts to identify the APES passages and the corresponding APES level. The unit of analysis for the APES ratings was the passage (Honos-Webb et al., 2003), defined as a stretch of discourse on one topic. The raters coded a new passage every time there was a change of topic or a change in the APES level (Honos-Webb et al., 2003) or if a new assimilation marker appeared (see Honos-Webb, Lani, & Stiles, 1999) and assigned an APES rating to each passage. Disagreements on passages (units) and APES ratings were subsequently resolved by consensus between the two raters for that case. The mean number of passages per session in the 22 cases was 45.44 (SD = 23.46; range 6 - 118). The interrater reliability on APES ratings, calculated before consensus, ranged from ICC [2,2] = .81 to ICC (2,2) = .96; these are considered high (Cicchetti, 1994). We used ICC [2,2], which assesses the reliability of the average of two raters, because our aim was to estimate the reliability of the two-person teams that produced the final ratings.

As an example of theme and voice identification, the theme of perfectionism emerged in the case of Laura, a CBT client (drawn from the case study by Basto et al.,

2016). This theme involved the highly demanding standards Laura imposed on herself in a variety of intra- and interpersonal contexts. The problematic voice identified in this case was characterized as “I am failing" and the dominant voice was characterized as “I must be perfect.” That is, the dominant voice required perfection in all situations. The problematic voice emerged to point out failures in a variety of intra- and interpersonal contexts. The following passage illustrates Laura's dominant voice:

Laura: 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? (APES level 2, session 3).

The following passage illustrates Laura's problematic voice:

Therapist: interesting… we fear the worst and but it’s even difficult to conceive what is worst

Laura: yes

Therapist: (laugh) interesting

Laura: it is the fear of failure and not being capable…not only….if I fail what is the problem? I don’t know…but I'm afraid to fail. (APES level 3; session 9)

As example of a higher APES rating, the following passage was rated as APES 4:

Laura: But, it wasn’t so bad. I realized that, even when I fail, I can do it.

Therapist: You won’t explode.

Laura: Right. It doesn’t mean that everything will go back. Therefore, I am getting used to it and I realized that I go slowly [referring to her efforts in losing weight]. (APES level 4; session 8)

Many of the assimilation references cited in our introduction are intensive case studies that offer further extended examples at each APES level.

Statistical Analysis

Hierarchical Linear Modeling (HLM) was used to assess whether APES level predicted symptom intensity in the subsequent session and, conversely, whether symptom intensity predicted assimilation in the subsequent session. This form of analysis

accommodated the hierarchical structure of our data, that is, session-level observations (APES and OQ-10) nested within clients. It allowed us to assess relations between variables within clients (level 1) and between clients (level 2). In our models, session number was level-1 covariate, which permitted assessment of change across sessions. Variability in the level 1 coefficient was treated as a time invariant covariate at level 2. Variability in the level 1 coefficient was treated as a function of client-level time-invariant covariates. Since we aimed to assess whether degree of assimilation (APES level) predicted symptom intensity (OQ-10 score) in the subsequent session, and whether symptom intensity predicted assimilation level in the subsequent session, two different sets of models were estimated.

Results

There were no significant differences in mean APES level between the CBT and EFT groups in any session; on average, clients reached an APES of about 4 by session 16 in both treatments (see Table 2).

There were differences in mean OQ-10 scores between the CBT and EFT groups in only two of the 17 sessions (sessions 7 and 13); in these sessions, the EFT group had the higher scores (see Table 3). Because mean progress in the two treatment groups was so similar on both measures, and because there was no theoretical expectation that APES-outcome relations would differ across treatments, we decided to combine the approaches in our analyses.

Table 2.

APES levels across sessions in CBT and EFT: mean, standard deviation and effect size

Session number	EFT (n=12)		CBT (n=10)		EFT-CBT difference	Mann-Whitney	
	M	SD	M	SD	ES(r)	*U*	*p-value*
Session 1	2.13	.32	1.99	.33	.21 [-.19, .55]	45.5	.339
Session 4	2.26	.43	2.33	.51	-.08 [-.45, .31]	51	.552
Session 8	2.56	.62	2.49	.53	.06 [-.34, .44]	54	.692
Session 12	2.95	1.16	3.35	1.21	-.16 [-.52, .23]	46	.356
Session 16	4.12	1.45	4.15	1.44	-.01 [-.39, .37]	55.5	.767

Table 3.

Symptom intensity in CBT and EFT: mean, standard deviation and effect size

Session number	EFT (n=12)		CBT (n=10)		EFT-CBT difference	Mann-Whitney	
	M	SD	M	SD	ES(r)	*U*	*p-value*
Session 0	27.58	4.89	24.7	3.65	.66 [-.20, 1.54]	39.5	.17
Session 2	24.5	5.14	23	4.73	.30 [-.54, 1,14]	52	.6
Session 3	22.67	5.38	21.1	5.13	.30 [-.55, 1.14]	53.5	.68
Session 5	22.25	5.34	20.1	3.81	.39 [-.15, 1.31]	43.5	.27
Session 7	23.5	4.46	19	4.11	1.05 [.15, 1.94]	25	.02
Session 9	19.67	8.3	17	4.78	.39 [.15, 1.94]	36.5	.12
Session 11	19.91	8.58	19.4	5.76	.07 [-.77, .91]	52	.6
Session 13	19.83	7.91	13.5	4.88	.94 [.058, 1.82]	22	.11
Session 15	19	7.91	13.4	6,60	.81 [.05, 1.69]	31	.59
Session 17	17.08	9.95	11.3	6.93	.65 [-.20, 1.51]	37.5	.14

Note: APES= Assimilation of Problematic Experiences Scale. CBT= Cognitive-Behavioral Therapy. EFT= Emotion Focused Therapy. ES= Effect Size.

To see if using a multilevel model was appropriate, we used the null model to analyze the variance in OQ-10 scores within and between clients. The intercept component in the null model was significant, b=25.70, p<.001, indicating that the ICC was also significant which means that using a multilevel model was appropriate and needed.

Next, a random intercepts model was used to analyze the relation between Session (level 1 predictor) and OQ-10 scores, that is, to analyze the evolution of symptom intensity across sessions. This model showed a negative and statically significant regression coefficient for the effect of Session on OQ-10 scores, b = -2.09, p<.001 (Table 4). That is, symptom intensity tended to decrease across sessions. Residual variance dropped from 26.13 in the null model to 10.45 in this random intercepts model. This difference was significant as indicated by the likehood ratio test, $\chi 2$=70.47, p<.001.

To test whether symptom intensity was predicted by assimilation in the preceding session, we added APES Level to the model as a Level-1 predictor. As shown in Table 5, the regression coefficient for the effect of APES level on symptom intensity in the subsequent session was negative and statistically significant, b = -1.85, p<.001 (Table 5). That is, when assimilation levels rose in one session, symptom intensity tended to fall in

the subsequent session. This model explained 66% of the variance in OQ-10 scores in the subsequent session (R^2 = .66). Residual variance dropped from 26.41 in the null model and from 10.45 in the previous random intercepts model (only session as level 1 predictor) to 8.79 in the final random intercepts model (with APES level and Session as predictors); likelihood ratio test indicated both differences were significant, (χ^2= 83.07, p< .001 and χ^2= 12.60, p< .006, respectively). This indicates that this random intercepts model with both Session and APES level as predictors explained OQ-10 variance in symptom intensity better than did either the null model or the model with only Session as a predictor.

Table 4.

Session (level-1 variable) predicting Symptom Intensity: Random Intercepts Model

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
INTERCEPT (β_{00})	19.04	1.16	16.45	21	<.001
SESSION (β_{01})	-2.09	.37	-5.68	21	<.001

Table 5.

Assimilation (level-1 variable) and Session (level-1 variable) predicting symptom intensity in the subsequent session: Random intercepts model

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
INTERCEPT (β_{00})	19.05	1.16	16.45	21	<.001
ASSIMILATION (β_{01})	-1.85	.49	-3.73	21	.001
SESSION (β_{02})	-1.12	.32	-3.56	21	.002

Note: Symptom intensity was measured using the OQ-10; assimilation was measured using the APES.

Next, we assessed the reverse relation between Symptom intensity (measured by the OQ-10 scores) and assimilation (measured by the APES), that is, we tested whether OQ-10 scores predicted APES levels in the subsequent session. Again, we first used a null model to test if multilevel modelling was appropriate. The intercept component was significant, b=.26, p=.002, indicating that the ICC was also significant; thus, using a

multilevel model was appropriate.

Next, we analyzed the evolution of APES levels across sessions. We added Session as a level 1 predictor in the random intercepts model. This random intercepts model showed a positive and statically significant regression coefficient for the effect of Session on APES levels, b = .50, p<.001 (Table 6). That is, assimilation tended to increase across sessions. Residual variance dropped from 1.08 in the null model to .28 in the random intercepts model indicating that the random intercepts model explained the variance in symptom intensity better than the null model did. The likelihood ratio test indicated that this difference was significant, χ^2=107.86, p<.001. Then, we added OQ-10 scores as another level-1 predictor to the model. We found that OQ-10 scores did not predict APES levels, b = -.01, p > .203, as shown in Table 7.

Table 6.

Session (level-1 variable) predicting Assimilation: Random Intercepts Model

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
INTERCEPT, β_{00}	2.83	.14	19.81	21	<.001
SESSION, β_{01}	.49	.06	7.95	21	<.001

Table 7.

Symptom intensity (level-1 variable) predicting assimilation in the subsequent session: Random Intercepts Model

Fixed Effect	Coefficient	Standard error	*t*-ratio	Approx. *d.f.*	*p*-value
INTERCEPT, β_{00}	1.44	.11	13.039	21	<.001
SESSION, β_{10}	.46	.06	7.260	21	<.001
SYMPTOM INTENSITY, β_{20}	-.01	.01	-1.314	21	.203

Note: Symptom intensity was measured using the OQ-10; assimilation was measured using the APES.

As an additional way to show the relation of assimilation progress to changes in symptom intensity, we divided our sample into those who did (n = 13) or did not (n = 9) meet the Jacobson and Truax (1991) criteria for reliable and clinically significant improvement (RCSI) on the BDI-II. There were no significant differences on our

demographic variables between these two groups. We plotted these two groups' progress across sessions. RCSI criteria require that (a) across treatment, a client's scores had to improve from above to below the cut-off dividing the normal from clinical populations (we required BDI-II < 13), and (b) the magnitude of the change amount of change had to be greater than likely to have occurred by chance (at $p < .05$; this was 7.75 points on the BDI-II in our sample). As shown in Figure 1, the RSCI group's APES levels were higher and rose faster than the non-RCSI group's APES levels.

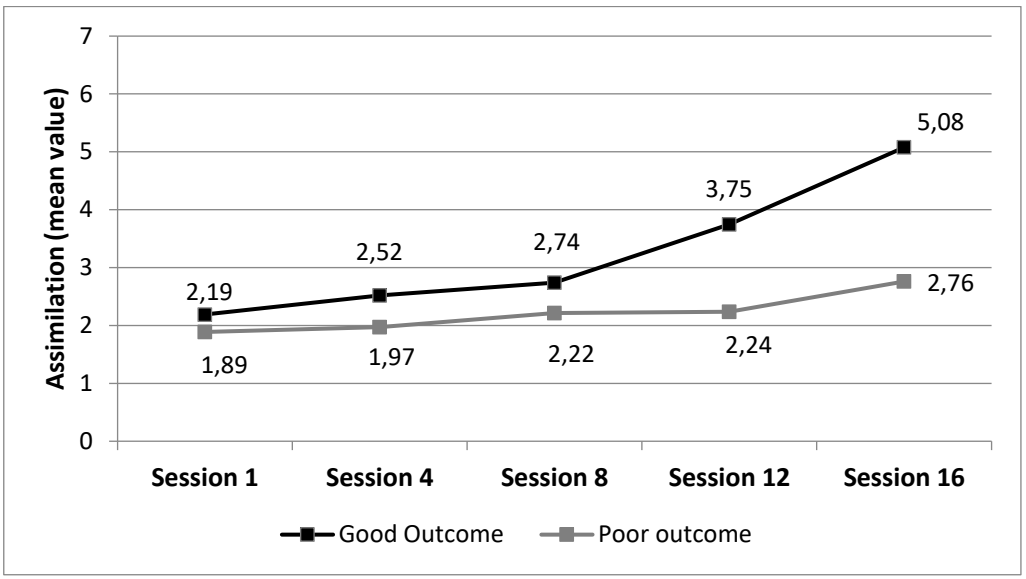

Figure 1. Evolution of the APES level across sessions in the good and poor outcome group.

Replicating an observation by Detert and collaborators (2006), we found that all 13 RCSI clients achieved APES levels of 4 or higher. However, whereas none of Detert et al.'s poor-outcome clients achieved this level, four out of our nine non-RCSI clients did achieve levels of APES 4 or higher, at least briefly. Five clients of the nine met criteria for reliable improvement (decrease of 7.75 or more points on the BDI-II), but not clinically significant improvement (posttreatment BDI-II < 13). Of these 5 responders, 3 achieved APES level 4 or higher in at least one passage. Thus, only one client who reached APES 4 or higher was not a responder.

Discussion

Our results confirmed the theoretical expectation that achieving higher APES levels is associated with better outcome as measured by self-report symptom intensity inventories. They extend previous work (e.g., Basto et al., 2016; Caro Gabalda, 2006; Detert et al., 2006; Honos-Webb et al., 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999) by tracking both APES levels and symptom intensity across multiple sessions in contrasting groups and indicating that assimilation progress (APES levels) predicted reduced symptom intensity (OQ-10 scores) in the subsequent session, whereas symptom intensity did not predict assimilation in the subsequent session. These findings seem to support the assimilation model suggestion that assimilation in the range of about APES 2 to APES 6, as was observed in this study (Table 2), has a direct role in promoting the decrease in symptom intensity (Basto et al., 2016; Stiles et al., 2004).

More broadly, this support for the link between assimilation and conventionally-assessed outcome lends a small increment in confidence to the assimilation model's account of how therapeutic change occurs. The results are consistent with the suggestion that assimilation is a common process in successful psychological treatment, and least for clients being treated for with major depressive disorder.

Our results generally supported Detert et al.'s (2006) suggestion that APES 4 (understanding/insight) is a threshold for conventional treatment success. All of the clients who met RCSI criteria – and all but one who met the reliable improvement criterion – achieved APES 4 or higher. As shown in Figure 1, our non-RCSI clients tended to improve slightly on the average; none showed higher BDI-II scores at termination than at intake or reliable deterioration. Detert et al. (2006) studied very brief treatments (two weekly sessions plus one follow-up), whereas our treatments were 16-18 sessions long, offering more opportunity for sporadically higher APES ratings. Of course, these results should be interpreted carefully since clinical symptoms measures (like the BDI-II) not always assess small but significant changes that occur throughout therapy.

The lack of APES differences between the EFT and CBT treatment groups was parallel to the lack of differences between these treatment groups on the ISMAI study's outcome measures (Salgado, 2014) and consistent with the frequently-observed

equivalence of diverse bona fide psychological therapies (e.g., Wampold & Imel, 2015). Assimilation theory suggests that assimilation should be similarly related to symptom intensity in any bona fide treatment. Of course, our study was not intended as a treatment comparison, and our sample would have provided insufficient statistical power to detect small comparative treatment effects.

The observed inverse relation of APES levels with score on the OQ-10, a standard outcome measure, supports the construct validity of the APES and lends a small increment of confidence to assimilation theory more broadly, insofar as the APES is logically linked to the rest of the theory. Finding a linear assimilation-outcome relation recalls the critique that "psychotherapy process-outcome correlations may be misleading" (Stiles, 1998, p. 27) because participants' appropriate responsiveness systematically undermines the looked-for relation (Stiles, Honos-Webb, & Surko, 1999). However, this critique does not apply if more of the process variable is always better, as is the case for assimilation and for evaluative variables (Stiles, 1996; Stiles & Horvath, 2017).

The results support the theoretical suggestion that the APES can be used as a theoretically-grounded measure of therapeutic progress, as a passage-by-passage index of change occurring within sessions. Along this line, Penttinen and Wahlstrom (2013) used the APES to compare outcomes of subgroups of patients in group therapy. Because the APES can be assessed on small stretches of dialogue, it can be used to assess progress in a relatively fine-grained way.

More clinically, knowing the current APES level of a problem can enable therapists to set subgoals for therapeutic work, pointing toward therapeutic strategies to be used (Honos-Webb & Stiles, 2002; Meyste et al., 2014; Stiles, Shapiro, Harper, & Morrison, 1995). Therapists might use APES markers (Honos-Webb et al., 2003) to guide expectations regarding the next emerging therapeutic task.

Several authors have offered suggestions about what sorts of interventions might be effective or ineffective at various APES levels (Caro Gabalda, Pérez Ruiz, & Llorens Aguilar, 2014; Caro Gabalda, Stiles, & Pérez Ruiz, 2016; Meystre, Kramer, De Roten, Despland, & Stiles, 2014). However, more research is need in this area to understand, within each therapeutic approach, which strategies can best help the client evolve in a sustained way from the current assimilation level to the following one.

Limitations

Although our results add a small increment of confidence in assimilation theory by supporting the theoretically expected relation of the assimilation of problematic experiences to therapeutic improvement, the small size and relative homogeneity of our sample constrains confidence in its generality. It will be important to analyze more cases and to check that the relation holds across therapists, treatment approaches, and samples of clients with different characteristics (for instance, with different diagnosis). Another limitation was the minimal clinical experience of most of our raters (12 master students), insofar as APES rating procedures benefit from a clinical understanding of the cases. To minimize the consequences of this limitation, a more experienced coder was always involved in the coding team. Many more studies with larger and more diverse samples and with more clinically experienced raters are needed to consolidate the suggestion that assimilation underlies therapeutic change

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ESTUDO 4: Fluctuation in the assimilation of problematic experiences: a case study of dynamic systems analysis

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Abstract

Dynamic systems theory suggests that instability can be a key element in the promotion of human change processes. Several studies have confirmed an association between unstable patterns and successful psychotherapeutic outcome. Somewhat similarly, the assimilation model of psychotherapeutic change argues that clinical change occurs through the integration of problematic experiences that initially threaten the stability of the self. This study examined how instability in assimilation levels was related to assimilation progress and change in symptom intensity, within and across sessions, in a good-outcome case of Emotion Focused Therapy. We used the assimilation of problematic experiences scales (APES) to measure assimilation and the outcome-questionnaire (OQ-10) to measure clinical symptom intensity. To assess assimilation instability, we used a fluctuation measure that calculated the amplitude and the frequency of changes in assimilation levels. To analyze the structural relationships between variables we used a dynamic factor model. The results showed that APES level and APES fluctuation tended to increase across treatment, while OQ-10 scores tended to decrease. However, contrary to expectations, the dynamic factor model showed no significant associations between APES fluctuation and OQ-10 scores either within sessions or between adjacent sessions.

Keywords: dynamic systems theory; assimilation model; instability; psychotherapeutic change process; depression; fluctuation; dynamic factor model.

Introduction

Dynamic systems theory suggests that psychotherapeutic change requires periods of instability that permit the problematic state of maladaptive and rigid stability of the self to be transformed (Fisher et al., 2011). Due to therapeutic interventions, the self becomes permeable to new inputs that shift the system to a chaotic and instable state. The system then gradually changes to a more adaptive configuration as it returns to a state of homeostasis or stability (Fisher et al., 2011).

A similarly important role for instability can be derived within the assimilation model of psychotherapeutic change (Stiles, 2011). The assimilation model suggests that a person's usual self is composed of traces of previous experiences, interconnected (assimilated) into aggregates, which can be reactivated. The traces, like the original experiences, incorporate intentions and intended actions as well as perceptions, cognitions, and feelings, so the aggregates can act and speak when they are reactivated, and they are characterized metaphorically as voices. Thus, we say a person is composed of the voices of the people, activities, skill, interests, and so on, that have comprised their life experience. Although most experiences are assimilated unproblematically, some problematic (e.g., traumatic, unacceptable, threatening, incongruent) experiences remain disconnected and liable to cause distress and dysfunctional behavior when they are reactivated. Or to say it another way, the disconnected voices emerge and cause problems when they are addressed by circumstances. Their being disconnected also prevents access to them, depriving the self of potential experiential resources. Psychotherapeutic change occurs through the assimilation of these disconnected, problematic internal voices.

The emergence of the problematic voices in therapy initially jeopardizes the stability of the self's (maladaptive) state of functioning. The instability, manifested in the often difficult dialogue within sessions, begins a progressive transformation of both parts through the creation of mutual understandings. In successful therapy, this process of assimilation promotes a more adaptive and functional self-structure and a return to a state of stability. In this way, instability plays an important role in the assimilation model's account of change that is congruent with that of dynamic systems theory.

Instability during the assimilation process has been studied qualitatively through

the analysis of setbacks (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013), and dynamic systems approaches have been used to study fluctuations in symptom intensity (Gumz et al. 2010; Hayes et al. 2007b; Heinzel et al., 2014; Schiepek et al., 1997; Schiepek, 2013; Schiepek et al., 2014). The present study examined the associations among assimilation, fluctuation in the assimilation process, and symptom intensity across sessions in a good outcome case of Emotion Focused Therapy using structural equation modeling (Fisher, Newman, & Molennar, 2011). To quantify the amount of instability in the assimilation process we measured the amplitude and frequency of setbacks using a measure of fluctuation designed to assess nonstationary phenomena in short time-series (Schiepek & Strunk, 2010).

This was a theory-building case study; that is, we aimed to analyze how the observations of this specific case were congruent with the assimilation model or, if not, suggested modifications or elaborations of the theory (Stiles, 2009). In theory-building case study research, as in most research in paradigmatic sciences, results such as detailed case observations bear on confidence in the theory. Substantive generalizations proceed from the theory, not directly from the results, so they do not depend on representative sampling (Stiles, 2009; Stiles, Hill, & Elliott, 2015).

Dynamic Systems and Therapeutic Change

Studies within the Dynamic Systems approach have suggested that therapeutic change is associated with fluctuations or discontinuities in clinical symptoms (Ebner-Priemer et al., 2009; Hayes et al., 2007a; Gumz et al., 2010; Kowalik, 1997; Schiepek, 2009; Schiepek et al., 1997, 2009, 2010, 2013, 2014). This is contrary to the usual expectation that a higher dose of treatment will result in progressively better outcome, or in other words, that there is a linear relation between input (dosage of treatment) and output (clinical outcome) (Schiepek, Tominshek, & Heinzel, 2014). For example, in a study with depressive patients, Hayes and collaborators (2007b) found that, in some clients, the evolution of clinical symptoms assessed by standard measures was not regular but discontinuous and that this pattern of discontinuity predicted lower posttreatment

scores of depression. Two discontinuous patterns were identified: early responders (a sudden gain in the first few sessions) and V-shaped patterns, or depressive spikes that occurred in an exposure-activation phase of treatment (Hayes et al., 2007b). Comparable results were found in a group of clients diagnosed with Obsessive Compulsive Disorder (OCD), where critical instabilities preceded important and significant transitions (Heinzel et al., 2014; Schiepek et al., 2014). Periods of instability within the client-therapist interaction were also associated with better outcome (Gumz et al. 2010; Schiepek et al., 1997).

The results of these studies suggest a view of the self as a dynamic system (Schiepek, Tominshek, & Heinzel, 2014) in which instability is associated with flexibility, whereas stability is associated with order and rigidity (Fisher, Newman, & Molennar, 2011). When the organization of the system is too rigid, patterns of thoughts, feelings and behaviors are restricted, so that the individual may struggle to deal with new situations and may be vulnerable to clinical problems (Fisher et al., 2011). To promote more flexible and adaptive patterns of functioning, therapy has to introduce a bit of variability and chaos into the system (Fisher et al., 2011). According to Dynamics Systems approach, there may be transitions between one stable pattern of functioning and another, across the course of treatment (Gelo & Salvatore, 2016). First order change (also called within-order, stability-maintaining, or conservative change) refers to a pattern of relatively smooth, continuous changes occurring across therapy while maintaining the same dominant pattern of functioning (Gelo & Salvatore, 2016). Second order change (also called order-to-order or transformative change) refers to a significant and structural change from one previous pattern of functioning to a qualitatively different one. Usually, second order changes are characterized by periods of critical instability and fluctuations in specific therapeutic parameters (such as symptoms, alliance, etc) (Gelo & Salvatore, 2016). These significant disruptive periods seem to be unique opportunities for change, since they allow clients to explore "new, possibly more functional patterns of functioning" (Gelo & Salvatore, 2016, p. 386). Significant changes in therapy seem to be preceded by periods of critical and abrupt instability and fluctuation. It seems that both stepping forward and stepping back are essential for successful psychotherapeutic change (Pascual-Leone, 2009).

The assimilation of problematic experiences

The assimilation model suggests that the voices that compose the self are assimilated to each other by semiotic meaning bridges, forming a community of voices (Honos-Webb & Stiles, 1998; Osatuke et al., 2005). Voices emerge to speak for the community, usually voices representing past experiences that resemble the present situation in some way (Caro Gabalda, 2014; Caro Gabalda & Stiles, 2009). Flexibility in the organization of the community is needed to adapt to changing life events, and normally the voices to emerge and speak or act are appropriate to the requirements of the situation (Caro Gabalda, 2011; Humphreys, Rubin, Knudson, & Stiles, 2005). Voices representing new experiences are normally assimilated smoothly. However, the emergence of voices of experiences that threaten the community's stability (e.g., traumatic incidents, destructive relationships, threatening or painful situations) are too dystphoric and are, in effect, rejected or ignored by the community. Their assimilation would require a significant change in the structure of the community. Nevertheless, such problematic voices try to speak when they are addressed by circumstances (Osatuke & Stiles, 2006). This encounter with the community produces strong negative feelings (Stiles, Osatuke, Glick, & Mackay, 2004). Theoretically, such disruptions help explain the affective aspects of psychological disorders, such as depression and anxiety.

In psychotherapy, clients can assimilate such problematic voices into the community (the self) through a dialogue that creates semiotic meaning bridges, or mutual understandings, between them (Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles & Brinegar, 2007). The assimilation shifts the relation between voices, from conflict to understanding and joint action. It requires changes in both voices and a restructuring of the community into a more flexible and functional structure (Honos-Webb & Stiles, 2002). For example, in the case of Laura, a CBT client (drawn from the case study by Basto et al., 2017), her community was characterized as perfectionist, dominated by highly demanding voices that required perfection in every situation. Her problematic voice represented her experiences of failure in a variety of different intra- and interpersonal contexts. The conflict between the problematic voice's need to be heard

when it was addressed and the community's need to hide this voice generated suffering and depression. The therapeutic dialogue between the conflicting parts seemed to facilitate the assimilation of the problematic voice into the community and more generally the transformation of the community into a more flexible and less rigid structure. By the end of therapy, Laura could accept failure as a normal feature of her daily life, making her more resilient.

A series of intensive case studies on a variety different therapeutic models (e.g., Brinegar, Salvi, & Stiles, 2008; Honos-Webb, Stiles & Greenberg, 2003; Mosher, Goldsmith, Stiles, & Greenberg, 2008; Leiman & Stiles, 2001; Osatuke, et al., 2005; Osatuke et al, 2007) has suggested that the assimilation of problematic experiences into the self progresses through a regular sequence, summarized in the eight levels assessed by the Assimilation of Problematic Experiences Scale (APES; see Table 1; Caro Gabalda & Stiles, 2009; Stiles, 1999; Stiles et al., 1991). A problematic experience's assimilation into the self can evolve from level 0, where the problematic experience is completely out of awareness, to level 7 where the problematic experience is completely integrated into the self. Achieving higher APES levels during therapy is associated with good outcome (Basto et al., 2018; Detert et al. 2006).

Progress through different assimilation levels is not smooth but is characterized by frequent setbacks, defined as a return from a higher to a lower level of assimilation (Caro Gabalda & Stiles, 2013). Such setbacks have been observed in varied therapeutic approaches (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch, et al., 2001; Leiman & Stiles, 2001; Goodridge & Hardy, 2009; Osatuke et al., 2005). Setbacks are usually associated with transitions from one strand of a problem that is better assimilated to another strand that is not so well assimilated. Good outcome cases exhibit at least as many setbacks as poor outcome cases (Caro Gabalda, 2006; Mendes et al., 2016).

Setbacks represent a kind of destabilization or fluctuation. In light of the dynamic systems suggestion that destabilization can be therapeutically valuable, this suggested to us that it may be useful to find quantitative ways to assess this fluctuating pattern of assimilation progress.

Table 2. Assimilation of Problematic Experiences scale

APES 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, proud of accomplishment.
7.Integration/ Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

Purpose and aims of this study

We explored how fluctuation in APES levels was related to assimilation progress and change in symptom intensity within and across sessions in the case of a single good-outcome client. In this exploratory analysis, we used dynamic factor analysis, which "allows the articulation of specific relationships within a dynamic system using a structural equation modeling (SEM) framework" (Fisher, Newman, & Molennar, 2011, p. 554). To assess APES fluctuation, we used a measure that calculated the amplitude and the frequency of changes in assimilation levels (Schiepek & Strunk, 2010).

Method

Client, Therapist, and Treatment

Alice (a pseudonym) was a single-26 year old employed woman who was treated for depression at the Maia University Institute (ISMAI), Portugal. She participated in a randomized clinical trial called the ISMAI Depression Study (Salgado et al., 2014), which compared the efficacy of Cognitive behavioral therapy (CBT) and Emotion Focused Therapy (EFT) for patients diagnosed with major depressive disorder.

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 Ethical Principles of Psychologists and Code of Conduct, as well as the Code of Ethics of Portuguese Psychologists). The client of this study, like all other participants, signed an informed consent required in the Standard 3.10 of the ethics code. Previously, the client was informed about the purposes of the research, expected duration and procedures. In addition, it was clarified that participation was voluntary, preserving their right to refuse participation or to give up participating at any time. In this informed consent, Alice also authorized the use of the collected data for process and outcome studies.

Alice received 16 weekly sessions of EFT and was considered a good-outcome client, as described later. She lived with her parents, who were catholic and conservative. Her presenting problems concerned her relationships with her boyfriend and with her parents (mainly her father) and problems at work. Mendes and collaborators (Mendes et al. 2016) previously classified categories of setbacks in this case.

Alice's therapist was a Portuguese woman in her early thirties with 8 years of experience as a therapist, including 4 years of experience delivering EFT.

EFT is an empirically validated humanistic therapy (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Watson 2006) that views emotions as an essential element in human functioning. According to this therapeutic model, emotions signal important needs underlying people's experiences and promote adaptive action tendencies, helping them adapt and survive. Psychological problems are viewed as

consequence of maladaptive emotional processing. The main therapeutic goal is to change this maladaptive emotional processing, allowing adaptive emotions to emerge and promote more adaptive functioning (Pos & Greenberg, 2007).

Measures

Beck Depression Inventory-II (BDI-II).

The Portuguese version of the BDI-II (translated into Portuguese from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002) is a 21-item self-report questionnaire that assesses depressive symptoms. Higher total scores indicate severe depressive symptoms. For the Portuguese population, significant clinical depressive symptoms are signaled by a total score higher than 13. The results of the Portuguese validation were considered good (Coelho et al., 2002). Internal consistency reliability measured by Cronbach's Alpha was .89 (Coelho et al., 2002).

Outcome Questionnaire-10 (OQ-10).

The OQ-10 (Lambert, Finch, Okiishi, Burlingame, McKelvey, & Reisinger, 1998) is a self-report questionnaire composed by 10 items that measures health functionality. Each item is scored on a scale ranging from 0 to 4 and the total score goes from 0 to 40. Obtaining a higher score in this questionnaire indicates the presence of poorer mental health functionality. The OQ-10 Cronbach's Alpha was of .88 (Seelert, 1997) and the test–retest reliability of .62 (Lambert et al, 2005). In the sample from ISMAI Depression Study (*N*=64; Salgado, 2014), the internal consistency was of .88 (Cronbach's Alpha) and the test-retest reliability was of .74 over a 1-week interval.

Assimilation of Problematic Experiences Scale.

As summarized in Table 1, the APES (Caro Gabalda & Stiles, 2009; Stiles et al., 1991) describes the evolution of the relation of a problematic experience (or voice) to the self (dominant community of voices) using a sequence of eight stages, numbered 0 to 7,

ranging from warded off (i.e. muted or dissociated) to mastery (i.e. fully integrated and no longer a problem, serving as a resource in new situations). Theoretically, the APES is considered as a continuum, and intermediate ratings (e.g., 2.3, 4.6) are allowed. However, for this study, we used only whole numbers on the APES (e.g., 2, 3).

Procedure

The BDI-II was administered at initial and post-treatment assessments and at sessions 1, 4, 8, 12. The OQ-10 was administered immediately before each session. Alice's 16 sessions were videorecorded and later transcribed verbatim following the transcription conventions described by Mergenthaler and Stinson (1992).

Client selection.

Alice met criteria for the ISMAI Depression Study, which included: being diagnosed with Major Depression Disorder; Global Assessment of Functioning >50. The exclusion criteria were: currently on medication or another form of treatment; or currently or previously diagnosed with one of the following DSM–IV Axis I disorders: panic, substance abuse, psychotic, bipolar, or eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or at high risk of suicide. Screening for inclusion and exclusion criteria used the Structural Clinical Interview for the DSM-IV-TR (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002). After being admitted to the study, each client was randomly attributed to a therapeutic condition (CBT or EFT) and, afterwards, randomly assign to a therapist.

Alice's scores on the BDI-II the ISMAI trial's criterion measure, declined from 29 at initial assessment to 1 at her last session and 5 at one-year follow-up. She was considered a good-outcome case because she met criteria for clinically significant and reliable improvement, as described by Jacobson and Truax (1991): (a) Her scores improved from above to below the cut-off of 13 on the Portuguese BDI-II, indicating clinically significant improvement, and (b) the amount of change was greater than the reliable change index of

7.75, that is, a difference greater than likely to have occurred by chance (at $p < .05$), indicating reliable improvement (Coelho, Martins, & Barros, 2002). For this case study, she was selected from among the ISMAI trial clients who met the Jacobson and Truax (1991) criteria on the basis that complete transcripts were available.

Assimilation analysis.

Our assimilation analysis followed procedures used in previous studies (e.g., Honos-Webb, Stiles, & Greenberg, 2003; Stiles et al., 1991, 1992; Stiles & Angus, 2001).

The two APES raters were a PhD clinical psychologist, and a PhD student in clinical Psychology, both with previous experience in research on the assimilation model. Training took approximately four months and included weekly meetings in which journal articles about the assimilation model were read and discussed and, sample sessions were coded according to the APES until all raters were considered reliable, achieving an intraclass correlation coefficient reliability of ICC [2,1] ≥ .60 (Cicchetti, 1994).

Next, both members of the team read transcripts of the entire case and identified the main recurring issues. By consensual agreement, they chose and characterized two main themes based on clinical relevance and time spent in therapy. The first theme was “fear of being rejected and abandoned,” which concerned Alice's difficulty in imposing her needs to others, motived by an intense fear of not being accepted for what she was. The other theme selected was “hurt towards her father,” which concerned unfinished business with her father concerning an episode in which, at the age of 15, she discovered an affair her father was having. She had never confronted him about this, but she resented his infidelity. Alice's dominant voice was labeled as “fear of being rejected,” as she presented a similar interpersonal pattern across contexts: work, relationships with family and boyfriend. The problematic voice for both themes was labeled as “I have the right to express myself and be accepted,” characterizing similar experiences of wanting to assert her needs and rights. These two voices seemed closely similar for both of these themes.

After selecting the themes, raters excerpted all passages where the themes appeared (N = 554) and rated them, independently according to the APES. The passage was the rating unit and was defined as a stretch of discourse delineated by a change in the

topic of the conversation or by markers of changes in APES level (see Honos-Webb, Lani, & Stiles, 1999; Honos-Webb, Stiles, & Greenberg, 2003). Reliability of these independent APES ratings was assessed using the Intraclass Correlation Coefficient designated ICC [2,2] by Shrout and Fleiss (1979), which is the reliability of the average of two raters. The ICC [2,2] was of .966, which is considered good (Cicchetti, 1994). Subsequently, raters discussed and reached consensus on APES ratings of passages where they disagreed (see Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). The consensus ratings were used in our analyses.

Analysis

Calculation of mean APES levels. Figures 1 and 2 show the assimilation progress in each theme, across passages. Passages dealing with particular themes were not evenly spaced across sessions, and the divisions shown in the figures are meant to indicate the approximate parts of the treatment in which each theme was addressed. The “fear of being rejected and abandoned” theme was much more frequent than the “hurt towards her father” theme. However, because both themes involved the same problematic and dominant voices, suggesting they were different expressions of a common core problem, we decided to combine these themes for our analysis. We also noted that the evolution of the two themes, considered separately, appeared very similar in terms of both APES levels and instability. Thus, to obtain mean APES levels for each session, we averaged APES ratings across passages of both themes within each session.

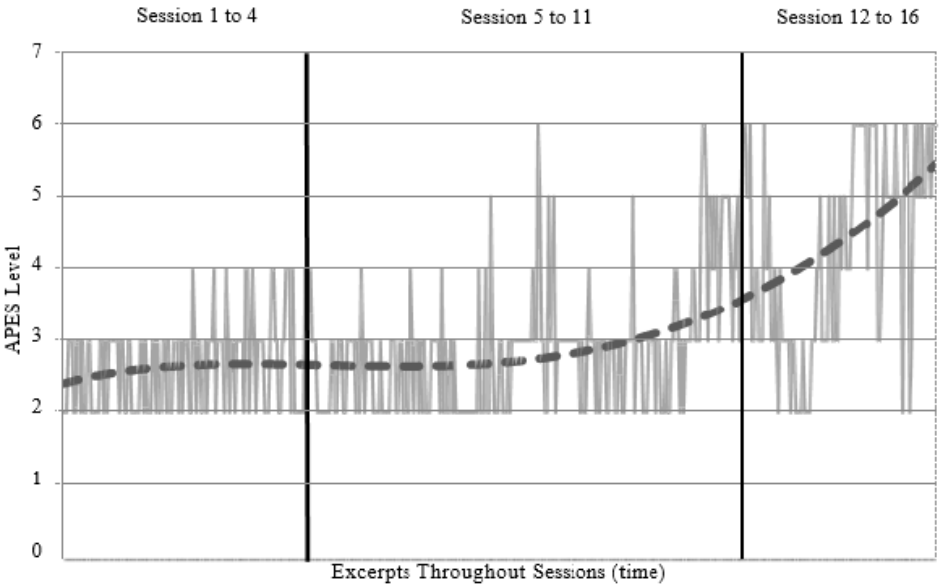

Figure 2. Assimilation progress of the "fear of being rejected and abandoned" theme across sessions.

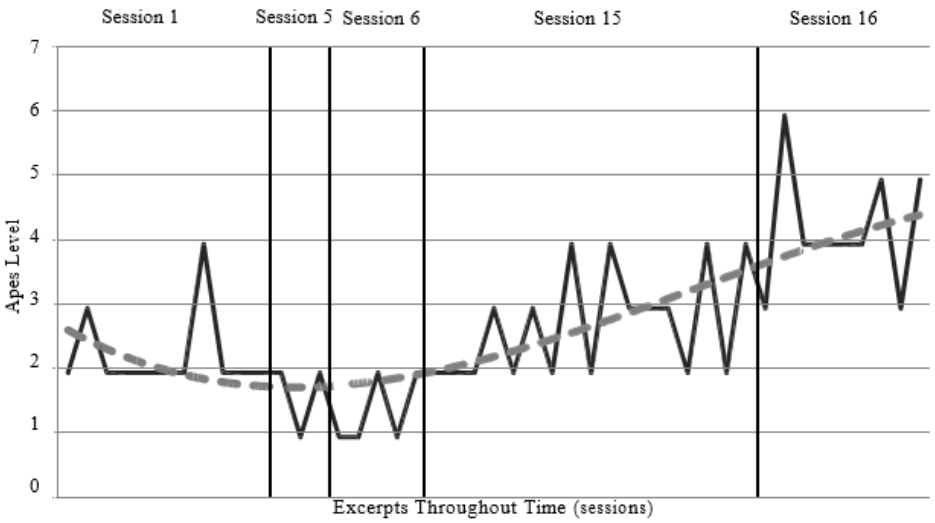

Figure 3. Assimilation progress of the "hurt towards her father" theme across sessions.

Index of fluctuation in assimilation progress. APES fluctuation in each session was indexed using a measure fully described by Schiepek and Strunk (2010), which assessed the amplitude and the frequency of changes in APES levels across one session. In effect, the APES fluctuations index is a way to index the incidence of APES setbacks. Fluctuation values can vary from 0 (low fluctuation) to 1 (high fluctuation). That is, the formula yields a normalized fluctuation intensity, $0 \leq F \leq 1$:

$$F = \frac{\sum_{i=1}^{I} \frac{y_i}{(n_{k+1} - n_k)}}{s(m-1)}$$

Where:

yi = |xnk+1 − xnk|

xn = nth session score

k = points of return (changes in slope in the data sequence)

i = periods between points of return

I = total number of such periods within the window

m = number of measurement points within a moving window

m−1 = number of intervals between all measurement points of a window

s = xmax − xmin with xmin smallest value of the scale, xmax largest value of the scale

Dynamic factor analysis.

In the present study we employed a dynamic factor model (Molenaar, 1985) that is a vector-autoregressive (VAR) method to measure contemporaneous correlations and time-lagged regressions in multivariate time series, using a structural equation model framework. The first step for this analysis was to smooth the time-series data and remove its trend. A moving average was calculated for the APES level, APES fluctuation, and symptom intensity measured by the OQ-10. The moving average was calculated by taking the arithmetic mean of a moving-window of four sessions. Total observations within each variable was equal to 16, the total number of sessions of Alice's treatment. For the dynamic factor analysis, we treated each variable as a separated dependent variable.

A VAR model with a lag of 1 session was tested by creating a block-Toeplitz matrix. The VAR model allowed to analyse intra- and intersession relationships between each variable. All VAR analyses were carried out in LISREL (Version 8.80; Joreskog & Sorbom, 2006). Since we had a single indicator for each latent variable, the lambda (λ) was set to identify and the beta (θ) matrix was fixed at zero. The beta matrix was then analysed to search for meaningful modification indices (MIs). To improve our model, whenever there was a significant MI, we rerun the analysis with the significant path. The final model was accepted when no more significant MIs were observed within the matrix.

Results

Table 2 shows the values of mean APES level, APES fluctuation, and symptom intensity (OQ-10) for each of Alice's 16 sessions. Alice's OQ-10 scores were relatively high in the first three sessions, varied a good deal across the next ten sessions, and were relatively low in the final three sessions, consistent with her having achieved reliable and clinically significant improvement on the BDI-II. Her APES levels remained moderate through most of the therapy but were higher in the last four sessions. Her APES fluctuation, similarly, was relatively low until session 12 and then increased for the last five sessions.

The dynamic factor model measures of goodness of fit were satisfactory, including the chi-square value ($\chi 2 = 6.84$, df = 10), the root-mean-square-error of approximation (RMSEA = 0), the standardized root mean square residual (SRMR = .16) and the comparative fit index (CFI = 1).

Table 3

Comparison between the results of the variables clinical symptoms, assimilation and instability in Alice's sessions

Session	Symptom intensity (OQ-10 score)	Assimilation (mean APES rating)	Assimilation instability (APES Fluctuation)
S1	21	2.4	.08
S2	19	2.54	.08
S3	20	2.88	.1
S4	12	2.77	.08
S5	10	2.6	.05
S6	15	2.25	.08
S7	17	2.65	.09
S8	14	2.28	.07
S9	18	2.56	.1
S10	19	3.14	.08
S11	18	2.78	.08
S12	**16**	**4.71**	**.13**
S13	**8**	**3.15**	**.09**
S14	**6**	**4.61**	**.1**
S15	**7**	**3.56**	**.13**
S16	**7**	**4.97**	**.14**

Figure 3 shows the dynamic factor model of Alice's case. Within session (t-1) there was a positive association (.54) between APES level and APES fluctuation. When the problem was at higher APES levels, APES fluctuation was also higher. Within session t, there was a similar positive association (.40) between those variables, but also a negative association (-.27) between OQ-10 scores and APES level. That is, when OQ-10 scores were relatively low, APES level was relatively high. Of particular interest, APES level in session t-1 negatively predicted OQ-10 scores at the following session (-.62), that is, when a problem was at relatively higher assimilation levels in one session, OQ-10 scores decreased in the following session. Finally, not surprisingly, OQ-10 scores at session t-1 positively predicted OQ-10 scores at the following session (.66).

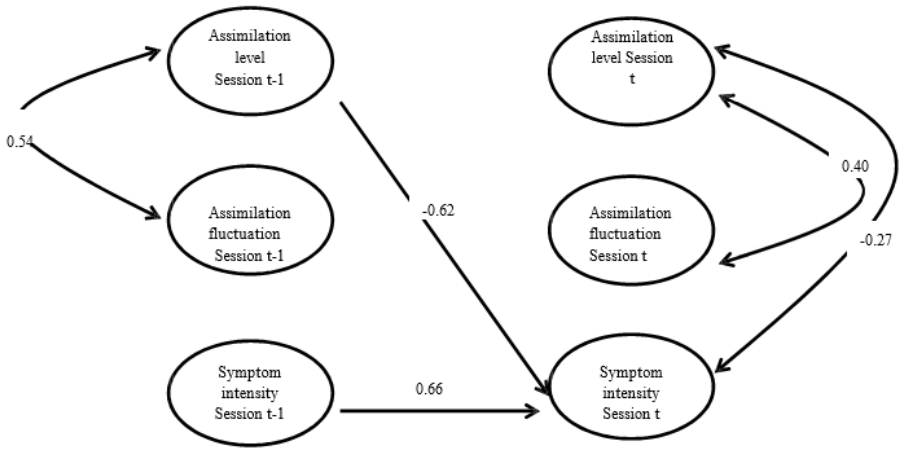

Figure 4. Dynamic Factor Model of Alice's session-level APES levels, APES fluctuation, and symptom intensity.

Discussion

In this good-outcome case, APES level and APES fluctuation tended to increase across treatment, while OQ-10 scores tended to decrease (Table 3). These changes were most apparent in the last four or five sessions of Alice's 16-session treatment. The inverse associations of APES level with OQ-10 scores in the same session and the preceding session are consistent with assimilation theory. The direct association between APES level and APES fluctuations suggests that, at least in this case, instability increased as degree of assimilation rose. However, contrary to the dynamic systems theory suggestion, the dynamic factor model (Figure 3) showed no significant associations between APES fluctuation and OQ-10 scores either within sessions or between adjacent sessions.

The inverse association between APES level in one session and symptom intensity in the following session in Alice's case was consistent with broader evidence that assimilation progress precedes therapeutic change as indexed by standard symptom intensity measures (Basto et al., 2018). Theoretically, the dialogue between the problematic voice and the community promotes the assimilation of the problematic voice, and this assimilation underlies progress toward to a state of wellbeing. Becoming aware

of and accepting previously avoided experiences overcomes the distress associated with encountering those experiences; it also gives access to experiential resources that were previously inaccessible to the self. Accepting diverse voices into the community promotes flexibility and a greater capability to adapt to diverse life situations.

At first sight, the failure of APES fluctuation to predict decreases in Alice's OQ-10 scores in the subsequent session seems contrary to the dynamic systems suggestion that instability promotes therapeutic change. As shown in Table 3, fluctuation tended to be higher later in therapy, from session 12 to the last session, than in earlier sessions. We might speculate, based on Gelo and Salvatore's (2016) suggestion about the role of instability in the promotion of therapeutic change, probably, that the lower instability up to session 11 could be reflect first order change, that is, relatively gradual, smooth, and continuous modifications around a dominant pattern of functioning. After session 12, the larger fluctuation values, might indicate the beginning of second order change, that is a more structural change in dominant pattern of functioning. This speculation is congruent with the increasing APES values on assimilation and the decreasing OQ-10 scores after session 12. From a dynamics system perspective, second order changes would be associated with more substantial therapeutic change and, consequently, with a reduction in the intensity of clinical symptoms (Gelo & Salvatore, 2016). Thus, even though the reduction in clinical symptoms may not be linearly dependent on instability session by session, it may be promoted by periods of greater, more abrupt instability. Our analysis would not have shown this association.

From this dynamic systems perspective, then, a limitation of this study is that we tested if destabilization was associated with clinical symptom's decrease only within the same session, or in the following session. If destabilization-improvement sequence occurs across multiple sessions, or in specific periods of the therapeutic process, then we might fail to detect it. For example, Hays and collaborators (2007b) reported that destabilization pattern across many sessions would predicted symptom improvement only at post-treatment or follow-up. More studies are needed to test these alternatives.

From an assimilation model perspective, the potential therapeutic value of destabilizing may apply only when clients are rigidly denying or avoiding their

problematic experiences, that is at APES levels 0 or 1, whereas even in her early sessions, Alice's problems were at moderate APES levels, between APES 2, (vague awareness/emergence) and APES 3 (problem statement/clarification). Theoretically, the psychological rigidity – the denial and avoidance of problems – reflects the danger of powerful negative affect associated with encountering problems at low APES levels (Basto et al., 2017; Stiles et al., 2004). If the beneficial effect of destabilization predicted by dynamic systems approaches applies only to problems that begin at lower levels (below APES 2), it is understandable why the prediction did not work in Alice's case.

More theoretically, perhaps APES fluctuation is not an appropriate measure of the sort of destabilization that is thought to promote change in dynamic systems. The previous work within the dynamic systems approach has focused on fluctuations in symptom intensity or distress. APES levels are related on symptom intensity (Basto et al., 2017), but they are expected to fluctuate with mood. As a different way to look at it, there is evidence that that large fluctuations in mood, or subjective distress are characteristic of the emotional upheavals of a problem's passage through APES 2 (vague awareness/emergence), the emotional low point of the APES feelings curve (Mackay, Barkham, Stiles, & Goldfried, 2002; Stiles et al., 2004). Perhaps passing through this emergence stage, with the accompanying emotional fluctuation, is the necessary step in therapeutic change.

Case studies such as this one can contribute to theory-building by their detailed correspondence or lack of correspondence with theoretical accounts and by showing where modifications in theory are required or where extensions are possible (Stiles, 2009). But of course, no case study is definitive. Further studies are needed to investigate the alternative possibilities we have raised.

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ESTUDO 5: Instability in the assimilation of problematic experiences process: A comparison of good- and poor-outcome case in Emotion Focused Therapy.

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Abstract

The assimilation model suggests that therapeutic change occurs through a gradual process of assimilation of problematic experiences. Previous case studies have shown that good outcome cases as well as poor ones exhibit an instable pattern in the assimilation progress. Our study aimed to examine more closely how this can occur through the analysis of the longitudinal relation between assimilation, instability in the assimilation process and clinical symptom intensity in two contrasting cases: a good and a poor outcome. A fluctuation measure was used to assess instability in the assimilation progress. The results showed that, in the good outcome case, assimilation levels and instability tended to increase, while clinical symptoms tended to decrease, more evidently in the final phase of treatment. On the contrary, in the poor outcome case, assimilation levels and instability didn't seem to progress across sessions.

Keywords: assimilation model; instability; setbacks; therapeutic change process.

Introduction

According to the assimilation model (Stiles, 2011; Stiles et al., 1990), therapeutic change occurs when previously avoided problematic experiences are accepted and assimilated into the self. Although the theory proposes a regular sequence of stages of change, in practice, this process often appears discontinuous and irregular. This instability in the assimilation process has been studied through the analysis of the setbacks (Caro Gabalda, 2006; Mendes et al., 2016). The results from these studies suggest that instability is an essential feature of the assimilation progress (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch et al., 2001; Goodrigde & Hardy, 2009; Osatuke et al., 2005). The aim of this study was to examine the relation between instability in the assimilation progress and the evolution of clinical symptoms, measured at each session in two contrasting cases: a good and poor outcome in Emotion Focused Therapy for depression.

The Assimilation Model

The assimilation model (Stiles 2001; Stiles 2011; Stiles et al., 1990; Stiles, et al., 1991; Stiles, Shankland, Wright, & Field, 1997) suggests that clinical change occurs when previously avoided experiences are accepted and assimilated into the self. The model conceptualizes the self as composed of multiple internal *voices* (Dimmagio & Stiles, 2007) that are interlinked, forming an organized, stable structure called a community of voices (Honos-Webb & Stiles 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999). These voices represent traces of previous experiences (Osatuke et al., 2005) that may be activated whenever present experiences resemble previous past experiences (Caro Gabalda, 2014; Caro Gabalda & Stiles, 2009). Sometimes the stability of this community is threatened by incongruent, problematic voices (Caro Gabalda, 2003; Honos-Webb & Stiles, 1998) representing experiences that are rejected because their integration would significantly change in the organization of the self (Osatuke & Stiles, 2006). The conflict between the problematic voices, which try to be heard whenever they are addressed, and the dominant voices, which try to ignore this intrusion, generates psychological distress (Basto et al., 2017; Stiles et al., 2004). Conversely, the inaccessibility of those problematic experiences tends to impoverish the self, making it less able to deal effectively with life situations in which the experiences might be relevant (Caro Gabalda, 2011; Humphreys, Rubin, Knudson, & Stiles, 2005). This may generate clinical problems.

According to this model, in psychotherapy, a person can find and develop connections between their problematic voices and the community. Through the therapeutic dialogue, the voices create mutual understandings, which are called *meaning bridges* (Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles & Brinegar, 2007; Stiles, 2011). Through the creation of mutual understandings between voices, conflict diminishes and the previously rejected voice is integrated in the community, serving as a resource for future life experiences.

The assimilation process can be assessed with the Assimilation of Problematic Experiences Scale (APES; Caro Gabalda & Stiles, 2009; Stiles, 1999; Stiles et al., 1991). The scale is composed by eight levels, or stages, and describes the changes in the relation between problematic voices and dominant voices, from a state of dissociation of the problematic voice at level 0, to a full integration into the community, at level 7 (Table 1).

Previous studies in the assimilation model

Group studies (Basto, Stiles, Rijo & Salgado, 2018; Detert et al., 2006) and intensive case studies involving a variety of therapeutic approaches (Brinegar, Salvi & Stiles, 2008; Caro Gabalda 2011; Field, Barkham, Shapiro, & Stiles, 1994; Gray & Stiles, 2011; Honos-Webb, Stiles & Greenberg, 2003; Knobloch, Endres, Stiles & Silberschatz ,2001; Leiman & Stiles 2001; Mosher, Goldsmith, Stiles & Greenberg, 2008; Osatuke, et al., 2005, 2007) have confirmed the model's expectations that successful cases advance along the APES continuum across therapy and that good outcome cases (conventionally assessed) tend to reach higher assimilation levels than poor outcome cases. Conventionally defined poor outcome cases, although they may progress to some degree in APES terms, tend to remain below APES level 4 (the understanding/insight stage), whereas good outcome cases usually reach, at least, APES level 4 (e.g., Caro Gabalda, 2011; Detert et al., 2006). That is, APES 4 seems to be a cutting point for distinguishing good from poor outcome cases, as defined using conventional symptom intensity measures (Caro Gabalda, 2006, 2007, 2008; Detert et al., 2006).

Table 1

Assimilation of problematic experiences scale (adapted from Caro Gabalda & Stiles, 2009)

APES 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, proud of accomplishment.
7.Integration/ Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

Instability in the assimilation progress

Although problems generally tend to evolve toward higher APES levels in good outcome cases, investigators who have analyzed assimilation progress more carefully have observed an instable pattern of progress, with many setbacks during this process (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al. 2006; Knobloch, et al., 2001; Goodrigde & Hardy, 2009; Osatuke et al., 2005). In these studies, a setback was defined as a decrease of at least one APES level from one passage to the next (Caro Gabalda & Stiles, 2013). Such setbacks seem to be a common feature of the assimilation

process across therapeutic approaches (Caro Gabalda, 2006, 2008; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch, et al., 2001; Leiman & Stiles, 2001; Goodridge & Hardy, 2009; Osatuke et al., 2005).

Most of the setbacks observed in these studies appear to be attributable to one of two reasons, either (a) exceeding the therapeutic zone of proximal development (TZPD; Leiman & Stiles, 2001; Ribeiro et al., 2016) or (b) a therapeutic strategy of balancing advances in one area by attention to relatively problematic material in a closely related area (Caro & Stiles, 2013; Mendes et al., 2016). The TZPD is the working zone within the APES for a problem at a specific point in therapy, analogous to Vygotsky's (1978) concept of the zone of proximal development in children's cognitive growth (see Leiman & Stiles, 2001). Theoretically, if a therapist's proposals or a client's own statements exceed the upper limit of the TZPD, then the client experiences the material as too risky or threatening and may retreat to another strand of the problem that is at more comfortable and lower APES level (Leiman & Stiles, 2001; Osatuke et al., 2005; Caro Gabalda, 2006). Alternatively, the therapist may use the balance strategy to facilitate the assimilation of strands of the problem that were not yet understood and integrated, attending to material that is at a lower APES level. Note that both of these reasons presume that each problem comprises multiple strands or subvoices that represent different aspects of the experience that needs to be assimilated. Although the strands tend to be interlinked, during active work in therapy, some aspects of the problematic experience may be assimilated faster than others (Caro Gabalda & Stiles, 2013), and switching to a less assimilated strand may be productive. Thus, rather than being an undesirable phenomenon, setbacks seem to be an important feature of the assimilation progress. Previous case studies have shown that good outcome cases as well as poor ones exhibit numerous, pronounced setbacks (Caro Gabalda, 2006, Mendes et al., 2015). Our study aimed to examine more closely how this can occur.

Purpose and aims of this study

This study aimed to analyze the relation between assimilation, instability in the assimilation process and outcome (clinical symptom intensity) in two contrasting cases: a good and a poor outcome. We explored how assimilation and symptom intensity evolved longitudinally across therapy in the two cases, noting similarities and differences

in their paths. Thus, our interest was how instability in the assimilation pattern is related to psychotherapeutic outcome at a session-to-session level.

We framed this as a theory-building case study (Stiles, 2009). We used both quantitative and qualitative observations on these cases, aiming to assess the fit of the theory to the observations and to suggest elaborations of the theory to accommodate observations of details or discrepancies that went beyond theoretical expectations. To assess instability in assimilation progress quantitatively, we calculated the amplitude and frequency of setbacks using a fluctuation measure designed specifically to assess nonstationary phenomena in short time-series (Schiepek & Strunk, 2010).

Method

Clients

Two clients were selected from the ISMAI Depression Study (Salgado et al., 2010), a randomized clinical trial that compared the efficacy of EFT and CBT in the treatment of clients diagnosed with mild or moderate Major Depressive Disorder. The inclusion criteria for the ISMAI Depression Study were: being diagnosed with Major Depression Disorder; Global Assessment of Functioning >50; and not being medicated. The exclusion criteria were: currently on medication or another form of treatment; or currently or previously diagnosed with one of the following DSM–IV Axis I disorders: panic, substance abuse, psychotic, bipolar, or eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or at high risk of suicide. The two clients met the criteria for inclusion in the study since both were diagnosed with major depressive disorder assessed using the Structural Clinical Interview for the DSM-IV-TR (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002). After being admitted into the clinical trial, the clients were randomly assigned to Emotion Focused Therapy. Then, both clients were randomly assigned to a therapist. For this study, the clients were randomly selected from the same therapist to control the effect of the therapist.

The therapist was a 31-year old woman with 8 years of experience in clinical practice and 1 year of experience in EFT. The clients received their treatment in the psychotherapeutic lab at Maia University Institute (ISMAI), Portugal. The therapeutic protocol specified 16 weekly sessions, and both clients attended all sessions. All sessions

were videotaped, except session 3 in the poor outcome case, due to technical problems. Before the beginning of therapy, a complete description of the clinical trial and the video recording of sessions was given and both clients gave informed consent.

The good outcome case, named Alice (a pseudonym), met the two conditions specified by Jacobson and Truax (1991), that a client's score should change from above to below the cut-off point dividing clinical from non-clinical populations on the criterion measured, in the study, the Beck Depression Inventory-II (BDI-II; Beck et al. 1996), and the amount of change should be greater than the Reliable Change Index (RCI) for that measure, an amount unlikely to have occurred by chance.

Alice was a single 26-year old woman who lived with her parents. At intake she was working, but during the middle phase of therapy her working contract ended and she became unemployed. During the final phase of therapy, she started a new job. Also, in the final phase of therapy, she decided to live with her boyfriend. This was considered a good outcome case because her clinical symptoms decreased significantly from intake to the last session, assessed by the self-report questionnaires presented in table 2.

The poor outcome case, named Afonso (a pseudonym), was a single 24-year old man, college student, who lived with his mother. In this case, although the clinical symptoms assessed with self-report questionnaires (Table 2) showed modest numerical improvement, they did not decrease significantly from intake to the last session, and it was considered a relatively poor outcome case.

Table 2

Pre-test, post-test and follow-ups scores (1 year after post-test) from the two cases

	Questionnaires	**Pre-test**	**Last Session**	**Follow-up**
Good Outcome	**BDI-II**	29	1	5
	OQ-45.2	86	39	49
	HDRS	17	3	N/A
	OQ-10	21	7	11
Poor Outcome	**BDI-II**	23	16	12
	OQ-45.2	83	80	65
	HDRS	10	8	N/A
	OQ-10	27	22	22

Note: BDI-II=Beck Depression Inventory (translated into Portuguese from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002) OQ-45.2=Outcome Questionnaire (Lambert & Burlingame, 1996; Vaz, Conceição, & Machado, 2013) is a 45 item self-report questionnaire designed to assess psychotherapy outcome (a total score higher than 63 is considered within clinical range); HDRS=Hamilton Depression Questionnaire (Hamilton, 1960) is a clinician depression assessment scale (a total score higher than 9 is

considered within clinical range); OQ-10= Outcome Questionnaire-10 (Lambert, Finch, Okiishi, Burlingame, McKelvey, & Reisinger 1998).

Therapy

EFT is an empirically validated humanistic therapy (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Watson 2006). This therapeutic model views emotions as the key element in human experience, contributing to an adaptive or a maladaptive functioning of the individual. The main therapeutic goal is to change maladaptive emotional processing (Pos & Greenberg, 2007). Specific markers that signal maladaptive emotional processing point towards matching interventions of transforming the core emotional schema into more adaptive emotional responses and new meanings (Pos & Greenberg, 2007).

Symptom intensity measures

Outcome Questionnaire-10 (OQ-10).

The OQ-10 (Lambert, Finch, Okiishi, Burlingame, McKelvey, & Reisinger 1998) is a 10-item self-report inventory designed to assess psychotherapy outcome. Each item is scored on a scale ranging from 0 to 4 and the total score goes from 0 to 40. Achieving higher scores points to poorer mental health functionality. The OQ-10 Cronbach's Alpha was of .88 (Seelert, 1997) and the test–retest reliability of .62 (Lambert et al, 2005). Concerning the Portuguese population (Basto et al., 2017), based on the ISMAI Depression Study sample (N= 64; Salgado et al., 2010), the internal consistency was of .88 (Cronbach's Alpha) and the test-retest reliability was of .74 over a 1-week interval.

Process measures

Assimilation of Problematic Experiences Scale (APES; Caro Gabalda & Stiles, 2009; Stiles et al., 1991)

The APES is applied to session discourse and measures the current level of assimilation of the problematic experience under consideration. As shown in Table 1, the scale has eight levels, numbered 0 to 7. The levels are considered as anchor points on a continuum, and intermediate ratings (e.g., 1.5, 3.4) are allowed.

Procedures

Symptom intensity measurement

The OQ-10 was administered immediately before all 16 sessions.

Process measurement

Assimilation analysis

All sessions of each case (except Afonso's session 3, which was not recorded) were transcribed verbatim following procedures described by Mergenthaler and Stinson (1992). These transcripts were analyzed and rated on the APES following the procedures described in previous assimilation studies (e.g., Honos-Webb, Stiles, & Greenberg, 2003; Stiles et al., 1991, 1992; Stiles & Angus, 2001).

The 4 raters were all specialized in clinical psychology: a PhD psychologist, a PhD student, a Master degree psychologist and a Master's student. All raters, except the master student, had previous experience in the assimilation model. The master student coded less than 20% of the entire material, since he was the less experienced rater. Each case was analyzed by an independent team of two raters. Before rating the material, the raters participated in training that lasted approximately four months. During training, raters met every week at least for two hours. The first part of training involved reading and discussing journal articles and rating manuals. Then, raters were given therapy sessions (not from this study) to rate. Initially, the ratings were made in group and afterwards individually, to establish reliability. Disagreements were discussed between raters and the expert rater and resolved by consensus. The raters were considered reliable after achieving a level of inter-rater reliability between each other characterized as good by Cicchetti (1994): ICC [2,1] $\geq$ .60.

The assimilation analysis followed the four phases described by Stiles and Angus (2001), familiarization, topic selection, excerpting, and describing the process of assimilation (APES rating and interpretation). First, all sessions of each case were read multiple times by both raters, and the recurring issues were identified. Then, by consensual judgment, the most central themes were selected, based on its clinical salience (e.g., high proportion of time spent in therapeutic sessions) and the problematic and dominant voices were defined.

In Alice's case the selected themes were "fear of being rejected and abandoned" and "hurt towards her father". The theme "fear of being rejected and abandoned" was selected because Alice had difficulty in expressing her needs and rights because she was

afraid she would disappoint others. This was a problem that occurred in a variety of interpersonal contexts, including in her relationship with her parents, her boyfriend, and her colleagues at work. As therapy progressed, Alice was increasingly able to assert her rights and needs without fear of being reject. In the final sessions, she was able to make important decisions. For example, she decided to live with her boyfriend before being married. She had long postponed this decision because she feared her parent's reaction. This theme was prominent throughout the therapeutic process, as in the following excerpt:

Therapist: Did you express how mad you were about the fact that both of you had an argument about you going to Braga to be with her?

Alice: I do not feel that I have the right to do that, and then I let it go… Susana was with me and she said: "You cannot allow others to step on you and you have to show that you have an opinion and that you know what is best for you". (Session 1)

The other theme, "hurt towards her father," described an unfinished business with her father, that emerged briefly in the initial session and then appeared again only in the final phase of therapy. Apparently, Alice did not feel prepared to deal with this theme until the final phase of therapy. In the last session, Alice was able to understand important aspects of this theme, which helped her move on with her life. The following excerpt is an example of this theme:

Alice: Yes, I think this is a situation that goes on for so long. I think that what contributed to my vulnerability was, without any doubt, this situation with my dad, the fact that he had a relationship outside of his marriage and that I discovered this relationship (cries).

Therapist: yes?

Alice: long before my mother… my mother always knew… I think women sense these things. I think women… I'm a woman and I think we sense when people are distant and… (session 1)

The dominant voice in Alice's case was labeled as "fear of being rejected" since she presented a submissive interpersonal pattern in different contexts of her life: work, relationships with family and boyfriend and this submissive pattern reflected a strong fear of being rejected by others. The problematic voice was labeled as "I have the right to express myself and be accepted" since it represented experiences related with the client's

need of expressing her needs and rights. These two voices (dominant and problematic) were the same for both themes.

In Afonso's case, the selected themes were "difficulty in accessing his emotional experiences", "resentment towards his parents" and "social anxiety". The theme "difficulty in accessing his emotional experiences" was the most frequent, related with the difficulty in feeling emotions and how this affected his life. Throughout therapy, Afonso avoided being in contact with painful aspects of different intra and interpersonal experiences. The following excerpt exemplifies this theme:

Afonso: I felt sad at that time and so what I did was to lock myself to, somehow, become stronger

Therapist: ok you felt sad…worn…

Afonso: I was not going to deal with that…what was going on and probably I blocked myself… I'm blocked and maybe now I'm feeling the consequences of this in other aspects of my life… other relationships. I blocked myself and since then I hardly cry. Then, that question that I saw in the questionnaire "Do you feel like crying?" I really can't. I didn't answer that question because I do not know what it's like to feel like crying. Sometimes I can get a little bit emotional with something, but it never overcomes this phase. (session 2)

In the theme "resentment towards his parents" Afonso expressed his hurt for feeling neglected by his parents, especially during his childhood. Because it this was a very painful issue, throughout therapy, Afonso avoided dealing with this experience. This theme is represented in the following excerpt:

Therapist: and you said that this uncomfortable sensation that appears in some situations is not new.

Afonso: Oh yeah, I think I get more stress up or worried when problems concerning my family emerge. These are situations that I can hardly change or solve but which usually I am asked to deal with.

Therapist: to deal with that

Afonso: to deal with that or to make decisions. This is something that has been happening for many years. For 15, 16 years… I watched those quarrels at night and usually the quarrels were always at night and it was disturbing for me… (session 2)

Finally, the theme "social anxiety" was linked with difficulties in coping with new social situations. Although Afonso frequently tried to hide his social difficulties, in some occasions, he was able to express them. The following excerpt is an example of this theme:

Afonso: when I came from Azores I came with overweight

Therapist: oh yeah?

Afonso: yes and this influenced my relationships with others

Therapist: it was a negative thing for you?

Afonso: yes, I thought very negatively about myself. (session 2)

The dominant voice in Afonso's case was "I need to be strong" since the client showed in different intra and interpersonal contexts the need to present himself as a strong man, who does not depend on others and never feels vulnerable. The problematic voice "I am vulnerable" represented experiences related with the need to express his emotions and vulnerability and the need to be loved and protected by others. In Afonso's case, the dominant and the problematic voices were the same across the different themes.

After identifying and characterizing the themes, raters selected excerpts where the themes emerged. Then, the APES scale was independently applied, by each rater, to all relevant excerpts raters, identifying the APES passages and the assimilation level in each passage. The passage is considered the unit of analysis in the APES ratings and is defined as a stretch of discourse delineated by a change in the topic of the conversation or by markers of changes in APES level (see Honos-Webb, Lani, & Stiles, 1999; Honos-Webb, Stiles, & Greenberg, 2003). 554 passages were found in the good outcome case and 681 passages in the poor outcome case. Disagreements were solved by consensus between each group of two judges (see Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). Before consensus, the interrater reliability was calculated using the Intraclass Correlation Coefficient (ICC; Shrout & Fleiss, 1979). Alice´s case achieved an interrater reliability of .97 (ICC [2,2]). Afonso's case achieved an interrater reliability of .84 (ICC [2,3]). The average reliability, in both cases, was considered good.

Identification of instability in the assimilation progress

Instability was determined by a fluctuation intensity measure (F) which assessed the amplitude and the frequency of changes throughout time. The fluctuation measure was calculated as way to assess quantitively, in each session, the degree of instability in the assimilation process. All procedures used to calculate the fluctuation measure were based on a previous study of Schiepek and Strunk (2010). This measure was calculated within a data-window moving over the time-series. The data window used in this time-series was the session. All measurement points within the window were aggregated into periods defined by a change in the trend of the assimilation pattern: increasing, decreasing or no change. We only used the absolute numbers (not considering if it was a positive or negative trend). The difference between the x values was calculated and then divided by the duration of the period (number of data points within the period). Each of these results was summed. To normalize the values, a maximum amount of change was calculated (greatest possible fluctuation) within the minimum period possible. Then the sum of the obtained differences was divided by the greatest possible fluctuation within the moving window to obtain a normalized fluctuation intensity 0<F<1.

$$F = \frac{\sum_{i=1}^{1} \frac{Y_i}{n_{k+1} + n_k}}{\mathrm{s(m\text{-}1)}}$$

Results

First, we will present the results of the evolution of clinical symptoms, assimilation and fluctuation, in both cases, throughout sessions. Concerning Afonso's case, we did not have the results from session 3. Due to this fact, we decided to exclude the results from session 3 of both cases. Then, we will present a qualitative description of the assimilation progress and its instability using representative clinic vignets of each case.

The progress of clinical symptoms, assimilation and fluctuation

Initially we will present a description of the progress of the three variables across the therapeutic process, in both cases. An overall description of the results is possible to observe in Table 3.

Table 3.

Overall results of clinical symptoms, assimilation and fluctuation in both cases

		Alice's case (Good-outcome)	Afonso's case (Poor-outcome)
Clinical symptoms	**Mean**	13.8	23.06
	Standard deviation	5.26	2.15
Assimilation	**Mean**	3.15	1.49
	Standard deviation	.90	.26
Fluctuation	**Mean**	.09	.08
	Standard Deviation	.02	.02

Clinical symptoms progress

Regarding the evolution of clinical symptoms, as it is possible to see in Figure 1, although both cases begun with similar levels of clinical symptoms, from session 3 until the end of therapy, each case evolved very differently. Alice showed a strong symptom decrease from session 3 to session 5 and then an increase from 6 to session 10 (except for the transition from session 7 to session 8, where there was a slight decrease). From session 10 until the last session, clinical symptoms progressively decreased (more pronouncedly from session 12 to session 13). Thus, in Alice's case it was possible to observe a progressive decrease in clinical symptoms, from the initial until the final phase of therapy, but this decrease was non-linear. On its turn, in Afonso's case, although there were some variations in the intensity of clinical symptoms between sessions, it was not possible to observe any positive or negative trend, throughout therapy.

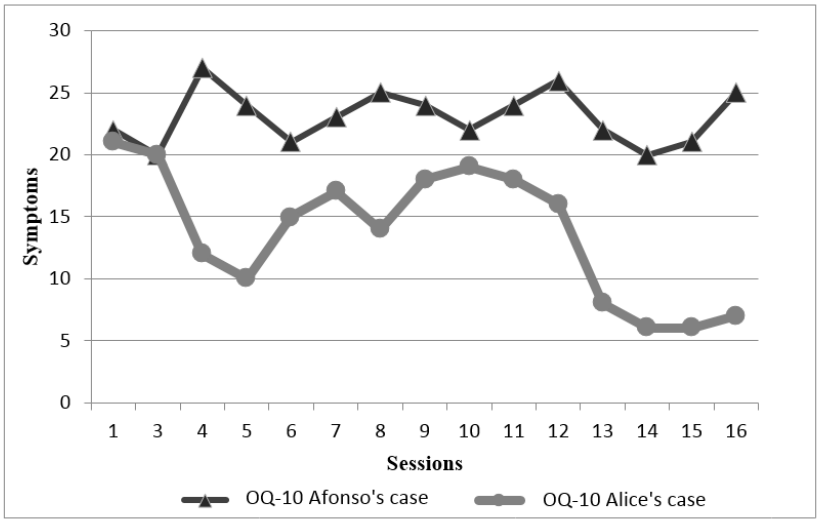

Figure 1. Evolution of clinical symptoms throughout therapy in Alice's and Afonso's case.
Note: OQ-10= Outcome Questionnaire-10 (Lambert et al., 1998).

Assimilation progress

Figure 2 shows the assimilation progress in both cases, across therapy. Although each case had different themes, we decided to present the overall results of the assimilation progress (gathering themes), since the voices were the same in the different themes, within each case.

When comparing the assimilation progress of each case, in Alice's case, higher assimilation levels (equal or higher than APES 4) were achieved. On the contrary, in Afonso's case, lower assimilation levels (lower than APES 4) were maintained across therapy. In Alice's case, it was also possible to observe a more instable pattern in the assimilation progress in the final phase of therapy (from session 10 to session 16), with increases and decreases in the assimilation levels between sessions. In Afonso's case, the assimilation progress was more stable and regular with only few increases or decreases in the assimilation levels between sessions.

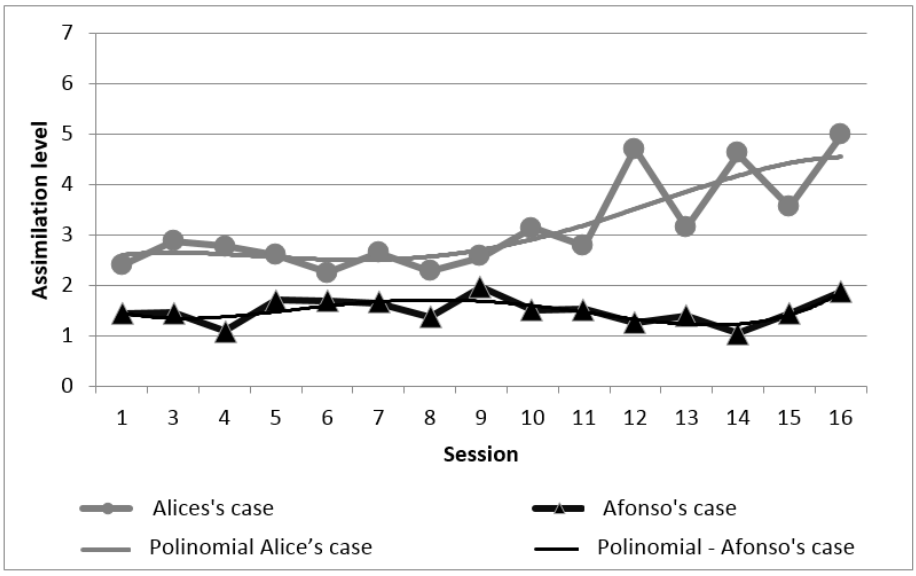

Figure 2. Evolution of assimilation (mean values) throughout therapy in Alice's and Afonso's case.

Figure 3 and 4 describe the assimilation progress intra-session, in each case. With this microanalitic perspective it was possible to confirm differences between cases. When we analyzed the evolution of assimilation in Alice's case, passage by passage, across sessions (Figure 3), it was possible to observe that, in the initial sessions, APES 2 and 3 were the most frequent assimilation levels. However, even during the initial phase, APES 4 started to appear. Then, from the middle phase until the final phase of therapy, higher assimilation levels become progressively more frequent.

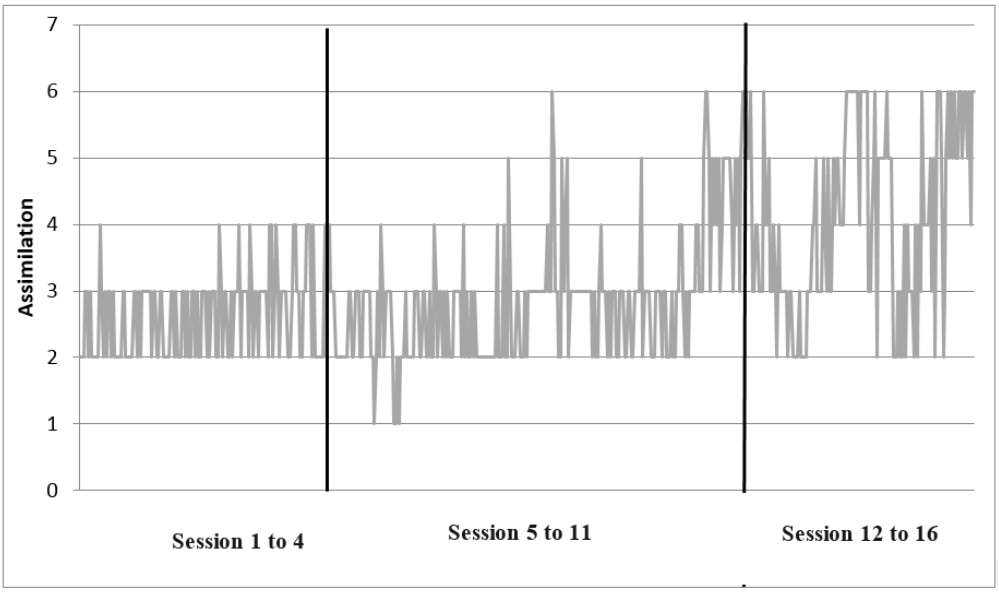

Figure 3. Assimilation process throughout sessions (554 passages) in the Alice's case.

When we analyzed the evolution of assimilation in Afonso's case, passage by passage, in each session and across therapy (Figure 4), it was possible to verify that low assimilation levels were maintained across therapy, ranging from APES level 0 to APES level 3.

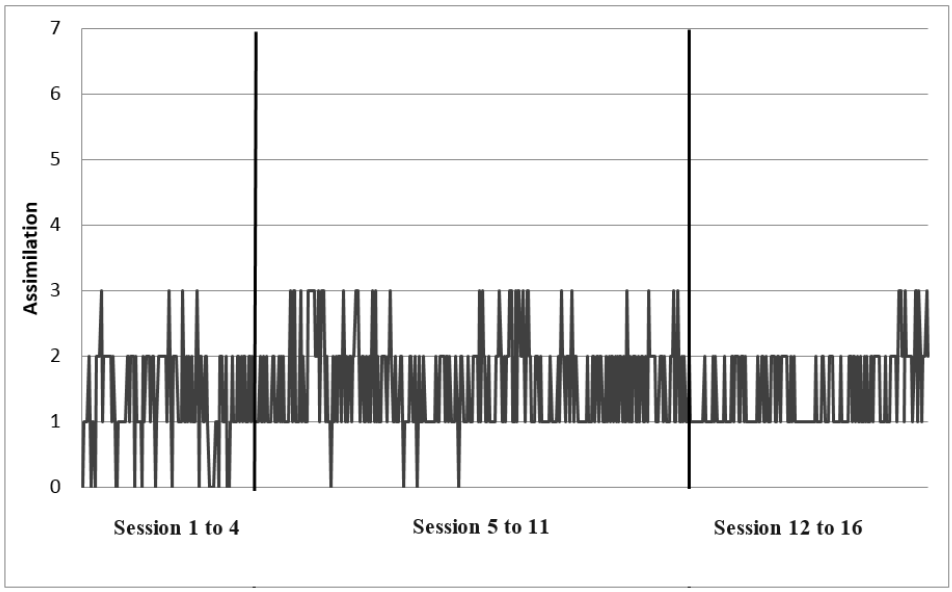

Figure 4. Assimilation process throughout sessions (681 passages) in the Afonso's case

Instability progress

As it was possible to observe in figure 3, in Alice's case, instability in the assimilation progress increased throughout therapy. Nevertheless, instability seemed to increase from the initial to the final phase of the therapeutic process, more evidently in the final phase of therapy (from session 12 to session 16) (Figure 3).

On the contrary, in Afonso's case, it was also possible to observe that instability in the assimilation progress was not very accentuated intra and inter session, maintaining a stable pattern across therapy, excepting in the final phase, where there was a slight decrease (Figure 4).

The results mentioned above as a microanalysis of the assimilation process (figure 3 and 4) were used to calculate a fluctuation measure (used to measure quantitively, for each session, the degree of instability). Each value of fluctuation represents the amplitude and the frequency of changes in the assimilation process for each session. Therefore, this fluctuation measure synthetizes the results mentioned in figure 3 and 4 and allows a comparison between cases in terms of instability in the assimilation progress. Figure 5 presents the evolution of instability in the assimilation progress, session by session, in both cases. When we compared both cases in terms of instability in the assimilation levels, it was possible to observe that they evolved very similarly from session 1 to session 11. From session 12 to the final session, in Alice's case, there was a gradual increase in the fluctuation measure. In Afonso's case there was a decrease from session 12 to session 14

and then an increase to the final session. Thus, the two cases assume different trajectories at the final phase of therapy.

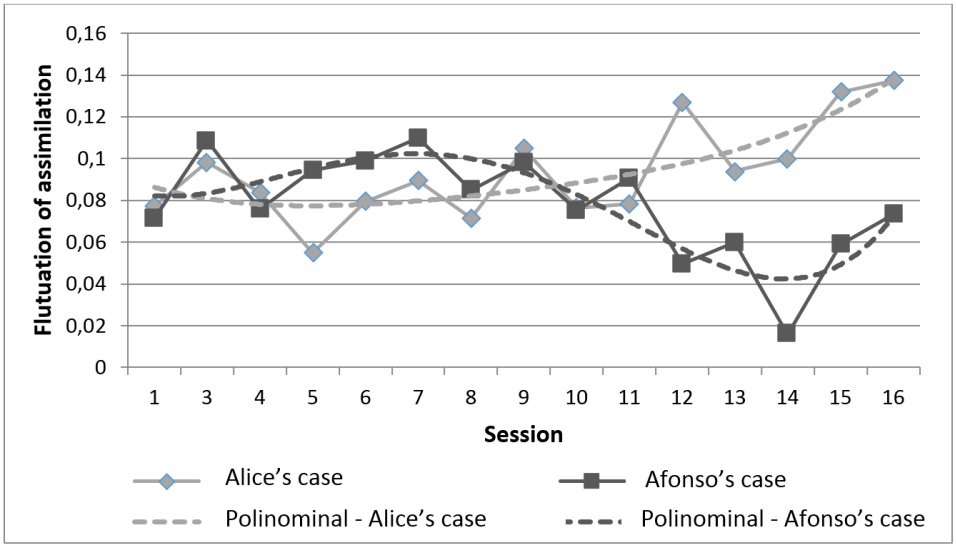

Figure 5. Comparison between Alice's and Afonso's case in terms of the evolution of fluctuation throughout therapy.

Comparison between the longitudinal results of the three variables (clinical symptoms, assimilation and fluctuation) of both cases

To allow and facilitate the comparison in the evolution of the three variables of each case we decided to present the results in two tables, one for Alice's case (table 5) and one for Afonso's case (Table 6).

In Alice's case (Table 4) it was possible to observe that clinical symptoms decreased in the initial phase of therapy (session 4), increased in the middle phase session 6) and then decreased again from session 13 to the final session. Assimilation and Fluctuation maintained the same values with some slight variations until session 11. After session 12 it is possible to observe a gradual increase in the assimilation and fluctuation values (with exception of session 13) until the end of therapy.

Table 4

Clinical symptoms, assimilation and fluctuation evolution throughout therapy in the Alice's case

Session	**S1**	**S2**	**S3**	**S4**	**S5**	**S6**	**S7**	**S8**	**S9**	**S10**	**S11**	**S12**	**S13**	**S14**	**S15**	**S16**
Symptoms	21	19	20	12	10	15	17	14	18	19	18	**16**	**8**	**6**	**6**	**7**
Assimilation	2.4	2.5	2.8	2.7	2.6	2.3	2.7	2.3	2.6	3.2	2.9	**4.7**	**3.2**	**4.6**	**3.6**	**5**
Fluctuation	.08	.08	.10	.08	.05	.08	.09	.07	.10	.08	.08	**.13**	**.09**	**.10**	**.13**	**.14**

In Afonso's case (table 5), the evolution pattern was relatively stable throughout therapy for the three variables, except for fluctuation that presented a slight decrease from session 11 to session 14.

Table 5

Clinical symptoms, assimilation and fluctuation evolution throughout therapy in the Afonso's case

Session	**S1**	**S3**	**S4**	**S5**	**S6**	**S7**	**S8**	**S9**	**S10**	**S11**	**S12**	**S13**	**S14**	**S15**	**S16**
Symptoms	22	20	27	24	21	23	25	24	22	24	26	22	20	21	25
Assimilation	1.4	1.5	1.1	1.7	1.7	1.7	1.4	2.0	1.5	1.5	1.3	1.4	1.1	1.5	1.9
Fluctuation	.07	.11	.08	.09	.10	.11	.08	.10	.08	.09	**.05**	**.06**	**.02**	**.06**	**.07**

Descriptive qualitative analysis of Assimilation and its Instability

Alice: Good outcome case

In the initial phase of therapy, negative feelings were very predominant. Alice felt stuck and confuse about expressing her needs to important people in her life. Probably, because giving voice to what she wanted could mean disapproval from others. This disapproval was associated with possible rejection. The entitlement of the problematic voice "I have the right to express myself and be accepted" was not very relevant in the beginning of therapy, but progressively became more salient. The presence of vulnerability related with possible rejection, the conflict between wants and shoulds and the progress towards the entitlement of the problematic voice could explain the fact that, in terms of instability, the setbacks to APES level 2 and the upgrades to APES level 3 were the most frequent. This implied that the setbacks were small in terms of extension. The following excerpt represents the assimilation progress and its fluctuation in the initial phase of the therapeutic process:

Alice: **[**But at the same time I felt once more, there was this pressure "so when will you decide to marry? ". We are always talking about it. In that Christmas, we spent a week in Paris and everyone thought he was going to propose. There is pressure from his family, there is pressure from both sides and he feels this pressure.

Therapist: what do you feel about this?

Alice: I feel pressure from my family and he feels that and it is complicated to manage this pressure. For example, I never know I never know what to say to my family - he knows this but he says 'forget it because I will not get married' but I didn't had the courage to say this to my parents. For instance, they do not know… they still do not know that he is atheist. I will have to choose the best time (laughter) and the best day to - to reveal this (crying) I do not know when and how

Therapist: Of course

Alice: They thought he was going to propose (crying). His cousin said "I always thought you would propose to her in this trip" and he said no.**]** (**APES 2- emergence**)

Therapist: **[**and how the two of you were feeling about these things?

Alice: I was feeling uncomfortable with the situation because I was feeling this pressure again. They were talking about an issue that is very delicate for us and I already know what his position in relation to the wedding is. He joked with this situation – but he is very shy- and he feels…

Therapist: always upset

Alice: It is obvious that he feels uncomfortable with this situation, but he remains silent: he won't say anything but then when I went away to the train he told me "I fell that you are not well" and I wasn't.

Therapist: of course

Alice: I felt sad to know that, probably, I will never have a day like that.**]** (**APES 2- emergence**) (session 2)

Progressively throughout therapy, Alice was able to assert her needs and took important life resolutions that were more congruent with her desires. However, setbacks in the assimilation progress were frequent. Higher assimilation levels were achieved but fluctuation between distinct assimilation levels became more frequent and pronounced. These setbacks could be related with Alice's ambivalence between taking important life decisions and putting them to practice, but at the same time, a strong fear of being rejected. The following excerpt is representative of the fluctuation pattern in the final phase of therapy:

Therapist: **[**what do you need right now Maria?

Alice: I need her to understand me and to be supportive and to not be cruel and accept my decision. This is what I need from her, to accept and to stop telling me that!

Therapist: and if she doesn't accept that?

Alice: if she doesn't accept…I am going to feel bad about myself…but she has to accept because…

Therapist: tell her… tell her that

Alice: you have to accept because I'm going to make that decision! You will have to get used to…. it´s better to accept, it is much better for me to accept because I'm going to make that decision and then, after I make that decision I will forget this and I'm not going to think about it anymore

Therapist: because I know what I want

Alice: because I know what I want and I'm not thinking about it anymore and I'm not going to think about it anymore!

Therapist: I have no doubts

Alice: I have no doubts and the little strength she has at this moment…that you have right now, it will disappear because I have made my decision, and this is the best for me.**]** (**APES 3 - clarification**)

Therapist: **[**how do you feel right now?

Alice: I feel good

Therapist: Do you feel stronger?

Alice: Yes, Yes. I try not to think about her much

Therapist: uh-huh and what does she wants to respond?

Alice: it’s not worth it

Therapist: it’s not worth it

Alice: it’s not worth it

Therapist: tell her that

Alice: I've already decided

Therapist: tell her that

Alice: it is not worth talking to me because I have made my decision and I've already made up my mind whether people accept my decision or not

Therapist: uh-huh. How are you feeling right now?

Alice: I am feeling good

Therapist: by letting her that?

Alice: Yes, I don't want to… I don't care about what she has to tell me.**]** (**APES 5 - application**) **[** because if I go back to that chair these thoughts are going to arise and she will gain strength. This is what I have been doing… to ignore… to not hear! I don't care! Because I know what I want and even though she's trying to change my opinion, to make sure I stay insecure and with doubts…**]** (**APES 4 - insight**)

Therapist: **[**I won't allow

Alice: I won't allow! I'm not I'm not going to allow that to happen to my decision and today was important! This day was important! And my decision is final

Therapist: You are at peace

Alice: Yes, I have found peace within myself regarding this.**]** (**APES 5 - application**) (session 14)

Afonso: Poor outcome case

Afonso began therapy aiming to cope with his emotional experiences. He felt this was the main cause of his depressive symptoms: not being able to experience emotions. He connected this difficulty with his childhood experiences relating the conflicting relation between his parents and how this contributed for feeling emotionally neglected. This cognitive understanding about his problem showed some level of contact with the problematic voice of vulnerability. However, throughout therapy, Afonso constantly avoided dealing with negative emotions, not allowing a complete immersion and connection with the problematic experience. In the initial phase of therapy, Afonso remained in lower assimilation levels, like APES 0, 1 and 2. In terms of fluctuation, the setbacks and the upgrades were limited in terms of extension, but frequent throughout sessions. The following excerpt is representative of the assimilation progress and its fluctuation in the initial phase of therapy:

Therapist: **[**You woke up this morning feeling a little bit…

Afonso: It can also be related with smoking and taking coffee first thing in the morning…It may not help… It may have something to do with that. I have tried other alternatives**]** (**APES 0 - Warded off**)

Therapist: **[**and you said that this uncomfortable sensation that appears in some situations is not new

Afonso: yes… I think I get more stress up or worried when family matters emerge and ah these are situations that I can hardly change or resolve but which normally I am asked to deal with…

Therapist: to take the initiative

Afonso: to take the initiative or to decide or to make changes. This is something that has been happening for many years…**] (APES 2 - emergence) [**For 15, 16 years 16. I have watched to those quarrels at night and… usually the quarrels were always at night. That was affecting me…I felt sad at that time and so what I did was to lock myself to somehow make me stronger

Therapist: ok you felt sad…worn…

Afonso: I was not going to deal with that…what was going on and probably I blocked myself… I'm blocked and maybe now I'm feeling the consequences of this in other aspects of my life

Therapist: other relationships

Afonso: other relationships exactly. I made this block and since then I hardly cry**] (APES 2- emergence)** (session 2)

In the final phase of therapy, avoidance became more frequent, and changes between assimilation levels were less frequent. Thus, fluctuation became even more limited in terms of extension and less frequent, especially in session 14. It seemed that Afonso was less available to explore and access his problematic experience of vulnerability. This could indicate a rigidification in community of voices with a consequent decrease in the dialogue between the dominant voice of the community and the problematic voice. For several times, Afonso's therapist tried to promote a connection with the problematic voice, but Afonso constantly avoided it, changing the topic of the conversation or not answering the therapist's questions. The following excerpt is representative of the assimilation progress and its fluctuation in the final phase of therapy:

Therapist: **[**How are you feeling with this?

Afonso: I've been well but it's a situation that…

Therapist: worries you…

Afonso: Yes and, no, because I don't know, because only when you are working, is when you have the right to criticize… But in my opinion, we should always have savings to use in these moments…

Therapist: in case of an emergency.

Afonso: Yes, in that case…

Therapist: So…

Afonso: on one hand I am… how should I say this? I don't push too hard and I don´t bother him because he said that it is not worth neither me nor my mother pushing him….but

he has problems with my mom because… When I was living with my mother in Switzerland, she had to provide me…. And then she said she would settle accounts with him, but it creates this sort of thing. I mean, my mother is a teacher, with a low salary and then she sees my father, an engineer and earning a good salary… and she doesn't understand how this happens.**] (APES 1- Avoidance)**

Therapist: **[**and how are you feeling with all of this?

Afonso: no, and also my mother can make some financial savings and my father is unable to do this… Isn't this strange?**] (APES 1 - Avoidance)**

Therapist: **[**and how do you feel? Concerning these two things?

Afonso: hm: I, I enjoyed visiting the Netherlands. They are very organized, very civilized too and they earn well. Things are more expensive but, it seemed like a good place to work**] (APES 1-Avoidance)** (Session 14)

Discussion

As expected, each case presented a different path of evolution in the three measured variables, more specifically, in the final phase of the therapeutic process.

Concerning the evolution of clinical symptoms, both cases departed from very similar symptomatic levels, but, throughout therapy, they presented different evolutions. Alice´s case presented a significant decrease in clinical symptoms from the beginning until the end of therapy. Although clinical symptoms decreased until the last session, the evolution pattern was irregular or non-linear. Afonso's case maintained a clinically significant level of symptoms until the final session.

Regarding the evolution of assimilation, both cases departed from different assimilation levels. Alice begun therapy with higher assimilation levels than Afonso. This difference was maintained across the therapeutic process since there was a positive evolution to higher assimilation levels in Alice's case. Still, in Alice's case, the pattern was discontinuous and irregular, more considerably in the final phase of therapy, with several intra and inter-session increases and decreases. In Afonso's case, the assimilation progress intra and inter-session was more stable, maintaining very similar assimilation levels across sessions. This contrasting assimilation evolution between the two cases could be partiality explained by this difference in the initial assimilation levels. Despite this, Alice's case presented a considerable evolution from the beginning to the final phase of therapy, achieving higher assimilation levels, like APES level 5 and 6. In Afonso's case, on the contrary, the assimilation progress was minimal. This finding adds support

to the idea that progressing in the assimilation continuum and achieving higher assimilation levels are associated with therapeutic success. These results seem to be congruent with previous studies (Caro Gabalda, 2006; 2007; 2008; Detert et al 2006), as the good outcome case achieved higher assimilation levels, namely assimilation levels equal or above APES 4, whereas the poor outcome case stayed below APES 4.

Concerning the instability in the assimilation process, the main difference between the two cases occurred after the middle phase of therapy. The assimilation progress intra-session was more irregular and discontinuous in Alice's case, but this difference only appeared from the middle to the final phase of the therapeutic process. In Alice's case, instability in the assimilation process increased from the middle to the final phase of therapy which could indicate that some aspects of the problematic experience were still being assimilated. As it was possible to observe in a more qualitative analysis of this case, the emergence of an important theme "hurt towards my father" at the final phase of therapy could explain the increase in fluctuation at this phase of the therapeutic process. The focus in problematic themes or strands of the problem less assimilated could explain the increase of setbacks and promote a more irregular assimilation pattern (Caro Gabalda & Stiles, 2013). Also, as it was possible to observe in a more qualitative analysis, the gradual integration of the problematic voice "I have the right to express myself and be accepted" in Alice's self gave her the strength to make important life decisions. Yet, making these decisions was a major challenge to her dominant voice "fear of being rejected". This ambivalence between feeling insecure in her decision-making because she did not know if everyone would approve what she wanted and her need to make her own decisions no matter what others would think could explain this instable pattern in the assimilation progress.

In Afonso's case, instability in the assimilation process remained the same pattern throughout therapy, with exception of a slight decrease from session 11 to session 14. The qualitative analysis of this case indicated that Afonso became progressively less collaborative throughout therapy suggesting that his dominant voice "I need to be strong" became more rigid, resulting in a strong avoidance of his problematic voice "I am vulnerable". Our hypothesis is that, in Afonso's case, the zone of proximal development was more restrict since he presented a clear need to avoid his problematic experience (as it was possible to depict through the presence of lower assimilation levels throughout the entire therapeutic process). Probably, in these situations, therapy can easily force the client far beyond his zone of progression. This might have created a counter-productive

effect because it might have promoted a greater rigidification of the community structure (Fisher et al, 2011). This rigidification could have further hinder the progression in the assimilation of problematic experiences, and consequently, it might have compromised the therapeutic change process.

The results from this study seem to be congruent with previous results suggesting that instability in the assimilation progress is a common feature (Caro Gabalda, 2006; Mendes et al., 2016). Moreover, the results from this study may amplify previous knowledge about this phenomenon since they suggest that instability can act as an indicator of the assimilation progression, especially in the middle phase of the assimilation continuum. As previous studies seem to indicate (Caro Gabalda, 2011), the ability to remain, more frequently, at higher assimilation levels, may help to consolidate the assimilation of problematic experiences. The fact that therapy is focused on these less assimilated subtopics may promote a more consolidated and generalized change (Caro Gabalda, 2011). Thus, the instable assimilation pattern may not only indicate that the client is more capable of staying in higher assimilation levels but may also suggest that less assimilated aspects of the problem are being worked through. At lower assimilation levels, although instability may indicate that fundamental aspects of the problematic experience are being worked through, it may be important to consider the client's zone of proximal development, since at lower levels it may be more restrict. Systemically exceeding the client's zone of proximal development may have an undesirable effect in the therapeutic change process, resulting in a stronger rigidification of the community of voices and in a decrease of the dialogue between the dominant and the problematic voices. In these clinical cases, it may be necessary for the therapist to have extreme caution in using therapeutic tasks focused on parts of the assimilation continuum for which the client is able to progress. If this does not occur, therapy can force the client far beyond his zone of progression and this may constrain the therapeutic change process. Although these results seem to be an important contribute to the validate import assumptions of the assimilation model it is an exploratory study with only two cases. More studies are needed to give empirical support to these findings.

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CAPÍTULO III: DISCUSSÃO GERAL

Ao longo das últimas décadas, tornou-se evidente e aceite que a psicoterapia é uma forma eficaz de tratamento para diferentes perturbações psicológicas e emocionais (Wampold & Imel, 2015). A investigação tem consecutivamente demonstrado que a psicoterapia apresenta um tamanho do efeito grande e significativo na redução dessas perturbações (Glass & Miller, 1980; Wampold & Imel, 2015). Mesmo quando comparada com a farmacoterapia, de uma forma geral, a psicoterapia revela-se igualmente eficaz na melhoria sintomática no final do tratamento (Cuijpers et al., 2013), e mais eficaz a longo-prazo (Hollon, Stewart, & Strunk, 2006). No entanto, pouco se sabe sobre como é que a psicoterapia é eficaz. Curiosamente, se um dos objetivos principais da investigação em psicoterapia é aumentar a eficácia clínica, dever-se-ia privilegiar uma compreensão mais aprofundada dos fenómenos ou processos que conduzem a melhores resultados terapêuticos (Llewelyn et al., 2016). A investigação de processo-resultado surgiu como forma de resposta a esta lacuna e tem contribuído, ao longo dos últimos anos, para aprofundar o conhecimento sobre os fenómenos cognitivos, emocionais, interpessoais e comportamentais relacionados com o resultado terapêutico e a mudança clínica (Llewelyn et al., 2016).

A presente dissertação enquadra-se na investigação de processo-resultado, e teve como objetivo primordial apoiar e alargar o conhecimento existente sobre os processos envolvidos na mudança psicoterapêutica. É importante referir que o presente trabalho se insere numa perspetiva de estudo “theory building”, o que significa que através da análise exaustiva de casos clínicos se pretendeu informar e corroborar a teoria pé-existente, ou modificá-la e transformá-la, com o objetivo de promover o seu refinamento (Stiles, 2007).

1. Síntese e discussão integrada dos principais resultados

O primeiro estudo teve como objetivo central efetuar uma síntese sobre o estado atual da investigação sobre os processos de mudança em psicoterapia. Tal como já foi referido na introdução desta dissertação, os processos mais amplamente estudados no âmbito da investigação de processo-resultado são os denominados fatores comuns, ou seja, os processos ou fenómenos transversais aos diferentes modelos psicoterapêuticos. No entanto, seria de esperar que diferentes modelos psicoterapêuticos, com enfoques teóricos e práticos diversos, alimentassem processos de mudança distintos. Assim, o primeiro estudo pretendeu analisar se os resultados obtidos por cada modelo

psicoterapêutico são promovidos pelos processos que, supostamente, esse mesmo tratamento promove. Mais concretamente, pretendeu-se analisar o papel mediador dos processos cognitivos e emocionais na mudança clínica, ao longo do tratamento. A revisão teórica efetuada dos diferentes estudos sobre os processos emocionais e cognitivos parece corroborar o papel medidor dos referidos mecanismos para a mudança terapêutica. No entanto, parece não existir uma associação entre a especificidade dos mecanismos e o tipo de psicoterapia que, teoricamente, os promove. Ou seja, as terapias parecem promover mudança simultânea nos diferentes processos, cognitivos e emocionais, mesmo quando um dos tratamentos é a farmacoterapia (Garratt, et al., 2007). Uma hipótese explicativa que poderá apoiar a compreensão destes resultados está relacionada com a existência de limitações metodológicas numa parte significativa dos estudos analisados, mais especificamente, em relação ao tamanho da amostra (Crist-Cristophe et al., 2013). O facto de as amostras apresentarem um *N* reduzido poderá ter comprometido a capacidade da análise estatística para encontrar diferenças significativas entre as terapias, apoiando de forma falaciosa a perspetiva de que não há diferenças entre os modelos psicoterapêuticos em relação à mudança promovida pelos mecanismos cognitivos e emocionais. No entanto, poderá existir uma outra hipótese explicativa para estes resultados. Esta segunda hipótese relaciona-se com a perspetiva teórica e empírica amplamente adotada nos estudos sobre os processos de mudança. O enfoque teórico e empírico, na maioria dos estudos, parece ter como base um modelo linear e restritivo sobre o funcionamento intrapsíquico, e consequentemente, sobre a mudança terapêutica. Assim, os fenómenos psicológicos parecem ser perspetivados e medidos através de uma lógica simplista e reducionista, o que, por sua vez, dificulta uma compreensão mais abrangente do aparelho intrapsíquico e da mudança psicológica. Esta perspetiva não contempla a complexidade da interconexão entre os diferentes mecanismos e processos psicológicos num todo que se auto-organiza numa identidade pessoal e que vive em constante interligação com o mundo que o rodeia. Nesta perpectiva, os diferentes processos psicológicos encontram-se interligados sendo que a mudança num dos processos implica a mudança nos restantes (ex: mudanças ao nível das nossas cognições/pensamentos implicam mudanças na nossa experiência emocional, e vice-versa). Em suma, uma das principais conclusões do primeiro estudo desta dissertação diz respeito à necessidade de adotar um modelo de mudança terapêutica que incorpore esta perspetiva mais integradora e abrangente dos diferentes processos psicológicos envolvidos na mudança em psicoterapia.

O facto de os resultados do estudo 1 não permitirem confirmar a associação entre os fatores específicos e as terapias que supostamente os suscitam reforça ainda mais a necessidade de se estudarem modelos transteóricos, como o modelo de assimilação.

O modelo de assimilação tem uma perspetiva integradora e abrangente sobre o processo de mudança terapêutica, e sobre o próprio funcionamento intrapsíquico. Tal como referido no capítulo introdutório, para os autores deste modelo (Stiles, 1990), o processo de mudança terapêutica ocorre através de um processo progressivo e gradual de assimilação de experiências problemáticas no *self*. Para os clientes alcançarem mudanças clinicamente significativas, é necessário que reconheçam, reformulem, compreendam e integrem as experiências problemáticas que lhes causam sofrimento (Stiles, 1990). A assimilação de experiências problemáticas envolve a mudança gradual e progressiva dos processos cognitivos, emocionais, comportamentais, entre outros, associados não só à experiência problemática, mas também à estrutura do *self* (também denominada de comunidade de vozes; Honos-Webb & Stiles 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999). Estudos prévios verificaram que os casos de sucesso terapêutico, conseguem usualmente uma mudança mais profunda nesses processos, i.e., atingem níveis mais elevados de assimilação do que os casos de insucesso (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; Osatuke et al., 2007; Ribeiro, Braga et al., 2016; Ribeiro, Cunha et al., 2016). No entanto, uma parte significativa destes estudos utiliza metodologia qualitativa de análise de dados. Assim, o segundo estudo surge como uma tentativa de complementar os resultados obtidos em estudos prévios, propondo uma análise quantitativa e longitudinal da relação da assimilação de experiências problemáticas com dois processos que, teoricamente, se encontram associados: a sintomatologia clínica e a valência emocional. Mais concretamente no que concerne à relação da assimilação e da valência emocional, pretendeu-se verificar se a evolução da assimilação da experiência problemática seria acompanhada por mudanças na valência emocional dessa mesma experiência. Por outras palavras, pretendeu-se verificar se a evolução para um maior contacto com a experiência problemática,que ocorre do nível de assimilação 0 (evitamento da experiência problemática) para o 2 (consciência vaga da experiência problemática) estaria associado à emergência progressiva de emoções mais negativas e se a posterior clarificação e integração da experiência,que ocorre a partir do

nível 3 de assimilação (clarificação) estaria associada à emergência progressiva de emoções mais positivas. Assim, pretendeu-se contribuir para a validação empírica de pressupostos importantes do modelo de assimilação. A análise foi realizada, sessão a sessão, num caso de sucesso em Terapia Cognitivo-Comportamental. Os resultados do estudo parecem apoiar a perspetiva de que a mudança clínica ocorre através da assimilação progressiva de experiências problemáticas. O caso em estudo evoluiu, ao longo das sessões terapêuticas, para níveis progressivamente mais elevados de assimilação. Este progresso na assimilação ocorreu de forma irregular, ou seja, com retrocessos a níveis mais baixos de assimilação. Contudo, estes retrocessos parecem ter progressivamente diminuído ao longo do processo terapêutico. Foi também possível verificar a existência de uma relação negativa e estatisticamente significativa entre os sintomas clínicosmedidos pela escala de avaliação de resultados-OQ-10 e pela escala de Beck para a depressão- BDI-II) e a assimilação de experiências problemáticas (medida pela escala de assimilação de experiências problemáticas – APES). Verificou-se também a existência de um padrão similar entre a curva teórica do afeto e os resultados do caso analisado. Os resultados deste estudo parecem, não só, validar as observações de estudos prévios (Detert et al., 2006), no que se refere à relação entre a assimilação com os sintomas clínicos, como ainda contribuir para compreender como esta relação ocorre longitudinalmente, ou seja, sessão a sessão. O facto de a relação entre a assimilação e a sintomatologia clínica ser negativa, apesar da presença de retrocessos no progresso da assimilação, fez-nos refletir sobre o possível papel destes mesmos retrocessos para a mudança clínica. Mudar a atenção para aspetos do problema menos assimilados pode contribuir para a existência de retrocessos, mas também para uma assimilação do problema mais completa e sólida (Caro Gabalda & Stiles, 2013). É importante referir que os dados obtidos através do segundo estudo não nos permitiram responder a esta questão, mas apenas refletir sobre uma possível hipótese explicativa para a mesma. Assim, no que diz respeito à relação entre a assimilação e a valência emocional, os resultados do segundo estudo parecem reforçar a importância de os clientes entrarem em contacto com os problemas para os conseguirem resolver. Assim, quando existem problemas evitados ou reprimidos, o contacto progressivo e mais próximo com o problema, promovido pela terapia, poderá estar interligado com a emergência de emoções mais negativas. Consequentemente, a posterior clarificação e compreensão do problema poderá estar conectada com a emergência de emoções mais positivas. Este resultado parece ir ao encontro da premissa defendida por Varvin e Stiles (1999) de que, para resolvermos

problemas evitados, pode ser necessário nos sentirmos pior antes de nos sentirmos melhor. Tal como já foi referido, os resultados do estudo 2 parecem apoiar a perspetiva do modelo de assimilação em relação à mudança terapêutica. Em suma, a assimilação de experiências problemáticas parece ser um processo psicoterapêutico relevante visto se encontrar associado, ao longo da terapia, à mudança sintomática e emocional.

Sendo o segundo estudo baseado na análise intensiva de um caso clínico, os resultados obtidos podem dever-se a características específicas desse mesmo caso. Neste sentido, pareceu-nos importante verificar a relação entre a assimilação e a sintomatologia clínica numa amostra de casos clínicos. Assim, no terceiro estudo, decidiu-se utilizar uma amostra de 22 casos clínicos em Terapia Cognitivo-Comportamental e Terapia Focada nas Emoções diagnosticados com perturbação depressiva *major*. O objetivo deste estudo foi testar a consistência dos resultados encontrados no estudo anterior a partir de um único caso, utilizando uma amostra de casos clínicos para investigar a existência de uma relação preditiva entre a assimilação das experiências problemáticas e a sintomatologia clínica e a direção dessa relação. Assim sendo, os objetivos do terceiro estudo foram verificar se (1) o aumento da assimilação prediz a diminuição da sintomatologia clínica, ou, se pelo contrário, (2) a diminuição da sintomatologia clínica prediz o aumento na assimilação de experiências problemáticas. Para efetuar a referida análise, utilizaram-se modelos lineares hierárquicos (HLM) com o intuito de perceber se o nível médio de assimilação predizia a intensidade na sintomatologia clínica da sessão seguinte, e/ou o inverso, ou seja, se a intensidade na sintomatologia clínica predizia o nível médio de assimilação da sessão seguinte. Os resultados deste estudo confirmaram as hipóteses teóricas, ou seja, o progresso da assimilação ao longo das sessões previu a diminuição da intensidade na sintomatologia clínica. O inverso não se verificou, i.e., a mudança na sintomatologia não foi preditor significativo do nível de assimilação atingido na sessão seguinte. Estes resultados validam a perspetiva de que a assimilação de experiências problemáticas é um processo importante para a mudança clínica, visto que precede e parece influenciar, ao longo das sessões, a diminuição na sintomatologia clínica. É também importante realçar que não se verificaram diferenças significativas no progresso da assimilação, entre as terapias em análise (Terapia Cognitivo-Comportamental e Terapia Focada nas Emoções). Tal como estudos anteriores haviam verificado (e.g. Osatuke et al., 2005), o presente estudo valida a perspetiva da assimilação das experiências problemáticas como um

processo transteórico, ou seja, que ocorre independente do modelo psicoterapêutico utilizado.

De uma forma geral, os resultados do terceiro estudo validaram e ampliaram a evidência empírica já encontrada em estudos anteriores. Mais concretamente, tal como no estudo de Detert e colaboradores (2006), todos os casos de sucesso atingiram o nível 4 de assimilação (compreensão). No presente estudo verificou-se ainda que a maioria dos casos que não alcançaram níveis subclínicos de sintomatologia, mas que apresentaram um decréscimo significativo nos sintomas clínicos, também atingiram o nível 4 de assimilação (compreensão da experiência problemática). Este resultado diverge dos resultados obtidos em estudos prévios, onde apenas os casos de sucesso atingiram o nível 4 de assimilação (Detert et al., 2006). No entanto, é de referir que este estudo se baseou num protocolo de intervenção mais longo do que os utilizados em estudos anteriores (Detert et al., 2006). Nesse sentido, no presente estudo foi possível analisar a evolução da relação entre variáveis de forma mais sistemática, ao longo do tempo, possibilitando a observação de fenómenos menos frequentes, nomeadamente os casos de insucesso atingirem níveis mais elevados de assimilação, de forma pontual. Este resultado pode também indicar que a APES poderá ser capaz de captar mudança clínicas mais micro que podem não ser detetadas através de medidas sintomáticas (medidas de auto-relato). Assim, poderá ser importante utilizar a APES com o intuito de detetar micro-mudanças, momento a momento, ao longo do processo terapêutico, e que sendo exploradas e integradas, poderão contribuir para uma maior compreensão e solidificação dos conhecimentos sobre a mudança terapêutica.

Resumidamente, o terceiro estudo veio colmatar algumas das fragilidades detetadas em estudos anteriores e ampliar a evidência empírica relativa à relação entre a assimilação de experiências problemáticas e o resultado terapêutico. Mais concretamente os resultados do terceiro estudo parecem sugerir que o progresso na assimilação antecede e prevê o decréscimo na sintomatologia clínica, ao longo das sessões terapêuticas (e não apenas no final da terapia). Obviamente, e muito devido aos constrangimentos inerentes ao processo de codificação, algumas limitações podem ser apontadas a este estudo, nomeadamente, a utilização de uma amostra pequena e demasiado homogénea, o que constrange a possibilidade de generalização dos resultados. A utilização de amostras mais heterógenas, i.e., de população clínica em contexto real de atendimento, permitirá

aumentar a validade ecológica dos resultados e perceber se esses são transponíveis para a população em geral.

Ao analisar o processo de assimilação de experiências problemáticas dos diferentes casos clínicos foi possível verificar a existência de irregularidade na progressão da assimilação, quer dentro das sessões, quer ao longo do processo terapêutico. Este progresso irregular, que estudos anteriores denominaram de retrocessos (Caro Gabalda & Stiles, 2013), deve-se à existência de avanços e recuos durante o processo de integração de experiências problemáticas. A perspetiva teórica do modelo de assimilação sobre o processo de mudança parece salientar a importância da instabilidade na mudança (Stiles, 2011). A mudança clínica parece estar dependente da instabilidade promovida pela intrusão da voz problemática na estrutura prévia de vozes do *self* (comunidade de vozes), normalmente caracterizada como inflexível ou rígida. Esta instabilidade poderá conduzir à sua reorganização e posterior integração da voz problemática. Estudos anteriores têm tentado caraterizar este fenómeno, estudando a forma como este ocorre durante o progresso da assimilação. Os resultados destes estudos permitiram verificar que os retrocessos são um fenómeno comum no progresso da assimilação, ocorrendo tanto em casos de sucesso como de insucesso, bem como em diferentes modelos psicoterapêuticos (Caro Gabalda, 2006; Mendes et al., 2016). No entanto, pouco ainda se conhece sobre o seu contributo para o resultado terapêutico.

A Teoria dos Sistemas Dinâmicos sugere que a instabilidade pode desempenhar um papel de relevo nos processos de mudança humana (Fisher et al., 2011). Nesta perspetiva, a psicopatologia encontra-se comummente associada a processos de rigidificação e inflexibilidade das estruturas de funcionamento intrapsíquico e interpessoal, o que por sua vez condiciona a capacidade de adaptação do *self* aos diferentes *inputs* recebidos através da relação com o mundo exterior (Fisher et al., 2011). Desta forma, do ponto de vista da Teoria dos Sistemas Dinâmicos, para existir mudança significativa, seria necessária a introdução de instabilidade no funcionamento das estruturas prévias, de forma a permitir uma reorganização do sistema mais adaptativa e flexível (Fisher et al., 2011). Diferentes estudos, dentro da perspetiva dos sistemas dinâmicos, verificaram que a instabilidade pode ter impacto no resultado terapêutico (Ebner-Priemer, Eid, Kleindienst, Trull, & Stabenow, 2009; Hayes et al., 2007; Gumz et al., 2010; Kowalik et al., 1997; Schiepek, 2009; Schiepek et al.,1997, 2009, 2010, 2013, 2014). Neste sentido, partindo da evidência empírica existente relativamente à

importância da instabilidade para o resultado terapêutico, pareceu-nos relevante estudar qual o impacto dos retrocessos (ou instabilidade) no processo de assimilação, quer para o próprio progresso da assimilação e quer para o resultado terapêutico. De forma a medir a instabilidade no processo de assimilação, utilizou-se uma medida que permite quantificar a amplitude e a frequência dos retrocessos nos níveis de assimilação (Schiepek & Strunk, 2010). No estudo 4 efetuou-se uma análise exploratória da relação entre os níveis de flutuação na assimilação, o progresso na assimilação e a intensidade na sintomatologia clínica intra e inter sessões, num caso de sucesso em Terapia Focada nas Emoções. Utilizou-se a análise de equações estruturais para explorar a relação entre as referidas variáveis. Os resultados permitiram verificar a existência de uma relação negativa entre a assimilação e os sintomas clínicos (medidos através da escala de avaliação de resultados-OQ-10), tanto na própria sessão, como na sessão seguinte. Estes resultados parecem apoiar os resultados obtidos em estudos prévios, que apontam para a existência de uma relação preditiva e negativa entre a assimilação e a sintomatologia clínica (Basto, Stiles, Rijo, & Salgado, 2018). No que diz respeito à relação entre a flutuação na assimilação e o seu progresso, foi possível verificar a existência de uma relação positiva entre a flutuação na assimilação e o seu progresso, o que parece dar alguma indicação sobre a importância da instabilidade para o aumento da assimilação das experiências problemáticas. Os avanços e recuos na assimilação das experiências problemáticas podem contribuir para a sua progressão para níveis mais elevados, tal como esperado teoricamente. Tal como os próprios autores do modelo referem (Stiles, 2011), o contacto da voz problemática com a comunidade de vozes conduzirá à emergência de disrupção, conflito e instabilidade, o que por sua vez, poderá promover a ocorrências de modificações significativas na estrutura da comunidade de vozes do *self* e da própria voz problemática. No entanto, contrariamente ao esperado, não se verificou a existência de uma relação entre a flutuação na assimilação e a sintomatologia clínica, quer intra, quer inter sessão, sendo necessário refletir possíveis hipóteses explicativas para estes resultados. Uma das possíveis explicações para este último resultado relaciona-se com o facto de o potencial de destabilização poder ser maior quanto maior for a rigidicação da estrutura de vozes, i.e., em níveis mais baixos de assimilação (nível de assimilação 0 e 1), onde a voz problemática é rejeitada. O caso clínico analisado inicia o processo terapêutico em níveis mais elevados de assimilação onde, possivelmente, a estrutura prévia da comunidade de vozes, devido aos sucessivos contatos com a voz problemática, já se encontra mais permeável a novos *inputs*, ou seja, mais flexível. Assim sendo, o potencial

de destabilização poderá ser menor, podendo influenciar a relação entre a instabilidade na assimilação e a sintomatologia clínica. Outra hipótese, e que poderá ser perspetivada como uma limitação do estudo, relaciona-se com o facto de ter sido analisada a relação entre a instabilidade na assimilação e a sintomatologia na própria sessão, ou na sessão seguinte, e em múltiplas sessões. No entanto, os estudos prévios dentro da teoria dos sistemas dinâmicos relacionaram a instabilidade ao longo do processo terapêutico com o resultado terapêutico final. Estas diferenças no *design* de investigação poderão ter originado resultados dissonantes com a investigação anterior. Assim sendo, o que os resultados deste estudo indicam é que, pelo menos neste caso clínico, parece não existir uma relação sequencial entre as variáveis. No entanto, tal não significa que a ocorrência de instabilidade no processo de assimilação, numa determinada fase da terapia, não influencie o resultado terapêutico final. Mais estudos serão necessários para verificar esta hipótese.

No seguimento do quarto estudo, pareceu-nos relevante efetuar um novo estudo (estudo 5) com o objetivo de comparar a evolução do progresso da assimilação, da instabilidade na assimilação e da intensidade da sintomatologia clínica em dois casos contrastantes, um caso de sucesso e um caso de insucesso terapêutico em Terapia Focada nas Emoções. No estudo 5 (tal como já havia sido efetuado no estudo 4), de forma a medir quantitativamente a instabilidade no processo de assimilação, utilizou-se uma medida de flutuação que quantifica a amplitude e a frequência das mudanças nos níveis de assimilação (Schiepek & Strunk, 2010). A análise dos resultados permitiu verificar que os casos evoluíram de forma distinta ao longo da terapia, principalmente em relação à evolução da assimilação de experiências problemáticas e à instabilidade no seu progresso. Em relação à evolução da assimilação, foi possível verificar que o caso de sucesso progrediu positivamente ao longo da terapia. O caso de insucesso não apresentou uma evolução semelhante, visto que o progresso da assimilação se mostrou mais estável intra e inter sessão. Os resultados deste estudo são congruentes com os resultados já obtidos em estudos anteriores, contribuindo para validar a perspetiva sobre a mudança terapêutica como ocorrendo através do processo de assimilação de experiências problemáticas (Basto, et al., 2018). No que se refere à instabilidade no processo de assimilação, os casos clínicos evoluiram de forma similar até à fase intermédia. A partir desta fase do processo terapêutico, o caso de sucesso aumentou o nível de instabilidade na assimilação, enquanto o caso de insucesso diminuiu. É de realçar que, no caso de sucesso, a sintomatologia

clínica e a assimilação também parecem aumentar a partir desta fase, enquanto no caso de insucesso se mantêm relativamente estáveis.

As diferenças existentes no padrão de progressão das três variáveis em análise suscitam algumas considerações. O facto do nível de instabilidade não se alterar até à fase intermédia do processo terapêutico em ambos os casos, parece sugerir que nos níveis mais baixos e intermédios de assimilação, a zona de desenvolvimento proximal do cliente poderá ser mais restrita, resultando em níveis mais baixos de instabilidade. Quando o cliente atinge níveis mais elevados (a partir da fase intermédia até à final) a instabilidade aumenta, indicando provavelmente uma maior permeabilidade da comunidade de vozes ao contacto com a voz problemática e, consequentemente à existência de uma zona de desenvolvimento proximal mais ampla. Mais ainda, durante esta fase mais avançada do processo de assimilação, as tentativas de colocar em prática as novas compreensões obtidas em terapia sobre o problema podem ser desafiantes e assustadores para o cliente, originando uma série de avanços e recuos na progressão da terapia. Nesta fase do processo, também podem surgir subvozes ou partes do problema com diferentes níveis de assimilação. Neste sentido, focar a atenção em aspetos do problema menos assimilados pode promover o aparecimento de maior instabilidade (Mendes et al., 2016). Assim, a existência de maior instabilidade, no caso de sucesso, na fase final do processo terapêutico, poderá significar que a experiência problemática ainda não se encontra totalmente assimilada e, portanto, ainda se encontra numa fase ativa do processo de mudança. Nesta perspetiva, será expectável a partir do momento em que a experiência problemática se encontre totalmente assimilada, a instabilidade diminua, permitindo o retorno a um estado de maior homeostasia e posterior estabilização da estrutura que compõe a comunidade de vozes. No caso de insucesso, da fase intermédia para a fase final, a instabilidade no processo de assimilação parece diminuir. Tal resultado parece sugerir que, apesar da voz problemática ter emergido em alguns momentos do processo terapêutico de forma mais evidente, o conflito que emergiu pelo contacto entre as diferentes vozes não foi suficiente para promover a sua integração na comunidade de vozes do *self*. Consequentemente, parece ter ocorrido uma rigidificação da comunidade de vozes e um retorno a um estado de funcionamento prévio (Fisher et al., 2011). Uma hipótese explicativa para não ter ocorrido mudança terapêutica neste caso pode estar relacionada com o facto de a instabilidade promovida pela terapia não ter sido suficiente para promover a emergência de níveis mais elevados de assimilação, o que teria sido

importante para promover um maior contato com a voz problemática e uma maior clarificação da mesma, visto que o cliente se encontrava em níveis muito baixos de assimilação. Tal como já foi referido, é possível que em níveis mais baixos de assimilação, a zona de desenvolvimento proximal, ou seja, o potencial de progressão do cliente seja menor. Nestes casos, pode ser necessário ter extrema cautela em dirigir as tarefas terapêuticas para níveis de assimilação para os quais o cliente esteja capaz de progredir. Caso isto não ocorra, a terapia pode forçar o cliente para níveis muito fora da sua zona de progressão, podendo ocorrer um efeito perverso, ou seja, uma maior rigidificação da organização da comunidade de vozes. Esta rigidificação pode dificultar ainda mais a progressão na assimilação das experiências problemáticas, e consequentemente, comprometer o processo de mudança terapêutica. Os resultados do estudo 5 parecem, assim, ser congruentes com os resultados de estudos prévios que descrevem a presença de instabilidade no progresso da assimilação como um fenómeno comum (Caro Gabalda, 2006; Mendes et al., 2016). Mais ainda, parecem ampliar os resultados obtidos no estudo 4, já que sugerem que a instabilidade pode funcionar como um indicador de progressão da assimilação e posterior solidificação da mudança, principalmente a partir da fase intermédia da terapia. Tal como os estudos prévios parecem indicar (Caro Gabalda, 2011), a capacidade de permanecer, com maior frequência, em níveis mais elevados de assimilação, poderá promover uma assimilação mais eficaz e generalizada das experiências problemáticas. Os retrocessos, por norma, evidenciam a presença de subtópicos menos assimilados. O facto de a terapia promover o foco nestes mesmos subtópicos poderá promover uma mudança mais consolidada e generalizada (Caro & Stiles, 2013). Assim, o padrão de avanços e recuos poderá indicar, não só, que o cliente está mais capaz de permanecer em níveis mais elevados de assimilação, mas também que aspetos menos assimilados do problema estão a ser trabalhados. Em níveis de assimilação mais baixos, apesar de a instabilidade poder indicar que estão a ser trabalhados aspetos fundamentais da experiência problemática de forma sistemática e que esse trabalho poderá promover a sua clarificação e posterior assimilação, é necessário ter em consideração que a zona de desenvolvimento proximal do cliente poderá ser restrita e que excedê-la, de forma sistemática, poderá ter um efeito inverso ao que seria pretendido. Nomeadamente, poder-se-á promover uma maior rigificação da comunidade de vozes, diminuindo assim o potencial de progressão para níveis mais elevados de assimilação e, consequentemente, minimizando a probabilidade de mudança terapêutica significativa. É importante referir que os resultados do quinto

estudo partem da análise de dois casos clínicos, o que limita a possibilidade de generalizar os resultados obtidos. No entanto, inserindo-se a presente investigação numa perspetiva de estudo "*theory building*", os dados obtidos através da análise aprofundada de casos clínicos podem servir para informar a teoria, enriquecendo-a ou transformando-a (Stiles, 2007).

2. Limitações

É importante referir que existiram limitações que podem condicionar as elações retiradas dos presentes estudos. Uma limitação fundamental está relacionada com a natureza e o tamanho das amostras utilizadas. A utilização de amostras reduzidas ou de estudos de caso dificultam a possibilidade de generalizar os resultados encontrados. Desta forma, em futuros estudos seria importante analisar um maior número de casos. É importante salientar que o processo de codificação da assimilação é moroso e dependente de acordo entre juízes. Obviamente que a opção por este procedimento de análise mais qualitativa dos dados tem as suas vantagens, nomeadamente, aceder com maior profundidade e riqueza aos micro-processos que ocorrem ao longo do processo terapêutico. No entanto, em futuros estudos, e com o objetivo de aceder a uma amostra maior de casos, poderá ser importante privilegiar uma análise mais geral e menos sistemática, o que permitirá analisar mais casos num menor espaço de tempo. A utilização de uma medida observacional, sem recurso a transcrição e que permita obter um valor médio geral de assimilação para cada sessão, poderá ser uma ferramenta importante a desenvolver no futuro. Analisar mais casos irá conceder maior robustez estatística à análise de dados, o que permitirá responder a algumas questões importantes, nomeadamente, qual o efeito do terapeuta no progresso da assimilação. Um outro aspeto importante a ser referido está relacionado com as medidas de sintomatologia utilizadas. Parece-nos que poderá ser importante utilizar medidas mais extensas e que avaliem, de forma mais diversificada, a sintomatologia clínica apresentada pelo cliente. Na verdade, no presente trabalho privilegiou-se a utilização de instrumentos mais breves, por questões de conveniência no acesso a uma amostra já recolhida no âmbito do ensaio clínico "Descentração e Mudança em Psicoterapia". No entanto, em futuros estudos poderá ser importante, utilizar instrumentos que avaliem a sintomatologia clínica de forma mais extensa e diversificada. É ainda importante realçar que a utilização de uma amostra já recolhida no âmbito de um ensaio clínico, apesar de ter trazido inúmeras vantagens para

o presente trabalho, diminuiu a possibilidade de generalização dos resultados obtidos, devido às caraterísticas mais restritivas da amostra, em termos de diagnóstico, caraterísticas socio-demográficas, motivação para o processo terapêutico. Neste sentido, em futuros estudos, poderá ser importante replicar os estudos efetuados em amostras clínicas recolhidas em contextos de prática de rotina.

3. Conclusão

De uma forma geral, os resultados da presente tese contribuíram para validar a perspetiva de que a mudança terapêutica ocorre através de processos psicológicos abrangentes e complexos. Tal como as conclusões do primeiro estudo parecem indicar, apesar dos diferentes modelos terapêuticos focarem a sua intervenção em processos psicológicos específicos do funcionamento intra e interpessoal, a mudança parece ocorrer de forma semelhante nas várias abordagens. Assim, parece importante perceber o processo de mudança em psicoterapia de uma forma menos restritiva, adotando uma perspetiva integradora.

Os resultados da presente tese contribuíram para validar a perspetiva teórica do Modelo de Assimilação das Experiências Problemáticas sobre a mudança terapêutica, apoiando pressupostos importantes do referido modelo e reforçando a sua perspetiva integradora e abrangente dos diferentes processos psicológicos envolvidos na mudança em psicoterapia. Um dos pressupostos mais relevantes do Modelo de Assimilação refere-se à associação entre a assimilação de experiências problemáticas e o sucesso terapêutico. Os resultados da presente tese apoiaram empiricamente esta premissa, reforçando a perspetiva de que a mudança terapêutica, nomeadamente a mudança sintomática, poderá ser promovida pela assimilação das experiências problemáticas. Mais ainda, a presente tese parece indicar que a assimilação de experiências problemáticas não é apenas um *output* ou resultado da terapia, mas sim, um processo que ocorre ao longo das sessões e que poderá ter uma interferência direta na redução dos sintomas clínicos.

É também importante salientar que os presentes resultados parecem corroborar a perspetiva de que a assimilação de experiências problemáticas é um processo transversal e transteórico visto que ocorre de forma similar, em diferentes modelos terapêuticos. Assim, independentemente do modelo terapêutico utilizado, ou das estratégias adotadas, a assimilação de experiências problemáticas parece progredir de forma similar e parece estar associada ao sucesso terapêutico. Neste sentido, os presentes resultados reforçam a perspetiva da assimilação de experiências problemáticas como um processo abrangente e que traduz mudanças transversais ao nível do funcionamento cognitivo, emocional, comportamental ou interpessoal. Mais concretamente, no que se refere à relação entre a assimilação das experiências problemáticas e experiência emocional, a presente tese parece validar empiricamente a relação teoricamente prevista entre os diferentes níveis

de assimilação e a experiência de emoções com diferentes valências. Este resultado parece evidenciar e validar empiricamente pressupostos teóricos importantes do modelo de assimilação, nomeadamente a relação entre o contacto inicial com a experiência problemática e a emergência de emoções mais negativas e a relação entre a clarificação, compreensão e posterior assimilação das respetivas experiências problemáticas e a emergência de emoções mais positivas. A validação desta associação entre a assimilação e a valência emocional parece evidenciar a importância de contactar com aspetos evitados das experiências problemáticas, apesar de esse contacto causar emoções negativas. Assim, antes de se sentirem melhores, os clientes poderão ter que passar por uma fase em que se sentem pior, por contactarem com as experiências problemáticas dolorosas e previamente evitadas (Varvin & Stiles, 1999).

É ainda importante salientar que os resultados da presente tese parecem salientar e consolidar a perspetiva de que o processo de assimilação é irregular e descontínuo. No entanto, é importante salientar que os resultados da presente tese não permitiram confirmar a relação esperada entre a instabilidade no processo de assimilação e a mudança nos sintomas clínicos. Uma hipótese explicativa para este resultado poderá ser o facto de a instabilidade poder ser relevante em momentos específicos do processo terapêutico, nomeadamente na fase de clarificação e compreensão da experiência problemática, e não ao longo de todo o processo terapêutico. Neste sentido, os resultados deste trabalho parecem indicar que a instabilidade pode funcionar como um indicador de progressão da assimilação e posterior solidificação da mudança, principalmente a partir da fase intermédia da terapia. Assim, apesar de os resultados da presente tese não permitirem validar a relação negativa entre a instabilidade na assimilação e a mudança sintomatológica, sugerem que a instabilidade durante o processo de assimilação poderá sinalizar a ocorrência de mudanças significativas e duradouras no padrão prévio de funcionamento do cliente.

Em suma, os resultados da presente dissertação apoiam a perspetiva de que a mudança terapêutica ocorre através de processos psicológicos abrangentes e complexos. De uma forma específica, a presente tese salienta a importância do papel da assimilação das experiências problemáticas no processo de mudança terapêutica, contribuindo para incrementar a compreensão sobre os processos promotores da eficácia terapêutica.

3.1. Implicações para a Investigação

Tal como já foi referido, de uma forma geral, os diferentes estudos realizados no âmbito da presente dissertação parecem salientar e validar empiricamente a importância do papel da assimilação no processo de mudança terapêutica. A investigação prévia já havia encontrado evidência sobre a importância da assimilação para a mudança clínica (Caro Gabalda, Stiles, & Pérez Ruiz, 2016; Detert et al., 2016; Honos-Webb, Stiles & Greenberg, 2003; Knobloch et al., 2001) e os estudos aqui desenvolvidos corroboraram esses mesmos resultados. É de salientar que o presente trabalho teve um contributo que, apesar de pequeno, parece ser significativo para a validação do modelo de assimilação. Destacamos a identificação de uma associação longitudinal entre a assimilação e a sintomatologia clínica, contribuindo para validar a premissa teórica que ainda não tinha sido empiricamente confirmada: a assimilação de experiências problemáticas contribuiu para a diminuição na sintomatologia clínica e, portanto, funciona como um processo promotor da mudança terapêutica em diferentes modelos terapêuticos.

Assim, o presente trabalho contribuiu para validar a perspetiva teórica sobre a assimilação como um fator transversal e integrador de mudança, ou seja, ocorrendo em diferentes modelos terapêuticos e integrando vários aspetos fundamentais do funcionamento humano (tais como aspetos emocionais, cognitivos e comportamentais). A instabilidade inerente ao processo de assimilação parece também ser uma característica importante da mudança clínica, o que, mais uma vez, apoia a conceptualização teórica que o modelo propõe sobre a mudança psicológica. A instabilidade promovida pelo contato entre a voz problemática e a comunidade de vozes parece ser um aspeto importante para a progressão da assimilação das experiências problemáticas, e consequentemente, para a mudança psicológica. Desta forma, tal como estudos prévios referiam (Caro & Stiles, 2013), a existência de retrocessos no progresso da assimilação, ao invés de ser uma característica indesejável, poderá ser um indicador de mudança e adaptação da estrutura do self a um funcionamento mais adaptativo e saudável.

É também importante referir que o facto de percebermos que a assimilação de experiências problemáticas ocorre também em casos onde não há mudança sintomática clinicamente significativa faz-nos refletir sobre a necessidade, em futuros estudos, de utilizar medidas mais abrangentes de mudança, que não se foquem meramente na presença ou não de sintomas clínicos. Perceber a doença psicológica como a presença de sinais ou sintomas psicológicos é concordante com o modelo médico, mas parece ser

extremamente redutor quando o nosso objeto de estudo são fenómenos e processos altamente complexos e subjetivos, i.e.,medir a mudança psicológica pela presença ou ausência de sintomas é ter acesso a uma pequena parte do fenómeno. Se a investigação de processo-resultado emergiu como alternativa ao modelo médico para compreensão da mudança em psicoterapia, seria importante encontrar formas alternativas mais capazes de aceder e compreender a complexidade do funcionamento humano. Assim sendo, utilizar a assimilação de experiências problemáticas como medida de mudança clínica poderá ser uma das possíveis alternativas para este problema. Avaliar o nível de assimilação do cliente implica perceber se determinadas mudanças cognitivas, emocionais e comportamentais ocorreram em relação a um determinado problema ou aspeto da sua vida. Neste sentido, não nos limitamos apenas a avaliar sinais específicos da presença ou não de uma determinada perturbação ou categoria de diagnóstico, mas conseguimos perceber de que forma o seu funcionamento global em relação a um aspeto problemático da sua vida evolui. Desta forma, a investigação conseguiria avaliar o seu objeto de estudo, i.e., o ser-humano, de forma mais próxima e congruente com a complexidade inerente ao seu funcionamento.

Esclarecer qual o papel da assimilação na promoção de mudança clínica poderá servir para compreender a evidência empírica prévia que indica a existência de eficácia similar entre as diferentes terapias. Se olharmos para o funcionamento humano de uma perspetiva mais abrangente e integradora percebemos que os fenómenos psicológicos não podem ser vistos como ocorrendo de forma isolada. Assim, tal como o Modelo de Assimilação sugere (Stiles, 2011), os fenómenos ou processos emocionais, cognitivos, interpessoais ou comportamentais têm de ser compreendidos de uma forma unificada e integradora. Nesse sentido, mesmo que o foco da intervenção terapêutica seja um processo específico (como por exemplo, na Terapia Cognitivo-Comportamental, o foco da intervenção é a cognição), alterações nesse processo implicam, inevitavelmente a existência de alterações noutros processos. Defender que determinadas terapias podem ser mais eficazes porque privilegiam determinados fenómenos psicológicos é olhar para o funcionamento humano de forma redutora. Assim, talvez a questão não seja tanto perceber se são fatores específicos ou comuns das terapias que explicam a mudança, mas sim perceber o processo de mudança e o resultado desse processo de uma forma mais abrangente e integradora. É óbvio que as limitações metodológicas na avaliação do nosso objeto de estudo limitam a nossa capacidade de aceder à complexidade do funcionamento

humano de forma objetiva. No entanto, ter esta complexidade em consideração é uma forma de reduzir ou minimizar o erro nas nossas conclusões. Perspetivarmos a mudança psicológica de uma forma mais integradora e complexa poderá apoiar a nossa compreensão sobre o que acontece em terapia. A assimilação de experiências problemáticas poderá ser uma dessas formas de olhar para a mudança terapêutica.

Em futuros estudos será importante ampliar os resultados obtidos no presente trabalho e avaliar a relação entre a assimilação e os resultados obtidos em follow-up com o intuito de verificar se níveis mais elevados de assimilação, no final do processo terapêutico, conduzem ou não à manutenção da mudança clínica ao longo do tempo e previnem a ocorrência de recaídas.

3.2. Implicações para a prática clínica

Perceber que o processo de mudança clínica pode ser promovido pela assimilação de experiências problemáticas poderá trazer implicações relevantes para a prática clínica. Nomeadamente, poderá ser importante que o terapeuta e as estratégias terapêuticas sejam orientadas para a promoção da assimilação das experiências problemáticas que vão emergindo no contexto terapêutico. Assim sendo, parece ser importante refletir sobre como esta perspetiva teórica do modelo de assimilação poderá ser articulada com a prática clínica. Tal como os resultados do segundo e do terceiro estudo parecem sugerir, a assimilação é um processo que acompanha a mudança clínica e sintomática ao longo da terapia. Assim, promover o progresso para níveis mais elevados de assimilação, ao longo do tempo, pode melhorar a eficácia da terapia. Tendo em consideração esta premissa, num primeiro momento, poderá ser importante que o terapeuta seja capaz de identificar, ao longo do tratamento, qual o nível de assimilação do cliente, em cada sessão. Nesse sentido, a utilização de um instrumento de auto-relato sobre o processo de assimilação preenchível pelo cliente poderá ser uma solução. Da mesma forma, poderá ser importante a utilização de um instrumento preenchível pelo próprio terapeuta, no sentido de aceder ao fenómeno de diferentes perspetivas. Um estudo efetuado por Halsteed (1999) respondeu a este mesmo propósito através da criação e desenvolvimento de duas escalas, uma versão do cliente e uma versão do terapeuta. Ambas as escalas apresentaram mostraram-se eficazes na avaliação do fenómeno e apresentaram boas propriedades psicométricas, nomeadamente em termos de estrutura fatorial, consistência interna e validade convergente, o que parece apoiar a sua utilização na avaliação da assimilação de

experiências problemáticas durante as sessões terapêuticas (Halsteed, 1999). Neste sentido, poderá ser importante, em futuros estudos, validar as respetivas medidas para a população portuguesa, avaliar a sua eficácia na deteção dos níveis de assimilação e de que forma a utilização destas medidas poderá influenciar o resultado terapêutico, ou seja, a informação dada pelas escalas pode servir para orientar o terapeuta na tomada de decisões e na escolha de procedimentos de intervenção. Mais ainda, além de perceber qual o nível de assimilação do cliente em cada sessão, poderá ser também importante aceder, de forma mais sistemática, e em momentos importantes da sessão terapêutica, ao nível de assimilação em que o cliente se encontra. Tal recurso facilitaria uma resposta mais eficaz do terapeuta em relação às necessidades do cliente. Uma possível solução para o propósito referido poderá ser a utilização dos marcadores de assimilação (Honos-Webb, Surko, & Stiles, 1999; Lani et al., 2002). Os marcadores podem ser definidos como *"episódios ou eventos terapêuticos que ocorrem em diferentes modelos psicoterapêuticos e que correspondem a sinais diretamente observáveis de processos internos dos clientes"* (Lani et al., 2002, p.190). Estudos anteriores debruçaram-se sobre a elaboração e a aplicabilidade da utilização de marcadores para a codificação da assimilação por codificadores externos (Honos-Webb, Surko, & Stiles, 1999; Lani et al., 2002). Futuros estudos deverão avaliar a sua aplicabilidade ao contexto terapêutico. Apoiar os terapeutas na deteção do nível de assimilação em que o cliente se encontra num determinado momento do processo terapêutico pode incrementar a capacidade de resposta, momento a momento, do terapeuta em relação às necessidades do cliente. Por outras palavras, pode tornar o terapeuta mais responsivo às necessidades mais prementes do cliente, a cada momento, ao longo da terapia (Ribeiro, 2009).

Um passo seguinte poderá ser verificar quais as estratégias terapêuticas que melhor se adequam aos diferentes níveis de assimilação dos clientes. Estudos prévios em diferentes modelos psicoterapêuticos tiveram como objetivo verificar esta premissa (Caro Gabalda, Stiles & Ruiz, 2016; Meystre et al., 2014; Ribeiro et al., 2016), no entanto, há necessidade de mais evidência empírica para sustentar os resultados obtidos. Neste sentido, poderá ser importante em futuros estudos relacionar a utilização de estratégias de intervenção específicas e o progresso do cliente para níveis de assimilação superiores.

O presente trabalho contribuiu ainda para esclarecer a importância do papel da instabilidade para o progresso da terapia. A instabilidade parece ser uma característica essencial do processo de mudança terapêutica. Neste sentido, em termos terapêuticos, a

ocorrência de retrocessos na evolução do cliente pode servir como um indicativo de que a mudança está a ocorrer, principalmente em níveis mais elevados de clarificação e compreensão do problema. Em futuros estudos será importante avaliar de que forma a instabilidade no progresso da assimilação evolui após o término da terapia e qual o seu papel na manutenção dos ganhos, a longo prazo.

Em suma, o presente trabalho contribuiu para validar e solidificar a perspetiva do modelo de assimilação em relação à mudança terapêutica. No entanto, tal como já foi referido, o objetivo primordial da investigação de processo-resultado é também contribuir para melhorar a eficácia dos tratamentos psicoterapêuticos. Nesse sentido, em futuros estudos parece ser importante refletir sobre como a assimilação de experiências problemáticas pode e deve melhorar a prática clínica.

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