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Patrícia de Jesus Lopes Pinheiro

# Client's Emotional Processing and Therapeutic Change

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# Client's Emotional Processing and Therapeutic Change

Tese de Doutoramento em Psicologia Aplicada

Trabalho efetuado sob a orientação do
**Professor Doutor Mário Miguel Machado Osório Gonçalves**
e do
**Professor Doutor João Manuel Castro Faria Salgado**

março de 2019

DECLARAÇÃO DE INTEGRIDADE

Declaro ter atuado com integridade na elaboração da presente dissertação. Confirmo que em todo o trabalho conducente à sua elaboração não recorri à prática de plágio ou a qualquer forma de falsificação de resultados.

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(Isaac Newton, 1675)

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# RESUMO

PROCESSAMENTO EMOCIONAL DO CLIENTE E MUDANÇA TERAPÊUTICA

Nos últimos anos, a investigação em psicoterapia tem-se focado no esclarecimento dos processos e mecanismos que tornam este tipo de intervenção eficaz. As terapias humanisto-experienciais sugerem que a mudança terapêutica é promovida pelo processamento emocional, i.e., pela consciência, ativação, experienciação e exploração das experiências emocionais para lhes atribuir significado e transformar as emoções desadaptativas em adaptativas. A investigação, desenvolvida maioritariamente na depressão, tem conferido apoio empírico a essa hipótese, sugerindo que, em diferentes modalidades terapêuticas, a maior capacidade de processamento emocional prediz melhores resultados no final do tratamento.

Os estudos prévios, avaliaram o nível de processamento emocional num número reduzido de sessões (usualmente, 2 ou 3) e estimaram o seu efeito na mudança dos sintomas do início para o final da terapia, o que se poderá associar a dois potenciais problemas. Primeiro, ignorar a variabilidade entre as sessões poderá ter conduzido à generalização de resultados enviesados. Segundo, não considerar na análise de dados o efeito do alívio sintomático nas sessões anteriores àquelas em que foi avaliado o processamento emocional, poderá ter enviesado (causalidade inversa) e/ou sobrestimado os resultados observados. Assim, apesar de os estudos prévios reportarem que o processamento emocional contribui para a redução dos sintomas, a associação longitudinal entre essas variáveis carece de investigação adicional.

Para compreender de forma mais aprofundada o papel do processamento emocional em psicoterapia, para além de estimar o efeito na mudança sintomática, importa rastrear o tipo de emoções ativadas ao longo da terapia, e o contributo do seu processamento para a mudança nas experiências emocionais desadaptativas dos clientes. Por fim, para conferir suporte adicional à hipótese de que este é um fator comum de mudança, urge explorar o papel do processamento das emoções na explicação da mudança sintomatológica e emocional noutras problemáticas.

Desenvolvemos três estudos para clarificar o contributo do processamento emocional para a mudança terapêutica, especificamente, (1) para a redução dos sintomas e (2) para a mudança das experiências emocionais desadaptativas dos clientes. Para tal, medimos (1) o processamento emocional através da *Experiencing Scale* (EXP), (2) o tipo de emoções ativadas através dos Episódios Emocionais (EEs), e (3) a intensidade dos sintomas através do *Beck Depression Inventory II* (BDI-II)*, do Outcome Questionnaire 10.2* (OQ-10.2) e do *Inventory of Complicated Grief* (ICG)*.*

No primeiro estudo, realizamos uma análise intensiva de todas as sessões de um caso de sucesso em Terapia Focada nas Emoções para a depressão. A análise longitudinal da associação entre o nível de processamento emocional atingido pela cliente e a intensidade dos sintomas clínicos (OQ-10.2) sugeriu que as variáveis se encontravam forte e negativamente associadas ao longo do processo terapêutico (*lag* 0). Observamos, ainda, que durante o aumento da capacidade de processamento emocional, as experiências emocionais desadaptativas da cliente foram transformadas em respostas mais adaptativas.

No segundo estudo, investigamos o efeito do processamento emocional na mudança sintomática durante o tratamento numa amostra de 50 casos diagnosticados com depressão e atendidos em Terapia Focada nas Emoções e Terapia Cognitivo-Comportamental. Observamos que o aumento da capacidade de processamento emocional durante a terapia contribuiu para (1) a diminuição dos sintomas depressivos (BDI-II) do início para o final do tratamento, e (2) para a redução gradual da intensidade dos sintomas clínicos ao longo das sessões (*lag* +1).

Por fim, no terceiro estudo investigamos de forma intensiva todas as sessões de dois casos que experienciavam luto complicado, atendidos em Terapia de Reconstrução de Significado no Luto. Verificamos que, o caso de sucesso apresentou um aumento mais acentuado na capacidade de processamento das suas emoções, comparativamente com o caso de insucesso. Tal como no primeiro estudo, durante o aumento da capacidade de processamento emocional, as emoções desadaptativas associadas às experiências de luto foram transformadas em respostas mais adaptativas ao longo das sessões, principalmente no caso de sucesso.

Os resultados observados no âmbito da presente dissertação devem ser interpretados tendo em consideração as limitações associadas aos estudos levados a cabo, não podendo ser generalizados. Ainda assim, parecem conferir apoio empírico adicional à hipótese proposta pelas abordagens humanisto-experienciais de que o aumento, durante as sessões, da capacidade dos clientes processarem as suas experiências emocionais contribui para a mudança terapêutica ao longo da terapia. O processamento emocional poderá funcionar como um fator que contribui para a mudança em diferentes problemáticas e abordagens psicoterapêuticas. Com base nos resultados observados, elencamos implicações para a prática clínica e para a investigação em psicoterapia.

# ABSTRACT

CLIENT'S EMOTIONAL PROCESSING AND THERAPEUTIC CHANGE

Over the recent years, research in psychotherapy has been focused on clarifying the processes and mechanisms associated to the efficacy of this type of treatment. According to humanistic-experiential therapies therapeutic change is promoted by emotional processing, i.e., by awareness, activation, experiencing and exploration of emotional experiences to create meaning and transform maladaptive emotions into adaptive ones. Research, mainly conducted on depression, has supported this hypothesis, suggesting that an improved capability of emotional processing predicts better outcome at the end of treatment in different modalities.

Prior studies assessed emotional processing in a short number of sessions (usually 2 or 3 per case) and estimated its effect on symptom change from pre- to post-therapy, which may be associated to twofold issues. First, not considering the variability between sessions may lead to the generalization of inaccurate results. Second, not accounting for the symptomatic improvement prior to the sessions where emotional processing was assessed may misrepresent (reverse causality) and/or overestimate the findings. Although previous studies found emotional processing to be a contributor to the decrease of symptoms, the longitudinal association between these variables needs further investigation.

In addition to estimate the effect of emotional processing on symptom reduction, tracking the type of emotions that emerge throughout therapy and the contribution of their processing to the transformation of maladaptive emotions may be informative to understand its role in psychotherapy. Finally, to support the hypothesis of being a common factor, the role of emotional processing in the explanation of change in different emotional disorders also needs to be further explored.

In the current thesis we have developed three empirical studies to clarify the contribution of emotional processing to therapeutic change, specifically, (1) to symptom reduction and (2) to the transformation of maladaptive emotional experiences. We assessed (1) emotional processing through the *Experiencing Scale* (EXP), (2) the type of emotions through the *Emotion Episodes* (EEs), and (3) the intensity of symptoms through the *Beck Depression Inventory II* (BDI-II), the *Outcome Questionnaire 10.2* (OQ-10.2), and the *Inventory of Complicated Grief* (ICG).

In the first study we performed an intensive analysis of all the therapeutic sessions of a good outcome case in emotion-focused therapy for depression. The longitudinal analysis of the association between the level of emotional processing and the intensity of clinical symptoms (OQ-10.2) suggested these variables were strong and negatively associated throughout sessions (*lag* 0). We also observed the

transformation of the client's maladaptive emotions into more adaptive responses alongside the increase in emotional processing.

In the second study we investigated the effect of emotional processing on symptom change, during treatment, in a sample of 50 cases of depression treated with emotion-focused therapy and cognitive-behavioral therapy. We found that an increase in the capability to process emotional experiences during treatment contributed to (1) a decrease in depressive symptoms (BDI-II) from pre- to post-therapy, and to (2) a reduction in clinical symptoms' intensity in the next-session (*lag* + 1).

Finally, in the third study we performed an intensive analysis of all the therapeutic sessions of two cases experiencing complicated grief treated with meaning reconstruction grief therapy. When compared to the poor outcome case, the good outcome case presented a higher improvement of her capability to process emotions. As observed in the first study, in the good outcome case maladaptive emotions were transformed into more adaptive responses alongside the increase in the client's emotional processing capability.

Our findings on the current thesis should be carefully interpreted considering the limitations associated to the studies we carried out, which prevents their generalization. Nonetheless, our results seem to provide additional empirical support to the humanistic-experiential approaches' hypothesis that the improvement of the clients' capability to process emotional experiences contributes to therapeutic change throughout therapy. Regardless of the psychiatric disorder and the psychotherapeutic approach, emotional processing may operate as a factor that contributes to explain the client's change process. Building on our findings we presented and discussed implications to clinical practice and psychotherapy research.

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# CAPÍTULO I – ENQUADRAMENTO TEÓRICO

A psicoterapia é eficaz no tratamento da psicopatologia, tanto na fase aguda dos sintomas, como na prevenção da recaída (Clarke, Mayo-Wilson, Kenny, & Pilling, 2015; Cuijpers, Andersson, Donker, & van Straten, 2011; Llewelyn, Macdonald, & Doorn, 2016; Machmutow, Holtforth, Krieger, & Watzke, 2017; Messer & Wampold, 2002; Vittengl, Clark, Dunn, & Jarrett, 2009; Wampold et al., 1997). Apesar de a investigação focada nos resultados ter demonstrado que a psicoterapia funciona, ainda não são claros os processos e mecanismos que a tornam eficaz (Crits-Christoph, Gibbons, & Mukherjee, 2013; Gelo, Pritz, & Rieken, 2015; Greenberg, 1986; Llewelyn et al., 2016; Pascual-Leone, Paivio, & Harrington, 2016; Pos, Greenberg, Goldman, & Korman, 2003; Wampold, 2001). Assim, urge explorar de que forma o processo terapêutico, i.e., os fenómenos, características, ou situações associadas à psicoterapia, contribuem para a sua eficácia (Gelo et al., 2015; Greenberg, 1986; Hill & Lambert, 2004; Llewelyn et al., 2016; Orlinsky, Rønnestad, & Willutzki, 2004; Wampold, 2001).

Os estudos de processo-resultado exploram o contributo das variáveis cognitivas, afetivas e comportamentais associadas ao cliente, ao terapeuta, à díade e ao contexto, para a mudança nos problemas, sintomas ou funcionamento do cliente (Crits-Christoph et al., 2013; Llewelyn et al., 2016). O principal objetivo deste tipo de investigação é explorar e compreender os mecanismos e processos que explicam a eficácia terapêutica (Gelo et al., 2015). O esclarecimento desta questão é relevante tanto a nível empírico, como a nível clínico. A investigação em psicoterapia deve contribuir, portanto, para identificar os processos de mudança e demonstrar o seu contributo para a melhoria do cliente, orientando o treino de terapeutas e o desenvolvimento de tratamentos mais eficazes (Gelo et al., 2015; Goldman, 2019; Greenberg, 1986; Pascual-Leone et al., 2016; Wampold, 2001).

A larga maioria dos estudos de processo-resultado em psicoterapia tem-se focado em variáveis associadas à relação terapêutica, tais como a aliança terapêutica (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Flückiger, Wampold, & Horvath, 2018; Horvath, Del Re, Flückiger, & Symonds, 2011; Zilcha-Mano, Muran, Eubanks, Safran, & Winston, 2017). Os processos intrapessoais do cliente têm sido alvo de menor investigação (Pascual-Leone & Yeryomenko, 2017). Contudo, para compreender os fatores que contribuem positivamente para a eficácia da psicoterapia, é essencial explorar a ligação entre esses processos intrapessoais do cliente e o resultado terapêutico (Goldman, 2019; Pascual-Leone et al., 2016; Watson, Mcmullen, Prosser, & Bedard, 2011). No âmbito da presente dissertação, desenvolvemos três estudos de processo-resultado que exploraram o contributo de uma variável intrapessoal do cliente para a mudança terapêutica – o processamento emocional. Esses estudos focaram-se no processamento emocional, tal como é conceptualizado pelas abordagens

humanisto-experienciais (e.g., Terapia Centrada no Cliente, Terapia Focada nas Emoções, Terapia *Gestalt*).

As diferentes abordagens terapêuticas propõem a primazia de mecanismos e processos específicos envolvidos na mudança dos clientes. O processamento emocional é, nas perspetivas humanisto-experienciais, um fator central para a promoção da mudança terapêutica. Contudo, tal como se observou com outros fatores cognitivos e emocionais específicos (Basto & Salgado, 2014), o processamento emocional não é apenas promovido pelas abordagens terapêuticas que lhe atribuem um papel central (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Choi, Pos, & Magnusson, 2016; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Goldman, Greenberg, & Pos, 2005; Hendricks, 2009; Makinen & Johnson, 2006; Malin & Pos, 2015; Pascual-Leone, 2018; Pascual-Leone & Greenberg, 2007; Pascual-leone & Kramer, 2019; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003; Pos, Greenberg, & Warwar, 2009; Pos, Paolone, Smith, & Warwar, 2017; Rudkin, Llewelyn, Hardy, Stiles, & Barkham, 2007; Toukmanian, Jadaa, & Armstrong, 2010; Watson & Bedard, 2006; Watson et al., 2011). Ao invés, o processamento emocional, tal como conceptualizado pelas teorias humanisto-experiencias, surge na literatura como um possível fator comum de mudança, i.e., que contribui para explicar a mudança dos clientes em diferentes abordagens psicoterapêuticas (Elliott et al., 2013; Greenberg & Pascual-Leone, 2006; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017). Assim sendo, a investigação sobre o processamento emocional poderá ser relevante para compreender de forma mais aprofundada o processo de mudança terapêutica dos clientes.

## 1. Processamento emocional em psicoterapia: Das abordagens comportamentais às humanisto-experienciais

Em psicoterapia, o conceito "processamento emocional" tem sido usado para explicar qual a forma mais produtiva de lidar com as experiências emocionais (Baker et al., 2012; Foa, Huppert, & Cahill, 2006; Foa & Kozak, 1986; Fosha, 2000; Greenberg & Safran, 1989; Rachman, 1980; Teasdale, 1999). As perspetivas tradicionais que surgem na literatura sobre este construto podem ser organizadas em duas categorias, nomeadamente, (1) perspetiva de inibição e (2) de transformação emocional. A primeira perspetiva deriva das teorias comportamentais tradicionais, propondo que o processamento emocional envolve a inibição ou diminuição de respostas emocionais disfuncionais (e.g., Foa et al., 2006; Foa, Rothbaum, & Furr, 2003; Foa & McLean, 2016; Goldfried, 2003; Rauch & Foa, 2006; Whelton, 2004). A segunda, na qual se encaixam as abordagens humanisto-experienciais, defende que a mudança do cliente implica, necessariamente, a criação de significado sobre essas experiências emocionais (e.g., Elliott & Greenberg, 2017; Greenberg, 2002; Greenberg & Watson, 2006). Em seguida, apresentamos uma breve descrição do conceito de processamento emocional proposto pelas perspetivas comportamentais mais tradicionais, para, posteriormente, explorar de forma aprofundada a perspetiva das terapias humanisto-experienciais.

### 1.1. O processamento emocional nas abordagens comportamentais tradicionais

O construto de processamento emocional foi introduzido na literatura por Rachman (1980), numa tentativa de integrar um conjunto de observações clínicas e experimentais relativas ao efeito da técnica de exposição nas perturbações de ansiedade. Este mesmo autor definiu processamento emocional como *"a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behavior can proceed without disruption"* (p. 51).

Assente nesse trabalho, Foa e Kozak (1986) desenvolveram um modelo explicativo sobre os mecanismos de ação envolvidos na redução das respostas do medo patológico – Teoria do Processamento Emocional. Para estes autores, as respostas emocionais e comportamentais disfuncionais resultam da associação do estímulo fóbico a respostas e significados que distorcem a realidade. O evitamento cognitivo e comportamental desse estímulo impede a aquisição de informação relevante e inconsistente com a estrutura patológica associada às respostas fóbicas (Foa et al., 2006). A alteração dessas estruturas patológicas envolve a incorporação de novas informações nas estruturas de memória subjacentes às respostas de medo, através da confrontação sistemática e repetida com o

estímulo que as desencadeia (Foa et al., 2006; Foa & Kozak, 1986; Rauch & Foa, 2006). A técnica de exposição permite ativar a estrutura subjacente às respostas de medo (e.g., memórias, emoções, cognições) e, ao mesmo tempo, potenciar a recolha de informação corretiva que sustente o cariz não ameaçador do estímulo fóbico, promovendo a redução ou inibição das respostas de medo perante esse estímulo, i.e., o processamento emocional (Foa et al., 2006, 2003; Foa & McLean, 2016; Goldfried, 2003; Rauch & Foa, 2006; Whelton, 2004).

Em suma, para as perspetivas comportamentais tradicionais, um processamento emocional bem-sucedido envolve, (1) a ativação da estrutura de memória disfuncional associada às respostas emocionais de medo e (2) a redução ou inibição dessas respostas durante a exposição ao estímulo fóbico (Foa et al., 2006; Foa & Kozak, 1998; Rauch & Foa, 2006).

## 1.2. O processamento emocional nas abordagens humanisto-experienciais

Apesar de as abordagens comportamentais terem sido pioneiras ao apontar a importância da ativação emocional em psicoterapia, foi no contexto das abordagens humanisto-experienciais que as emoções e o seu processamento receberam maior atenção a nível teórico e empírico (Pascual-Leone et al., 2016). Para estas perspetivas, o processamento emocional envolve um *continuum* de estádios que vai para além da ativação e redução ou inibição das respostas emocionais desadaptativas. Em suma, envolve (1) estar consciente das experiências emocionais (atender e simbolizar), (2) ativar e tolerar o contacto direto com as emoções, (3) explorar e refletir sobre essas experiências emocionais para lhes atribuir significado, e, finalmente, (4) transformar as emoções desadaptativas em mais adaptativas, i.e., mudar os esquemas emocionais desadaptativos (Elliott et al., 2013; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Samoilov & Goldfried, 2000). Para entender a perspetiva das abordagens humanisto-experienciais sobre o processamento emocional é fulcral atender à sua conceptualização sobre o papel das emoções no funcionamento humano.

### 1.2.1. O papel das emoções no funcionamento humano

As abordagens humanisto-experienciais conceptualizam as emoções como uma fonte inata e essencial de significado e informação para o funcionamento humano (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002, 2010, 2015, 2019; Greenberg & Paivio, 1987). As emoções estão associadas às necessidades e objetivos centrais de cada pessoa, sinalizando o que é importante para o seu bem-estar e mobilizando-a para o atingir (Elliott & Greenberg, 2017; Greenberg, 2002, 2019;

Greenberg & Watson, 2006). Por exemplo, o medo perante uma situação de perigo prepara para uma resposta rápida de fuga; a raiva perante a violação de limites mobiliza para uma resposta de assertividade e proteção; a tristeza perante a perda de uma relação mobiliza para a aceitação e procura de apoio; e a alegria sinaliza segurança e mobiliza a pessoa para a manutenção das condições que lhe trazem bem-estar.

As emoções não resultam apenas de fatores biológicos, representando um produto complexo de vários processos que integram, entre outros, fatores cognitivos, motivacionais e comportamentais (Greenberg, 2019). O tipo de respostas emocionais que experienciamos é largamente influenciado pela aprendizagem (Greenberg, 2010, 2019). A associação entre as experiências vividas e as respostas emocionais ativadas nesse momento criam uma estrutura organizada de memórias emocionais, i.e., esquemas emocionais (Greenberg, 2002, 2019; Greenberg & Paivio, 1987; Greenberg & Safran, 1989). Esses esquemas envolvem estruturas afetivo-cognitivas dinâmicas que são ativadas por pistas internas ou externas, permitindo de forma rápida e automática sintetizar uma variedade de informação, dar resposta e atribuir significado às experiências, aos outros e ao *self* (Goldman, 2019; Greenberg, 2002, 2010, 2019). A ativação dos esquemas emocionais produz respostas que favorecem a sobrevivência e adaptação da pessoa ao seu contexto (Goldman, 2019; Greenberg, 2002, 2010, 2019; Greenberg & Watson, 2006). Por exemplo, a interpretação automática da aproximação dos outros como potencialmente perigosa e a experienciação de medo, constituem respostas adaptativas e protetoras para uma criança que vive num ambiente abusivo. Contudo, os esquemas emocionais podem também ser disfuncionais quando ativam respostas emocionais desadaptativas, i.e., inconsistentes com as necessidades e objetivos atuais da pessoa (Goldman, 2019). Nesse exemplo, se no contexto de uma relação segura aquela criança ativar o mesmo esquema emocional e experienciar medo perante o afeto e cuidado dos outros, impede que as suas necessidades de proteção e amor sejam satisfeitas. O funcionamento desses esquemas emocionais desadaptativos está associado a sofrimento e pode resultar em quadros de psicopatologia, visto que as respostas emocionais que produz não mobilizam a pessoa para cumprir as suas necessidades centrais e, consequentemente, não promovem o seu bem-estar (Goldman, 2019).

Na depressão, por exemplo, o *self* é organizado como não-amado ou sem valor, impotente ou incompetente, devido à ativação de memórias esquemáticas precoces de humilhação, abuso, crítica e abandono (Elliott & Greenberg, 2017; Salgado, Cunha, & Monteiro, 2019; Watson & Bedard, 2006). Essas memórias esquemáticas são usualmente ativadas pela associação estabelecida entre a situação atual (e.g., rutura amorosa, crítica por parte do chefe) e eventos significativos do passado (Elliott &

Greenberg, 2017; Greenberg, 2019; Greenberg & Watson, 2006). Uma vez ativado, o esquema emocional produz respostas desadaptativas, tais como sentimentos de impotência e desamparo, sensações corporais de mal-estar intensas, bem como significados e tendências para a ação inconsistentes com a situação atual, prejudicando a capacidade da pessoa processar essas respostas emocionais dolorosas e lidar com a situação que as desencadeou (Elliott & Greenberg, 2017; Greenberg & Watson, 2006). Para as abordagens humanisto-experienciais, a psicopatologia está associada a dificuldades em processar esses estados emocionais dolorosos produzidos pelos esquemas emocionais desadaptativos (Greenberg, 2019; Greenberg & Watson, 2006; Pascual-Leone et al., 2016).

### *Tipos de emoções*

Assente no pressuposto de que diferentes tipos de emoções servem funções distintas, Greenberg e colaboradores (Elliott et al., 2004; Greenberg, 2002, 2015, 2019; Greenberg & Paivio, 1987; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006) estabeleceram uma diferenciação clínica entre emoções primárias e secundárias, atendendo ao seu caráter adaptativo ou desadaptativo. As emoções primárias podem ser categorizadas como adaptativas ou desadaptativas, enquanto as secundárias são necessariamente desadaptativas.

As emoções secundárias são respostas a pensamentos ou a emoções primárias assoberbantes, dolorosas ou ameaçadoras, ao invés de respostas às situações atuais (Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). Sentir vergonha por experienciar tristeza, sentir tristeza e expressar raiva, expressar um estado fusional de tristeza/raiva, ou profundo desamparo, são exemplos de emoções secundárias que devem ser validadas, reguladas e exploradas para aceder às emoções primárias que lhes estão subjacentes (Greenberg, 2002, 2010; Greenberg & Watson, 2006; Vrana & Greenberg, 2018). Frequentemente, estas são parte dos sintomas que o cliente apresenta (e.g., ansiedade, depressão, irritabilidade; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2018; Greenberg & Watson, 2006; Herrmann & Auszra, 2018).

As emoções primárias referem-se a respostas emocionais imediatas às situações, podendo, como referido anteriormente, ser adaptativas ou desadaptativas. As emoções primárias desadaptativas, apesar de ativadas por situações atuais, resultam de aprendizagens emocionais esquemáticas, refletindo problemas não resolvidos e necessidades que não foram cumpridas (Greenberg & Goldman, 2019). São sentimentos antigos e familiares que ocorrem repetidamente, não mudam ao longo do tempo, nem de acordo com as circunstâncias, contribuindo para que a pessoa não lide de forma adaptativa com a situação que os desencadeou. Experienciar medo do afeto nas relações atuais por ter sido abusado no

passado, sentimentos intensos de abandono perante pistas mínimas de afastamento dos outros devido à ativação de memórias de abandono na infância, ou sentimentos de vergonha pela falta de valor pessoal, são exemplos de emoções primárias desadaptativas usualmente associadas a quadros de psicopatologia (Elliott & Greenberg, 2017; Elliott et al., 2004; Goldman, 2019; Greenberg & Goldman, 2019; Greenberg & Paivio, 1987; Greenberg & Pascual-Leone, 2006; Greenberg & Watson, 2006; Pascual-Leone et al., 2016). O objetivo central das terapias humanisto-experienciais é transformar estas emoções dolorosas produzidas pelos esquemas emocionais desadaptativos subjacentes (Elliott & Greenberg, 2017; Greenberg & Watson, 2006; Pascual-Leone et al., 2016).

Por último, as emoções primárias adaptativas estão associadas às necessidades centrais da pessoa (Greenberg, 2002, 2010, 2015). Por exemplo, aceder à raiva por situações de injustiça, e à tristeza pelo que foi irreparavelmente perdido, são exemplos de emoções adaptativas que mobilizam a pessoa para ações consistentes com as suas necessidades e objetivos, garantindo o seu bem-estar (Goldman, 2019; Greenberg & Watson, 2006). Desta forma, aceder e explorar a informação associada a este tipo de emoções é importante para o funcionamento saudável da pessoa (Goldman, 2019; Greenberg, 2002, 2010, 2015; Greenberg & Watson, 2006; Pascual-Leone et al., 2016).

### 1.2.2. O *continuum* afetivo-cognitivo envolvido no processamento emocional

As teorias humanisto-experienciais consideram que apesar das emoções desempenharem um papel central na psicopatologia, também têm um potencial inato de transformar os estados emocionais associados a esses quadros (Greenberg & Watson, 2006). Assim, não conceptualizam as emoções desadaptativas como experiências que devem ser inibidas ou extinguidas através da exposição, como propõem as perspetivas comportamentais tradicionais (Pascual-Leone et al., 2016). Ao invés, as abordagens humanisto-experienciais defendem que é importante o cliente ganhar consciência sobre as suas experiências internas, ativar, explorar e refletir sobre as emoções para lhes atribuir significado, transformar as emoções desadaptativas e aceder às suas necessidades centrais (Elliott & Greenberg, 2017; Greenberg, 2002, 2010, 2015; Greenberg & Watson, 2006).

O processamento emocional envolve, antes de mais, ter consciência, atender e simbolizar em palavras as experiências internas (Elliott & Greenberg, 2017). A consciência emocional não significa pensar sobre o que se está a sentir, mas estar ligado à experiência interna e ser capaz de a articular verbalmente (Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Pascual-Leone et al., 2016). No início da terapia, os clientes tendem a focar-se nos eventos externos, ou a pensar sobre a sua experiência e, gradualmente, ganham maior consciência e tornam-se mais capazes de atender e simbolizar em

palavras as suas emoções (Angus et al., 2012; Greenberg & Goldman, 2019; Pascual-Leone et al., 2016). O terapeuta deve facilitar essa mudança do foco externo para o interno, aumentando a consciência do cliente sobre as suas experiências internas, mas também a capacidade deste regular as suas emoções mais intensas e dolorosas, para que possam ser ativadas e experienciadas em terapia (Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Pascual-Leone et al., 2016).

Ativar as emoções e tolerar o contacto direto com essas experiências é essencial para promover o seu processamento e a mudança terapêutica (Samoilov & Goldfried, 2000). As emoções têm que ser ativadas, contudo, a um nível moderado (regulação emocional); caso contrário, o cliente não será capaz de aceder à informação que lhes está associada (Carryer & Greenberg, 2010; Pascual-Leone et al., 2016). As emoções secundárias não estão associadas às necessidades da pessoa, pelo que a sua ativação durante a terapia tem como intuito a sua exploração para aceder às emoções primárias subjacentes (Elliott et al., 2004; Greenberg, 2002, 2010, 2012, 2015; Greenberg & Paivio, 1987). Por outro lado, a ativação e experienciação das emoções primárias previamente inibidas é um passo crucial para a mudança terapêutica, já que essas estão associadas às necessidades centrais do cliente (Elliott & Greenberg, 2017; Greenberg, 2002; Greenberg, Auszra, & Herrmann, 2007; Greenberg & Goldman, 2019; Greenberg & Paivio, 1987).

Apesar de a ativação emocional ser importante, explorar e refletir cognitivamente sobre a informação associada às emoções ativadas é um passo central para a promoção da mudança terapêutica (Auszra & Greenberg, 2007; Auszra, Greenberg, & Herrmann, 2013; Carryer & Greenberg, 2010; Greenberg et al., 2007; Herrmann & Auszra, 2019; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Pos et al., 2017). A integração do afeto e da cognição é fulcral para um processamento emocional produtivo, i.e., o cliente tem que experienciar as suas emoções, mas também explorar cognitivamente a informação que lhes está associada (Greenberg, 2002, 2019; Greenberg & Goldman, 2019; Greenberg & Pascual-Leone, 2006; Pos & Choi, 2019; Whelton, 2004). A exploração e reflexão sobre as emoções ativadas contribui para fazer sentido dessas experiências, tornando os sentimentos, necessidades e objetivos dos clientes mais claros e organizados em autonarrativas (Angus, 2012; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). Este trabalho interno permite que o cliente aumente a consciência e conhecimento sobre si próprio, compreenda e reenquadre as suas experiências significativas, promovendo uma experienciação mais adaptativa do *self*, dos outros e do mundo (Elliott & Greenberg, 2017; Pascual-Leone et al., 2016). Desta forma, a criação de novos significados baseados na informação associada às emoções ativadas tem um contributo importante na mudança terapêutica (Goldman, 2019; Greenberg, 2019; Pos et al., 2003).

O processamento emocional envolve, por último, a mudança das respostas emocionais antigas, familiares e dolorosas associadas às condições de psicopatologia. Segundo Greenberg (Greenberg, 2002, 2010, 2015, 2019; Greenberg & Goldman, 2019), este passo implica *"changing emotion with emotion"*. Esta transformação não envolve a exposição a pistas internas ou externas ameaçadoras e evitadas, nem se traduz na inibição ou extinção de emoções desadaptativas, como proposto pelas perspetivas comportamentais tradicionais (Greenberg & Goldman, 2019). Em vez disso, a transformação emocional envolve a criação de novos estados emocionais mais adaptativos com base na aceitação, ativação, exploração e atribuição de significado às experiências emocionais desadaptativas e dolorosas (Greenberg & Goldman, 2019).

Para as abordagens humanisto-experienciais, o terapeuta deve dirigir a atenção do cliente para os aspetos centrais e dolorosos da sua experiência (emoções primárias desadaptativas), já que esses usualmente não estão completamente conscientes (Goldman, 2019; Greenberg, 2015; Greenberg & Watson, 2006; Pascual-Leone et al., 2016). As emoções secundárias têm que ser validadas, reguladas e exploradas para que se perceba a sua função protetora e seja possível diferenciá-las e aceder às emoções primárias subjacentes (Elliott & Greenberg, 2017; Elliott et al., 2004; Greenberg, 2002; Greenberg & Goldman, 2019; Pascual-Leone et al., 2016). De facto, o objetivo central da intervenção terapêutica é transformar estas emoções esquemáticas desadaptativas (Greenberg, 2010; Greenberg & Goldman, 2019).

As emoções desadaptativas são transformadas pela ativação de respostas adaptativas e dialeticamente opostas em relação aos mesmos eventos (Elliott & Greenberg, 2017; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Vrana & Greenberg, 2018). Por exemplo, respostas emocionais de tristeza perante uma situação de maus-tratos podem ser transformadas pela ativação de emoções incompatíveis de raiva assertiva e autocompaixão (Greenberg, 2010). A informação associada a estas emoções adaptativas tem que ser explorada para que o seu potencial "curativo" seja ativado, transformando as emoções desadaptativas e mobilizando a pessoa para cumprir as suas necessidades centrais (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Herrmann, Greenberg, & Auszra, 2016; Pascual-Leone & Greenberg, 2007). Aceder a respostas emocionais mais adaptativas contribui, em última instância, para introduzir mudanças nos esquemas emocionais (Elliott & Greenberg, 2017; Elliott et al., 2013; Greenberg, 2002, 2010, 2015, 2019; Greenberg & Watson, 2006; Paivio & Pascual-Leone, 2010; Pascual-Leone & Greenberg, 2007; Pos et al., 2003; Watson, Goldman, & Greenberg, 2007). As emoções adaptativas funcionam, assim,

como experiências corretivas que desafiam as perceções do *self*, dos outros e do mundo associadas às memórias esquemáticas desadaptativas (Elliott & Greenberg, 2017; Greenberg, 2010).

Em suma, a transformação emocional envolve a seguinte sequência: (1) aceder e explorar as emoções secundárias, (2) para posteriormente ter acesso às emoções primárias desadaptativas e, finalmente, (3) às primárias adaptativas (Greenberg, 2002, 2010, 2015). Herrmann, Greenberg e Auszra (2016) exploraram empiricamente essa sequência de mudança emocional numa amostra de casos diagnosticados com depressão e atendida em Terapia Focada nas Emoções. Observaram que o acesso a emoções primárias, bem como a transformação de emoções desadaptativas em adaptativas durante a terapia prediziam melhores resultados terapêuticos, conferindo suporte ao modelo de mudança emocional proposto pelas abordagens humanisto-experienciais.

## 2. Investigação sobre o papel do processamento emocional na mudança terapêutica

A investigação sobre o papel do processamento emocional na mudança terapêutica, desenvolvida predominantemente em casos de depressão, tem-se focado no efeito que a promoção dessa capacidade tem no alívio dos sintomas apresentados pelos clientes. Independentemente da abordagem teórica adotada para definir e operacionalizar o conceito (e.g., comportamental, humanisto-experiencial), (1) dificuldades no processamento emocional têm sido associadas a condições de psicopatologia, enquanto (2) o aumento da capacidade para processar as experiências emocionais tem sido associada a melhores resultados terapêuticos (e.g., Baker et al., 2012; Elliott et al., 2013; Foa et al., 2006; Greenberg, 2010; Whelton, 2004).

Diferentes perspetivas e lentes têm sido usadas na compreensão do conceito de processamento emocional proposto pelas abordagens humanisto-experienciais, tal como foi apontado por Pascual-Leone e colaboradores (2016) numa revisão da literatura recente sobre essa variável. O processamento emocional tem sido operacionalizado na investigação de processo-resultado sobretudo através de três medidas observacionais: (1) *Classification of Affective-Meaning States* – CAMS (Pascual-Leone & Greenberg, 2007); (2) *Client Emotional Productivity Scale* – CEPS (Auszra & Greenberg, 2007; Greenberg et al., 2007); e (3) *Experiencing Scale* – EXP (Klein, Mathieu-Coughlan, & Kiesler, 1986; Klein, Mathieu, Gendlin, & Kiesler, 1969). A CAMS e a CEPS assumem, respetivamente, a transformação emocional e o processamento produtivo (ou bem-sucedido) como medidas desse construto. Por sua vez, a EXP mede o nível de processamento emocional atingido pelo cliente num *continuum* desde a reduzida consciência e envolvimento com as experiências internas até à exploração e transformação das emoções (Klein et al., 1986, 1969).

Em seguida, apresentamos as conceptualizações de processamento emocional subjacentes à CAMS, CEPS e EXP, bem como os principais resultados observados nos estudos que investigaram o papel do processamento emocional na mudança terapêutica. Importa salientar que o maior foco será dirigido para a EXP. Esta medida fornece uma perspetiva mais desenvolvimental sobre o *continuum* afetivo-cognitivo do processamento emocional, pelo que foi usada para operacionalizar o conceito nos estudos empíricos desta dissertação.

### 2.1. *Classification of Affective-Meaning States*

Pascual-Leone e Greenberg (2007) desenvolveram a CAMS, um modelo racional/empírico sobre o processo pelo qual as emoções secundárias dos clientes se transformam em primárias desadaptativas

e, finalmente, em primárias adaptativas. Segundo estes autores, os clientes avançam das emoções secundárias iniciais (*global distress*) para emoções primárias desadaptativas de raiva rejeitante/destrutiva (e.g., ódio e nojo) ou medo/vergonha. Da articulação entre as necessidades associadas a estas emoções desadaptativas e a auto-avaliação negativa do *self* (e.g., quero ser amado vs. não mereço ser amado), emergem experiências emocionais mais adaptativas de raiva assertiva, autocompaixão e/ou dor/luto. Estas experiências emocionais contribuem para a autoaceitação do *self* e das suas necessidades, bem como para o abandono das necessidades que não podem ser cumpridas (Kramer, Pascual-Leone, Despland, & De Roten, 2015; Pascual-Leone, 2009, 2018; Pascual-Leone & Greenberg, 2007; Pascual-leone & Kramer, 2019; Pascual-Leone, Yeryomenko, Sawashima, & Warwar, 2019).

Esta sequência específica de transformação emocional foi validada por estudos realizados com diferentes abordagens terapêuticas (e.g., Terapia Focada nas Emoções, Terapia Psicodinâmica, Terapia Comportamental-Dialética) e problemas clínicos (e.g., depressão, ansiedade social; Pascual-Leone, 2018). O acesso e exploração das experiências emocionais adaptativas de raiva assertiva, autocompaixão e/ou dor/luto, têm sido associados a melhores resultados terapêuticos no final do tratamento (Choi et al., 2016; Pascual-Leone, 2018; Pascual-Leone & Greenberg, 2007; Pascual-leone & Kramer, 2019).

### 2.2. *Client Emotional Productivity Scale*

Greenberg e colaboradores (Auszra & Greenberg, 2007; Auszra et al., 2013; Greenberg et al., 2007; Herrmann & Auszra, 2019) desenvolveram a CEPS, uma medida da produtividade, ou eficácia, do processamento emocional. Esta escala permite operacionalizar e diferenciar o processamento emocional produtivo (ou bem-sucedido) do não produtivo. O processamento produtivo implica que o cliente ative uma emoção primária e que aceda à informação que lhe está associada para transformar as experiências desadaptativas e se mobilizar para os seus objetivos e necessidades centrais. Para tal, o cliente deve atender, aceitar e simbolizar em palavras as suas emoções primárias, bem como mostrar congruência (verbal e não verbal), capacidade de regulação, agência e diferenciação sobre essas experiências (Auszra et al., 2013; Greenberg et al., 2007; Herrmann & Auszra, 2019). Os estudos prévios em terapias humanisto-experienciais para a depressão observaram que a capacidade dos clientes processarem produtivamente as suas emoções se encontrava associada ao resultado terapêutico (Auszra et al., 2013; Greenberg et al., 2007). Nomeadamente, a maior produtividade emocional explicava uma maior redução na sintomatologia depressiva e geral no final do tratamento.

## 2.3. *Experiencing Scale*

A EXP (Klein et al., 1986, 1969) é uma escala ordinal de 7 pontos que tem sido usada nos estudos de processo-resultado para avaliar o nível de processamento emocional atingido pelos clientes nas sessões de psicoterapia (e.g., Goldman, Greenberg, & Pos, 2005; Malin & Pos, 2015; Pos, Greenberg, Goldman, & Korman, 2003; Pos, Greenberg, & Warwar, 2009; Pos et al., 2017; Watson, Mcmullen, Prosser, & Bedard, 2011). Do nível 1 ao nível 7 da EXP observa-se um aumento da capacidade de processamento emocional.

A EXP foi desenvolvida por Klein e colaboradores (1986, 1969), tendo por base o trabalho de Rogers (1958, 1959, 1961) e de Gendlin (1962, 1997) sobre o conceito de experienciação. "Experienciar" refere-se ao estar consciente, atender, simbolizar, contactar e explorar as experiências internas, sensações e emoções para construir e aceder a novos significados e experiências sobre o *self*. Considerando o grande contributo desses autores para o desenvolvimento das teorias humanisto-experienciais, compreende-se a sobreposição e congruência conceptual entre os processos envolvidos na "experienciação" e no "processamento emocional". Contudo, enquanto para Rogers e Gendlin "experienciar" referia-se a qualquer fenómeno passível de ser representado na consciência, o processamento emocional foca-se, especificamente, nas experiências emocionais (Pos & Choi, 2019).

Klein e colaboradores (1986) sugeriram a utilidade de aplicar a EXP a segmentos clinicamente relevantes para os objetivos de cada investigação. Nesse sentido, a EXP tem sido aplicada a narrativas emocionais, sendo reconhecida na literatura como uma medida adequada do *continuum* afetivo-cognitivo de processamento emocional proposto pelas abordagens humanisto-experienciais (e.g., Elliott et al., 2004; Goldman et al., 2005; Greenberg, 2008, 2012; Malin & Pos, 2015; Pos & Choi, 2019; Pos et al., 2003, 2009, 2017; Watson & Bedard, 2006; Watson et al., 2011). A adequação desta medida é empiricamente apoiada por estudos que observaram a associação da EXP com variáveis conceptualmente relacionadas com o processamento emocional, nomeadamente a ativação emocional (Pos et al., 2017), a capacidade de regulação emocional (Watson et al., 2011) e a transformação emocional (Pascual-Leone & Greenberg, 2007).

### *Níveis da EXP*

Os níveis mais baixos da EXP (nível 1 e 2) são caracterizados por descrições externas, intelectuais e superficiais, sem referências às experiências emocionais (Klein et al., 1986, 1969). Os níveis moderados da EXP (nível 3 e 4) envolvem descrições de reações emocionais ou de experiências e processos internos que tornam mais clara a forma como os eventos são experienciados pelos clientes

(Klein et al., 1986, 1969). Nos níveis mais elevados da EXP são exploradas associações e hipóteses sobre as experiências emocionais (EXP nível 5) e, como resultado desse trabalho interno, os clientes criam novos significados sobre as suas emoções e acedem a novas experiências emocionais e sobre o *self*, usando essa informação para resolver os seus problemas internos (EXP nível 6 e 7).

Em seguida, serão descritos de forma mais detalhada cada um dos níveis da EXP (Klein et al., 1986, 1969). A descrição é ilustrada com excertos clínicos de um caso de uma jovem adulta que desenvolveu sintomatologia depressiva após o término de uma relação amorosa. Os dados pessoais que poderiam comprometer o anonimato da cliente foram alterados.

No nível 1 da EXP, o conteúdo e forma do discurso é impessoal, abstrato, genérico e superficial. O conteúdo não é sobre a cliente ou, quando existe algum envolvimento na situação descrita, não é clara a associação, já que os sentimentos ou o impacto emocional dessa não são comunicados.

O excerto a seguir apresentado foi codificado com EXP nível 1. Apesar de a cliente estar envolvida no evento descrito ("ele disse-me"), o foco é no comportamento do namorado.

> **Rute:** *Ele [namorado] disse-me que estava solteiro e que ia viver com os pais porque tinha acabado a relação anterior. Ele disse-me que não havia volta a dar. Disse que era infeliz e que já há muitos anos não a amava.*

O nível 2 da EXP é caracterizado por uma associação clara entre o conteúdo do que é descrito e a cliente. A narrativa é externamente focada, não são descritos os sentimentos da cliente de forma explícita, mas o seu envolvimento torna-se mais claro pela elaboração de associações, avaliações, ou reações comportamentais.

No excerto clínico a seguir apresentado, a cliente está envolvida no evento narrado e avalia o seu comportamento ("sinto-me mesmo uma parva", "fui burra"). Ainda assim, não é claro o impacto emocional da situação descrita na cliente.

> **Rute:** *Sinto-me mesmo uma parva (chora). Eu devia ter percebido que ele [namorado] me estava a mentir, não é? Toda a gente, até a minha família me tinha dito que ele não estava a ser sincero, que ele ainda estava com ela [esposa do namorado], mas eu fui burra e não acreditei neles.*

No nível 3 da EXP, o conteúdo narrativo é ainda externo, mas a cliente apresenta breves referências ao impacto emocional das situações descritas, ou descreve-se a si mesma a nível comportamental. Apesar de o conteúdo da narrativa adquirir um cunho mais pessoal, as referências emocionais são breves, específicas e limitadas à situação descrita.

Na vinheta clínica a seguir apresentada, a cliente descreveu a situação que levou ao termo da relação amorosa e referiu, de forma breve, o impacto emocional que esse evento teve em si ("sinto-me triste e magoada").

> **Rute:** *Eu disse-lhe [ao namorado] que eu não podia continuar com ele depois de ter descoberto que ele ainda estava com ela [esposa do namorado]. Eu, eu estava à espera que ele sentisse a minha falta, mas não. Isto ainda mexe muito comigo, não consigo falar disto sem... sinto-me triste e magoada. (chora)*

No nível 4 da EXP, o foco do discurso é a experiência interna. A atenção da cliente está focada nas suas experiências emocionais, ao invés das situações ou eventos em si. Ao invés de falar sobre, descreve as suas experiências emocionais a partir do contacto direto com essas. A cliente descreve as suas perceções pessoais, sentimentos e emoções, tornando clara a experiência do *self*, os conflitos internos, ou o impacto dos problemas. Esta descrição internamente focada não dá lugar, contudo, à reflexão ou exploração sobre as experiências emocionais.

No excerto clínico a seguir apresentado, a cliente torna mais clara a sua experiência emocional perante o término da relação amorosa. Através da apresentação de várias referências internas ("zangada", "triste", "humilhada", "rejeitada", "destruir-me"), é possível perceber a forma como a cliente experienciou a rutura.

> **Rute:** *Eu estou zangada com ele [namorado], mas também triste, muito triste... sinto-me humilhada e profundamente rejeitada... Isto está a destruir-me por dentro, nem parece que eu sou eu, é como se tivesse parado naquele momento e não conseguisse avançar.*

No nível 5 da EXP, a cliente define e elabora internamente problemas pessoais e coloca hipóteses sobre as suas experiências emocionais e sobre o funcionamento do *self*. A codificação deste nível implica (1) a identificação de um problema relativo a sentimentos, processos internos ou à perceção

do *self* e, ainda, (2) a exploração e elaboração sobre os sentimentos, reações e experiências internas associados.

Na vinheta clínica a seguir apresentada, a cliente define como problemáticos os sentimentos intensos de rejeição e tristeza pelo término da relação ("Por que é que me sinto tão triste e tão rejeitada?"), e reflete e explora o que estava na base dessas experiências emocionais. No final do excerto elabora sobre a possível associação entre a forma como se estava a sentir e a perceção de falta de valor do *self* para ser amado ("Talvez... é como se eu não tivesse valor").

> **Rute:** *Esta situação [rutura amorosa] fez-me sentir profundamente rejeitada.*
>
> **Terapeuta:** *Hum hum, ok. Este sentimento de rejeição é novo, ou reconhece-o de outras fases da sua vida?*
>
> **Rute:** *Não é completamente novo, mas eu acho que nunca me senti assim tão rejeitada. Mas eu não percebo... Por que é que me sinto tão triste e tão rejeitada se eu sei que ele não é a pessoa certa para mim? Eu nunca iria querer ter ao meu lado alguém que me mente e é capaz de trair... Eu deveria esquecer e avançar com a minha vida.*
>
> **Terapeuta:** *Ok, mas é difícil fazer isso neste momento. O que é que significa para si esta rejeição?*
>
> **Rute:** *Eu... eu achava que era uma pessoa importante para ele, que o confortava, que o apoiava, que tomava conta dele, mas ele escolheu ficar com ela [esposa do namorado] em vez de ficar comigo. Acho que foi isso...*
>
> **Terapeuta:** *Ok, o que é que isso diz sobre si?*
>
> **Rute:** *Talvez... é como se eu não tivesse valor como pessoa, como mulher, eu não valesse nada. Acho que é isso, eu nunca senti que as pessoas gostassem de mim, mas isto foi... "vou ficar sempre sozinha" (chora)... Mas eu sei que não é verdade!*

No nível 6 da EXP, em sequência da exploração interna, a cliente apresenta uma síntese sobre novos sentimentos, significados e experiências do *self*. O processo envolvido na aceitação ou transformação das suas experiências internas, bem como o impacto dessas mudanças são descritos com referências internas vívidas e frequentes.

No excerto a seguir apresentado, a cliente descreve mudanças nas suas experiências emocionais em relação ao término do relacionamento amoroso ("já não me causa tanta dor e sofrimento", "eu culpava-me por tudo"). Narra o processo subjacente a estas mudanças e o impacto

dessa transformação, usando referências internas com elevada frequência. A cliente apresenta um maior acesso, consciência e aceitação das suas experiências internas.

> **Rute:** *Eu ainda sinto saudades dele, mas isso já não me causa tanta dor e sofrimento, já não me sufoca. A raiva que eu sentia diminuiu e eu agora estou mais focada noutras coisas, o que me faz sentir melhor, mais leve.*
> **Terapeuta:** *Ok. O que facilitou esta mudança na forma como se sente em relação a isto?*
> **Rute:** *Eu quero ser a pessoa que era antes. Eu não era eu nos últimos meses. Eu culpava-me por tudo o que estava a acontecer. Eu achava que tinha sido fraca por lhe ter dito que não podia estar com ele sabendo que ele tinha uma mulher, que devia ter aguentado, que por isso é que ele a preferia a ela... Naquela altura os sentimentos de perda e culpa davam cabo de mim. Mas não, eu agora sei que fiz o que estava certo, fiz o melhor para mim. Agora vejo que esse foi o primeiro passo que dei para agora me conseguir sentir aliviada e mais feliz comigo. Eu já sou mais eu!*

Finalmente, no nível 7 da EXP há uma expansão da consciência da cliente em relação ao *self* e às suas experiências emocionais. A cliente apresenta uma perspetiva nova e enriquecida do *self*, o que se traduz em experiências internas diferentes em vários contextos de vida. Implica que os critérios para a codificação da EXP nível 6 estejam presentes, mas que as mudanças sejam transversais a vários contextos. O discurso tende a ser eufórico, expansivo e confiante.

Na vinheta clínica a seguir apresentada, a cliente descreve a mudança na experienciação do *self* ("sinto-me uma pessoa mais segura e confiante"), os processos subjacentes a essa transformação e o seu impacto interno. Adicionalmente, torna clara a mudança em diferentes contextos e relações interpessoais em sequência da forma segura e confiante como se começou a sentir.

> **Terapeuta:** *O que significa "eu sou mais eu"?*
> **Rute:** *Eu, eu... eu estou diferente, sinto-me uma pessoa mais segura e confiante.*
> **Terapeuta:** *Como é que nota essa segurança e confiança? Em que contextos?*
> **Cliente:** *Não estou só a referir-me à relação com o António [namorado], é mais do que isso. Mesmo com o meu irmão, com os meus amigos, no trabalho, e mesmo com os meus pais sinto-me uma pessoa diferente... Até com a minha mãe consigo por limites e*

*dizer "não!". Antigamente sentia que tinha que estar disponível para todos e para tudo, porque tinha que lhes agradar. Agora percebo que só queria que gostassem de mim e por isso é que me esforçava tanto para fazer tudo bem e com um sorriso. Mas não é por aí... eu sinto-me diferente. Não tenho que fazer tudo e agradar sempre para que tenha valor e gostem de mim.*

**Terapeuta:** *Como é que é sentir esta confiança e segurança em si?*

**Cliente:** *(sorri) É bom... estou mais em paz comigo... É como se antes estivesse sempre a ansiosa, a correr e a apagar fogos, sempre a cuidar dos outros, e agora não. Posso parar, respirar e... parece que me aceito melhor a mim e que mesmo que algumas pessoas não gostem de mim, não é o fim do mundo. Fico triste, mas em paz comigo!*

Considerando o conceito de processamento emocional proposto pelas perspetivas humanisto-experienciais (Elliott et al., 2013; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Samoilov & Goldfried, 2000), nos níveis mais baixos da EXP (nível 1 e 2) os clientes apresentam reduzida consciência sobre as suas emoções, não sendo capazes de atender e simbolizar em palavras essas experiências. Nos níveis moderados (nível 3 e 4), ganham uma maior consciência sobre as suas emoções, atendendo e simbolizando-as no seu discurso. No nível 4 da EXP, o foco torna-se completamente interno, as emoções estão ativadas e os clientes entram em contato direto com essas experiências. Por último, os níveis mais elevados da EXP (nível 5, 6 e 7) avaliam a capacidade dos clientes explorarem e refletirem sobre as suas experiências emocionais para aceder à informação adaptativa que lhes está associada e transformar as experiências desadaptativas. Conceptualmente, esta mudança nas respostas emocionais reflete a transformação do esquema que lhes está subjacente (Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006).

Importa salientar que, apesar da EXP não considerar o tipo de emoções ativadas (secundárias, primárias adaptativas e desadaptativas), Pascual-Leone (2009) verificou que a sequência produtiva de transformação emocional proposta pela CAMS (i.e., de emoções secundárias para primárias desadaptativas e, finalmente, primárias adaptativas) tendia a surgir nas sessões em que os clientes atingiam níveis mais elevados da EXP (nível 5, 6 e 7). Não obstante, não foi ainda empiricamente clarificada a relação entre os níveis da EXP e o tipo de emoções ativadas ao longo do processo terapêutico (i.e., medida indireta do funcionamento dos esquemas emocionais). Esta questão é particularmente relevante para conferir apoio empírico à hipótese defendida pelas abordagens

humanisto-experienciais de que o aumento da capacidade de processamento das emoções contribui para a transformação dos esquemas emocionais subjacentes e, consequentemente, para melhores resultados terapêuticos (Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006).

### *EXP e resultado terapêutico*

A EXP é uma das medidas mais usadas na investigação sobre o processo de mudança, tendo sido aplicada com diferentes propósitos e para responder a diferentes questões (Hendricks, 2009; Pascual-Leone et al., 2016; Pascual-Leone & Yeryomenko, 2017). Dos mais de 100 estudos realizados com esta medida (Hendricks, 2009), apenas uma pequena parte se focou, de forma sistemática, em avaliar a sua associação com o resultado terapêutico (Pascual-Leone & Yeryomenko, 2017). A seguir apresentamos os principais resultados dos estudos que investigaram essa relação, focando especificamente os que mediram a EXP durante segmentos emocionalmente salientes do discurso terapêutico (e.g., ativação emocional, episódios emocionais). Importa salientar que, tal como observado nos estudos de revisão da literatura, a maior parte desta investigação foi conduzida em amostras de casos diagnosticados com depressão (Elliott et al., 2013; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017).

No que concerne ao padrão de evolução, os níveis médios na EXP tendem a aumentar da fase inicial para a intermédia da terapia e a manterem-se estáveis ou diminuírem na fase final do tratamento (Pascual-Leone & Yeryomenko, 2017; Pos et al., 2009; Watson & Bedard, 2006). Estes resultados sugerem que os clientes aumentam o processamento das suas experiências emocionais durante a terapia e que esse trabalho é promovido, essencialmente, na fase intermédia do tratamento.

Vários estudos com terapias humanisto-experienciais observaram que os clientes que atingiam níveis mais elevados na EXP durante o tratamento tendiam a apresentar melhores resultados no final do mesmo (e.g., sintomas depressivos e gerais; Goldman et al., 2005; Makinen & Johnson, 2006; Malin & Pos, 2015; Pos et al., 2003, 2009, 2017; Toukmanian, Jadaa, & Armstrong, 2010). Estes resultados não se limitaram, contudo, a essas abordagens terapêuticas. Não obstante as terapias humanisto-experienciais promoverem níveis mais elevados na EXP comparativamente com outras abordagens (Castonguay et al., 1996; Klein et al., 1986; Pascual-Leone & Yeryomenko, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011), em Terapia Cognitivo-Comportamental (Castonguay et al., 1996; Watson & Bedard, 2006; Watson et al., 2011) e Psicodinâmica (Rudkin et al., 2007) os casos de sucesso atingiram níveis mais elevados na EXP, comparativamente aos casos de insucesso. Assim,

em diferentes modalidades terapêuticas, o atingir de níveis mais elevados na EXP ao longo da terapia tem sido relacionado com sintomas menos intensos no final da mesma, ou com uma maior redução dos sintomas do início para o final do tratamento (Castonguay et al., 1996; Klein et al., 1986; Pascual-Leone & Yeryomenko, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011). No mesmo sentido, Pascual-Leone e Yeryomenko (2017), numa meta-análise recente com 10 estudos e 406 clientes (depressão e problemas interpessoais), observaram que, (1) independentemente da abordagem terapêutica adotada e (2) da fase da terapia (inicial, intermédia e final) em que fosse aplicada, a EXP era um preditor significativo do resultado no final do tratamento, com um efeito pequeno a moderado (*r* = -.19, 95% CI -.10 a -.29).

Os resultados supracitados ganharam maior robustez com os estudos que investigaram simultaneamente o potencial efeito da EXP e da aliança terapêutica na intensidade dos sintomas no final do tratamento. As abordagens humanisto-experienciais defendem que a criação de uma relação terapêutica empática e colaborativa é fulcral para facilitar o processamento emocional em terapia (Elliott et al., 2004; Greenberg, 2002, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Pos & Choi, 2019; Timulak, Iwakabe, & Elliott, 2019; Warwar & Ellison, 2019). Esses estudos empíricos verificaram não só que a qualidade da aliança predizia positivamente os níveis atingidos na EXP, mas também que a EXP explicava melhor a variância nos resultados do que aliança terapêutica (i.e., o fator comum cuja associação ao resultado terapêutico se encontra melhor sustentada empiricamente, Flückiger et al., 2018; Horvath et al., 2011).

Em suma, o processamento emocional tem apresentado resultados robustos na predição do resultado final do tratamento da depressão (Elliott et al., 2013; Goldman, 2019; Hendricks, 2009; Klein et al., 1986, 1969; Pascual-Leone et al., 2016; Pascual-Leone & Yeryomenko, 2017; Pos & Choi, 2019). No entanto, apesar do grande contributo dos estudos prévios, consideramos que o papel do processamento emocional na mudança terapêutica carece de investigação adicional. No contexto da presente dissertação focar-nos-emos em algumas das questões que carecem de uma investigação mais aprofundada.

A primeira questão diz respeito à natureza da associação entre EXP e resultado terapêutico. Como referido anteriormente, os casos de depressão que terminam a terapia com melhores resultados terapêuticos atingem níveis mais elevados na EXP. Quer isso dizer que, ao longo da terapia, à medida que a capacidade de processamento emocional aumenta, a intensidade dos sintomas diminui? Isto é, qual o contributo do processamento emocional para a gradual diminuição dos sintomas ao longo das sessões? Considerando os resultados previamente observados, esperaríamos que as variáveis se

encontrassem negativamente associadas durante a terapia, especificamente, que o aumento do processamento emocional explicasse a diminuição da intensidade dos sintomas ao longo das sessões. Contudo, uma vez que os estudos anteriores se focaram no contributo do processamento emocional para a intensidade dos sintomas no final da terapia, não incluíram no seu *design* medidas sessão-a-sessão das variáveis que permitissem clarificar a sua associação longitudinal (e.g., Castonguay et al., 1996; Goldman et al., 2005; Makinen & Johnson, 2006; Pos et al., 2003, 2009, 2017; Toukmanian et al., 2010; Watson & Bedard, 2006; Watson et al., 2011). Nomeadamente, (1) usaram medidas de sintomas apenas no pré e pós-teste, não monitorizando estes indicadores do resultado noutros momentos do tratamento, e (2) aplicaram a EXP a um número reduzido de sessões (frequentemente 2 ou 3 sessões por caso), devido aos recursos e morosidade que acarreta a codificação. Na maior parte dos estudos, a seleção dessas sessões baseou-se em dois critérios aplicados de forma sequencial: (1) fase da terapia a analisar (inicial, intermédia ou final), e (2) sessões avaliadas pelo cliente, terapeuta e/ou observador externo como mais úteis ou clinicamente relevantes. Enquanto as sessões da fase inicial e final foram usualmente selecionadas apenas com base no critério temporal (e.g., segunda e penúltima sessão para representar a fase inicial e final da terapia, respetivamente), as sessões da fase intermédia foram selecionadas a partir das "melhores" sessões dessa fase com base na avaliação do cliente, terapeuta, e/ou observador externo. Para além de este tipo de *design* não permitir explorar a associação, sessão-a-sessão, entre as variáveis em questão, pode ainda ter tido implicações significativas nos resultados observados. De facto, a seleção e análise de apenas algumas sessões do processo terapêutico é apontada por diferentes investigadores como uma potencial fonte de viés (e.g., Crits-Christoph, Gibbons, & Mukherjee, 2013). Ignorar a variabilidade entre as sessões, assumindo que uma ou duas sessões são representativas de uma determinada fase da terapia, pode resultar na generalização de resultados que não representam os dados. Este problema de representatividade é potencialmente agravado quando são selecionadas as "melhores" sessões. Nesse sentido, (1) tanto o padrão de evolução identificado na capacidade de processamento emocional dos clientes ao longo da terapia (i.e., aumento da fase inicial para a intermédia e estabilização ou diminuição na fase final; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2009; Watson & Bedard, 2006), (2) como a sua associação com os resultados terapêuticos, podem ter sido enviesados pelo número e tipo de sessões em que a EXP foi aplicada.

Para além de ainda não estar claro o contributo do processamento emocional para a mudança gradual nos sintomas clínicos, os resultados dos estudos anteriores podem ter sido influenciados por um artefacto estatístico, já que as análises de dados não tiveram em consideração a mudança nos

sintomas prévia à sessão em que foi aplicada a EXP (cf., Crits-Christoph et al., 2013). Especificamente, a mudança prévia nos sintomas clínicos (e.g., diminuição dos sintomas clínicos do pré-teste até à sessão 8) pode ter influenciado o nível atingido pelo cliente na EXP na sessão selecionada para codificação (e.g., sessão 8), enviesando e/ou sobrestimando a relação entre o processamento emocional e a mudança nos sintomas do início para o final da terapia. Assim, uma interpretação alternativa dos resultados supracitados é que o alívio prévio nos sintomas promove níveis mais elevados na EXP (causalidade inversa), sobrestimando o efeito da EXP nos sintomas depressivos no final do tratamento. Desta forma, urge esclarecer a seguinte questão: o processamento emocional explica a mudança nos sintomas clínicos, ou é a diminuição na intensidade desses sintomas que facilita uma maior capacidade do cliente processar as suas experiências emocionais? Ou, ainda, é esta uma relação bidirecional? A clarificação destas questões poderá contribuir para um conhecimento mais compreensivo e preciso sobre o papel do processamento emocional na mudança terapêutica na depressão.

Tal como referido anteriormente, a hipótese defendida pelas abordagens humanisto-experienciais sobre como o aumento na capacidade de processamento emocional dos clientes contribui para a mudança dos esquemas emocionais desadaptativos subjacentes às suas experiências dolorosas (Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006) carece de investigação adicional. Dado que os estudos prévios se focaram no contributo dos níveis atingidos na EXP para o resultado terapêutico, não clarificaram que tipo de emoções são ativadas durante a terapia, nem a associação entre o nível de processamento dessas experiências e a mudança nos esquemas emocionais desadaptativos. A investigação da relação entre o nível atingido na EXP e o tipo de emoções ativadas ao longo das sessões de psicoterapia é relevante para construir um conhecimento mais aprofundado sobre o papel do processamento emocional na mudança terapêutica e sobre o padrão de mudança emocional associado a melhores resultados terapêuticos (cf. Gelo & Salvatore, 2016). Desta forma, para além de esclarecer o efeito do processamento emocional na mudança dos sintomas, também é relevante explorar o seu contributo para a transformação das experiências emocionais dolorosas e desadaptativas dos clientes.

Por último, atendendo a que os estudos prévios usaram, maioritariamente, amostras de clientes diagnosticados com depressão, importa ainda esclarecer se noutros quadros psicopatológicos se observam resultados semelhantes aos encontrados nesses casos. Esta questão é importante para explorar se este é um mecanismo associado à mudança dos clientes em psicoterapia, independentemente da problemática e da abordagem terapêutica usada (Elliott et al., 2013; Greenberg & Pascual-Leone, 2006; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017).

## 3. A presente dissertação

Apesar de a investigação prévia ter verificado que níveis mais elevados de processamento emocional predizem melhores resultados no final do tratamento, não está ainda claro se, e em que medida, o processamento emocional está associado à mudança terapêutica ao longo das sessões. Mais especificamente, está por esclarecer qual o contributo do processamento emocional para a gradual (1) transformação das experiências emocionais desadaptativas (ou, esquemas emocionais) e (2) alívio dos sintomas. Os estudos empíricos que integram esta dissertação focaram-se na clarificação destas questões.

O *design* dos estudos empíricos que desenvolvemos no âmbito desta dissertação incluiu a avaliação longitudinal (1) do nível de processamento emocional, (2) do tipo de emoções ativadas e (3) da intensidade dos sintomas. O nível de processamento emocional foi avaliado pela aplicação da EXP a Episódios Emocionais (EEs), i.e., segmentos de psicoterapia em que os clientes expressaram uma resposta emocional em relação a uma determinada situação ou evento (Greenberg & Korman, 1993; Korman, 1991, 1998). A categorização do tipo de emoções ativadas durante esses EEs permitiu monitorizar o tipo de emoções experienciadas e a mudança nas respostas emocionais dos clientes ao longo da terapia. A mudança no tipo de emoções ativadas perante as mesmas situações, representa uma medida indireta da transformação dos esquemas emocionais que lhe estão subjacentes (Greenberg, 2010; Greenberg & Korman, 1993; Greenberg & Watson, 2006). Por último, os sintomas foram avaliados através de medidas de autorrelato. Nomeadamente, os sintomas depressivos foram avaliados através do *Beck Depression Inventory II* (BDI-II; Beck, Steer, & Brown, 1996), os sintomas clínicos gerais foram medidos através do *Outcome Questionnaire 10.2* (OQ-10.2; Lambert, Finch, Okiishi, & Burlingame, 2005), e os sintomas de luto foram medidos através do *Inventory of Complicated Grief* (ICG; Prigerson et al., 1995).

No sentido de colmatar a possível fonte de viés nos resultados, associada à análise de apenas algumas sessões do processo terapêutico (cf., Crits-Christoph et al., 2013), no primeiro estudo – *Emotional processing and therapeutic change in depression: A case study* – procedemos à análise intensiva de todas as sessões de um caso de sucesso atendido em Terapia Focada nas Emoções (Elliott et al., 2004; Greenberg & Watson, 2006). Este estudo de caso exploratório recorreu a metodologias de análise longitudinal de dados para clarificar a relação, sessão-a-sessão, do nível de processamento emocional atingido com (1) a intensidade dos sintomas clínicos experienciados pela cliente, e (2) o tipo de respostas emocionais ativadas. Esta análise longitudinal pretendeu clarificar e fornecer um

entendimento mais aprofundado sobre a evolução da capacidade de processamento emocional e o seu papel na mudança sintomatológica e emocional ao longo das sessões.

Tal como explicado na secção anterior, na investigação prévia a capacidade preditiva do nível de processamento emocional da mudança nos sintomas poderá ter sido enviesada e/ou sobrestimada devido a um artefacto estatístico (cf., Crits-Christoph et al., 2013). Assim, no segundo estudo – *What is the effect of emotional processing on depression? A longitudinal study* – usamos medidas e análises estatísticas longitudinais para controlar essa possível fonte de viés. Numa amostra de 50 casos diagnosticados com depressão e tratados com Terapia Focada nas Emoções (Elliott et al., 2004; Greenberg & Watson, 2006) e Terapia Cognitivo-Comportamental (Beck, Rush, Shaw, & Emery, 1997), estimamos (1) o efeito do nível de processamento emocional atingido durante o tratamento para a diminuição dos sintomas depressivos do início para o final da terapia, e (2) a relação, sessão-a-sessão, entre o nível de processamento emocional atingido e a intensidade dos sintomas clínicos. Especificamente, exploramos se o processamento emocional predizia os sintomas clínicos na sessão seguinte e/ou se os sintomas prévios explicavam o nível de processamento emocional atingido na sessão seguinte. Este estudo permitiu, ainda, identificar o padrão de evolução do processamento emocional ao longo da terapia.

Por fim, no terceiro estudo – *Emotional processing during the reconstruction of the grief experience: A case study* – exploramos a possibilidade de se observar noutros quadros clínicos resultados semelhantes aos encontrados nos casos diagnosticados com depressão. Apesar do luto complicado partilhar características com a depressão, apresenta características distintivas (Killikelly & Maercker, 2018). Estudos prévios sugerem que no luto complicado as pessoas apresentam dificuldades nos primeiros passos do *continuum* envolvido no processamento emocional, nomeadamente ao nível da consciência, ativação e experienciação do sofrimento associadas à perda do ente-querido (Castro & Rocha, 2013). Estas dificuldades poderão impedir que transformem as suas experiências emocionais desadaptativas e acedam às necessidades e tendências para a ação associadas às emoções adaptativas (Elliott et al., 2013; Greenberg, 2002, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Samoilov & Goldfried, 2000). A informação associada a essas emoções seria essencial para a reconstrução e integração da experiência de luto e para a adaptação à vida sem a presença do ente-querido (cf., Stroebe & Schut, 2010). Neste estudo intensivo, exploramos, em dois casos atendidos em Terapia Construtivista de Reconstrução de Significado no Luto (Neimeyer, 2001, 2006, 2016), a associação da capacidade de processamento emocional apresentada pelas clientes ao longo da terapia (sessão-a-sessão) com (1) a mudança no tipo de respostas emocionais ativadas, (2) e o resultado

terapêutico (sucesso vs. insucesso). Atendendo a que a maior parte dos estudos realizados na área se focaram nas características distintivas do luto complicado, ainda pouco se conhece sobre os processos ou mecanismos envolvidos na mudança dos clientes nesta problemática. Assim, para além de este estudo contribuir para clarificar como é que os clientes processam, ao longo da terapia, as suas emoções, permitiu explorar se o processamento emocional é um dos processos de mudança envolvidos no alívio dos sintomas de luto complicado.

# CAPÍTULO II – ESTUDOS EMPÍRICOS

# 1. Emotional processing and therapeutic change in depression: A case study[1]

## 1.1. Abstract

The association between clients' higher capability of emotional processing and good therapeutic outcome has been consistently observed in different therapeutic approaches. Despite previous studies that have reported an association between emotional processing and pre- to post-therapy change in symptoms, the session-by-session relation between emotional processing and therapeutic change needs further research. The current study explored, in a good-outcome case of depression, the session-by-session longitudinal association of the level of emotional processing with (1) clinical symptoms and (2) type of emotions aroused (adaptive or maladaptive). Using a time-series analysis, we observed a strong negative association between the intensity of clinical symptoms and the level of emotional processing in the same session, $r = -.71$, $p < .001$, but a nonsignificant association between emotional processing and the symptoms in the preceding session, $r = -.37$, $p = .101$, and the next session, $r = -.29$, $p = .180$. During the increase in the level of emotional processing, we observed a change in the type of emotions aroused, from maladaptive to more adaptive. The results support that emotional processing is associated with therapeutic change, although not necessarily precedes such change, at least from one session to the next. Since it is an exploratory study, the results must be interpreted carefully.

## 1.2. Introduction

The way clients process their emotional experiences and how this processing contributes to therapeutic change has received renewed interest in psychotherapy research (Baker et al., 2012; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Foa, Huppert, & Cahill, 2006; Greenberg, 2010; Whelton, 2004). In different therapeutic approaches, the achievement of a high capacity for emotional processing during therapy has been associated to good outcome (Baker et al., 2012; Greenberg & Watson, 2006; Whelton, 2004).

Although previous studies found a relationship between higher levels of emotional processing and greater symptomatic improvement from pre- to post-therapy, it is not yet clear whether those higher levels of emotional processing are associated with the session-by-session improvement. Such a

[1] Pinheiro, P., Mendes, I., Silva, S., Gonçalves, M. M., & Salgado, J. (2018). Emotional processing and therapeutic change in depression: A case study. *Psychotherapy*, 55(3), 263–274. http://doi.org/10.1037/pst0000190

longitudinal analysis would be relevant to clarify and provide a more comprehensive understanding of the role of emotional processing as a variable associated with gradual improvement during therapy. In the current article, we will explore in a good-outcome case of depression whether these variables are, as theoretically expected, associated throughout therapy. Consistent with the model of theory-building case studies (Stiles, 2015) the degree of congruency between our observations and the theoretical expectations may increase confidence in or suggest modifications to current assumptions about the contribution of emotional processing to therapeutic change in depression.

## Emotional processing

The concept of emotional processing was first introduced in the context of behavioral approaches, mainly to explain the effect of exposure in anxiety disorders (Foa et al., 2003; Goldfried, 2003; Whelton, 2004). For these approaches, successful emotional processing involved the activation of the dysfunctional emotion and the gradual reduction of its intensity during the exposure to the trigger stimulus (Rauch & Foa, 2006).

Later, humanistic-experiential approaches conceptualized emotional processing differently, giving it a prominent role in psychotherapy. For these approaches, the impairment in the processing of emotions is associated to psychopathological conditions, such as depression (Greenberg, 2010; Greenberg & Watson, 2006). According to Greenberg and Watson (2006) in depression the experiential self is organized as unlovable or worthless and helpless or incompetent because of the activation of early schematic memories of being humiliated, abused, criticized, trapped, and/or abandoned. Once activated, depressive emotional schemes automatically produce maladaptive emotional responses to situations, impairing the person's ability to process painful emotions (Greenberg & Watson, 2006). The therapeutic change involves promoting the client's capability to process their emotions, i.e., to be aware, to experience and make meaning of such emotions, and to transform the underlying emotional scheme into a more adaptive one (Elliott et al., 2013; Greenberg, 2010; Pos, Greenberg, Goldman, & Korman, 2003). In this sense, emotions are a source of information that needs to be explored to create new meaning and change the maladaptive emotional experiences (Greenberg, 2010; Greenberg & Watson, 2006).

To humanistic-experiential approaches, emotional processing is a continuum of stages that goes beyond the arousal (and eventual decrease) of the emotional experience that typically occurs in traditional exposure methods. In these approaches, the creation of new meaning based on the information derived from aroused emotions is a key process associated with the achievement of higher levels of emotional

processing and with the transformation of the depressive emotional scheme (Pos et al., 2003). To make sense of emotions, the client needs to cognitively explore the emotional information, integrating affect and cognition (Greenberg, 2010; Greenberg & Pascual-Leone, 2006; Whelton, 2004). In sum, for humanistic-experiential approaches, emotional processing broadly involves (1) being aware of emotions, (2) arousing emotions and tolerating live contact with them, (3) exploring to make meaning of the emotional experience, and finally (4) transforming the emotional scheme, i.e., the maladaptive emotions that underlie and influence how the client feels, thinks, and behaves (Elliott et al., 2013; Greenberg, 2010; Greenberg & Watson, 2006).

The humanistic-experiential concept of emotional processing has been measured through different scales. In the current study, we used the concept as it is operationalized by the application of the Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986) to emotionally loaded segments of psychotherapy – Emotion Episodes (EEs; Greenberg & Korman, 1993; Korman, 1991). In previous studies, the rating of the EXP during EEs was an appropriate measure of the emotional processing continuum within emotional clinical relevant segments of therapy (e.g., Pos et al., 2003; Pos, Greenberg, & Warwar, 2009). The EXP is an observational scale that provides a cognitive-affective continuum of a client's engagement and exploration of inward experiences to make sense of those experiences, transform maladaptive emotions, and solve personal problems in a meaningful way (Klein et al., 1986). From lower to higher levels of the EXP, clients increase their ability to access feelings, to be in contact with them, to explore them, to create meaning from them, and to achieve new ones. Although its focus is on the emotional component, the EXP also considers the cognitive component involved both in the exploration of inner experiences to create new meaning and to transform emotions, and in the coherent integration of those experiences into the self.

### Emotional processing and symptomatic improvement

The facilitation of in-session emotional processing, as assessed by the EXP, has been recognized as a promoter of therapeutic change (Elliott et al., 2013; Greenberg, 2010; Greenberg et al., 2007). Several studies on emotion-focused therapy (EFT) and client-centered therapy found that the achievement of higher levels on EXP during psychotherapy predicts better outcomes in depression (Goldman et al., 2005; Pos et al., 2003, 2009, 2017). These results are not limited to humanistic-experiential therapies. In cognitive-behavioral therapy (CBT), higher levels on EXP was predictive of a greater decrease in symptoms from pre- to post-therapy (Watson et al., 2011), and in both CBT and psychodynamic-interpersonal therapy for depression, good-outcome cases presented higher levels of emotional

processing than poor-outcome cases (Rudkin et al., 2007). More importantly, a meta-analysis of 10 studies and 406 clients using different psychotherapeutic approaches found that the level of EXP achieved was a significant outcome predictor at the end of treatment, with a small to medium effect size ($r$ = -.19; Pascual-Leone & Yeryomenko, 2017).

Although there is evidence of the association between emotional processing and therapeutic outcome, previous studies have not clarified whether there is a session-by-session association between the increase in the level of emotional processing and the decrease in symptom intensity throughout therapy. Since those studies were focused on the contribution of emotional processing to pre- to post-therapy change in symptoms, their design did not include a longitudinal assessment of variables, namely, (1) they did not consider session-by-session measurements of clinical symptoms, and (2) emotional processing was assessed in a reduced number of sessions sampled from the entire treatment (usually, 2 to 3 sessions per case). Leading process-outcome researchers (e.g., Crits-Christoph, Gibbons, & Mukherjee, 2013) point out that ignoring the session to session variability and analyzing only a few sessions of the therapeutic process, may result in the generalization of unrepresentative results. Thus, they recommended that longitudinal studies be carried out to avoid this potential source of bias.

To the best of our knowledge, no studies have been carried out to explore the relationship between emotional processing and symptoms change on a session-by-session basis. Only a recent study in psychodynamic therapy (Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016) has explored the longitudinal association between the clients' level of emotional engagement in therapy (a process related to, but distinct from emotional processing) and their functioning, observing a bidirectional relation between variables. Although emotional engagement is a less comprehensive process (EXP considers emotional engagement and a cognitive component) and has been assessed using a retrospective self-report measure (EXP is an observational measure), those results suggest a more complex (non-unidirectional) relation between variables than suggested in previous studies. As such, further clarification of the session-by-session patterns of association between emotional processing and symptoms may provide a more comprehensive and accurate understanding of the role of emotional processing on the gradual improvement in depression.

### Emotional processing and change from maladaptive to adaptive emotions

For humanistic-experiential approaches, the transformation of the emotional scheme is the ultimate stage on the continuum of emotional processing. The increase in the clients' capability to process their emotions contributes to transforming the depressive emotional scheme, resulting in the

emergence of new and more adaptive emotional responses to daily situations (Greenberg, 2010; Greenberg & Watson, 2006).

Based on the clinical distinction of types of emotions, Greenberg (2010) described a three-step sequence involved in the change of the maladaptive emotional experiences: secondary maladaptive emotions evolve to primary maladaptive emotions, and then to primary adaptive emotions. Secondary maladaptive emotions, such as worthlessness, are secondary reactive responses to primary emotions (e.g. sadness) that are perceived as threatening or overwhelming; and they need to be transformed in order to make it possible to access primary emotions, the first fundamental responses to situations (Greenberg, 2010; Greenberg & Watson, 2006). Primary adaptive emotions refer to immediate responses to situations that mobilize the person for adaptive actions, while primary maladaptive emotions trigger dysfunctional action tendencies and cognitive processes that interfere with a person's adaptive functioning (Greenberg, 2010). For instance, primary maladaptive shame can be replaced by primary sadness, assertive anger, self-forgiveness, and self-worth (Greenberg & Watson, 2006). Primary adaptive emotions need to be accessed to symbolize their information, which is essential for the enhancement of the level of emotional processing and to change the depressive emotional scheme (Greenberg, 2010; Greenberg, Auszra, & Herrmann, 2007; Greenberg & Watson, 2006; Pascual-Leone & Greenberg, 2007). In this sense, accessing adaptive emotions such as anger to replace unfairness or sadness for what was lost is important to ensure the self-capacity to be loved and to achieve self-worth (Greenberg & Watson, 2006).

Supporting this theoretical background, Herrmann, Greenberg, and Auszra (2016) found that a high frequency of primary emotions during the therapeutic working phase and a high frequency of change from maladaptive to adaptive emotions are predictors of good outcome. However, to sustain the theoretical claim that the increase in the clients' capability to process their emotions is associated to the change from maladaptive to more adaptive emotional responses, we still need to explore this relationship further.

### Aims

This research consists of an intensive case study analysis of a good-outcome case of depression treated with EFT (Elliott, Wattson, Goldman, & Greenberg, 2004; Greenberg, 2010; Greenberg & Watson, 2006) and aims to explore if emotional processing is longitudinally associated with the gradual therapeutic change in depression. The first specific aim was to explore the session-by-session associations between the levels of emotional processing and the intensity of symptoms. The second aim

was to explore the relationship between the increase in the levels of emotional processing and the change in the type of emotional responses (adaptive or maladaptive) aroused throughout therapy.

## 1.3. Method

### 1.3.1. Participants

**Client.** Elizabeth (fictional name) was a Portuguese woman in her early forties with low levels of both education and socioeconomic status. She was divorced and lived with her three children. Elizabeth participated in the ISMAI Depression Study (Salgado, 2014), a clinical trial that compared the efficacy of EFT and CBT in the treatment of major depression (outcome study). The inclusion criteria for the clinical trial were a diagnosis of major depressive disorder, no medication, and a Global Assessment of Functioning above 50. The exclusion criteria were (1) currently using medication; (2) a current or previous diagnosis with one of the following the following Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), Axis I disorders: panic, substance abuse, psychosis, bipolar, or eating disorder; (3) diagnosis of one of the following DSM-IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or (4) a high risk of suicide. At baseline assessment, Elizabeth received the diagnosis of mild major depression and she was randomly assigned to the EFT treatment. She received her treatment in the psychotherapeutic lab at ISMAI during 16 therapeutic sessions. Elizabeth consented to have her sessions videotaped, which was obtained after she had been informed about the aims and procedures of the clinical trial and about the further use of the collected data in process-outcome studies (such the current study that demanded qualitative analyzes of the level of emotional processing and the type of emotions aroused throughout sessions). The ethical principles of both the American Psychological Association and the Order of Portuguese Psychologists were followed.

Elizabeth's case was randomly chosen from EFT good outcome cases ($N$=18) according to the Beck Depression Inventory-II (BDI-II; translated and validated to the Portuguese population from Beck, Steer, & Brown, 1996 by Coelho, Martins, & Barros, 2002). It was considered a recovered and reliably changed case since (1) in the last session the total score was below the cutoff point of 13 (BDI-II scores = 0), and (2) the change from pre-test to post-test was higher than the reliable change index (RCI; Christensen & Mendoza, 1986; Jacobson & Truax, 1991) of 7.75 (Δ BDI-II scores = 31).

Elizabeth's core issues were related to experiencing feelings of worthlessness and of being an unlovable person. First, she felt that she failed as a mother since she got divorced and could not provide her children with the traditional family she had idealized. Because of her early experience as a victim of

her father's intimate violence, she had the main goal of providing a nonviolent and supportive family for her children. Although she got divorced to avoid a violent family environment for her children, she believed that not providing her children with the presence of a father meant that they would be ultimately unhappy. Second, she felt unlovable and rejected by others, mostly by her critical and dismissive father and her ex-husband, making her question her self-worth and her ability to be loved.

**Therapist.** Elizabeth's therapist was a female doctorate in clinical psychology who was in her early thirties. She had 9 years of experience as a psychotherapist and had been trained in EFT during the prior 4 years. The therapist received weekly supervision.

### 1.3.2. Therapy

EFT is an integrative humanistic-experiential therapy that incorporates techniques from person-centered and gestalt approaches (Greenberg, 2010; Greenberg & Watson, 2006). According to EFT, emotions play a unique role in the human experience, contributing both to adaptive and maladaptive functioning (Elliott et al., 2004; Greenberg, 2010; Greenberg & Watson, 2006). In depression, clinical problems are associated with maladaptive emotional processing, and therapy aims to solve those difficulties through specific emotion-evocative therapeutic tasks (Watson & Bedard, 2006). The goal of those experiential strategies is to promote access to the depressive emotional scheme and to enhance the level of emotional processing, facilitating the change in the maladaptive scheme, and the consequent experiencing of new and more adaptive emotions (Greenberg & Pascual-Leone, 2006). According to this approach different and opposing self-aspects or voices compose the self, and poor or disturbing communication between them causes emotional pain, impairing access to adaptive emotions and the resolution of personal problems (Elliott et al., 2004). Thus, therapeutic tasks facilitate contact between the opposing voices or parts of the self. Throughout Elizabeth's treatment, the prevailing experiential tasks used were the two-chair dialogue with her critical and blaming internal voice and the empty-chair dialogue with her father and ex-husband regarding unfinished business.

### 1.3.3. Measures

#### Process Measures

**Emotion Episodes (EEs)**. An EE (Greenberg & Korman, 1993; Korman, 1991) is an emotionally loaded segment of psychotherapy in which the client expresses an emotion (e.g., sadness) or an associated action tendency (e.g., crying) in response to a situation or context (e.g., relationship

breakup). According to the emotional response (emotion or action tendency) presented in the EEs, these are categorized into six basic emotions: EE of Love, EE of Joy, EE of Fear, EE of Anger, EE of Sadness, and EE of Guilt/Shame (EE Manual; Korman, 1991). Since the client's emotional scheme underlies the activation of specific emotional responses to situations (Greenberg & Korman, 1993), changes in the aroused emotions regarding the same situation may indicate some transformation of the scheme.

Following the EE Manual (Korman, 1991), the coding of EEs involved: (1) identification in the client's speech of an emotional response towards a situation, context or event; (2) delimitation of the EE by tracking the client's speech back to where the situation or context relevant to the emotional reaction emerged and forward to where either the theme of the discourse or the emotion changed; and, finally, (3) categorization of the basic emotion of the EE according to the expressed emotional response (whenever an EE contained different basic emotions the rule was to categorize it according to the dominant one, based on clinical judgment). In prior studies the inter-rater agreement on the identification of EEs was strong (99%; Pos et al., 2003). Clinicians were able to discriminate between EEs and non-EEs in psychotherapy segments, suggesting an appropriate validity (Greenberg & Korman, 1993).

**Experiencing Scale (EXP)**. The EXP (Klein et al., 1986) assesses the level at which the client is cognitively and emotionally involved in the processing of inward experiences through a 7-point ordinal rating scale. Namely, it assesses to what level a client focuses on, experiences, explores and reflects on information to create new meaning, transform emotional experiences, and solve personal problems in a meaningful way. Higher levels indicate higher emotional processing. At EXP level 1 clients describe their experience from an external perspective. At EXP level 2 clients are only behaviorally or intellectually involved with the described situation. At EXP level 3 clients describe external events, presenting feelings and personal reactions circumscribed to these events. At EXP level 4 clients shift to an inward focus, describing feelings, inner experiences and personal assumptions and perceptions. At this stage clients speak "from" instead of talk "about" their personal experience. At EXP level 5 clients present and explore hypotheses about their feelings, inner experiences and personal problems. At EXP level 6 they present a synthesis of vivid and accessible feelings to describe the achievement of personal problem resolution and/or the transformation of meanings and emotional experiences. Finally, at EXP level 7 the new inner experiences and feelings are applied to a wider range of situations, resulting in clients' new and expansive understanding of themselves.

The rating of the EXP involved the identification of the EXP peak level, i.e., the highest level achieved during each EE (EXP Manual; Klein et al., 1986). In prior research the inter-rater reliability

coefficients (*Intraclass Correlation Coefficient – ICC*) ranged from .76 to .91 and the rating–rerating correlation coefficient was approximately .80 (Klein et al., 1986). The EXP presented a moderate concurrent validity with the Observer-Rated Measure of Affect Regulation (*Pearson's r* = .44; Watson et al., 2011).

### Symptoms measure

**Outcome Questionnaire 10.2 (OQ-10.2).** The OQ-10.2 (Lambert, Finch, Okiishi, & Burlingame, 2005) is a self-report inventory that assesses a client's general clinical symptoms. The 10 items (e.g., "I am satisfied with my life", "I feel blue") are scored on a scale ranging from 0 to 4. The total score ranges from 0 to 40, with higher scores indicating more intense symptomatic distress. The Portuguese version presented an adequate internal consistency (*Cronbach's Alpha* = .77) and test–retest reliability over a 1-week interval (*Pearson's r* = .74) in the ISMAI Depression Study's sample (Salgado, 2014; *N* = 64). The instrument presented a moderate concurrent validity with the BDI-II (*Pearson's r* = .51).

## 1.3.4. Procedures

### Process measurement

**EEs. *Judges' training.*** The judges were two female PhD students of clinical psychology (first and third authors), both with previous training in EFT. One of the judges was an expert in the coding of EEs and provided the second judge with training based on the EEs' Manual (Korman, 1991). The training procedures encompassed weekly meetings (2 hours) over approximately 3 months, which included the following steps: (1) reading and discussion of the coding manual, (2) coding of all excerpts from the manual, and finally (3) coding of videotaped sessions from the ISMAI Depression Study's cases (not from Elizabeth's case). The last step was concluded when a good level of reliability was achieved between judges (*Cohen's kappa* ≥ .65). ***Reliability.*** The judges were unaware of the evolution of the clinical symptoms (OQ-10.2 scores) of Elizabeth's case and performed an independent coding of the sessions (following their chronological order). Reliability was determined by comparing the judges' independent codification of the (1) presence/absence of EEs, and (2) the emotion in each EE. The inter-judge agreement for the presence/absence of the EEs was a Cohen's kappa of .80 and for the emotions of EEs the Cohen's kappa was .81. Disagreements were discussed afterwards to reach a consensus. ***Data***

***analysis.*** For the final codification we computed the total frequency of EEs and the frequency of the EEs categorized in each of the basic emotions, both for the entire case and for each session.

**Adaptive or maladaptive EEs.** ***Judges.*** The judges were the same ones who previously coded the EEs. They were clinicians trained in EFT and familiarized with Greenberg's (2010) distinction between adaptive and maladaptive emotions. ***Reliability.*** Based on theoretical knowledge and clinical judgment, the judges performed an independent categorization of each EE (following their chronological order) as presenting adaptive or maladaptive emotions. The inter-judge agreement was excellent (*Cohen's kappa* = .95). Disagreements were discussed to reach a consensus. ***Data analysis.*** For the final codification we computed the frequency of the adaptive and maladaptive EEs of Love, Joy, Fear, Anger, Sadness, and Guilt/Shame, both for the entire case and for each session.

**EXP.** ***Judges' training***. A clinical psychologist with a doctoral degree, expert in the EXP and in EFT, trained two judges, namely, a female PhD student (first author) and a master's degree student in clinical psychology. The training was based on the EXP Manual (Klein et al., 1986) and encompassed weekly meetings (2 hours) over approximately 4 months. It included 3 steps: (1) reading and discussion of the rating manual, (2) rating of excerpts from the manual, and finally (3) rating on previously delimitated EEs in ISMAI Depression Study's videotaped sessions (not from Elizabeth's case). This last step was completed when a good reliable index was achieved between the trainees' and the expert judge's ratings (*ICC* [2,1] ≥ .65). ***Reliability.*** Both judges were unaware of the evolution of the clinical symptoms (OQ-10.2 scores) of Elizabeth's case and performed an independent rating of the EXP of each previously identified EE (following the chronological order of the sessions). The inter-rater agreement was based on their ratings of each EE and presented a good reliability index (*ICC* [2,2] = .85). Disagreements were discussed to reach a consensus. ***Data analysis.*** The final EXP ratings were averaged for each session based on a varied number of EEs.

## Symptoms measurement

The OQ-10.2 was filled in by the client at the beginning of all 16 therapeutic sessions, at the assessment and at the 1-month follow-up session. Since it is an appropriate measure of changes in general clinical symptoms over short time periods, it will be used in the current study as a session-by-session measure of symptoms.

## Statistical analysis

The longitudinal association between the client's emotional processing and the clinical symptoms was computed based on bootstrapping methods using the simulation modeling analysis software (SMA; Borckardt & Nash, 2014). SMA was designed to statistically account for autocorrelated time-series data streams of single-case designs (i.e., several observations of the same variable throughout the sessions). Pearson rho tests based on SMA cross correlation models were computed to explore multiple temporal associations between variables. Since it is an exploratory study, we compared the strength of the association between the level of emotional processing in one session and the intensity of clinical symptoms in the same session (*lag* 0), the subsequent session (*lag* +1), and the preceding session (*lag* -1). We used the Bonferroni-adjusted alpha level of .016 (.05/3).

## 1.4. Results

The entire case presented 132 EEs, with an average of 8 EEs per session (range from 5 to 12). Elizabeth presented a growing tendency of her ability to process her emotions across therapy, as the EXP average level in session 1 ranged from 3 to 4 (EXP average = 3.5) and in the last session ranged from 5 to 6 (EXP average = 5.5).

### Emotional processing and clinical symptoms

The evolution of the client's level of emotional processing (EXP average levels per session) and the intensity of clinical symptoms (OQ-10.2 scores) throughout therapy are presented in Figure 1.1. Whereas the EXP level tended to increase, the intensity of the clinical symptoms decreased, achieving lower scores. Regarding symptoms some setbacks happened (session 4, 7, 15), but these peaks were progressively lower throughout therapy. Pearson's correlation coefficient indicated a strong, significant negative association between the EXP level and the OQ-10.2 scores in the same session (*lag* 0), $r = -.71$, $p < .001$. We found nonsignificant negative associations between EXP levels and OQ-10.2 scores in the subsequent session (*lag* +1), $r = -.29$, $p = .180$, and the preceding session (*lag* -1), $r = -.37$, $p = .101$.

### Emotional processing and type of emotions aroused (adaptive or maladaptive)

During the entire case the most frequent EEs were of Joy ($N = 54$), Anger ($N = 37$), Guilt/Shame ($N = 20$), and Sadness ($N = 12$). The EEs of Fear ($N = 9$) presented a lower frequency and no EEs of Love were identified (Figure 1.2). All EEs of Guilt/Shame were categorized as maladaptive, while all the EEs of Joy and Sadness were categorized as adaptive. The EEs of Anger were both categorized as adaptive ($n = 19$) and maladaptive ($n = 17$; Figure 1.3). Most of the EEs of maladaptive Anger ($n = 14$)

were identified within the first 5 sessions. After session 5, EEs of adaptive Anger ($n$ = 15) were identified more often. Regarding the EEs of Fear, only one was categorized as maladaptive (session 6). We decided not to further explore the EEs of Fear since these presented a residual frequency and in its majority were adaptive responses to a restricted situation not related to the client's main issues – the illness of her young child (session 7).

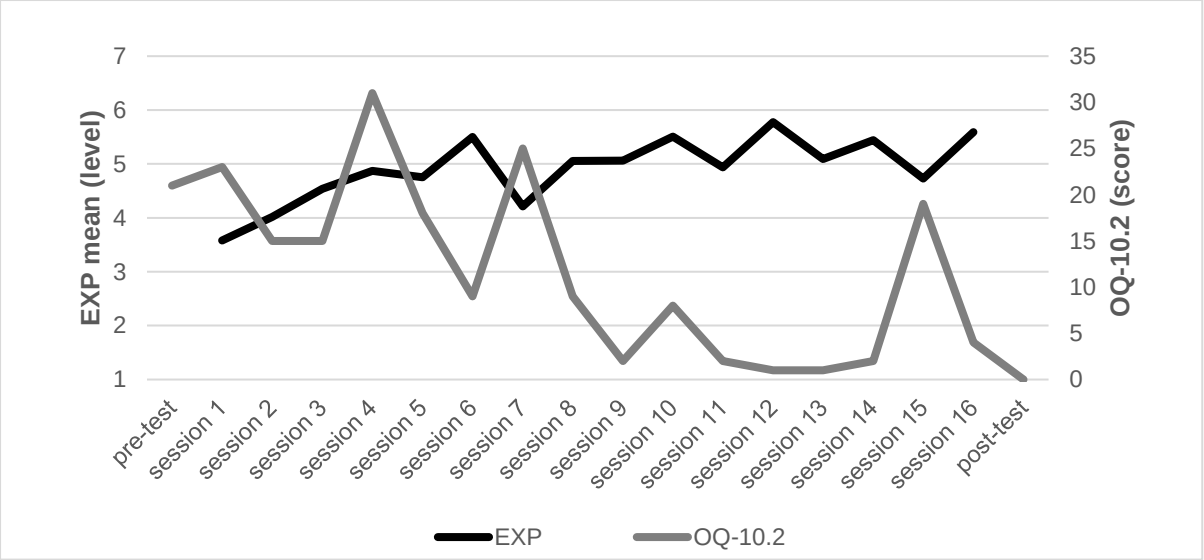


*Figure 1.1.* Average EXP level and OQ-10.2 scores throughout Elizabeth's therapy.

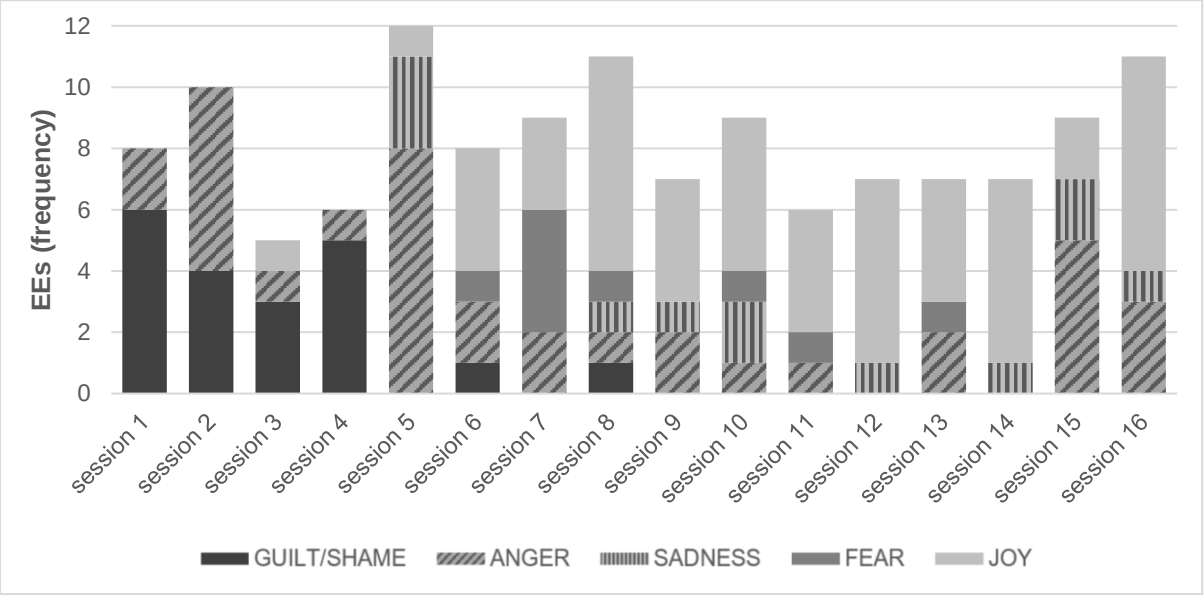


*Figure 1.2.* Frequency of EEs of Guilt/Shame, Anger, Sadness, Fear, and Joy throughout Elizabeth's therapy.

Overall, as the EXP levels increased throughout treatment, the most frequent EEs also changed, i.e., the initial EEs of maladaptive Guilt/Shame (session 1 to 4) were replaced by EEs of maladaptive Anger and adaptive Sadness (session 5), and finally by EEs of adaptive Anger and Joy (session 6 to 16).

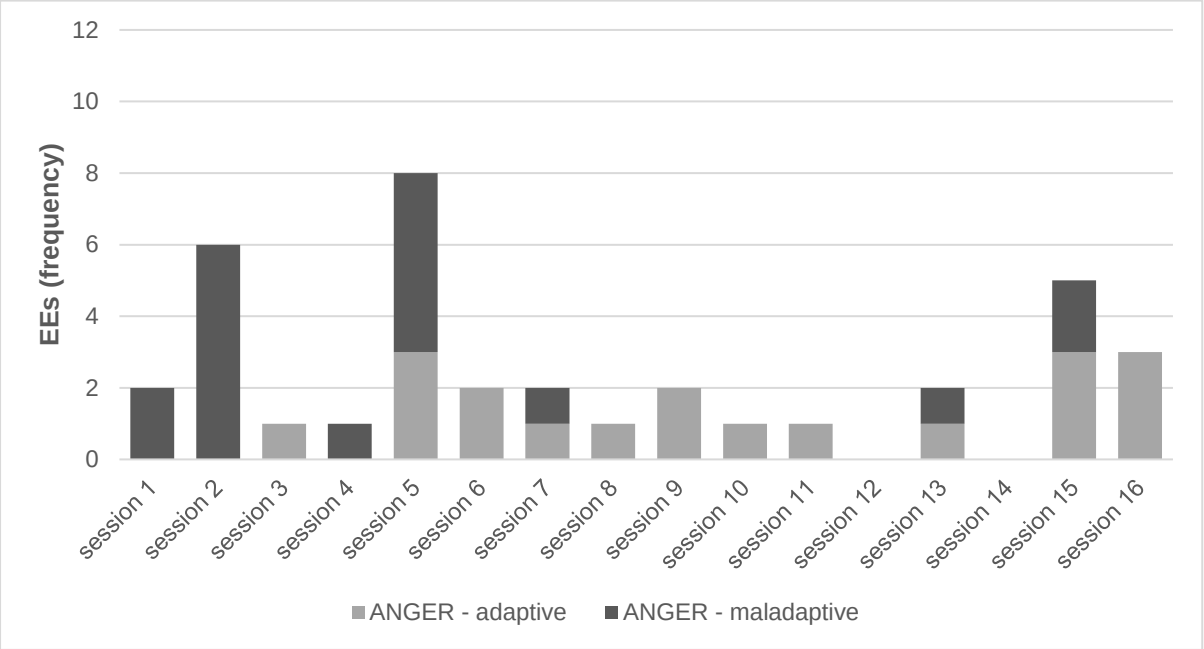


*Figure 1.3.* Frequency of EEs of Anger categorized as adaptive and maladaptive throughout Elizabeth's therapy.

### ***Session 1 to 4***

The EEs of maladaptive Guilt/Shame were prevalent in the initial sessions, being associated with Elizabeth's perception of failing as a mother. The client predominantly presented EXP levels 3 and 4 in those sessions.

At EXP level 3 Elizabeth mainly described situation in which she identified the negative impact her decision to get divorced had on her children. Although she enriched those descriptions with brief references to the inward impact of such situations (spontaneously or at the request of the therapist), her focus was on the events themselves. In the following excerpt[2] rated as EXP level 3 (EEs of Guilt/Shame; session 1), the client described a situation with her son and made a brief reference to her feelings of guilt.

[2] The clinical vignettes were translated from Portuguese.

**Elizabeth:** *My son told me "my father will make lots of money and will come back home" and I said to him "he can't come here, son" [...]. Perhaps my son will blame me because his father is trying to reconnect (cries). It makes me feel so guilty.*

The therapist's interventions, namely, the request for further inner elaboration (e.g., "How's that feeling of guilt?") and the empathic conjectures (e.g., "It saddens you"), seems to have promoted the redirection of the client's focus to her inner experiences associated with feelings of Guilt/Shame. Instead of describing the external events, at EXP level 4 the client focused on her experience of failure, clarifying how this was felt for her. The following excerpt (EEs of Guilt/Shame; session 1) illustrates a detailed description of the client's inner experience and feelings following the therapeutic intervention.

**Elizabeth:** *I failed, I deprived my children of an important person* [father] *in their growth.*
**Therapist:** *It's so painful*.
**Elizabeth:** *It's hurting me so much. I feel so guilty. It's a terrible feeling, gives me a great desire to do nothing, to not fight for anything. I just wanted to sleep today and wake up tomorrow again with twenty years and have the chance to change everything* [...]

From session 1 to session 4, the average EXP level presented a trend of constant growth. Elizabeth reached EXP level 5 more frequently, i.e., she defined and explored internally her problem of failing as a mother. In the following excerpt (EE of Guilt/Shame; session 4) the client initially reached EXP level 4 when she accessed the internal conflict between two different parts of herself: the need to protect her children from a disturbed family and an inner pressure to ensure her children's happiness by maintaining their connection to their father. To expand the client's awareness about her feelings of guilt, the therapist promoted the exploration of the emotional impact of this issue and its association with her childhood experiences. Elizabeth achieved EXP level 5 when she hypothesized that her feelings of guilt resulted from the non-achievement of her cherished goal of providing her children a happy childhood. Through this meaning making, she caught her first glimpse of the idea that the presence of her children's father might not guarantee that they would be happier, since she had experienced the negative impact of having a dismissive father.

**Elizabeth:** *For me, it is very hard to raise my children alone, but if I was still with their father this would be harder because he was destroying everything I did. But sometimes*

*that lady there* (critical part of herself) *tells me: "how can you be so sure that he was not going to change?" This is terrible! (cries) I've given so many opportunities to him and he never changed, why would he change now? But I believe I'm stealing a happy childhood from them.* **(Therapist:** *It's so painful.*) *This drives me crazy, it's an unbearable guilt and powerlessness. It's a feeling of worthlessness and failure.*

**Therapist:** *You've dreamed of a family so many years. How was the family you dreamed of?*

**Elizabeth:** *I dreamed of a family with a husband who would like to be with our kids.*

**Therapist:** *You dreamed about a father who cares.*

**Elizabeth:** *Exactly, because I already had had a dismissive father and it was horrible!*

**Therapist:** *It is painful for you to realize that you can't give your children something that you've also wanted for you but didn't have.*

**Elizabeth:** *Of course. It is a feeling of guilt due to a failed promise I made to myself "to give my children a better father than I had". Somehow, I got it, but to give them a different father from my own, I had to get my children away from their own father.* [...]

**Therapist:** *The inner child who dreamed of this family, what would she tell you?*

**Elizabeth:** *She would tell me: "you have destroyed all my dreams". I couldn't do it!* (cries) *I feel so guilty. I destroyed everything I wanted for my children. They deserved...*

**Therapist:** *"Your children are not happy!"* [voice of the critical part of the client]

**Elizabeth:** *They are happy, but of course they miss a part.*

**Therapist:** *The same that you would've felt if you had not had the presence of your father.*

**Elizabeth:** *If I had not had my father I would be a much confident and happier person. I wish I hadn't had a father. Maybe my kids will prefer the life they have to the life they could take.*

***Session 5***

After session 4, the high frequency of EEs of maladaptive Guilt/Shame decreased and became absent after session 8. In session 5 the EEs of Anger were the most frequent. Although the EEs of maladaptive Anger already emerged in the previous sessions, in session 5 they emerged together with EEs of adaptive Sadness.

The EEs of maladaptive Anger were mainly associated with Elizabeth's father's and ex-husband's criticism to her value as a mother and as a person. During the expression of this rejecting anger, Elizabeth reached the first EXP level 6, presenting both a new and enriched self-experience and the inner work that fostered the development of this change. In the following excerpt (EE of maladaptive Anger), extracted from the beginning of session 5, the client described how her feelings of worthlessness were transformed into rejecting anger regarding her father and her ex-husband. She realized that what prevented the accomplishment of her inner child's dream of having a happy family was not her fault, changing her feelings of guilt.

> **Elizabeth:** *In the last session we have stirred up the destruction of the dreams of my inner girl who has never forgiven me. I didn't want to see her because I know it would hurt me.*
> **Therapist:** *Because it is very painful to think that you did not accomplished her dream.*
> **Elizabeth:** *Yes, but now I'm sure I have no reason to continue to blame myself. Perhaps what has changed from the last session is that I used to feel rejected, humiliated and dismissed, and it was transformed into contempt, detachment, revolt and anger. I feel a lot of anger for them [father and ex-husband] because they helped destroy my inner girl's dream. I want them to suffer for all the pain they've caused me.*
> **Therapist:** *You've always felt that they devalued, rejected, and despised you, feeding that part of you that criticizes and blames yourself for having failed.*
> **Elizabeth:** *Now, I'm feeling that differently. I'm relieved, I don't blame myself. This doesn't mean that I didn't have any responsibility, but that heavy guilt that it had on me is gone. I realized that they were the main culprits for destroying my inner child's dreams.*

In session 5, after some of the EEs of maladaptive Anger, Elizabeth described EEs of adaptive Sadness regarding the same issue. Specifically, the client aroused emotions of Sadness for what she had lost in her childhood and for the failed relationship with her father and ex-husband. In the following excerpt, in response to the therapist's efforts to internally focus the client, she differentiated her feelings of sadness. Elizabeth reached EXP level 5 when she hypothesized that her feelings had resulted from (1) not having a father who valued her, and (2) having a changeless relationship with him.

> **Elizabeth:** *It is discouraging. My father doesn't realize that someday it will be too late!*

**Therapist:** *Realizing that he and your relationship with him is not going to change is painful.*

**Elizabeth:** *Yes. It doesn't make me guilty or angry, but sorry. It saddens me the words I have to say to a person who should be one of the most important persons in my life.*

**Therapist:** *It's like you still have some hope that he could be the father you needed.*

**Elizabeth:** *Maybe that's what makes me sad. The hope that he would change was always there for me, but now it is very, very, very tiny. I know our relationship is not going to change. It saddens me not to have a loving and supporting father.*

***Session 6 to session 16***

As Elizabeth moved towards the end of therapy, the EXP average level increased between 5 and 6. She more frequently achieved EXP level 6 in the EEs of Anger and Joy. At this stage of the therapy, the EEs of Anger were the most frequent only in session 15, being associated with a quarrel between the client and her eldest daughter on the eve of the session. In the remaining sessions, these EEs were the second most frequent (second to Joy).

After session 5, the frequency of EEs of maladaptive Anger declined, being replaced by EEs of more adaptive Anger. In these EEs of adaptive Anger, the client draws a clearer identification and assertion of her own rights. In the following excerpt rated with EXP level 6 (session 6), Elizabeth felt frustrated with her father's behavior while deciding not to get involved in his problem. Encouraged by the therapist's internally focused interventions, she identified the emotional impact of her new behavior and described the inner work underlying this change. The client realized how her involvement with other people's problems caused her feelings of worthlessness. She assumed that she is someone who likes to take care of others but must do it in a different way to protect herself. The statement of the client's personal value and rights resulted in feelings of self-confidence and empowerment.

**Elizabeth:** *Instead of bringing people closer to him [her father], he pushes them further away. I'm frustrated about that, but I know it's not my business, so I turned away.*

**Therapist:** *And do you feel guilty?*

**Elizabeth:** *No. I don't feel guilty anymore. I spent a lot of time thinking about others, feeling sorry for others and forgetting and ignoring myself. I have a life and I deserve to enjoy it.*

**Therapist:** *You deserve time for yourself, to take care of yourself.*

**Elizabeth:** *Yes, and I'm not being selfish. I deserve it, I've always deserved it! I used to think I had the responsibility to change the world and the people, which made me feel worthless.*

**Therapist:** *You felt the weight of the world on your shoulders.*

**Elizabeth:** *Yes, it was a burden. I'm a person who likes to help others, but I'm not going to put them first. It is enough! I must accept it or walk away to protect myself. (pause) Protect myself makes me feel confident and stronger. I deserve it!*

From session 6 to the last one, the EEs of adaptive Joy were the most frequent. The client usually achieved higher EXP levels (EXP level 4, 5 and 6) in these EEs. These EEs were related to Elizabeth's accomplishment of her self-worth (1) as a mother, since she realized that she did in fact provide a happy childhood to her children, and (2) as a person, since she recognized herself as a more able, stronger and lovable person. The next clinical excerpt (session 12) rated as EXP level 6 referred to the client's current relationship with her inner child, who dreamed of raising a different, happy family from the one she had. The client's awareness that she was actually providing a happy childhood to her children allowed her to both be at peace with her inner child and recover happy memories of her own childhood. She explored and elaborated on the change in the experience of her inner child, accessing to the meaning and emotional impact of such transformation. Elizabeth's awareness of herself as responsible for the achievement of her cherished goal resulted in feelings of self-pride and empowerment, changing her previous self-experience of worthlessness.

**Elizabeth:** *When I saw my inner girl for the first time she was in a confused and dark scenario. Now she is happy and quiet at my grandparents' house, where I had the best moments of my childhood.*

**Therapist:** *What do you think that helped your inner girl to go over there?*

**Elizabeth:** *Now, I know I provided the best family to my kids, where they feel safe and happy. Perhaps my peace today is reflected in her peace. Maybe that's it.*

**Therapist:** *Now she can be peaceful and content. Does her peacefulness help you too?*

**Elizabeth:** *Seeing her like that gives me peace. That means that I haven't missed everything in my childhood. For me, if I didn't have a happy childhood, I wouldn't have anything in my life. But I was happy with my grandparents, only that was obscured by what went wrong.*

**Therapist:** *Do you think your peace let her go there and she also gave you more peace?*

**Elizabeth:** *It gives me the sense that I gave her enough to stop crying. So, instead of feeling guilty for not accomplishing what she wanted, I'm glad she's happy.*

**Therapist:** *"I helped her to find happiness". How does that feel?*

**Elizabeth:** *It's comforting, it's almost a trophy, "I got this!". I was afraid because I thought that I'd never get her out of that state because she suffered so many disappointments, but I did! I'm at peace with my inner girl. It's a feeling of accomplishment! I'm not a loser!*

## 1.5. Discussion

The intensive study of Elizabeth's case was carried out to explore the humanistic-experiential assumption that the increase in the clients' capability of emotional processing is associated with successful therapeutic change in depression. More specifically, we aimed to explore the session-by-session association between the level of emotional processing achieved and the client's gradual improvement. According to Stiles' theory-building case studies perspective (2015), the comparison of our observations in the Elizabeth's case with the theoretical assumptions may increase confidence or suggest modifications to the theory. Thus, this case study may improve and extend the current knowledge on the role of emotional processing on therapeutic change in depression.

### Emotional processing

During the therapeutic process, Elizabeth enhanced her ability to process emotions. In the initial sessions, the client wavered between brief references to the inward and emotional impact of specific daily situations (EXP level 3), and a deeper focus on what it was like to be herself and how events were inwardly experienced by her (EXP level 4). As expected, this good-outcome case began with moderate levels of emotional processing (Watson & Bedard, 2006), i.e., she did not initiate therapy by refusing to get involved (EXP level 1) or presenting only a behavioral or intellectual involvement with her inner experiences (EXP level 2).

In the final sessions, Elizabeth achieved a consistent trend of higher emotional processing, exploring her inner experiences (EXP level 5), developing new feelings, meanings and experiential insight, and diluting her personal feelings of worthlessness (EXP level 6). This observation of a gradual increasing on the level of emotional processing is consistent with the previous results in good-outcome cases (e.g.,

Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Watson & Bedard, 2006).

### Emotional processing and clinical symptoms

During Elizabeth's therapy, while the levels of emotional processing presented a trend of growth, the intensity of clinical symptoms decreased. The time-series analysis indicated that these variables were strongly and negatively associated in the same session (*lag* 0), $r$ = -.71, $p$ <.001. The associations between emotional processing and symptoms in the subsequent (*lag* +1), $r$ = -.29, $p$ =.180, and preceding session (*lag* -1), $r$ = -.37, $p$ =.101, were found to be nonsignificant.

In the same session, the decrease of clinical symptoms was strongly associated with an increase in the level of emotional processing. This means that when Elizabeth initiated a session with a lower intensity of clinical symptoms, she achieved higher levels of emotional processing. On the other hand, when she started the session with more intense symptoms, she presented a lesser ability to process her emotional experiences. Therefore, the intensity of clinical symptoms may influence the clients' capability to process their emotions during the same session. This association throughout therapy suggest that in good-outcome cases of depression, the reduction of symptoms may be related to an increase in the clients' ability to be aware, arouse, explore, make meaning, and transform their maladaptive emotions.

Although in Elizabeth's case the variables were synchronically associated, neither the negative association between the level of emotional processing with the next-session intensity in symptoms, nor the negative association between the intensity of symptoms with the next-session level of emotional processing were statistically significant. These results were not expected based on previous research that found in different samples of clients that the achievement of a higher level of emotional processing predicted a decrease in symptoms from pre- to post-therapy (Elliott et al., 2013; Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009; Watson & Bedard, 2006).

For Elizabeth, achieving higher levels of emotional processing in one session did not ensure a better clinical condition in the next session, while the intensity of symptoms assessed at the beginning of the session was strongly associated with the emotional processing during the same session. First, these results suggest that the session-by-session relationship between the level of emotional processing and the intensity of clinical symptoms may not be linear in Elizabeth's case. In a detailed analysis, we observed steeper variations throughout therapy in the intensity of symptoms than in the average level of emotional processing. Specifically, the decrease in the intensity of clinical symptoms showed clear setbacks throughout therapy, while the levels of emotional processing had a more steady and constant

development. Thus, at an idiographic level, the theoretically expected benefits of achieving higher levels of emotional processing may not emerge necessarily in the following session. Additionally, achieving higher levels of emotional processing may not be translated in symptoms gains, as subsequent unexpected negative life events occurred. There were unpredictable negative events between sessions (e.g., the illness of her child and a quarrel with her daughter at sessions 7 and 15, respectively) which apparently disturbed the client and may account for the sudden increase in the intensity of clinical symptoms. Therefore, Elizabeth's increased ability to process her emotions did not prevent her from feeling worse about negative life events in the next session. Instead, we hypothesized that it may have had a delayed effect on symptoms, i.e., that her increased capability to process her painful emotions may have reduced the symptomatic impact of next negative life events. Therefore, it could take longer than one session interval to have translation at the symptoms level. Last, these nonsignificant results may be due to the low number of observations ($N = 16$), thus reducing the statistical power to detect effects.

Summarizing, this study suggests that in good-outcome cases of depression the level of emotional processing may be strongly dependent on the level of suffering reported by the client at the onset of the same session and it may not have a direct effect on symptoms in the next session.

**Emotional processing and type of emotions aroused (adaptive or maladaptive)**

As the levels of emotional processing increased throughout Elizabeth's case, we observed a transformation from maladaptive Guilt/Shame (session 1 to 4) to maladaptive Anger, adaptive Sadness (session 5), and finally to adaptive Anger and Joy (session 6 to 16). This change from maladaptive to more adaptive emotions seem to be largely consistent with the theoretical sequence of the emotional change proposed by Greenberg (2010).

During initial sessions (session 1 to 4), the level of Elizabeth's emotional processing increased from the brief contact with the emotional experience (EXP level 3) to the inward exploration of personal issues activating emotions of Guilt/Shame (EXP level 5). We hypothesized that such increased in the level of emotional processing resulted in the subsequent decline of the EEs of maladaptive Guilt/Shame and in the emergence of EEs of Anger (session 5). Indeed, the client described the transformation of her feelings of failure into rejecting anger regarding her father and ex-husband (EXP level 6) after she had explored more deeply her feeling of Guilt/Shame.

These responses of maladaptive Anger, focused on the attack and rejection of her father and ex-husband, are expected to be the first step to change the client's negative self-evaluation (Pascual-Leone

& Greenberg, 2007). Elizabeth's higher emotional processing of these feelings of Anger (EXP level 6) seemed to have been connected to the emergence of EEs of Sadness regarding the same issue (session 5). These emotional responses of Sadness were associated with what the client lost and will not achieve, mobilizing her to accept and let go of those unfulfilled needs (Greenberg & Watson, 2006). The client's awareness, arousing, exploring and reflecting on the meaning of that feelings of Sadness (EXP level 5) may have contributed to transform the maladaptive Anger into a more adaptive emotional response. In the late EEs of Anger (session 6 to 16), instead of being focused on her father and ex-husband, she accepted that they would not change and made a clear statement of her rights to be happy and protect herself from others' criticism (Greenberg, 2010).

Until the end of therapy, Elizabeth deeply explored those adaptive emotions of Anger. She described her new assertive behaviors, the inner work and the experiential impact of her process of change, namely, the experiencing of feelings of self-pride and empowerment (EXP level 6). Alongside this assertive statement (EEs of adaptive Anger), the EEs of adaptive Joy became the most frequent (session 6 to 16), mobilizing her to be congruent with her rights and needs (Greenberg, 2010). This transformation is theoretically expected. According to Greenberg and Watson (2006) accessing adaptive emotions such as anger to replace unfairness and sadness for the unfulfilled needs, ensures the self-capacity to achieve self-worth and to feel loved.

The emotional scheme underlies the activation of specific emotions, therefore changes in the aroused emotions regarding the same issue may suggest a transformation of the scheme (Greenberg, 2010; Greenberg & Korman, 1993; Greenberg & Watson, 2006). Specifically, the observed change in the Elizabeth's in-session aroused emotions suggest that her shame-based worthlessness scheme associated with her early experiences with her father was transformed and became more adaptive during therapy (cf., Greenberg & Watson, 2006). Since this changing to more adaptive emotions occurred during the increasing in the level of emotional processing, it seems to provide further support for the claim of humanistic-experiential approaches that emotional processing contributes to transforming the underlying emotional scheme, resulting in new and more adaptive emotions (Greenberg, 2010; Greenberg & Watson, 2006).

Contrary to our expectation, we observed a low frequency of EEs of Sadness (Greenberg & Watson, 2006). First, the absent of maladaptive EEs of Sadness (e.g., hopelessness) in the initial sessions, may have been masked by the high frequency of EEs Guilt/Shame. Sporadic emotional responses of Sadness may have been expressed along with emotional responses of Guilt/Shame, thus considered non-dominant during the EE. Second, instead of adaptive Sadness, accessing adaptive Anger

for unfairness was more frequent in Elizabeth's case. This high frequency of EE of Anger may be associated with Elizabeth's specific issues. Since she was victim of a critical and dismissive father and ex-husband, Anger was an adaptive emotional response that mobilized her to a proactive affirmation and healthy entitlement, ensuring her self-capacity and self-worth (Greenberg & Watson, 2006; Pascual-Leone, 2009). Hence, accessing adaptive sadness, even with a low frequency, may have been productive for her acceptance and letting go of her unfulfilled needs of be loved by her father (Greenberg & Watson, 2006). Although this result may be due to this client's specific problems and idiosyncrasies, it suggests that in some cases of successful change of depression the arousing of Sadness can have a low frequency.

### 1.6. Conclusion, limitations and further investigation

Considering that this research is an exploratory case study, the results may be due to the client's idiosyncrasies, which prevents any generalization. However, the congruencies and discrepancies between our observations and the theory can be informative (Stiles, 2015).

First, the change from maladaptive to more adaptive emotions during the increase in the level of emotional processing was theoretically expected, strengthening the hypothesis that it may contribute to changes in clients' emotional responses and the underlying emotional scheme (Greenberg, 2010; Greenberg & Watson, 2006). Thus, a client's ongoing ability to process his or her emotions may hint at the gradual transformation of the client's depressive schema.

Second, instead of the level of emotional processing contributing to the subsequent intensity of symptoms (e.g., Elliott et al., 2013; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009), we observed that it was the intensity of the symptoms that may have influenced the level of emotional processing achieved during the same session. Thus, symptoms in a given session may provide information about the client's capability to emotionally process their experiences, allowing therapists to adjust their interventions. Specifically, favoring the use of strategies focused on promoting higher levels of emotional processing in sessions with less intense symptoms.

Future studies should address the relationship between emotional processing and symptoms in the following sessions, since the pattern observed may have resulted from: (1) idiosyncrasies of the case, (2) procedures of data analysis (i.e., the impact on symptoms may have been nonlinear or delayed), or (3) additional variables influencing the results.

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## 2. What is the effect of emotional processing on depression? A longitudinal study [3]

### 2.1. Abstract

A high level of emotional processing during therapy has been identified as a predictor of pre- to post-therapy improvement in depression. Despite this finding, the longitudinal association between emotional processing and symptom improvement has not yet been clarified. In the current study, we estimated the effect of emotional processing on pre- to post-therapy changes in depressive symptoms and the session-by-session association of emotional processing with clinical symptoms. In a sample of 50 clients with depression treated with emotion-focused therapy or cognitive-behavioral therapy, we found that a greater increase in emotional processing during treatment predicted a greater reduction in pre- to post-therapy depressive symptoms. Furthermore, emotional processing functioned better as a predictor of the next-session intensity of clinical symptoms than did symptoms as predictors of the next-session level of emotional processing. In addition to strengthening previous findings on the contribution of emotional processing to pre- to post-therapy changes, our observations suggest that clients' capabilities to process their emotions may facilitate a gradual improvement in symptoms. These results highlight the potential contribution of promoting emotional processing in therapeutic change.

### 2.2. Introduction

Several studies have explored the contribution of emotional processing to therapeutic outcomes. Regardless of the therapeutic model used, emotional processing has been associated with improvements in depressive symptoms (e.g., Auszra, Greenberg, & Herrmann, 2013; Baker et al., 2012; Goldman, Greenberg, & Pos, 2005; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Pos, Paolone, Smith, & Warwar, 2017; Watson, Mcmullen, Prosser, & Bedard, 2011; Whelton, 2004). Although the relationship between emotional processing and therapeutic outcome (change in symptoms from pre- to post-therapy) has been widely studied, (1) previous results may have been influenced by a reverse causality statistical artifact since the possible impact of symptoms on emotional processing was not accounted for in statistical analyses, which may have resulted in the misrepresentation or overestimation of the observed effect of emotional processing on the therapeutic outcome, and (2) the longitudinal contribution of

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emotional processing to the gradual improvement in symptoms has not yet been clarified. The current study aims (1) to analyze the contribution of the evolution of emotional processing to the pre- to post-therapy change in depressive symptoms and (2) to explore the session-by-session association between the level of emotional processing and the change in the intensity of clinical symptoms, accounting for the abovementioned reverse causality issue.

### Emotional processing in humanistic experiential approaches

In humanistic experiential approaches, difficulties in processing emotions are associated with psychopathological conditions, such as depression, and therefore, the facilitation of emotional processing is seen as critical for therapeutic change (Greenberg, 2010; Greenberg & Pascual-Leone, 2006; Greenberg & Watson, 2006; Pos et al., 2017). To become aware, to express and to be in direct contact with aroused emotional experiences are taken as the initial, though not sufficient, steps to promote the change in emotions. Optimal emotional processing comprises the integration of affective and cognitive components (Greenberg, 2002, 2008, 2010; Greenberg & Pascual-Leone, 2006; Whelton, 2004). Understanding emotional experiences and making them meaningful require the client to be cognitively oriented towards the reflection and exploration of that intrinsic information. This process is unique in emotional processing since it should result in the creation of new meanings and in the emergence of more adaptive emotional responses. These new emotions can be integrated into and transform the cognitive–affective meaning structures that underlie the depressive state (Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Greenberg, 2010; Pos, Greenberg, Goldman, & Korman, 2003). Therefore, in humanist experiential approaches, emotions contain innate information that needs to be accessed and explored to take advantage of the health-promoting potential of emotions (Greenberg, 2010; Greenberg & Watson, 2006). In summary, the continuum of emotional processing broadly involves: (1) attending to and being aware of the emotional experience, (2) arousing and tolerating live contact with emotions, (3) reflecting and exploring inner experiences to make meaning out of them, and (4) transforming maladaptive emotions into more adaptive ones (Elliott et al., 2013; Greenberg, 2008, 2010; Greenberg & Watson, 2006).

In this paper, we will explore the humanist experiential approaches' concept of emotional processing as it is operationalized by the Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). The EXP is an observational scale that assesses the level at which clients are able to attend, contact, and engage in affective and cognitive exploration of their inner experiences, making sense of them and using such information to transform maladaptive emotions and to solve personal problems in

a meaningful way (Klein et al., 1986). Therefore, although it is focused on the emotional component, the EXP also considers the cognitive component involved in the exploration of emotions and in the coherent integration of the new inward experiences into the self.

### Research on emotional processing using the EXP

A meta-analysis of 10 studies and 406 clients resulted in an estimation that emotional processing, assessed by the EXP, is a significant predictor of treatment outcome ($r$ = -.19; Pascual-Leone & Yeryomenko, 2016). Emotional processing is a consistent predictor of outcome in depression (Elliott et al., 2013; Greenberg, 2008, 2010; Pascual-Leone & Yeryomenko, 2016), not only in therapies centered on emotional change, such as emotion-focused therapy (EFT; Goldman et al., 2005; Pos et al., 2003; Pos, Greenberg, & Warwar, 2009; Pos et al., 2017), but also in approaches centered on other change processes, such as client-centered therapy (Goldman et al., 2005; Pos et al., 2003, 2009, 2017), psychodynamic therapy (Rudkin et al., 2007)(Rudkin, Llewelyn, Hardy, Stiles, & Barkham, 2007), and cognitive-behavioral therapy (CBT; Watson & Bedard, 2006; Watson et al., 2011). Specifically, clients who achieved higher levels of EXP (Rudkin et al., 2007; Watson & Bedard, 2006) or a greater increase in the EXP levels throughout therapy (Pos et al., 2003, 2009) presented a greater improvement in depressive symptoms than clients with lower levels.

These process-outcome studies usually assessed the level of emotional processing in a small number of sessions (commonly 2 or 3 sessions) and assessed depressive symptoms in pre- and post-therapy. Therefore, they used the mean level of emotional processing achieved as a predictor of the difference in pre- to post-therapy depressive symptoms (outcome). This design may be associated with two potential problems. First, the relation observed between emotional processing and clinical outcome could be influenced by a statistical artifact since the change in symptoms from the sessions that preceded the assessment of emotional processing was unaccounted for in the statistical analysis (cf., Crits-Christoph, Gibbons, & Mukherjee, 2013). Specifically, the prior symptomatic change could have influenced the level of emotional processing observed in a given session, hence misrepresenting or overestimating the relationship between the level of emotional processing and the change in symptoms from pre- to post-therapy. Therefore, an alternative interpretation to the results of previous studies is that prior alleviation in symptoms promoted an increase in the level of emotional processing (reverse causality), overvaluing the effect of emotional processing on the reduction in depressive symptoms. Second, although previous studies observed that the achievement of higher levels of emotional processing during therapy predicted a greater reduction in pre- to post-therapy depressive symptoms,

they did not clarify the specific contribution of emotional processing to the session-by-session change in symptoms.

To the best of our knowledge, no study has been conducted to systematically explore the session-by-session relationship between the level of emotional processing achieved and the intensity of symptoms in a sample of depressed individuals. The study that came closest to this sort of analysis was a recent one that found a reciprocal predictive effect between clients' level of emotional experiencing (i.e., emotional engagement) and the next-session intensity of clinical symptoms (Fisher et al., 2016). Although emotional processing is a more comprehensive process than emotional experiencing (in addition to emotional engagement, it involves cognitive exploration of emotions), the aforementioned study suggested a more complex bidirectional relation between emotional processing and symptoms. Pos and colleagues (2003) also hypothesized this kind of bidirectional influence, arguing that while emotional processing contributes to the reduction in symptoms, it may also be promoted by the reduction in symptoms, as a beneficial byproduct of such alleviation. Therefore, it is important to clarify the role of emotional processing in therapeutic change: do higher levels of emotional processing predict clinical symptom reduction, or is emotional processing preceded by a decrease in symptoms? Is this relationship unidirectional or bidirectional? The clarification of the role of emotional processing in symptom change may make both a theoretical and a clinical contribution. On the one hand, this contribution may improve our knowledge about the change processes; on the other hand, it may allow for a better adjustment of therapeutic interventions and potentially increase the efficacy of the treatments used for depression.

### Aims

The current study aimed to explore the relationship between the level of emotional processing achieved during therapy and the alleviation of symptoms. First, we aimed to analyze the contribution of the level of emotional processing achieved throughout therapy to the change in pre- to post-therapy depressive symptoms. Based on the results observed in previous studies, we hypothesize that the achievement of higher levels of emotional processing during therapy will result in a greater reduction in depressive symptoms. Second, accounting for the abovementioned reverse causality issue that may have influenced prior studies and results, we aimed to explore the session-by-session association between the level of emotional processing achieved and the change in the intensity of clinical symptoms. Specifically, we explored the following hypothesis: (1) whether the level of emotional processing achieved predicts the next-session intensity of clinical symptoms and (2) whether the previous intensity of clinical symptoms predicts the next-session level of emotional processing. Based on the previous main theoretical and

empirical findings, we would expect that achieving greater levels of emotional processing would contribute to the next-session decrease in the intensity of symptoms. Nevertheless, since we performed a longitudinal session-by-session analysis of the relationship between the variables, we assume that the findings may suggest different directions.

## 2.3. Method

### 2.3.1. Participants

**Clients.** The sample in this study was comprised of all 50 clients who completed the assigned treatment ($N$ = 64) in the ISMAI Depression Study (Salgado, 2014), a clinical trial designed to analyze the comparative effectiveness of CBT and EFT in the treatment of mild to moderate depression. The initial assessment for selecting participants for this trial was conducted using the Structural Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002). The inclusion criteria were as follows: (1) a diagnosis of major depression disorder and (2) a global assessment of functioning score above 50. The exclusion criteria were as follows: (1) currently using medication; (2) high risk of suicide; (3) currently or previously diagnosed with the following DSM–IV Axis I disorders: bipolar disorder, panic disorder, substance abuse, eating disorder, or psychosis; and (4) diagnosis of the following DSM–IV Axis II disorders: borderline, narcissistic, antisocial, or schizotypal disorders. The clients were informed about the aims, procedures, and further use of the collected data in the clinical trial before signing the informed consent form to have their sessions videotaped. They received weekly individual psychotherapeutic sessions in the research laboratory at ISMAI.

Out of the 50 clients considered in the current study, 26 were treated with CBT and 24 with EFT. All clients were Portuguese, and forty-two were women (84%). Their age ranged between 19 and 57 years old ($M$ = 36.18, $SD$ = 9.7). Concerning marital status, 21 clients were single, 20 were in a common-law relationship or married, and 9 were divorced or separated. Only one client had a primary education as their highest level of education, 17 had a secondary education, and 32 had a higher education. Finally, 35 clients were professionally active, 12 were unemployed and 3 were students.

**Therapists.** The clinical trial had 11 therapists who randomly attended one to eight clients each ($M$ = 5, $SD$ = 2.3). Of the CBT therapists, all five were females aged between 28 and 37 years ($M$ = 32.4, $SD$ = 3.6 years) who had four to 14 years of experience in clinical practice ($M$ = 8, $SD$ = 4.3 years) and

three to 14 years of experience in CBT (*M* = 7.8, *SD* = 4.5 years). Of the EFT therapists, four were females and two were males aged between 32 and 45 (*M* = 35.8, *SD* = 4.7 years). These therapists had three to 22 years of clinical experience (*M* = 11, *SD* = 6.5 years), and their experience in EFT ranged between one and six years (*M* = 3.8, *SD* = 1.6 years). All therapists were trained for six months in the specific therapeutic protocol and received weekly supervision of their clinical practice in group sessions (2 hours per week).

### 2.3.2. Therapies

**CBT.** The CBT therapeutic protocol used in the present study was based on Beck and colleagues' manual of cognitive therapy for depression (Beck et al., 1997). In CBT, cognitive errors in the interpretation of reality are the root of clinical problems. Through cognitive restructuring, CBT promotes changes in dysfunctional thoughts, beliefs and maladaptive depressive schema, facilitating the emergence of more adaptive behaviors and positive emotions (Beck et al., 1997).

**EFT.** The EFT therapeutic protocol used in the present study was based on Greenberg and Watson's (2006) and Elliott and colleagues' (Elliott et al., 2004) manuals of EFT for depression. EFT is a humanist experiential approach that conceptualizes clinical problems of depression as resulting from the client's difficulties in processing painful emotional experiences (Watson & Bedard, 2006). In this sense, through emotion-evoking therapeutic tasks, EFT facilitates the client's emotional processing, promoting the emergence of new and more adaptive emotional responses and the transformation of the underlying depressive emotional schemes (Greenberg & Pascual-Leone, 2006).

### 2.3.3. Measures

#### Process measure

**EXP**. The EXP (Klein et al., 1986) is a seven-point ordinal rating scale used to assess the level at which clients are cognitively and emotionally involved in the processing of their inner experiences. The EXP assesses the extent to which clients experience, reflect on, explore and create new meaning from inner experiences and transform their emotions and self-experiences. Increases in EXP levels indicate a progressive improvement in the level of emotional processing. In level 1, the focus of the client's speech is on external events, and in level 2, the client exhibits intellectual or behavioral involvement. In level 3, the focus is still on external events, but clients already present brief internal reactions or feelings to these events. In level 4, the focus changes from external to internal referents, and clients describe their

personal experiences, feelings, assumptions and perceptions, making it clear what it is like to be them. In level 5, beyond identifying, the client reflects and explores their feelings, inner experiences and personal problems. As a result of the exploration of inward experiences, in level 6, the client presents a synthesis enriched with internal references of the transformation of personal experiences, meanings, emotions and problems. In level 7, those achievements are applied to a wider range of life contexts, promoting the client's self-understanding. In previous studies, the interrater agreement (*intraclass correlation coefficient – ICC*) of the EXP ranged from .76 to .91 (Klein et al., 1986).

### Outcome measures

**Beck Depression Inventory (BDI-II).** The BDI-II (Portuguese translation from Beck, Steer, & Brown, 1996 translated by Coelho, Martins, & Barros, 2002) is a 21-item self-report inventory that assesses cognitive, affective and somatic symptoms of depression. Each item is scored on a scale from 0 to 3, and the total score ranges between 0 and 63. For the Portuguese version (Coelho et al., 2002), the cutoff score for clinical depression (Coelho et al., 2002) is 13, and the reliable change index is 7.75 (RCI; Christensen & Mendoza, 1986; Jacobson & Truax, 1991). This version of the BDI-II presented good internal consistency (*Cronbach's alpha* = .89).

**Outcome Questionnaire 10.2 (OQ-10.2).** The OQ-10.2 (Lambert, Finch, Okiishi, & Burlingame, 2005) is a 10-item self-report inventory to assess the client's clinical symptoms over short time periods. Each item is scored on a scale that ranges from 0 to 4; therefore, the total score ranges from 0 to 40. Higher scores indicate more intense symptoms. The Portuguese version of the OQ-10.2 presented adequate internal consistency (*Cronbach's alpha* = .77) and test-retest reliability over a 1-week interval in ISMAI Depression Study's sample (Salgado, 2014; *N* = 64; Salgado, 2014).

## 2.3.4. Procedures

### Treatment procedure

After each client was considered admissible for the clinical trial, they were randomly assigned to receive CBT or EFT treatment and were then assigned to one of the therapists. The clients received 16 individual psychotherapy sessions. Due to clients' idiosyncrasies, two clients received a reduced number of sessions, finishing the treatment at ninth and twelfth sessions, while three received extra sessions, finishing at the seventeenth (two clients) and eighteenth sessions (one client). These changes in the protocol were previously evaluated and discussed in the supervision group.

## Assessment of outcome

The clients completed the BDI-II at the assessment session (pretherapy) and after the treatment (post-therapy). The difference between the post-therapy and pretherapy total scores on the BDI-II was used as a measure of change in depressive symptoms ($BDI\text{-}II_{post}$ - $BDI\text{-}II_{pre}$). Lower values indicated a higher reduction in depressive symptoms throughout therapy. OQ-10.2 was completed at the assessment session and at the beginning of all therapy sessions. OQ-10.2 was used to assess the session-to-session intensity of clinical symptoms.

## Process measurement

**Session sampling.** We sampled every fourth session of each client, namely, sessions one, four, eighth, 12, and 16. For clients with an irregular number of sessions, the last session was also selected.

**Rating segments.** As in prior research, emotion episodes (EEs) were the units of analysis from which the EXP was rated (e.g., Pos et al., 2003, 2009). An EE is a segment of the client's discourse in which they express an emotional response to a situation or context (Greenberg & Korman, 1993; Korman, 1991). The mandatory components of an EE are as follows: (1) an emotional response (e.g., sadness) and/or an action tendency associated with the experienced emotion (e.g., crying) and (2) a situation, context or event that causes such emotion (e.g., parental criticism). According to the EE manual, once (1) an emotional response to a situation has been identified, the rater must (2) reflect upon the therapeutic discourse to identify where the trigger of the emotional reaction emerged and when either the subject or the emotion changed or disappeared. ***Judges and judges' training.*** A clinical psychology PhD student provided weekly training based on the manual of EEs (Korman, 1991) to four master's degree students studying clinical psychology over a period of approximately 3 months (40 hours). The training included the following components: (1) reading and discussion of the EEs coding manual; (2) codification of clinical excerpts from the manual; and (3) identification of EEs in videotaped sessions from ISMAI Depression Study (not the sessions used in this study) until the judges reached a good level of agreement with the main judge's coding (*Cohen's Kappa* ≥ .75). ***Reliability.*** The PhD student was the main judge and teamed up with each of the four master's degree students. The sessions were randomly assigned to one of the four coding pairs. The coders were unaware of the evolution of the depressive and clinical symptoms of the clients. Each judge performed an independent identification of EEs for each session and then pooled their data with the data of their coding pair to compute the level of agreement and discuss the disagreements to reach a consensus. The interrater agreement of the

coding pairs, computed before consensus, ranged between .80 and .88 (*Cohen's Kappa*). After consensus was reached, a total of 1239 EEs were identified in the 251 sessions of the 50 clients. Each client had an average of 29.78 EEs *(Min.*= 16, *Max.* = 56, *SD* = 7.64), and each session included an average of 4.94 EEs (*Min.*= 1, *Max.*=12, *SD* = 1.95).

**EXP rating.** For each EE, the judges rated the highest level of emotional processing achieved (the EXP peak level). ***Judges' training***. A clinical psychology PhD student provided weekly training based on the EXP manual (Klein et al., 1986) to five master's degree students studying clinical psychology over the course of approximately 3 months (40 hours). The judges were trained by the following steps: (1) reading and discussing the EXP manual, (2) rating of excerpts from the manual, and finally (3) rating previously identified EEs in ISMAI Depression Study's videotaped sessions (not the sessions used in this study) until they achieved an acceptable reliable index with the expert judge's ratings (*ICC* [2,1] ≥ .75). ***Reliability.*** Five coding pairs were formed, with the PhD student acting as the main judge who teamed up with each of the master's degree students. The sessions with the previously identified EEs were randomly assigned to one of the five coding pairs. The judges were unaware of the evolution of the depressive and general symptoms of the clients. Each judge performed an independent rating of the EEs and then met with their coding pair to compute the level of agreement and discuss the disagreements to reach a consensus. The interrater agreement for the judge pairs, computed before consensus, ranged from .78 (*ICC* [2,2] = .78) to .91 (*ICC* [2,2] = .91). ***Data analysis.*** The final EXP rating was averaged for each of the 251 sessions of the 50 clients.

## 2.4. Results

### Statistical analysis

Our data had a hierarchical structure, as sessions ($n$ = 251) were nested within clients ($n$ = 50), and clients were nested within different types of treatments (CBT or EFT). Hierarchical linear modeling (HLM; Raudenbush & Bryk, 2002) analyses were fitted to our data to accommodate this nested structure. Through mixed regression models, HLM was used to estimate the within (level 1) and between client (level 2) effects. Considering the longitudinal nature of our data, the session number was considered as a level-1 covariate in our models, allowing for the assessment of the response variable as a function of time. The variability at the within-client level was modeled as a time-invariant covariate of level 2. HLM analysis was computed with random effects. A time dependent correlation structure was tested in the models, but this did not show significance. That is, the correlation structure with random effects in the

models is constant in time. In addition to longitudinal models (HLM), regression analyses were also performed in the current study. Both analyses were performed using R version 3.2.1 (R Core Team, 2017). Specifically, for the HLM, we used the nonlinear mixed-effects modeling (nlme) package.

**Evolution of emotional processing throughout therapy**

We computed an HLM model (Table 2.1 – model 1) using the number of sessions, the type of treatment (CBT and EFT) and the interaction between these variables as predictors of the evolution of emotional processing throughout therapy (slope of the EXP). Although the EFT clients presented higher levels of the EXP in the first session than the CBT clients (Figure 2.1), $\beta$ = .215, $p$ <.05, the results suggest that there were no significant differences between the CBT and EFT clients in the evolution of the EXP throughout therapy, $\beta$ = .006, $p$ >.05.

Considering these results, we computed a simpler HLM model (Table 2.1 – model 2) to fit our data, using the session number as the only predictor of the EXP slope. We observed that the passage of sessions predicted an increase in the EXP level (slope of the EXP), $R^2_{adj} = .820$, $\beta$ = .057, $p$ < .001.

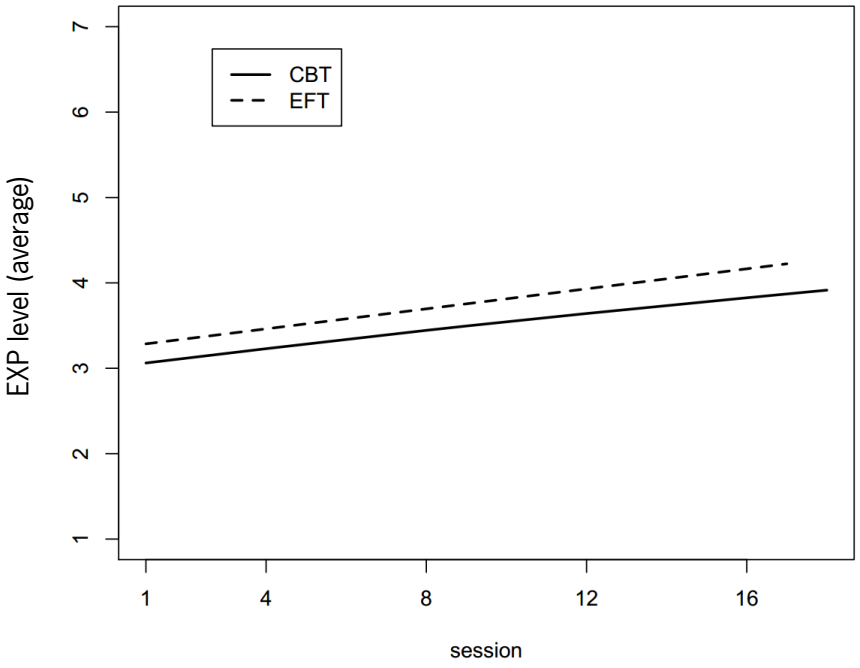


*Figure 2.1.* Nonparametric smooth spline of the evolution of the EXP level (average) throughout sessions of cognitive-behavioral therapy (CBT) and emotion-focused therapy (EFT).

Table 2.1

*Results of HLM analyses explaining the evolution of emotional processing throughout therapy (EXP slope)*

| *Models* | *Fixed effects* | *Coefficient* | *SE* | *t* | *p-value* | $R^2$ |
|---|---|---|---|---|---|---|
| 1 | Intercept, $\beta 00$ | 3.006 | .061 | 49.380 | .000 | .882 |
| | Session, $\beta 01$ | .054 | .006 | 9.837 | .000 | |
| | EFT, $\beta 02$ | .215 | .088 | 2.442 | .018 | |
| | Session IF EFT, $\beta 03$ | .006 | .008 | .723 | .471 | |
| 2 | Intercept, $\beta 00$ | 3.110 | .046 | 67.530 | .000 | .820 |
| | Session, $\beta 01$ | .057 | .004 | 14.443 | .000 | |

Note: HLM = hierarchical linear modeling; EXP = Experiencing Scale; EFT = emotion-focused therapy.

**Emotional processing and depressive symptoms**

The EXP slope of the individual clients estimated in the aforementioned HLM model (Table 2.1 – model 2) was used as a predictor of pre- to post-therapy changes in depressive symptoms (BDI-II). The results (Table 2.2) indicated that the EXP slope predicted the change in BDI-II scores, $R^2_{adj} = .215$, $\beta = -226.726$, $p < .001$. Specifically, a greater increase in the EXP levels throughout therapy (EXP slope) predicted a greater decrease in BDI-II scores from pre- to post-therapy. This model explained 21.5% of the variance in the response variable.

Table 2.2

*Results of regression analysis using the EXP slope to explain the change in pre- to post-therapy depressive symptoms ($BDI\text{-}II_{post} – BDI\text{-}II_{pre}$)*

| *Fixed effects* | *Coefficient* | *SE* | *t* | *p-value* | $R^2$ |
|---|---|---|---|---|---|
| Intercept, $\beta 00$ | -6.277 | 3.548 | -1.769 | .083 | .215 |
| EXP slope, $\beta 01$ | -226.728 | 59.754 | -3.794 | .000 | |

Note: HLM = hierarchical linear modeling; EXP = Experiencing Scale; BDI-II = Beck Depression Inventory – II.

**Emotional processing and clinical symptoms**

We estimated two different sets of HLM models to analyze the following hypothesis: (1) the level of emotional processing (average EXP level) in a given session predicting the next-session intensity of

clinical symptoms (OQ-10.2 scores) and (2) the intensity of clinical symptoms (OQ-10.2 scores) in a given session predicting the next-session level of emotional processing (average EXP level). Before computing the predictive effect of the variables of interest in the next-session response variable, we computed a simpler HLM model using the number of sessions as a predictor of the next-session response. This simpler model allowed us to estimate if the addition of the variables of interest as predictors resulted in an increase in the variance explained by the model.

### *Emotional processing as a predictor of clinical symptoms*

First, we modeled the next-session intensity of clinical symptoms (OQ-10.2 scores) as a function of the number of sessions (Table 2.3 – model 1). The increase in the number of sessions predicted a decrease in the next-session OQ-10.2 scores, $R^2_{adj} = .696, \beta = -.514, p < .001$. Second, the HLM model using the number of sessions and the level of emotional processing (EXP average level; Table 2.3 – model 2) predicted the next-session OQ-10.2 scores. The increase in the number of sessions, $\beta$ = -.228, $p$ < .001, and in the EXP level, $\beta$ = -5.939, $p$ < .001, predicted the next-session decrease in OQ-10.2 scores, $R^2_{adj}$ = .775. The addition of the EXP level as a predictor of OQ-10.2 scores increased the variance explained by the model from 69.6% to 77.5%.

Table 2.3

*Results of HLM analyses using the number of sessions and EXP levels to predict next-session OQ-10.2 scores (lag +1)*

| *Models* | *Fixed effects* | *Coefficient* | *SE* | *t* | *p-value* | $R^2$ |
|---|---|---|---|---|---|---|
| 1 | Intercept, $\beta 00$ | 23.788 | .825 | 28.820 | .000 | .696 |
| | Session, $\beta 01$ | -.514 | .039 | -13.164 | .000 | |
| 2 | Intercept, $\beta 00$ | 42.218 | 2.621 | 16.106 | .000 | .775 |
| | Session, $\beta 01$ | -.228 | .052 | -4.368 | .000 | |
| | EXP, $\beta 02$ | -5.939 | .806 | -7.368 | .000 | |

Note: HLM = hierarchical linear modeling; EXP = Experiencing Scale; OQ-10.2 = Outcome Questionnaire 10.2.

### *Clinical symptoms as predictors of emotional processing*

First, we modeled the next-session level of emotional processing (average EXP level) as a function of the number of sessions (Table 2.4 – model 1). The increase in the number of sessions predicted the

next-session increase in the EXP level, $R^2_{adj} = .775$, $\beta = .056$, $p < .001$.

Second, the HLM model using the number of sessions and the intensity of clinical symptoms (OQ-10.2 scores; Table 2.4 – model 2) predicted the next-session level of EXP, $R^2_{adj} = .775$. Specifically, the increase in the number of sessions, $\beta = .05$, $p < .001$, and the decrease in the intensity of clinical symptoms, $\beta = -.01$, $p = .011$, predicted the next-session increase in the EXP level. Although, the addition of the OQ-10.2 scores to the model as a predictor of the next-session level of EXP did not increase the variance explained by the model (77.5%).

Table 2.4

*Results of HLM analyses using the number of sessions and OQ-10.2 scores to predict next-session EXP levels (lag +1)*

| *Models* | *Fixed effects* | *Coefficient* | *SE* | *t* | *p-value* | $R^2$ |
|---|---|---|---|---|---|---|
| 1 | Intercept, $\beta 00$ | 3.113 | .063 | 48.962 | .000 | .775 |
| | Session, $\beta 01$ | .056 | .003 | 17.868 | .000 | |
| 2 | Intercept, $\beta 00$ | 3.400 | .128 | 26.547 | .000 | .775 |
| | Session, $\beta 01$ | .049 | .004 | 12.271 | .000 | |
| | OQ-10.2, $\beta 02$ | -.011 | .004 | -2.562 | .011 | |

Note: HLM = hierarchical linear modeling; OQ-10.2 = Outcome Questionnaire 10.2; EXP = Experiencing Scale.

## 2.5. Discussion

The aim of the current study was to clarify the relationship between the level of emotional processing achieved by the clients during the treatment of depression and the alleviation of symptoms. First, we will discuss the overall evolution of emotional processing throughout therapy. Second, the predictive effect of emotional processing on the pre- to post-therapy changes in depressive symptoms will be discussed. Finally, we will discuss the longitudinal effect of emotional processing on clinical symptoms.

### Evolution of emotional processing throughout therapy

HLM analysis (Table 1 – model 1) indicated that, regardless of the therapeutic model used, the level of emotional processing tended to increase throughout the sessions. Namely, the increase in the

level of emotional processing throughout the sessions (EXP slope) was not significantly different between the CBT and EFT clients, $\beta$ = .006, $p$ >.05. However, compared to the CBT clients, the EFT clients presented higher levels of emotional processing in the initial session, $\beta$ = .215, $p$ <.05, and maintained higher levels during therapy (Figure 2.1).

The observed increase in the capability of the clients to process their emotions during therapy was consistent with the findings of previous studies (Goldman et al., 2005; Pos et al., 2003, 2009, 2017; Watson & Bedard, 2006). The clients tended to increase their capability to be inwardly focused, explore and reflect on their experiences to achieve more adaptive emotions and self-experiencing, and solve their personal problems in a meaningful way.

Despite the similar increases found during both treatments, the levels of emotional processing achieved by clients seemed to differ between the two psychotherapeutic approaches (Pascual-Leone & Yeryomenko, 2017; Watson & Bedard, 2006; Watson et al., 2011). Therapy may be critical in the development of the client's capability to process their emotions (Elliott et al., 2013; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017). While EFT therapists promote clients' awareness, experiencing, elaboration and exploration of their inner emotional experiences, CBT is more focused on problem-solving using cognitive strategies. EFT therapeutic strategies may have had a unique contribution to the achievements of higher levels of emotional processing from the first session, suggesting the clients' early responsiveness to the EFT-specific emotion-evoking interventions. However, in the discussion of this finding, we should also consider an alternative explanation. Although the clients were randomly assigned to the therapeutic treatments, those who were treated with EFT could have had a better capacity for emotional processing prior to treatment.

Regarding the evolutionary pattern of emotional processing throughout therapy, our results suggest that clients' level of experience, exploration, and resolution of their maladaptive experiences and problems tended to progressively increase throughout therapy. Previous studies observed a different tendency, namely, that the EXP level increased from the initial to the middle phase of therapy and maintained a stable or decreasing trend until the end of therapy (Pascual-Leone & Yeryomenko, 2017; Pos et al., 2009; Watson & Bedard, 2006). We hypothesized that this inconsistency with previous results may be associated with the differences in the design and type of statistical analysis adopted. Specifically, (1) we assessed the EXP level throughout therapy at constant time intervals, while previous studies selected one session of the initial and final phase of therapy (e.g., second and second-to-last sessions, respectively) and the "best" session from the working phase (e.g., highest change session, highest emotional arousal session); (2) and we used longitudinal multilevel models to assess the slope of the

EXP during therapy. Our results suggest that the EXP tended to increase from the initial to the final session of treatment. Clients' emotional processing skills are potentiated in the work that they do with their therapists, resulting in the cumulative improvement of such capabilities.

### Emotional processing and depressive symptoms

The linear regression results suggest that a greater increase in emotional processing capability during treatment predicted a greater reduction in depressive symptoms from the pre- to post-therapy assessments, $R^2_{adj}$ = .215, $\beta$ = -226.726, $p$ < .001 (Table 2.2). This finding is consistent with the results of previous studies, suggesting that the achievement of greater levels of emotional processing throughout therapy is associated with better therapeutic outcomes in depression (Elliott et al., 2013; Goldman et al., 2005; Greenberg, 2008, 2010; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011). Thus, we speculate that emotional processing is an important mechanism associated with the change in depressive states. This result supports the idea that the clients who more frequently attended, aroused, tolerated, and engaged in a deeper exploration of their inner experiences to create new meaning and solve problems achieved a greater alleviation of their depressive symptoms.

### Emotional processing and clinical symptoms

The HLM analyses suggest that the increase in the number of sessions predicted the next-session decrease in OQ-10.2 scores (Table 2.3 – model 1), $R^2_{adj}$ = .696, $\beta$ = -.514, $p$ < .001. The addition of the EXP level as a predictor increased the variance explained by the model (Table 2.3 – model 2) from 69.6% to 77.5%. Therefore, in addition to the number of sessions, $\beta$ = -.228, $p$ < .001, the increase in the EXP levels also contributed to explaining the next-session decrease in OQ-10.2 scores, $\beta$ = -5.939, $p$ < .001. Our results also suggested that the increase in the number of sessions predicted the next-session increase in EXP levels (Table 2.4 – model 1), $R^2_{adj}$ = .775, $\beta$ = .056, $p$ < .001. When we added the OQ-10.2 scores as predictor in the HLM model, both sessions, $\beta$ = .05, $p$ < .001, and OQ-10.2 scores were significant predictors of the next-session level of EXP, $R^2_{adj}$ = .775, $\beta$ = -.01, $p$ = .011. However, the addition of the OQ-10.2 scores did not improve the explained variance in the next-session level of EXP.

In summary, these results suggest that the level of emotional processing (EXP level) functioned better as a predictor of the next-session intensity of clinical symptoms (OQ-10.2 scores) than did the symptoms as predictors of the next-session level of emotional processing. These findings are consistent with the humanistic experiential theory and previous research that hypothesized that the improvement in

emotional processing capability may contribute to reducing symptoms (Elliott et al., 2013; Goldman et al., 2005; Greenberg, 2008; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011). Although previous process-outcome studies assumed such a direction in the relationship between emotional processing and symptoms, they did not account for possible reverse causality, i.e., that symptoms may also influence the level of emotional processing achieved (cf., Crits-Christoph et al., 2013). Furthermore, previous studies did not clarify the longitudinal contribution of emotional processing to the gradual improvement in symptoms throughout therapy. Our study went further to increase confidence in the contribution of emotional processing to the improvement in pre- to post-therapy depressive symptoms. The current research suggests that the achievement of higher levels of emotional processing is not just an improved capability associated with a better therapeutic outcome, but it is a process variable that contributes to the gradual symptomatic improvement of depression.

## 2.6. Conclusion, limitations and further research

The findings of the current study increased our confidence in the contribution of emotional processing to the improvement in pre- to post-therapy depressive symptoms in different therapeutic approaches. The longitudinal analysis of the relationship between emotional processing and the intensity of clinical symptoms in multiple sessions highlights the contribution of higher levels of emotional processing to a gradual change in clinical symptoms of depression. These results should be interpreted carefully. Although we (1) selected sessions throughout the therapeutic process at regular intervals and (2) accounted for such time gaps between sessions in the statistical analyses, our observations may not be representative of the entire therapeutic process (cf., Crits-Christoph et al., 2013).

However, our findings may have been constrained by the design of the study or limited to the specific characteristics of the sample, our results suggest that the level of emotional processing is informative of clients' gradual therapeutic change. Furthermore, the facilitation of emotional processing throughout therapy may be important for the alleviation of depressive and clinical symptoms, as suggested by humanistic experiential therapies (Greenberg, 2010; Greenberg & Pascual-Leone, 2006; Greenberg & Watson, 2006). Clinicians may support clients to enhance their ability to be aware, arouse, explore, make meaning, and transform emotional experiences. Further research is needed to clarify the specific therapeutic strategies that may facilitate the client's achievement of higher levels of emotional processing in both EFT and CBT.

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## 3. Emotional processing during the reconstruction of the grief experience: A case study [4]

### 3.1. Abstract

Prior research, mainly conducted on cases of depression, observed that clients' improved capability to process their emotions predicted better therapeutic outcomes. In this paper, we analyzed two clients experiencing complicated grief treated with constructivist therapy, exploring whether emotional processing was related to therapeutic change. Specifically, we investigated the association of emotional processing with (1) therapeutic outcome (good or poor) and (2) change in the type of grief-related emotions (adaptive or maladaptive). Compared with the poor outcome case, the good outcome case achieved more improvement in the ability to process emotions throughout therapy. Such a session-by-session increase in the level of emotional processing occurred alongside a change in the type of grief-related emotions aroused, from maladaptive to more adaptive responses. Although there was a decrease in such emotions in the poor outcome case, a higher frequency of maladaptive emotions during the last phase of therapy was observed. These results suggest that emotional processing may be associated with symptom improvement and the transformation of grief-related maladaptive emotions throughout therapy. The findings from this exploratory study should be considered cautiously, since they may result from the cases' idiosyncrasies.

### 3.2. Introduction

The contribution of clients' ability to process their emotions to the emergence and alleviation of psychopathological symptoms has been widely recognized in psychotherapy research (Baker et al., 2012; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Foa, Huppert, & Cahill, 2006; Greenberg, 2010; Whelton, 2004). While difficulties with emotional processing have been associated with the emergence and maintenance of psychopathology, the development of emotional processing capacity during therapy has been associated with better outcomes. In the current paper, we will explore this association in two clients (one with a good and one with a poor outcome) experiencing complicated grief and treated with meaning reconstruction therapy (Neimeyer, 2001, 2006, 2016). Grievers present impaired ability to be aware of, arouse and be in live contact with their grief-related emotional experiences (Castro & Rocha,

[4] Pinheiro, P., Nogueira, D., Pereira, R., Alves, D., Gonçalves, M. M., & Salgado, J. (2019). *Emotional processing during the reconstruction of the grief experience: A case study.* Manuscript submitted for publication.

2013; Neimeyer, 2001, 2006), suggesting that difficulties with emotional processing may be associated with the development of complicated grief. We aimed to explore whether the clients' ability to process their emotions during therapy was associated with a change in grief-related emotions and with different therapeutic outcomes with respect to bereavement. Although several recent studies have focused on the distinctive characteristics of complicated grief, few have been conducted on the process of change during grief therapy. Furthermore, to our knowledge, no studies on the role of emotional processing in grief have been developed. Thus, the results of the current exploratory study may improve our knowledge of how bereaved clients emotionally process grief-related emotions in the course of therapy and whether emotional processing is a mechanism of change activated during complicated grief amelioration.

### Emotional processing

In humanistic-experiential therapies, the processing of emotional experiences plays a central role: clinical problems are seen as the result of impaired ability to process emotions, so therapy aims to facilitate such ability to promote change and well-being (Elliott et al., 2013; Greenberg, 2010; Greenberg & Watson, 2006; Pos, Greenberg, Goldman, & Korman, 2003). Emotions are conceptualized as having an innately healthy potential because they are intricately linked to core needs, mobilizing adaptive actions to fulfill them (Greenberg, 2010; Greenberg & Watson, 2006). In addition to being aroused and experienced, emotions must be explored and reflected on to activate such adaptive potential, hence transforming maladaptive emotional states and self-experiences associated with pathological conditions (Greenberg, 2010; Greenberg & Watson, 2006). The processing of emotions requires clients to be cognitively oriented to the exploration of and reflection on their inner information (Greenberg, 2010; Greenberg & Pascual-Leone, 2006; Pos & Greenberg, 2007; Pos et al., 2003; Whelton, 2004). Although the emotional experience may be explored and made sense of through a process of reflection, the transformation of maladaptive emotions occurs by generating and accessing new and more adaptive emotional responses that undo the maladaptive ones (Greenberg, 2010, 2015; Pos & Greenberg, 2007).

According to Greenberg (2010, 2015), maladaptive emotions may refer to (1) secondary emotions, i.e., responses to a primary emotion that is overwhelming, painful or threatening, thus obscuring and avoiding it (e.g., feeling sadness but expressing anger; expressing a fused global emotional state such as despair, hopelessness, or complaint), or (2) primary maladaptive emotions, i.e., immediate emotional responses that, although activated by the current situation, are overgeneralizations from past unresolved issues, thus leading the person to dysfunctional actions (e.g., experiencing loss with deep fear of being unable to survive alone; feeling profound sadness and abandoned at minor signs of

withdrawal). These maladaptive emotional experiences may be accessed during therapy to make them available to transformation by adaptive emotions (Greenberg, 2010; Greenberg & Watson, 2006). Adaptive emotions are primary or immediate emotional responses that are appropriate to the current situation and mobilize adaptive action tendencies consistent with the individual's needs (e.g., anger at boundary violations; sadness in loss). These primary adaptive emotions need to be accessed, explored, and reflected on to activate their innately healthy potential, hence promoting the transformation of maladaptive emotions and orienting the person to the achievement of core needs (Greenberg, 2010, 2015; Greenberg, Auszra, & Herrmann, 2007; Greenberg & Watson, 2006; Herrmann, Greenberg, & Auszra, 2014; Pascual-Leone & Greenberg, 2007). Consistent with Greenberg's theory (Greenberg, 2010, 2015), the change from maladaptive to more adaptive emotions during therapy predicted better outcomes (Herrmann et al., 2016). Additionally, a recent study on a case of depression with a good outcome observed that the client's improved emotional processing capacity was associated with a change from maladaptive to more adaptive emotions throughout treatment (Pinheiro, Mendes, Silva, Gonçalves, & Salgado, 2018). In sum, in humanistic-experiential approaches, emotional processing is a continuum of stages that broadly involves (1) being aware of emotions, (2) arousing and tolerating contact with them, (3) exploration and reflection to make sense of the emotional experience, and (4) when maladaptive, transforming such emotional states into more adaptive ones (Elliott et al., 2013; Greenberg, 2010; Greenberg & Watson, 2006).

Several concepts of emotional processing have been presented in the literature based on different theoretical frameworks and the measures adopted. In the current study, we will use the humanistic-experiential concept of emotional processing, as it is operationalized by the Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). The EXP is a seven-point scale that assesses the degree to which clients experience and explore their inner experiences to make sense of them, transform maladaptive emotions, and use the resulting adaptive inner information to solve personal problems in a meaningful way (Klein et al., 1986). The application of the EXP (Klein et al., 1986) to emotionally loaded segments of the therapeutic discourse – emotion episodes (EEs; Greenberg & Korman, 1993; Korman, 1991) – has been recognized as a sound measure of the cognitive-affective continuum of emotional processing in prior research on depression (e.g., Pinheiro et al., 2018; Pos, Greenberg, & Warwar, 2009). The EXP levels achieved during therapy have been consistently associated with therapeutic change in depression (Elliott et al., 2013; Greenberg, 2010; Greenberg et al., 2007). Regardless of the therapeutic approach used, the achievement of higher levels on the EXP predicted better outcomes (Goldman et al.,

2005; Pos et al., 2009; Watson et al., 2011), with a small to medium effect size ($r$ = -.19; Pascual-Leone & Yeryomenko, 2016).

### Emotional processing in grief

Grief over the loss of a significant figure is a common but also challenging experience (Milman et al., 2017; Neimeyer, 2001). Typically, when the loss is premature, sudden, or violent or the deceased is a securing and validating figure for the mourner's identity, the mourner's orienting core assumptions system may not be capable of accommodating the loss experience, resulting in a pathological condition (Milman et al., 2017; Neimeyer & Sands, 2011; Neimeyer & Thompson, 2014). Approximately 10% to 20% of grievers experience complicated grief, struggling with impairing chronic longing due to their separation from the deceased, accompanied by intense, overwhelming emotional pain (Prigerson et al., 2009).

A mourner's impaired ability to be aware of, arouse and tolerate live contact with grief-related painful emotions was associated with the development of complicated grief (Castro & Rocha, 2013; Neimeyer, 2001, 2006). This impairment of the first steps of emotional processing may prevent grievers from achieving the transformation of maladaptive experiences and access to core needs and action tendencies associated with adaptive emotions (the last steps on the continuum; Elliott et al., 2013; Greenberg, 2010; Greenberg & Watson, 2006). According to humanistic-experiential approaches, such healthy information may orient grievers to the necessary challenges ahead, i.e., the reconstruction and integration of their grief experience, and adaptation to their new life without the deceased (cf., Dual Process Model of Bereavement; Stroebe & Schut, 2010). To our knowledge, the role of emotional processing during grief therapy has yet to be empirically investigated.

The current exploratory research was focused on the session-by-session evolution of emotional processing in two cases experiencing complicated grief – one with a good and one with a poor outcome – using meaning reconstruction grief therapy (Neimeyer, 2001, 2006, 2016). We aimed to explore whether the level of emotional processing achieved during therapy was associated (1) with a change in grief-related emotions (adaptive or maladaptive) and (2) with different outcomes with respect to bereavement (good or poor outcome). A deeper understanding of how these bereaved clients experience and process grief-related emotions during therapy may contribute to clarifying whether emotional processing is associated with the improvement of complicated grief.

## 3.3. Method

### 3.3.1. Participants

**Clients.** Anna's and Jane's cases were collected in the "Complicated Grief Research Study" conducted by Alves and collaborators (Alves et al., 2014)(Alves et al., 2014) to investigate the processes of narrative change during grief therapy. People who presented a persistent and impaired reaction to a loss during at least the six previous months were referred for the study by the local hospital and health centers. Clients were informed about the protocol, aims, procedures and further use to research of the collected data before they consented to participate. The study was approved by the ethics committee of the local hospital and followed the principles of both the American Psychological Association and the Order of Portuguese Psychologists.

To ensure that complicated grief was the core clinical issue, clients were assessed using the Structured Clinical Interviews I and II for Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 2002), and the severity of grief symptoms was evaluated using the Inventory of Complicated Grief (ICG; translated and adapted for the Portuguese population from Prigerson et al., 1995 by Frade, Rocha, Sousa, & Pacheco, 2009). Of the eight patients referred for the study, six completed the protocoled intervention. Anna's and Jane's cases were randomly selected from the subgroup that finished the treatment below ($n = 4$) and above ($n = 2$) the cut-off point on the ICG (the cut-off score for the Portuguese population was 30; Sousa & Rocha, 2011). Although both clients improved in terms of bereavement symptoms, Anna achieved normative scores on the ICG (pre-test = 61; post-test = 28), while Jane remained in the non-normative population at the post-therapy assessment (pre-test = 51; post-test = 36); the cases were thus categorized as good and poor outcome cases, respectively.

Anna (pseudonym) was a 50-year-old Portuguese housemaid living with two of her three young adult sons. She had lost her husband two years prior to beginning therapy, a month and a half after he had been diagnosed with cancer. According to Anna, her husband "saved" her from an abusive and violent childhood, representing a secure attachment figure for her. She attended 13 therapeutic sessions. In the initial sessions, the client felt angry and struggled with a strong and uncontrollable desire for others to suffer the same pain and grief that she felt. She also described profound bereavement over the loss of her partner.

Jane (pseudonym) was a 20-year-old Portuguese waitress who had been living with her father since her older sister left to live abroad. She was in a romantic relationship. Jane suddenly lost her mother to a stroke one year prior to beginning therapy. She had had a very close relationship with her

mother. Jane attended 13 therapeutic sessions. In the initial sessions, Jane presented intense feelings of loneliness and emptiness. Despite the support of her family and her boyfriend, she felt alone, abandoned and neglected because they were not able to take care of her as her mother had.

**Therapist.** Anna's and Jane's therapist was a 28-year-old female PhD student trained in the therapeutic approach. She had 4 years of prior experience as a psychotherapist and had been trained in constructivist grief therapy during the prior two years. The therapist received supervision every two weeks (2 to 3 hours) by a clinician with 18 years of experience in constructivist psychotherapy to ensure adherence to the therapeutic approach.

### 3.3.2. Therapy

Anna and Jane were treated within the framework of Neimeyer's constructivist meaning reconstruction grief therapy (Neimeyer, 2001, 2006, 2016). This therapeutic modality aims to help clients make meaning of their loss experiences, promoting the integration of such events into their orienting core assumptions system (Burke & Neimeyer, 2013). Such accommodation of the loss involves looking back on the story shared with the deceased but also looking to the present and future to reengage with a world changed by the absence of the loved one and to reconstruct an ongoing bond with the deceased (Stroebe & Schut, 2010). Mourner's ability to make meaning from loss has been associated with better bereavement outcomes (Bellet, Neimeyer, & Berman, 2016; Milman et al., 2017; Neimeyer, 2016; Rozalski, Holland, & Neimeyer, 2017). The meaning reconstruction interview was used to orient the initial exploration of both clients' stories of loss, exploring the details related to the death and the inner experience of grief (Neimeyer, 2001, 2006, 2016; Neimeyer, Burke, Mackay, & Van Dyke Stringer, 2010). Throughout treatment, the main therapeutic meaning-oriented activities used in Anna's and Jane's cases were narrative retelling and imaginal conversations with the deceased to reduce the pain associated with the grief episodes and facilitate the construction of a new and more adaptive post-loss relationship with the deceased (Burke & Neimeyer, 2013).

### 3.3.3. Measures

#### Process Measures

**Emotion episodes (EEs)**. EEs (Greenberg & Korman, 1993; Korman, 1991) are segments of the psychotherapeutic discourse during which clients express an emotion (e.g., sadness) or an associated action tendency (e.g., crying) in response to a situation, context or event (e.g., death of a loved one).

According to the EEs Manual (Korman, 1991), these segments may be categorized based on the expressed emotional responses (emotions and action tendencies) into EEs of Love, EEs of Joy, EEs of Fear, EEs of Anger, EEs of Sadness, and EEs of Guilt/Shame. Tracking the EEs during therapy may provide information about clients' grief-related emotions and allow us to identify changes in such emotional responses.

The codification of EEs involves the following: (1) identification of an emotional response and the trigger situation, context, or event in the clients' speech; (2) definition of the beginning and end of the EE by tracking backward and forward in the clients' discourse until the emotional response, the trigger and the speech theme change; and (3) categorization of the EEs based on the emotional responses expressed into one of the following basic emotions – Love, Joy, Fear, Anger, Sadness, and Guilt/Shame. This measure presented strong reliability and validity in prior studies (e.g., Greenberg & Korman, 1993; Pinheiro et al., 2018; Pos et al., 2003).

**Experiencing Scale (EXP).** The EXP (Klein et al., 1986) is a 7-point rating scale that measures clients' cognitive and emotional involvement in the processing of inner information. An increase from lower to higher levels on the EXP indicates increased ability to be inwardly focused; to experience, explore and reflect on emotions; to transform maladaptive emotions; and to use the information from adaptive emotions to solve personal problems in a meaningful way. The initial EXP levels are focused on the description of external episodes: EXP level 1 – the clients are not involved in the described situations; EXP level 2 – the involvement is behavioral or intellectual; and EXP level 3 – the references to feelings and emotions are brief, circumscribed reactions to the situations described. At the intermediate and final EXP levels, the clients' discourse is inwardly focused: EXP level 4 – description of feelings, emotions, and personal assumptions or problems that clearly show the client's inward experience; EXP level 5 – exploration of hypotheses about feelings, emotions and personal assumptions and problems; EXP level 6 – a synthesis of vivid and accessible feelings is presented to describe the new self-experiences and meaningful resolution of personal problems; and EXP level 7 – new and expanded self-understanding to a wider range of life contexts due to the employment of new and more adaptive inner experiences.

According to the EXP Manual (Klein et al., 1986), the rating involves the identification of the highest EXP level (peak level) during segments of the psychotherapeutic discourse (EEs in the current study). This measure presents adequate reliability and validity indices (Klein et al., 1986).

### 3.3.4. Procedures

#### Process measurement

**EEs.** The judges were a PhD and a master's student in clinical psychology. Over approximately 3 months (2 h per week), the judges were trained on the EEs Manual (Korman, 1991) via (1) reading and discussion of the manual's coding procedures; (2) coding of the manual excerpts; and (3) coding of videotaped psychotherapy sessions (not from Anna's or Jane's case) until a good level of reliability with respect to the identification of EEs and categorization of the basic emotions (*Cohen's kappa* ≥ .65) was achieved. In the current study, the coding of EEs in the sessions was performed independently by the judges. The inter-judge agreement (1) on the presence/absence of EEs was a Cohen's kappa of .88 and (2) on the basic emotion categorization of each EE was a Cohen's kappa of .92. After the reliability had been computed, the judges discussed any disagreements to reach consensus on the final coding.

Regarding the final coding of the EEs, the judges independently categorized the EEs as adaptive or maladaptive. Both judges were familiar with Greenberg's (2010) distinction between adaptive and maladaptive emotions, and both were trained in EFT. This distinction was based on the judge's clinical judgment. The inter-judge agreement was excellent – Cohen's kappa was .93. The final categorization of EEs as adaptive or maladaptive resulted from the consensus reached between the judges after they discussed the disagreements. Finally, we computed for each session of each case the (1) frequency of EEs of Love, Joy, Fear, Anger, Sadness, and Guilt/Shame and (2) the frequency of adaptive and maladaptive EEs.

**EXP.** The judges were a PhD student and PhD and a master's in clinical psychology. Over approximately 4 months (2 hours per week), the judges were trained based on the EXP Manual (Klein et al., 1986), which involved: (1) reading and discussion of the manual's rating procedures; (2) rating of the manual's clinical excerpts; and (3) rating of previously delimitated EEs (identified by a different pair of judges) from videotaped psychotherapy sessions (not from Anna's or Jane's case) until a good level of reliability with respect to the identification of the EXP peak level (*Intraclass Correlation Coefficient – ICC* [2,1] ≥ .65) was achieved. In the current study, the PhD student was paired with each of the two other judges to code a randomly assigned case. Each judge independently rated the EXP peak level for the previously identified EEs. The inter-judge agreement was .81 (*ICC* [2,2] = .81) and .95 (*ICC* [2,2] = .95). The final rating resulted from discussion of any disagreements and the reaching of a consensus between each pair of judges. The final EXP ratings were averaged for each session of Anna's and Jane's cases.

## 3.4. Results

### Anna's good outcome case

During Anna's treatment (Figure 3.1), a total of 71 EEs were identified (*M* = 5.56, *SD* = 1.98). EEs of Joy (*n* = 31; 44%) were the most frequent, followed by EEs of Sadness (*n* = 19; 27%) and Anger (*n* = 16; 23%). EEs of Guilt/Shame (*n* = 3; 4%) and Fear (*n* = 2; 3%) presented a very low frequency and only emerged in the initial sessions (sessions 1 and 3). No EEs of Love were identified. Of the 71 EEs (Figure 3.2), 58 were categorized as adaptive (82%) and 13 as maladaptive (18%). The maladaptive EEs were mostly found in the first half of therapy (only one maladaptive EE appeared after session 7). Adaptive EEs appeared in all the therapeutic sessions, being the most frequent type during the first (sessions 1 to 7) and the second (sessions 8 to 13) half of therapy.

Regarding the EXP, levels 2 to 6 were identified. During the first and the second half of therapy, the client achieved EXP level 6. The mean EXP levels ranged from 3 to 5 and presented an increasing tendency throughout therapy (Figure 3.1). Next, we describe and provide clinical vignettes to illustrate this increase and the change in the type of EEs aroused during therapy.

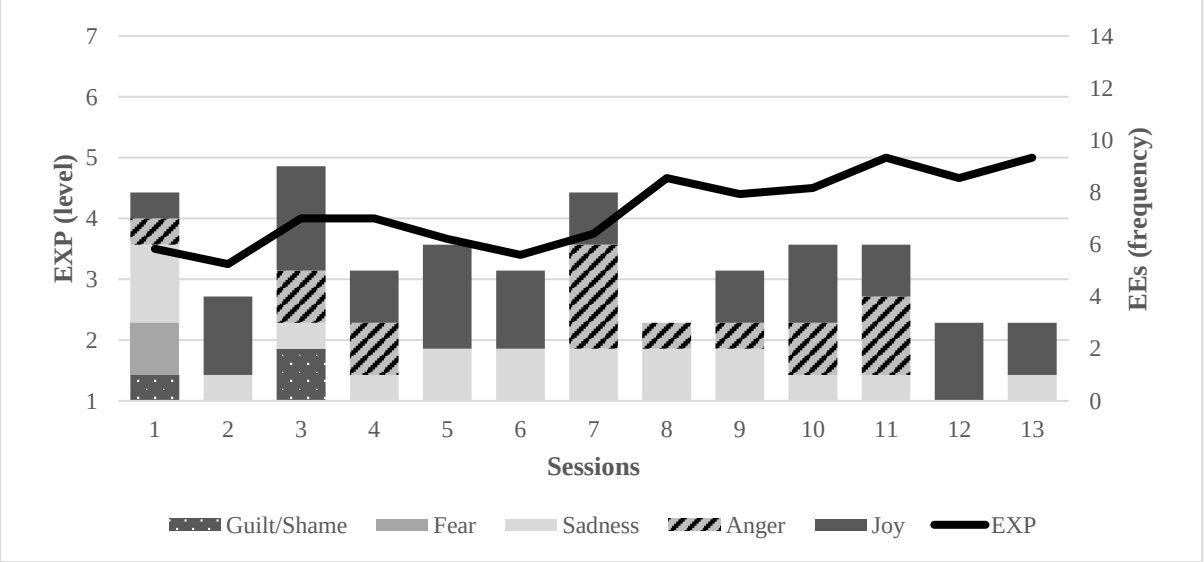


*Figure 3.1.* Average level of emotional processing (EXP) and frequency of Emotion Episodes (EEs) of Guilt/Shame, Fear, Sadness, Anger, and Joy throughout Anna's case (good outcome case).

### ***Sessions 1 to 7***

During the initial sessions (sessions 1 to 3), in addition to adaptive EEs of Sadness associated with the grieving of her husband, Anna presented maladaptive EEs of Anger, Fear, and Guilt/Shame. EEs of Anger were associated with feelings of anger, loathing, and jealousy toward others, all secondary emotional responses to grief. The "unacceptable" desire that people who had the same illness as her

husband would also die was associated with secondary emotional responses of Guilt/Shame and Fear about being punished by God.

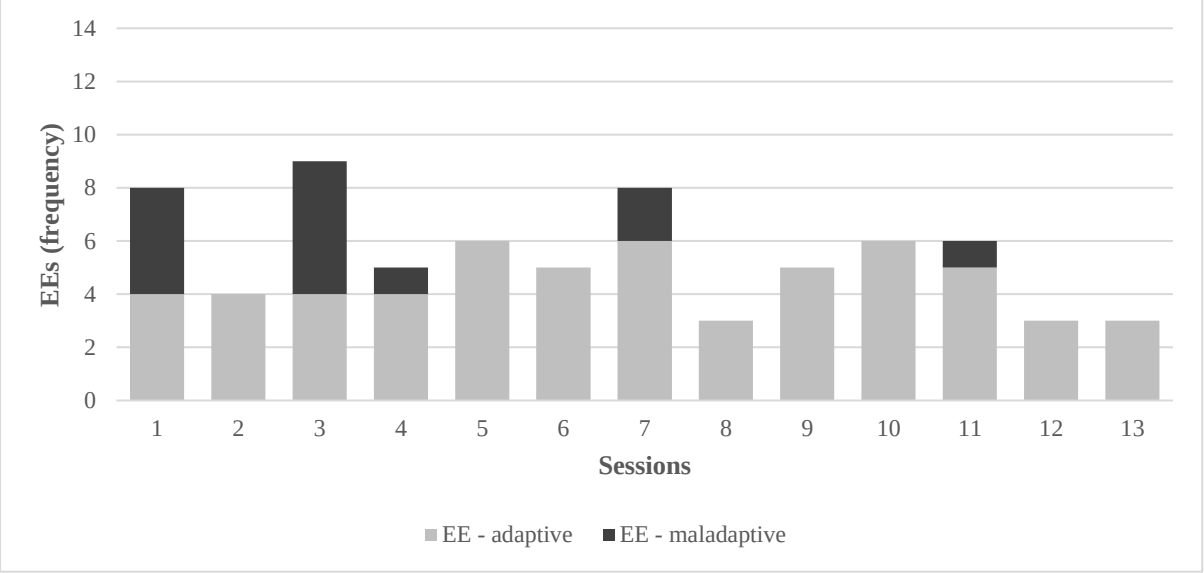


*Figure 3.2.* Frequency of EEs categorized as adaptive and maladaptive throughout Anna's good outcome case.

Even in the first session, during these maladaptive EEs of Anger, Guilt/Shame, and Fear, Anna reached EXP level 4 and, sporadically, level 5. The client described her experiences and issues from an inward perspective (EXP level 4) and explored her feelings, emotions and problems (EXP level 5). The following clinical vignette retrieved from an EE of maladaptive Anger (session 1), rated as EXP level 5, illustrates such inner work. Anna described her desire to know that other people also grieved and felt pain and hypothesized that such feelings of Anger were associated with her pain and her difficulty accepting the death of her husband, achieving EXP level 5.

> ***Anna:*** *I got mad at people. Sometimes I feel like I want to hear bad news about other people. Oh my God, it's a wrong way of thinking, but that's how I feel.*
> ***Therapist:*** *I'm not seeing a bad person, I see you as a human being who has stumbled upon a painful situation and is trying to get a sense of what happened.*
> ***Anna:*** *I've never been like this. (**Therapist:** Hum um.) I got so sick that two years after his death I still can't accept that it happened.*
> ***Therapist:*** *So, do you think this difficulty in accepting is related to your anger?*

***Anna:*** *Yes. Maybe this anger means I'm not accepting his death... Maybe I go through the obituaries in the newspaper to realize that it wasn't just my husband who died. I need to know that the same happened to other people to be able to accept it.*

Following further therapeutic facilitation of inner work on the meaning of her feelings of Anger, during session 3 Anna achieved, for the first time, EXP level 6 in a maladaptive EE of Anger regarding the same theme. The excerpt below was taken from that EE. Anna achieved EXP level 5 when she identified her Anger towards others as problematic and explored the meaning of this emotion in her mourning experience. The therapist-guided exploration of the client's inner experiences resulted in the achievement of EXP level 6 when the client described the underlying process associated with the transformation of her secondary feelings of guilt about being angry. Anna acknowledged her anger as an emotional response to the painful and premature death of her husband. Furthermore, in the final part of the excerpt, Anna focused on her feelings of grief instead of on the maladaptive anger.

***Anna:*** *When I hear that someone has died, I think, "that's just the way it is".*
***Therapist:*** *What would you tell someone who tells you that you are cruel?*
***Anna:*** *What happened to me wasn't cruel also? I have a reason to be angry.*
***Therapist:*** *Okay. What is the role of this anger in your experience of mourning?*
***Anna:*** *I've never been a person to conform to the idea that God is in charge.*
***Therapist:*** *You are telling me that you have the right to have a voice in what happened to you: "this revolt is in response to my husband's passing."*
***Anna:*** *Yes. I consider this to be the salt of my life. If I do not feel this anger, it seems that I'm not doing any justice to my husband's death, it seems as if I accepted it.*
***Therapist:*** *How do you imagine your life keeping that salt, that nonconformity?*
***Anna:*** *Now I don't feel so guilty for thinking this way because I realized I'm not harming others. I just feel comfort in knowing that I'm not the only one experiencing loss. I'm a grieving person who has the right to feel anger because a part was removed from me. I'm suffering for having lost him.*

After session 3, the maladaptive EEs of Anger, Guilt/Shame and Fear regarding this theme disappeared. Instead, Anna accessed and explored the adaptive EE of Sadness over her loss. As can be seen in the following excerpt retrieved from the beginning of session 4 (EE of Sadness), the client

elaborated on the transformation of her feelings of secondary Anger into adaptive Sadness due to the irreversible loss of her husband, achieving EXP level 6.

> ***Therapist:*** *What do you want to do with that emotion, with that salt of your life?*
>
> ***Anna:*** *The way I feel now about my husband's death, I think it's not even anger anymore... I feel hurt with everything that's happened to me. I don't think it's fair, it didn't do justice to what happened to me, to us. So, I'm disappointed, but I'm not like I was in the beginning when I was blaming everyone. Now it's not... I feel sad and hurt with what happened to me, to us. I miss him, and I know I will always miss him, but I'm more at ease with that pain. I'm trying to accept and adjust myself to my new life.*

Alongside this internal work in accepting her mourning, Anna embraced her post-loss life. For instance, she donated her husband's clothes and engaged in a new professional project. Beginning in session 4, Anna confronted others' expectation that she should be a widow who should be fulfilled by being a mother and a grandmother. The client began to identify others' pressure as an issue during adaptive EEs of Anger. Throughout the first half of therapy, the client mostly achieved EXP level 3 in these EEs, briefly describing and accessing the emotional impact of others' pressure.

***Sessions 8 to 13***

During the second half of therapy, Anna reached EXP level 5 in the EEs of adaptive Anger regarding others' intrusion in her life. In the following excerpt from an EE of adaptive Anger (session 8), the client described the conflict between conforming to others' pressure to fill the role of a widow and asserting her own needs (EXP level 4). Anna achieved EXP level 5 when she described the inner impact of such issues and stated her personal value and right to choose the life she wanted to have after her husband's death.

> ***Anna:*** *People think that any random thing will please me now, I can even stay in a corner in the smallest room of my house. I could follow that thought, "ok, now I'm alone, anything works for me", but on the other hand I don't think I should. Thinking of me, I want to create a space for myself where I feel good. This revolts me because I'm not something that's stuck in a corner. People tell me, "now you have your grandbabies". It*

*sounds like I'm worthless, that I have no rights as I did before because my husband is no longer at my side. It's like they're telling me that it's over for me.*

***Therapist:*** *Hum hum. Regarding your rights, how would you respond to them?*

***Anna:*** *I'd say that I'm the person I've always been. I just don't have him by my side, but I'm still me. (**Therapist:** Hum hum) Of course, now it's different because I have this constant grieving, but I'm me. I'm trying to feel comfortable and to feel better with this new life that I'm embracing.*

Adaptive EEs of Joy related to Anna's investment in her new life and to a greater acceptance of her husband's death emerged during this second phase of therapy. The client frequently achieved EXP levels 5 and 6. In the following excerpt of an EE of Joy rated EXP level 6 (session 12), Anna presented a synthesis of the evolution of her post-death relationship with her husband, resulting in a less painful ongoing connection.

***Anna:*** *I begin to see him in everything that is not material. (...) I miss him a lot, but it is less painful, I already accept my life much better. I now realize that it is not those things, like the furniture in my room, that connect me to him... He is always there. When I decided to change my bedroom's furniture, I was afraid to do it because it represented our life, so many beautiful and good moments. I thought it was going to disturb me a lot, but that didn't happen. Then, I realized that he is always with me, even if many of his objects, or the ones used by him, are gone. (**Therapist:** Hum hum) He's in my house, he's still the center of my attention.*

***Therapist:*** *Hum... It's interesting, you are saying that he's still the center of attention. This relationship with your husband now seems much less painful, seems freer because it is not confined to specific objects.*

***Anna:*** *I feel it. I seem to be freer to think of him. It's as if I was stuck on a schedule, with things that depressed me, and now I'm not, I feel free. (**Therapist:** Hum hum) I miss him, I miss him a lot, but I feel glad for having him with me with less pain.*

**Jane's poor outcome case**

During Jane's treatment (Figure 3.3), a total of 97 EEs were identified ($M$ = 7.46 EEs; $SD$ = 2.50). EEs of Sadness were the most frequent ($n$ = 36; 37%), followed by EEs of Anger ($n$ = 23; 23%),

EEs of Joy (*n* = 22; 23%), and EEs of Fear (*n* = 15; 15%). We only identified one EE of Guilt/Shame (*n* = 1; 1%), and no EEs of Love were identified. Of the 97 EEs (Figure 3.4), 43 were categorized as adaptive (44%) and 54 as maladaptive (56%). We identified both adaptive and maladaptive EEs in all therapeutic sessions. Although there were fewer than in the first half of therapy (sessions 1 to 7), the maladaptive EEs were still frequent during the second half of therapy (sessions 8 to 13).

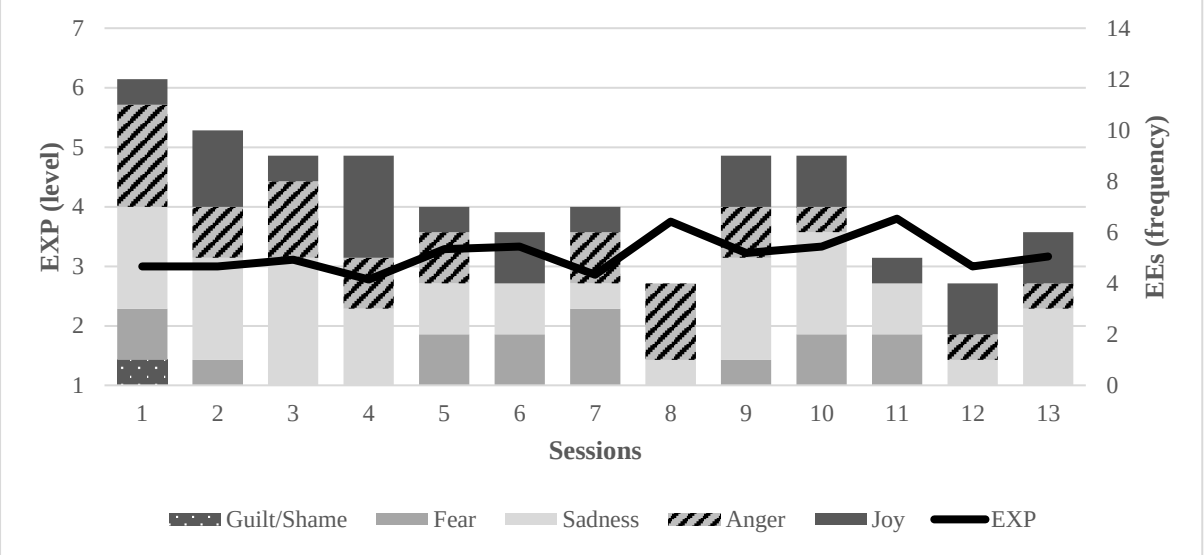


*Figure 3.3.* Average level of emotional processing (EXP) and frequency of Emotion Episodes (EEs) of Guilt/Shame, Fear, Sadness, Anger, and Joy throughout Jane's poor outcome case.

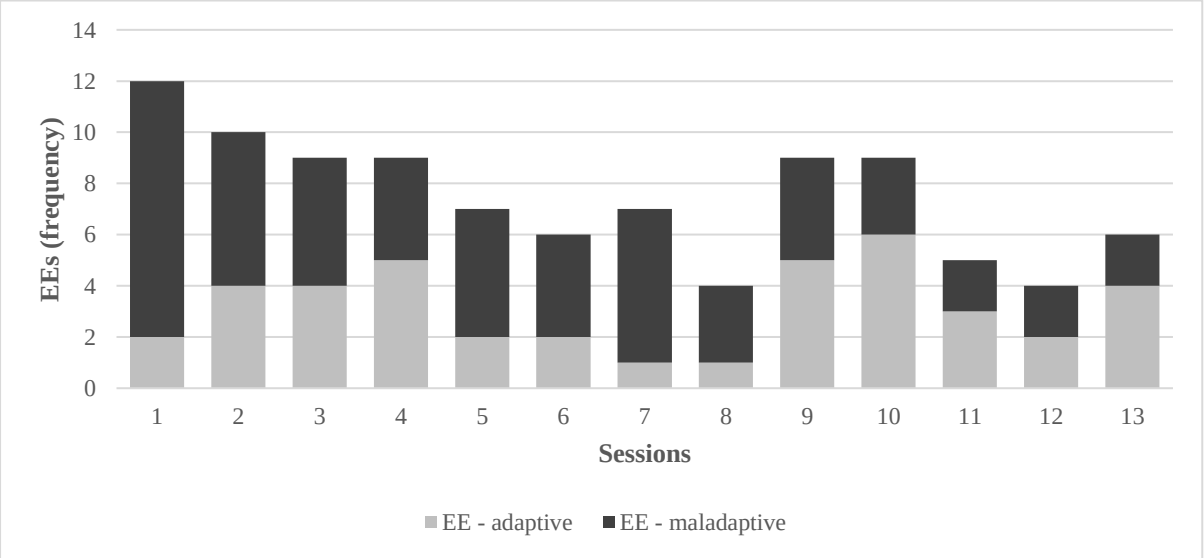


*Figure 3.4.* Frequency of EEs categorized as adaptive and maladaptive throughout Jane's poor outcome case.

EXP levels 2 to 5 were identified in Jane's case. During the first half of therapy, the client almost exclusively achieved EXP level 3. During the second half of therapy, the client sporadically reached EXP level 5. The average EXP level ranged from level 2 to 4 and presented a slight increasing tendency throughout this case (Figure 3.3). Next, we will describe and provide clinical vignettes to illustrate the evolution of the EXP levels and in the type of EEs aroused.

***Sessions 1 to 7***

During the first half of therapy, Jane presented mostly maladaptive EEs of Sadness, Anger, and Fear. The EEs of Fear were maladaptive primary emotional responses associated with the client's perception of her inability to survive without her mother's support. The maladaptive EEs of Sadness were frequently overwhelming secondary reactions, namely, under-regulated feelings of being lost, helpless, and alone in response to her mother's death and the lack of familiar support felt. We also identified maladaptive EEs of Anger in response to these events. Jane frequently expressed destructive anger and complaints regarding her family as a secondary emotional response to the pain of having lost her closest relationship. During these initial maladaptive EEs, Jane achieved almost exclusively EXP level 3, as illustrated by the excerpt below from an EE of Sadness (session 1). Jane focused on describing the episode of loss, presenting behavioral and intellectual involvement (EXP level 2). She achieved EXP level 3 when, in response to the therapist's intervention, she referred to global feelings of despair and loss.

> ***Jane:*** *My mother was sleeping with me, and when she got up, she fell. I immediately saw that something was happening to her. I was completely overwhelmed. I called the ambulance, and we went to the hospital. I was so shaken up. (...) Before I left the hospital, she just opened her eyes, looked at me and touched my tummy... (Cries)*
>
> ***Therapist:*** *Jane, this is a very strong image.*
>
> ***Jane:*** *It was the last time I saw her.*
>
> ***Therapist:*** *Ok... What does this memory symbolize for you?*
>
> ***Jane:*** *Despair. I'm feeling completely lost. (Cries)*

***Sessions 8 to 13***

During the second half of therapy, Jane continued to present maladaptive EEs of Anger associated with secondary responses to her grief over her mother, resulting in responses of accusatory and destructive anger toward others. Although EXP level 3 remained the most frequent level reached by

the client during this phase of therapy, Jane achieved EXP level 4 more frequently and reached EXP level 5 (highest level achieved during therapy) for the first time. The following excerpt was retrieved from the first EE of maladaptive Anger in which Jane achieved EXP level 5 (session 8). In addition to identifying feelings of Anger towards others as a problem, she caught her first glimpse of the association between this feeling and the sadness of her mourning, reaching EXP level 5.

> ***Jane:*** *I've been irritated with people...*
> ***Therapist:*** *And this irritation, what is its meaning for you?*
> ***Jane:*** *I don't know... Maybe it has to do with my longing for my mother...*
> ***Therapist:*** *Ok! We have seen that longing is one of the ingredients that flavors the experience of mourning. (**Jane:** Hum um) Right now, maybe your sadness and longing are covered in irritation. Is that it?*
> ***Jane:*** *Maybe... When I go to my boyfriend's house, the affection of his mother toward him reminds me of when I also had that care, the talking, the support... And for example, I went to the dentist and (**Therapist:** Hum hum) not having her company, as always, I think that's what made me feel more fragile and sometimes even angry.*

In addition to the maladaptive EEs of Anger, adaptive EEs of Sadness and Joy emerged during this second half of therapy. The EEs of secondary maladaptive Sadness almost disappeared. Instead, Jane presented adaptive responses of Sadness regarding the irreversible loss of her mother. The client achieved EXP levels 3 and 4 during these EEs. Next, we present an excerpt from an adaptive EE of Sadness (session 10) associated with Jane's grief. The client achieved EXP level 4, as she was internally focused on the description of her grief as an actual experience of longing. Although Jane described her experience with internal references, she avoided contact with such painful emotions, preventing her from achieving higher EXP levels.

> ***Therapist:*** *How do you think your grief experience is right now?*
> ***Jane:*** *At this moment I think my grieving experience is about longing, completely!*
> ***Therapist:*** *What does it mean to you, "my grieving experience is about longing"?*
> ***Jane:*** *I miss her, her support, her affection... I feel a longing for my mom.*
> ***Therapist:*** *Hum hum. And how have you been dealing with that longing?*

***Jane:*** *I don't, I try to pass by, and not be in contact. Even going to the cemetery, I'm like, "I'm going! No, I'm not going".*

***Therapist:*** *Hum hum. How would it be for you to give yourself the opportunity to go?*

***Jane:*** *I think it is going to be a painful time for me (**Therapist:** Hum hum). I want to get out of this situation. But sometimes it's complicated and I just start to cry.*

The EEs of adaptive Joy were mainly associated with emotional responses of relief, satisfaction, and empowerment regarding the therapeutic support and validation of the client's suffering. Jane mostly achieved EXP level 3 during the adaptive EEs of Joy. In the final excerpt, retrieved from the last session, Jane reached EXP level 3 when she briefly referred to inner experiences of security and confidence due to therapy. However, she did not clarify how these feelings were inwardly experienced by her (EXP level 4).

***Jane:*** *I enjoy coming to therapy; I leave feeling more secure and confident. Talking about and expressing what distresses me and puts me down makes me feel better.*

## 3.5. Discussion

The current intensive case study was carried out to explore the role of emotional processing in grief. We tracked how two clients (one with a good and one with a poor outcome) with complicated grief experienced and processed their grief-related emotions throughout meaning reconstruction grief therapy (Neimeyer, 2001, 2006, 2016). Specifically, we explored the association of the levels of emotional processing achieved with changes in the clients' grief-related emotional experiences (adaptive or maladaptive) and with the treatment outcome. Although this is a comparative case study, our results may contribute to theory building (Stiles, 2015) on the process of change in grief and specifically on the role of emotional processing as a possible mechanism of change associated with improvement in bereavement.

### Emotional processing and therapeutic outcome

Throughout therapy, both Anna and Jane enhanced their capacity to process grief-related emotions. Anna, the good outcome case, achieved mean EXP levels between 3 and 4 during the first half of therapy (sessions 1 to 7), but during the second half (sessions 8 to 13) achieved EXP mean levels between 4 and 5. Jane, the poor outcome case, reached EXP mean levels between 2 and 4 during the

first phase of therapy and mean EXP levels between 3 and 4 during the second phase. In both cases, the lowest EXP level was 2, while the highest EXP level achieved in the good outcome case was EXP level 6 and in the poor outcome case was EXP level 5. Although both clients presented at least behavioral or intellectual involvement with their inner experiences (EXP level 2), this low level of emotional processing was more frequent in the poor outcome case. Furthermore, Jane only sporadically explored and reflected on her emotions to make meaning of them (EXP level 5), while Anna, in addition to having been more frequently involved in such inner work, also applied the resulting more adaptive emotions and self-experiences to the productive transformation of her mourning experience (EXP level 6). Our findings suggested that the good outcome case reached higher levels of emotional processing and experienced greater improvement in the capacity to process emotions than the poor outcome case. Such findings are consistent with prior research on depression (Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2018; Pos et al., 2003, 2009, 2017; Watson & Bedard, 2006), suggesting both that emotional processing may be enhanced during grief therapy and that the achievement of higher levels may be associated with a better therapeutic outcome.

### Emotional processing and changes in grief-related emotions

During both Anna's and Jane's cases, we identified EEs of Sadness, Anger, Joy, Fear, and Guilt/Shame, suggesting that regardless of the outcome, these are emotional experiences associated with the grief experience. Although both clients experienced the same categories of emotions, they presented different frequencies (1) of EEs categorized as adaptive and maladaptive and (2) of the EXP levels achieved during these EEs. First, the good outcome case presented a higher frequency of adaptive EEs than the poor outcome case (82% and 44%, respectively). Although the frequency of maladaptive EEs decreased from the first to the second phase of therapy in both cases, the poor outcome case maintained a higher frequency of maladaptive EEs during the last phase of the treatment. Second, Anna reached higher EXP levels during both adaptive and maladaptive EEs, which we hypothesized would be associated with the different frequencies of maladaptive and adaptive EEs.

From the initial sessions, Anna deeply accessed, experienced, and explored her maladaptive responses of Anger, Guilt/Shame, and Fear regarding the death of her husband (EXP level 5), which may have contributed to accessing underlying adaptive Sadness for the loss (EXP level 6). Such transformation seems to have created room to explore more deeply the Sadness experience (EXP level 5) and access the associated healthy action tendencies, namely, letting go of the relationship she had with her husband (EXP level 6). During Anna's investment in her new life, emotional responses of adaptive Anger regarding

others' intrusion on her life decisions emerged. The exploration and reflection on such experiences (EXP level 5) seems to have contributed to the empowerment of the client in her current relationships. Finally, Joy emerged as an adaptive emotional response whose healthy information moved her to invest in rebuilding her new life, which included an ongoing and less painful relationship with her husband (EXP level 6). In contrast, although Jane also started therapy with frequent maladaptive responses of Anger, Fear, and Sadness associated with the loss of her mother and the lack of familiar support, she presented brief access to these maladaptive responses (EXP level 3). Though sporadically, during the second half of therapy, Jane explored and reflected on the meaning of her experiences of maladaptive Anger towards others, catching her first glimpse of its link to the Sadness she felt for the loss of her mother (EXP level 5). Although her Sadness for the irreversible loss of this crucial relationship became more adaptive and Jane became more capable of describing how grief was experienced by her (EXP level 4), she refused deeper contact with and reflection on this painful experience. Additionally, the client maintained brief contact with the experience of Joy associated with the therapeutic support and validation of her suffering (EXP level 3).

These observations suggest that therapy was more productive for Anna than for Jane with respect to the transformation of the grief-related maladaptive emotional responses into more adaptive ones. Anna's increased ability to access, experience, explore and make sense of her inner experiences may have been critical both to transforming her maladaptive emotions into more adaptive ones and mobilizing her to meet her core needs based on the healthy adaptive information. As we observed in the current case study, such access to the healthy information of adaptive emotions has been associated with greater therapeutic change (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2014; Pascual-Leone & Greenberg, 2007). Although Jane accessed, experienced, and sporadically explored grief-related maladaptive emotional experiences, this did not seem sufficient to deeply transform such experiences. In fact, such maladaptive emotional experiences may be transformed by the innately healthy information derived from the adaptive emotions (Greenberg, 2010, 2015; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2014; Pascual-Leone & Greenberg, 2007). Jane accessed and occasionally was in contact with adaptive emotions, but she was not involved in the necessary exploration of and reflection on such experiences to achieve new meanings and the transformation of the maladaptive emotions (Greenberg, 2010; Greenberg, Auszra, & Herrmann, 2007; Greenberg & Watson, 2006; Pascual-Leone & Greenberg, 2007). Specifically, in grief, adaptive Sadness would be important to mobilize Jane to accept the irreversible loss and invest in a new life without the presence of her mother, as we observed during Anna's good outcome case (Greenberg, 2010; Greenberg

& Watson, 2006). In sum, the greater change from maladaptive to more adaptive emotions during the good outcome case seems to be associated with the increase in the client's ability to process inner experiences, consistent with prior theoretical and empirical works on depression (Greenberg, 2010; Herrmann et al., 2014; Pinheiro et al., 2018).

### 3.6. Limitations, conclusion and further research

These findings should be cautiously interpreted, since they may result from the idiosyncrasies of the cases. We are aware that third variables may have led to the achievement of better outcomes in Anna's case than in Jane's, namely, (1) Anna's loss occurred longer ago, (2) although the period between the diagnosis and the death of her husband was not long, the loss was not sudden, and (3) she was older and had already experienced other significant losses. These variables are risk factors for complications in the grieving process and may have contributed to impairment of the integration of the loss into the meaning system in Jane's case (Burke & Neimeyer, 2013; Neimeyer, 2006, 2016).

Despite the limitations, the findings of the current exploratory study may improve our knowledge of clients' change process during grief therapy (cf. Stiles, 2015). The capacity for emotional processing might be impaired in grief, and its facilitation throughout therapy may be associated with (1) changing maladaptive grief-related emotions and (2) coping with grief and adapting to the new life based on healthy information from adaptive emotions. Furthermore, the achievement of higher levels of emotional processing during therapy seems to be associated with (3) a better therapeutic outcome. Further research is needed to clarify whether emotional processing is one of the mechanisms of change activated throughout therapy that may contribute to clients' improvement in clients experiencing complicated grief.

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# CAPÍTULO III – CONCLUSÃO

## 1. Discussão integrada dos resultados

No âmbito da presente dissertação, desenvolvemos três estudos empíricos para esclarecer o papel do processamento emocional dos clientes na mudança terapêutica. Para facilitar a apresentação e discussão integrada desses resultados, organizamos essa informação de acordo com os seguintes tópicos: (1) evolução no processamento emocional ao longo da terapia, (2) o papel do processamento emocional na mudança das experiências emocionais e, por último, (3) o papel do processamento emocional na mudança dos sintomas.

### 1.1. Evolução no processamento emocional ao longo da terapia

Adotamos uma perspetiva longitudinal nos estudos empíricos que levamos a cabo no âmbito da presente dissertação. Este tipo de *design* permitiu-nos identificar um padrão de desenvolvimento no processamento emocional dos clientes ao longo do tratamento.

No estudo intensivo de um caso de sucesso em Terapia Focada nas Emoções para a depressão (estudo 1), verificamos que a cliente aumentou a capacidade para processar as suas emoções ao longo das sessões. Os resultados sugeriram que, apesar de o padrão de evolução dos níveis da EXP ser irregular, a sua tendência foi crescente ao longo do processo terapêutico. No âmbito do estudo com uma amostra de 50 casos diagnosticados com depressão (estudo 2) observamos um padrão de evolução semelhante. Os resultados sugeriram que os clientes atendidos, quer em Terapia Focada nas Emoções, quer em Terapia Cognitivo-Comportamental, aumentaram a capacidade de processamento emocional ao longo das sessões.

A evolução na capacidade de processamento emocional observada nestes dois primeiros estudos é amplamente consistente com a investigação prévia que sugere que os clientes tendem a aumentar o foco interno, explorar e refletir sobre as suas experiências emocionais para aceder a emoções e experiências sobre o *self* mais adaptativas e, assim, resolver os seus problemas pessoais (Goldman et al., 2005; Pos et al., 2003, 2009, 2017; Watson & Bedard, 2006). Essa evolução foi semelhante nos casos atendidos em Terapia Focada nas Emoções e em Terapia Cognitivo-Comportamental, sugerindo que ambas as abordagens promovem o aumento da capacidade de processamento emocional (Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011).

Apesar do *slope* na EXP não ser estatisticamente diferente entre as estas abordagens terapêuticas (estudo 2), os casos atendidos em Terapia Focada nas Emoções apresentaram, desde a

primeira sessão, níveis mais elevados na EXP comparativamente aos casos atendidos em Terapia Cognitivo-Comportamental. Tal como observado em estudos prévios que compararam diferentes abordagens terapêuticas, os nossos resultados sugerem que a Terapia Focada nas Emoções, já que está vocacionada para a promoção da consciência, ativação, contacto, exploração e transformação das experiências emocionais, promove níveis mais profundos de processamento emocional (Pascual-Leone & Yeryomenko, 2017; Watson & Bedard, 2006; Watson et al., 2011). Estes resultados sugerem que o trabalho terapêutico tem um contributo crítico para o desenvolvimento da capacidade de processamento emocional dos clientes, sendo que as estratégias específicas das abordagens humanisto-experienciais parecem promover níveis mais profundos de processamento, comparativamente às restantes (Elliott et al., 2013; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017).

Consideramos, contudo, relevante refletir sobre outras hipóteses que expliquem a diferença observada entre os clientes atendidos nestas duas abordagens terapêuticas (estudo 2). Primeiro, apesar de os casos terem sido aleatoriamente distribuídos para a Terapia Focada nas Emoções e a Terapia Cognitivo-Comportamental, os dois grupos podem não ser equivalentes ao nível da capacidade de processamento emocional. Considerando esta hipótese, os clientes atendidos em Terapia Focada nas Emoções poderiam apresentar uma maior capacidade para processar as suas emoções antes de iniciarem a intervenção psicoterapêutica. Esta diferença *a priori* poderia, então, contribuir para que esses clientes atingissem níveis mais elevados na EXP desde a primeira sessão. Segundo, os resultados poderão ter sido influenciados pela lealdade terapêutica (*allegiance effect*) dos investigadores às abordagens humanisto-experienciais (cf., Boccaccini, Marcus, & Murrie, 2017; Dragioti, Dimoliatis, Fountoulakis, & Evangelou, 2015). Desta forma, as codificações das sessões poderão ter sido enviesadas pelo facto de os investigadores acreditarem na superioridade dessas terapias na promoção do processamento emocional, resultando na identificação de níveis mais elevados na EXP nesses casos.

Ainda que os resultados possam ter sido sobrestimados na Terapia Focada nas Emoções, sugerem que também a Terapia Cognitivo-Comportamental promove o aumento do processamento emocional. Assim, à semelhança de outros fatores cognitivos e emocionais específicos (Basto & Salgado, 2014), o processamento emocional não é apenas promovido pelas abordagens terapêuticas que lhe atribuem um papel central.

Relativamente ao padrão de evolução do processamento emocional durante o tratamento, os resultados que observamos nestes dois estudos empíricos sugerem uma tendência linear e crescente ao longo da terapia, o que difere dos resultados descritos na literatura. A investigação prévia propôs que a capacidade de processamento emocional dos clientes tende a aumentar da fase inicial para a

intermédia da terapia e a manter-se estável ou diminuir na fase final do tratamento (Pascual-Leone & Yeryomenko, 2017; Pos et al., 2009; Watson & Bedard, 2006). Esta discrepância nos resultados pode dever-se ao tipo de *design* e/ou às análises estatísticas efetuadas. Enquanto nos estudos que desenvolvemos analisamos todas as sessões do processo terapêutico (estudo 1) ou selecionamos sessões com base num intervalo de tempo constante (estudo 2), os estudos prévios usaram critérios de seleção díspares (e.g., Castonguay et al., 1996; Goldman et al., 2005; Makinen & Johnson, 2006; Pos et al., 2003, 2009, 2017; Toukmanian et al., 2010; Watson & Bedard, 2006; Watson et al., 2011). Nomeadamente, os estudos que avaliaram a capacidade de processamento emocional dos clientes ao longo do processo terapêutico tenderam a selecionar as sessões da fase inicial e final com base em critérios temporais (e.g., segunda e penúltima sessão, respetivamente), e usaram as "melhores" sessões da fase intermédia, i.e., as que o cliente, terapeuta, e/ou observador externo consideraram mais úteis ou clinicamente relevantes. Adicionalmente, usamos modelos multiníveis para avaliar o *slope* na EXP (estudo 2). Consideramos que estas opções poderão ter conduzido à observação de um padrão de evolução da capacidade de processamento emocional diferente ao longo da terapia. De acordo com as nossas observações empíricas, nos casos de depressão a capacidade de processamento emocional dos clientes tende a aumentar ao longo da terapia. Essa capacidade é promovida pelo trabalho terapêutico, resultando numa melhoria cumulativa na capacidade de processar as emoções, tanto na Terapia Focada nas Emoções, como na Terapia Cognitivo-Comportamental.

Observamos resultados semelhantes quando exploramos a evolução longitudinal da capacidade de processamento emocional em dois casos com luto complicado e atendidos em Terapia de Reconstrução de Significado no Luto (estudo 3). Este estudo exploratório foi um primeiro esforço para compreender como é que os clientes processam, durante a terapia, as emoções associadas à experiência de luto. Verificamos que, durante o tratamento, em ambos os casos houve um aumento da capacidade de processamento emocional. Apesar destes resultados se basearem num estudo de caso, sugerem que, tal como na depressão e nas abordagens terapêuticas previamente investigadas, também nesta problemática e terapia, a capacidade para processar as experiências emocionais é promovida ao longo do tratamento, especialmente no caso de sucesso.

Em suma, considerando os resultados observados nos estudos empíricos que levamos a cabo, a capacidade de processamento emocional dos clientes tende a aumentar ao longo do tratamento. Essa capacidade parece ser promovida pelo trabalho terapêutico, resultando numa melhoria cumulativa na aptidão para processar as emoções. Estas observações conferem suporte empírico à hipótese de que o

processamento emocional não é uma característica estável de cada cliente, mas uma capacidade que pode ser promovida durante a terapia (Goldman et al., 2005; Pos & Choi, 2019; Pos et al., 2003, 2009).

### 1.2. O papel do processamento emocional na mudança das experiências emocionais

Apesar de vários estudos empíricos apontarem o processamento emocional como um processo que promove a mudança terapêutica (Elliott et al., 2013; Goldman et al., 2005; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011), o padrão de transformação emocional ao longo da terapia não foi clarificado na literatura prévia (Gelo & Salvatore, 2016). No âmbito dos dois estudos de caso que desenvolvemos na presente dissertação (estudo 1 e 3), investigamos a associação, sessão-a-sessão, entre a evolução na capacidade das clientes processarem as suas emoções e a mudança nas respostas emocionais desadaptativas em adaptativas. Estes estudos permitiram desenvolver uma compreensão em profundidade sobre o tipo de emoções ativadas, o nível a que foram processadas e o padrão de mudança das respostas emocionais ao longo da terapia.

No primeiro estudo exploramos essas variáveis ao longo das 16 sessões de um caso de sucesso atendido em Terapia Focada nas Emoções para a depressão. Através da análise qualitativa das sessões, observamos que à medida que a capacidade de processamento emocional da cliente aumentou, as respostas emocionais desadaptativas (secundárias ou primárias desadaptativas) foram transformadas em respostas mais adaptativas, tal como proposto teoricamente pelas abordagens humanisto-experienciais (Greenberg, 2010).

No caso de sucesso no luto complicado (estudo 3), observamos resultados semelhantes aos verificados no caso diagnosticado com depressão (estudo 1). Desde as sessões iniciais, esta cliente acedeu, experienciou, e explorou as suas emoções desadaptativas, o que parece ter contribuído para que acedesse a emoções adaptativas que a mobilizassem para reconstruir uma relação simbólica e menos dolorosa com seu marido. Por sua vez, o caso de insucesso não processou tão profundamente as emoções associadas à experiência de luto. O trabalho emocional não parece ter sido suficientemente profundo para que esta cliente criasse novos significados e transformasse as experiências emocionais desadaptativas (Greenberg, 2010; Greenberg, Auszra, & Herrmann, 2007; Greenberg & Watson, 2006; Pascual-Leone & Greenberg, 2007).

De acordo com Stiles e colaboradores (Stiles, 2015; Stiles, Hill, & Elliott, 2015), na sua proposta de *theory building case studies*, a comparação das observações nos estudos de caso (estudo 1 e estudo 3) com a teoria deve aumentar a confiança ou sugerir modificações na mesma. Os resultados que

observamos conferem apoio empírico à hipótese teórica proposta pelas abordagens humanisto-experienciais de que o aumento da capacidade de processamento das emoções ao longo da terapia contribui para a mudança das experiências desadaptativas e para a mobilização dos clientes para tendências para a ação adaptativas, consistentes com as suas necessidades centrais (Greenberg, 2010; Greenberg et al., 2007; Greenberg & Watson, 2006; Herrmann et al., 2016; Pascual-Leone & Greenberg, 2007; Pinheiro et al., 2018). Para além de estas observações serem consistentes com a teoria relativa à associação entre o processamento emocional e a mudança nos esquemas emocionais na depressão, sugerem ainda que no luto complicado o processo e padrão de mudança emocional é semelhante. Por outras palavras, tanto na depressão como no luto, o aumento da capacidade de processamento emocional parece contribuir para a mudança das experiências desadaptativas em mais adaptativas.

## 1.3. O papel do processamento emocional na redução da intensidade dos sintomas

Um dos principais objetivos dos estudos levados a cabo no âmbito desta dissertação envolveu clarificar o papel do processamento emocional na mudança da intensidade dos sintomas em terapia. Investigamos a associação do nível de processamento emocional apresentado pelos clientes com (1) a mudança na intensidade dos sintomas do início para o final da terapia e (2) ao longo das sessões. Organizamos esta secção de acordo com estes dois tópicos.

### 1.3.1. Processamento emocional e mudança nos sintomas do início para o final da terapia

Na amostra dos 50 clientes atendidos em Terapia Focada nas Emoções e Terapia Cognitivo-Comportamental (estudo 2), verificamos que o aumento na capacidade para atender, ativar, estar em contacto, explorar e transformar as experiências emocionais, foi preditor do alívio nos sintomas depressivos. Esta observação providenciou apoio empírico adicional aos resultados da investigação prévia, sugerindo o contributo do processamento emocional do cliente para a redução dos sintomas depressivos, tanto em Terapia Focada nas Emoções, como em Terapia Cognitivo-Comportamental (Elliott et al., 2013; Goldman et al., 2005; Greenberg, 2008, 2010; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011).

As observações no estudo de caso intensivo no luto complicado (estudo 3) foram também consistentes com os resultados verificados na investigação prévia na depressão (Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pinheiro et al., 2018; Pos et al., 2003, 2009, 2017; Watson &

Bedard, 2006). Identificamos, no caso de sucesso e no de insucesso, padrões de evolução distintos nos níveis de processamento emocional. O caso de sucesso terapêutico atingiu níveis mais elevados na EXP e apresentou uma evolução mais acentuada e estável na capacidade para processar as emoções associadas à experiência de luto, comparativamente com o de insucesso. Apesar da natureza exploratória do estudo, estes resultados sugerem que, também nesta perturbação e tipo de intervenção terapêutica, o aumento da capacidade para processar as emoções durante a terapia poderá estar associado à redução dos sintomas de luto do início para o final da terapia.

Importa, contudo, enquadrar estes resultados no tipo de terapia em que foram observados. A reconstrução de significados sobre a experiência de luto promovida por esta abordagem terapêutica parece estar intrinsecamente relacionada com o aumento do processamento emocional. Especificamente, a transformação das emoções desadaptativas e o acesso às necessidades e tendências para a ação associadas às emoções adaptativas, poderá facilitar a reconstrução dos significados associados à experiência de luto com base em informação emocional mais adaptativa (Angus, 2012; Angus & Greenberg, 2011; Greenberg, 2010, 2015). Assim, colocamos a hipótese de que a reconstrução de significado sobre a experiência de luto poderá ser facilitada pelo aumento da capacidade de processamento emocional dos clientes, promovendo, consequentemente, o alívio dos sintomas de luto complicado.

Em suma, estas observações sugerem que o processamento emocional pode funcionar como um dos mecanismos que contribui para a melhoria nos sintomas depressivos e de luto. Facilitar o processamento emocional poderá ser importante para promover melhores resultados terapêuticos.

### 1.3.2. Processamento emocional e mudança nos sintomas ao longo da terapia

No âmbito do primeiro e do segundo estudo empírico da presente dissertação, exploramos o contributo longitudinal da capacidade de processamento emocional dos clientes para a melhoria gradual nos sintomas.

Ao longo das sessões do caso de sucesso em Terapia Focada nas Emoções para a depressão (estudo 1), observamos que a capacidade de processamento emocional e a intensidade dos sintomas clínicos se encontravam negativamente associados na mesma sessão (*lag 0*). Especificamente, os resultados desse estudo sugeriram que quando a cliente iniciou a sessão com menor intensidade nos sintomas, foi capaz de atingir níveis mais elevados de processamento emocional. Por outro lado, quando iniciou a sessão com sintomas mais intensos, apresentou uma menor capacidade para processar as suas emoções. Apesar de estes resultados apontarem para uma relação longitudinal entre as variáveis,

sugeriram uma direção inconsistente com a literatura. Uma vez que a investigação prévia sugere que o aumento da capacidade de processamento emocional do cliente prediz a redução dos sintomas do início para o final da terapia (Elliott et al., 2013; Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009; Watson & Bedard, 2006), esperávamos que o aumento na capacidade de processamento emocional numa dada sessão se encontrasse associada à redução da intensidade dos sintomas na sessão seguinte (*lag +1*).

Consideramos algumas hipóteses para compreender esta inconsistência entre a teoria prévia e as nossas observações no estudo de caso. A relação entre as variáveis, de uma sessão para a seguinte, pode não ser linear no caso analisado. Enquanto os níveis médios da EXP apresentaram um padrão de evolução mais constante e linear ao longo da terapia, verificamos aumentos acentuados na intensidade dos sintomas clínicos associados a eventos negativos e inesperados na vida da cliente. Os eventuais ganhos associados ao nível de processamento emocional atingido numa determinada sessão poderão não prevenir o agravamento dos sintomas clínicos perante eventos de vida críticos. Adicionalmente, esses ganhos poderão não emergir necessariamente na sessão seguinte (*lag* +1), mas ter um efeito cumulativo e mais tardio nos sintomas, reduzindo o impacto dos eventos de vida negativos ao longo da terapia. Por último, o reduzido número de observações ($N$ = 16 sessões) pode também ter contribuído para um baixo poder estatístico para detetar a associação entre as variáveis. Ainda assim, os resultados observados sugerem que a capacidade de processamento emocional e os sintomas estão associados ao longo do processo terapêutico. No caso analisado, o nível de processamento emocional parece estar relacionado com a intensidade de sofrimento reportado no início da sessão (*lag* 0), sugerindo que, pelo menos em alguns casos, o nível de processamento emocional poderá ser promovido pela redução prévia na intensidade dos sintomas (cf., Pos et al., 2003).

Na amostra de 50 casos diagnosticados com depressão e atendidos em Terapia Focada nas Emoções e Terapia Cognitivo-Comportamental (estudo 2), identificamos uma relação diferente entre o processamento emocional e os sintomas daquela que observamos no estudo de caso (estudo 1). Os resultados deste segundo estudo sugeriram que, nas duas terapias, o nível de processamento emocional é um melhor preditor da intensidade dos sintomas clínicos na sessão seguinte do que os sintomas são do nível de processamento emocional subsequente. Estas observações são consistentes com a perspetiva das abordagens humanisto-experienciais e com a investigação prévia que assume que a melhoria na capacidade para processar as emoções contribui para a redução dos sintomas na depressão (Elliott et al., 2013; Goldman et al., 2005; Greenberg, 2008; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011). Ainda que

a investigação prévia tenha assumido tal direção na relação entre as variáveis, focou-se no contributo da capacidade de processamento emocional para a mudança nos sintomas do início para o final da terapia e não considerou que os resultados poderiam ter sido enviesados (causalidade inversa) e/ou sobrestimados (cf., Crits-Christoph et al., 2013). Assim, o estudo que desenvolvemos contribuiu para esclarecer empiricamente qual o papel do aumento da capacidade de processamento emocional na redução dos sintomas clínicos ao longo do processo terapêutico. Especificamente, os nossos resultados sugerem que a promoção dessa capacidade contribui para o gradual alívio dos sintomas na depressão, tanto na Terapia Focada nas Emoções, como na Terapia Cognitivo-Comportamental.

Em suma, no que concerne à associação entre o processamento emocional e a mudança nos sintomas, os resultados que observamos no âmbito destes estudos empíricos sugerem que, independentemente do modelo terapêutico (Terapia Focada nas Emoções, Terapia Cognitivo-Comportamental e Terapia de Reconstrução de Significado no Luto) e problemática (depressão e luto complicado), o aumento do nível de processamento emocional dos clientes contribui para o alívio dos sintomas (sintomas clínicos, depressivos e de luto). Ainda que os resultados observados no primeiro estudo possam estar associados à idiossincrasia do caso em análise, ou a limitações no *design* e análise estatística, devemos considerar a hipótese de que, pelos menos em alguns casos, a intensidade dos sintomas no início da sessão poderá influenciar o nível de processamento emocional atingido durante a mesma sessão (Timulak & Elliott, 2018).

## 2. Limitações

Os resultados apresentados nesta dissertação devem ser interpretados tendo em atenção as limitações associadas aos estudos desenvolvidos. Consideramos que a principal limitação se relaciona com o tamanho e natureza da amostra. Enquanto os estudos de caso (estudos 1 e 3) permitiram uma compreensão mais aprofundada sobre o papel da capacidade de processamento emocional dos clientes na mudança terapêutica, o estudo com a amostra de casos de depressão (estudos 2) pretendeu identificar um padrão geral de relação entre as variáveis. Ainda assim, os resultados observados no estudo 2 não podem ser generalizados para além da amostra em que foram identificados.

Enquanto nos estudos de caso analisamos todas as sessões, apenas um número limitado de sessões de cada cliente foi analisado no segundo estudo. Esta opção relacionou-se com a morosidade e escassez dos recursos necessários para fazer uma codificação integral dos casos. Apesar de termos selecionado sessões ao longo do processo terapêutico com intervalos de tempo regulares para representar a evolução da capacidade de processamento emocional dos clientes, essas podem não ser representativas do que acontece nas restantes sessões (cf., Crits-Christoph et al., 2013). Não obstante, o tempo entre sessões ter sido considerado nas análises de HLM para estimar o impacto da variável preditora na variável resposta, os resultados podem ter sido enviesados pelas sessões selecionadas para análise. No sentido de colmatar este potencial problema, seria necessário conduzir estudos em que fosse avaliado o nível de processamento emocional em todas as sessões. Esta questão é particularmente relevante para esclarecer se a inconsistência entre os resultados observados na amostra (estudo 2) e no estudo intensivo com um caso de depressão (estudo 1) se relaciona com o baixo poder estatístico da análise ou com idiossincrasias do processo terapêutico ou da cliente.

No que concerne à amostra de depressão, usamos os 50 casos que completaram a intervenção protocolada (*per protocol*) no âmbito do ensaio clínico *ISMAI Depression Study* (Salgado, 2014). Os casos que desistiram do processo terapêutico ($n$ = 14) não foram incluídos nos estudos. Seria, contudo, interessante explorar se nesses casos se observa uma evolução na capacidade de processamento emocional e na relação com a intensidade dos sintomas semelhante à observada nos casos que completaram o tratamento. Considerando que esses casos são qualitativamente diferentes dos que concluíram o protocolo de intervenção, as variáveis em análise poderiam contribuir para compreender os processos associados ao abandono precoce do tratamento. A investigação desta questão é particularmente relevante uma vez que o abandono terapêutico representa um problema substancial no tratamento em psicoterapia e os processos associados a esse fenómeno ainda não são claros (Cooper & Conklin, 2015; Lopes, Gonçalves, Sinai, & Machado, 2015, 2018; Swift & Greenberg, 2012).

## 3. Implicações para a investigação e prática clínica

A investigação no processo de mudança em psicoterapia deve contribuir para clarificar como é que a terapia funciona e, com base nessa informação, melhorar o treino dos terapeutas e aumentar a eficácia da prática clínica (Gelo et al., 2015; Goldman, 2019; Greenberg, 1986; Pascual-Leone et al., 2016; Pascual-Leone & Yeryomenko, 2017; Wampold, 2001). Atendendo ao papel que o processamento emocional parece desempenhar em diferentes abordagens terapêuticas, contribuindo para a mudança dos clientes ao longo do tratamento, consideramos relevante refletir sobre como aplicar esse conhecimento empiricamente apoiado na prática clínica.

Com base na investigação prévia e nos resultados observados nos estudos empíricos que integram a presente dissertação, podemos sugerir que a terapia deve promover a capacidade de processamento emocional dos clientes, tal como é conceptualizada pelas abordagens humanisto-experienciais (Greenberg, 2010; Greenberg & Pascual-Leone, 2006; Greenberg & Watson, 2006). Especificamente, os terapeutas devem facilitar a consciência, ativação, contacto e exploração das experiências emocionais para que o cliente desenvolva um maior conhecimento sobre o seu mundo interno, crie novos significados e transforme as suas emoções desadaptativas em adaptativas.

Atualmente, a maioria das abordagens terapêuticas reconhece a importância de promover a consciência emocional, bem como de atender e explorar as emoções (Fosha, 2000; Whelton, 2004). Contudo, as abordagens humanisto-experienciais são as que têm contribuído de forma mais explícita para a definição de princípios que orientem os terapeutas na promoção do envolvimento, ativação, exploração, criação de significado e transformação emocional (Elliott et al., 2004; Greenberg, 2010, 2015, 2019; Greenberg & Watson, 2006; Pascual-Leone et al., 2016). Estas abordagens salientam a importância do terapeuta seguir, momento-a-momento, as experiências explícitas e implícitas do cliente, guiando-o para atender e explorar os seus sentimentos, emoções e necessidades centrais (Pascual-Leone et al., 2016; Pos & Choi, 2019). Desta forma, o terapeuta promove o interesse, respeito e valorização do mundo interno do cliente e facilita a experienciação e expressão do que por vezes é sentido como confuso, assustador, ou doloroso (Pascual-Leone et al., 2016; Pos & Choi, 2019).

Uma vez que, independentemente da abordagem, o aumento da capacidade de processamento emocional do cliente durante a terapia parece estar associada à mudança terapêutica (Castonguay et al., 1996; Goldman et al., 2005; Klein et al., 1986; Makinen & Johnson, 2006; Malin & Pos, 2015; Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Toukmanian et al., 2010; Watson & Bedard, 2006; Watson et al., 2011), consideramos que a identificação das intervenções terapêuticas específicas de cada modelo que promovem esse aumento traria um

importante contributo para a prática clínica. Neste âmbito, seria particularmente útil a identificação do tipo de intervenções terapêuticas que, encontrando-se o cliente num nível particular de processamento emocional (e.g., EXP nível 2), facilitam a transição para níveis mais elevados (e.g., EXP nível 3). Será que quando o terapeuta se foca num nível mais elevado da EXP, o cliente o segue? Quanto mais elevado pode ser o nível da EXP em que o terapeuta se foca para que o cliente o acompanhe? Que tipo de intervenções estão dentro da zona de desenvolvimento proximal terapêutica do cliente (cf., Leiman & Stiles, 2001; Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2013)? Esta investigação permitiria identificar as intervenções do terapeuta que têm sucesso na promoção da capacidade de processamento emocional do cliente no âmbito de diferentes modelos teóricos.

A criação de novos significados sobre as experiências emocionais envolve um processo colaborativo entre terapeuta e cliente (Pascual-Leone et al., 2016). Assim, apesar de ser um processo intrapessoal do cliente, as abordagens humanisto-experienciais sugerem que o aumento da capacidade de processamento emocional do cliente pode ser promovido pelo terapeuta. Contudo, o contributo deste último ainda não se encontra empiricamente esclarecido (Crits-Christoph et al., 2013; Pos & Choi, 2019). Não conhecemos publicações empíricas que se foquem no contributo, momento-a-momento, do terapeuta para o nível de processamento emocional atingido pelo cliente. A investigação desta questão, recorrendo a modelos hierárquicos longitudinais, seria relevante para avaliar o contributo específico do cliente e do terapeuta para a associação observada entre o processamento emocional e a mudança terapêutica. Para tal, seria necessário trabalhar com uma amostra maior do que a usada no âmbito desta dissertação, já que os resultados dos estudos com procedimentos estatísticos de modelação de dados podem ser enviesados pelo uso de amostras pequenas (Kline, 2005).

No âmbito clínico, o nível de processamento das experiências emocionais durante a terapia poderá, ainda, informar os terapeutas sobre a mudança gradual dos clientes ao longo das sessões. Considerando que o treino dos terapeutas na EXP pode contribuir para que esses sejam capazes de fazer uma avaliação momento a momento do nível de processamento emocional dos clientes (Pascual-Leone & Andreescu, 2013; Pascual-Leone et al., 2016), essa informação poderá ser útil para que ajustem as suas intervenções. Por exemplo, nos casos que apresentem maior dificuldade de processamento emocional, os terapeutas poderão recorrer a estratégias que promovam essa capacidade ou prolongar a duração do tratamento. Para esclarecer se o treino dos terapeutas na EXP contribui para a promoção intencional e sistemática do processamento emocional dos clientes (Pascual-Leone & Andreescu, 2013; Pascual-Leone et al., 2016), seria útil comparar o efeito de grupos de terapeutas com e sem treino na EXP.

Nos estudos de caso (estudo 1 e 3) observamos que o aumento na capacidade de processamento emocional se associou à mudança no tipo de respostas emocionais ativadas ao longo da terapia. Ainda assim, consideramos que esta associação com a transformação no tipo de emoções merece investigação adicional. O estudo quantitativo da relação entre essas variáveis ao longo do processo terapêutico permitiria esclarecer qual o nível de processamento das diferentes emoções e o seu contributo para a mudança no tipo de respostas emocionais apresentadas pelos clientes. Desta forma, contribuiria para desenvolver uma teoria mais compreensiva e empiricamente apoiada sobre como é que o aumento do processamento emocional contribui para a mudança emocional e para a redução dos sintomas (Greenberg, 2010, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006). Esta questão poderá ser investigada futuramente na amostra de casos de depressão usada na presente dissertação.

De acordo com as abordagens humanisto-experienciais, a empatia, genuinidade e aceitação incondicional do terapeuta contribuem para que o cliente sinta as suas necessidades de apoio, conexão e aceitação cumpridas, o que poderá facilitar o processamento de emoções dolorosas durante a terapia (Elliott et al., 2004; Greenberg, 2002, 2015; Greenberg & Goldman, 2019; Greenberg & Watson, 2006; Pos & Choi, 2019; Timulak et al., 2019; Warwar & Ellison, 2019). Estudos empíricos prévios verificaram uma associação positiva entre a aliança terapêutica e o processamento emocional durante terapias humanisto-experienciais para a depressão (Goldman et al., 2005; Pos et al., 2003, 2009). Mais importante, sugeriram que o nível de processamento emocional atingido pelos clientes seria um melhor preditor do resultado terapêutico do que a aliança, o fator comum cuja associação ao resultado terapêutico se encontra melhor apoiada empiricamente (Flückiger et al., 2018; Horvath et al., 2011). A investigação dessa questão na amostra usada nesta dissertação permitiria esclarecer se esse efeito é comum a outras abordagens terapêuticas, nomeadamente à Terapia Cognitivo-Comportamental.

Atendendo ao contributo do processamento emocional para a mudança terapêutica nos casos de depressão atendidos em Terapia Focada nas Emoções e Terapia Cognitivo-Comportamental, consideramos que seria interessante estudar o seu papel noutras problemáticas e abordagens terapêuticas. Os resultados observados no estudo intensivo de dois casos de luto complicado (estudo 3) atendidos em Terapia Construtivista de Reconstrução de Significado no Luto sugeriram que a capacidade de processamento emocional das clientes se encontrava associada à mudança terapêutica ao longo das sessões. Ainda assim, investigação adicional é necessária para sustentar a hipótese de que o processamento emocional é um fator comum de mudança em psicoterapia.

Enquanto os estudos desenvolvidos até ao momento se focaram na relação entre o nível de processamento emocional e a mudança dos clientes durante a terapia, consideramos que faz sentido, também, explorar o seu potencial efeito a longo prazo, após o término da terapia. Atendendo à elevada taxa de recaída (Hitchcock et al., 2018; Vittengl et al., 2009) e ao impacto social e económico que acarreta (World Health Organization, 2017), a identificação de processos e mecanismos terapêuticos que contribuam para a prevenção da depressão são especialmente relevantes (Clarke et al., 2015; Cuijpers et al., 2011; Machmutow et al., 2017; Vittengl et al., 2009). Assim, seria oportuno clarificar se o processamento emocional é um desses processos que, ativado durante a terapia, contribui para a prevenção da recaída na depressão. Nesse sentido, consideramos que seria importante conduzir estudos que permitam explorar o eventual impacto a longo-prazo do processamento emocional nos sintomas depressivos nas sessões de *follow-up*.

## 4. Considerações finais

A investigação em psicoterapia deve permitir identificar os processos de mudança que, quando ativados durante as sessões, a tornam eficaz (Gelo et al., 2015; Goldman, 2019; Greenberg, 1986; Pascual-Leone et al., 2016; Wampold, 2001). No âmbito desta dissertação pretendemos contribuir para desenvolver um conhecimento mais aprofundado sobre o papel da capacidade de processamento emocional dos clientes, tal como é conceptualizado pelas abordagens humanisto-experienciais, na mudança terapêutica.

Em suma, os resultados dos estudos empíricos contribuíram, ainda que de uma forma modesta, para apoiar empiricamente a perspetiva de que a capacidade de processamento emocional dos clientes, em diferentes abordagens teóricas, está associada à mudança terapêutica ao longo da terapia. As nossas observações parecem ser consistentes com a perspetiva de que o processamento emocional poderá funcionar como um fator comum de mudança, i.e., como uma variável que contribui para explicar a mudança em diferentes abordagens psicoterapêuticas (Elliott et al., 2013; Greenberg & Pascual-Leone, 2006; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2017). Assim, o nível de processamento emocional atingido em terapia poderá fornecer informação aos terapeutas e investigadores sobre a evolução do processo de mudança do cliente, permitindo o ajustamento das intervenções terapêuticas e, eventualmente, o aumento da eficácia do tratamento.

Consideramos que o próximo passo envolve explorar como é que os resultados da investigação em psicoterapia podem, de forma mais específica, contribuir para o aumento da eficácia do tratamento das perturbações psicopatológicas. Este representa um grande desafio, já que apesar da investigação em psicoterapia partir das questões levantadas na prática clínica, ainda é necessário transportar os resultados da investigação de volta para o "terreno". Esperamos que esta dissertação tenha contribuído para que, com base nos resultados observados, se avance para a identificação de *guidelines* que facilitem a promoção da capacidade de processamento emocional dos clientes e, assim, a eficácia da psicoterapia.

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