

EMOTION REGULATION AND PSYCHOTHERAPY: ADAPTATION AND ELABORATION OF AN APPLICATION MANUAL OF THE OBSERVER MEASURE OF AFFECT REGULATION (O-MAR)

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ABSTRACT

The aim of this work was to adapt and develop a Portuguese manual for the Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006), an observational measure of clients' emotion regulation in psychotherapy. Since the scale has not yet been adapted to Portuguese, initially a translation was performed. Then, to elaborate the manual, the middle 20 minutes of 20 therapy sessions were observed and classified and 2 illustrative excerpts were selected by consensus for each level of analysis of the various domains of the scale. All these videotaped sessions were collected in a randomized clinical trial carried out in Portugal for the treatment of depression, comparing 2 empirically supported models for the treatment of this disorder – cognitive behavioral therapy and emotion-focused therapy. All the participants were initially evaluated and diagnosed with mild or moderate major depressive disorder, and they attended 16 sessions of psychotherapy.

Keywords: Emotion Regulation, Psychotherapy, O-MAR.

JEL Classification: I10

1. INTRODUCTION

After a period during which emotions were regarded as a mysterious phenomenon and inaccessible to scientific research (Gross, 2007), currently there are no doubts about their importance to individuals' lives. In recent decades several scientific works have been conducted (Greenberg, 2002) in an attempt to understand the set of processes linked to emotions and their role in terms of physical and mental health (Davidson, Scherer, & Goldsmith, 2003; Fredrickson & Cohn, 2008; Gross, 2007).

Over their life cycle, human beings are faced with several challenges, difficulties, and distress situations, and emotions play a key role in adapting to these demands by organizing

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actions (Reeve, 2009). According to Greenberg (2006), emotions inform individuals that a particular purpose or need may be favorable or unfavorable, reflecting a biological trend determined to act according to our assessment of a situation based on goals, needs, or concerns. In this way, through emotions, the individual carries out an initial assessment of the situation, a key feature that informs the individual of the importance of events, preparing him or her for rapid adaptive action and directing his or her behavior (Greenberg, 2002). Consequently, the role of emotions in human psychological functioning is fundamental since they provide vital functions, such as guiding, communicating, preventing, signaling, and preparing for action.

Despite this adaptive character, emotions can emerge as pleasant or unpleasant, euphoric or dysphoric yet adaptive or maladaptive experiences according to what is appropriate in each situation experienced by individuals (Barrett & Wager, 2006; Greenberg, 2002). In this way, and as stated by Gross (2002, p. 281), *“One of life’s great challenges is successfully regulating emotions.”* In the field of scientific research, there do not seem to be any doubts about the importance of emotion regulation in the various dimensions of people’s lives. Emotion regulation is a core competence in social interaction, influencing emotional expression and behavior (Lopes, Salovey, Cote, & Beers, 2005). It is an important factor in determining the well-being and adaptive functioning of human beings (Cicchetti, Ackerman, & Izard, 1995), preventing high levels of stress and maladaptive behaviors in emotionally demanding situations (Gross, 1998).

In spite of the substantial amount of research attention paid to emotion regulation in recent years, there are different definitions of this construct. For instance, Thompson (1994, cit. Sloan & Kring, 2007, pp. 27–28) stated that emotion regulation “Consists of intrinsic and extrinsic processes responsible for monitoring, evaluating and modifying emotion reactions, especially their intensive and temporal features, to accomplish one’s goals.” Similarly, Gross (1998, p. 275) defined emotion regulation as the process by “which individuals influence which emotions they have, when they have them, and how they experience and express these emotions.” Considering the functional nature of emotion responses, Gratz and Roemer (2004, cit. Berna, Ott, & Nandrino, 2014; Slee, Spinhoven, Garnefski, & Arensman, 2008) defined emotion regulation from a more clinical perspective, integrating four dimensions into this process: awareness and understanding of emotions; acceptance of emotions; ability to control impulsive behaviors and behave in accordance with desired goals when experiencing negative emotions; and ability to use contextually appropriate emotion regulation strategies to modulate emotional responses as desired to meet individual goal and situation demands. Despite the lack of consensus, there are common points to the several conceptions of emotion regulation. For Berking and colleagues (2008) and Watson, McMullen, Prosser, and Bedard (2011), regulating emotions comprises the ability to process, model, and express the emotional experience. It is this perspective that underlies the development of this work.

The way in which we regulate our emotions is fundamental to our lives and therefore may be adaptive or maladaptive. According to Bridges, Denham, and Ganiban (2004), to be able to regulate their emotions, individuals need flexibility and the ability to adapt to the current circumstances and modulate their emotions. Such skills suggest, for instance, the initiation or maintenance of positive emotional states and the attenuation of negative emotional states. From this perspective, Cole, Martin, and Dennis (2004) reported that emotion regulation is associated with changes in activated emotions, taking into account their nature, intensity, and duration, or psychological processes such as memory and social interaction. Nevertheless, authors like Eisenberg and Spinrad (2004) supported a more specific view, suggesting that the concept of emotion regulation should be directed to the regulation of emotions and not to the regulation of cognitive, behavioral, and relational processes of emotions. Thus, the authors argued that emotion regulation may be understood

as the process of initiating, avoiding or maintaining, and modulating the occurrence, form, intensity, or duration of the emotional states.

Individuals' capacity to recognize and sustain emotions, to approach and/or move away from emotions like sadness and discouragement, to interpret the physiological activation, to develop effective self-control skills, and to understand emotions as an enhancing factor of performance are extremely important dimensions of their success in regulating emotions (Greenberg, 2004; Gross & Thompson, 2007). According to Greenberg (2004), it is essential to recognize and sustain emotions because only then can we eventually tolerate pleasant or unpleasant emotions. At this level Elliott, Watson, Goldman, and Greenberg (2004) underlined that the immediate difficulty that could arise is becoming disconnected from one of the emotion dimensions. For instance, a person can have difficulties in accessing the bodily experience of emotions or fail in the process of symbolizing them.

Currently emotion regulation research is considered to be extremely relevant to multiple areas of psychology. The importance of emotion regulation has been well documented, for instance in cognitive psychology, social psychology, and psychobiology, among other areas. However, being fundamental to the adaptive functioning and mental health of human beings, emotion regulation represents an extremely relevant field for clinical psychology and specifically for psychotherapy (Greenberg, 2004; Gross, 1998; Watson et al., 2011). In fact, as human beings, we constantly try to make sense of our experiences (Greenberg & Pascual-Leone, 1995). We seek to explain them and give them meaning by narrating them in a way that enables us to tell a continuous story about the person's life path. Giving words to emotions allows the non-symbolized previous experience to be assimilated in the person's consciousness and then facilitates reflections on what is felt, the creation of new meanings, and eventually the construction of a coherent story (Greenberg, 2008). The meaning that we take from our emotional experiences makes us what we are. All emotions stem from stories or significant events, and all events or stories involve significant emotions (Greenberg & Angus, 2004).

In fact, difficulties in emotion regulation are a common factor in the development and maintenance of several psychological disorders, and their treatment involves promoting emotion regulation skills (Berking, Wupperman, Reichardt, Pejic, Dippel, & Znoj, 2008; Fowler et al., 2014). While a person with depression fights not to cry during dinner at home, an obsessive-compulsive person feels intense anxiety and washes his or her hands many times before dinner. As Werner and Gross (2010) argued, despite the differences between disorders, many of them are characterized by the experience of negative emotions and the attempt to regulate them (e.g. suppressing the experience or the expression). The authors stressed that more than 75% of the diagnostic categories of psychopathology in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV; APA, 1994) are characterized by problems with emotion or with emotion regulation, so it is not surprising that emotion regulation deficits are integrated into many psychopathology models (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Berking & Wupperman, 2012; Forkmann et al., 2014). Depression, complicated grief, opiate addiction, bulimia, chronic fatigue (Watson, McMullen, Prosser, & Bedard, 2011), borderline personality disorder, and post-traumatic stress disorder (Fowler et al., 2014) are some examples of situations involving difficulties in emotion regulation. A study directed by Whelton and Greenberg (2001) found lower resistance to self-criticism in more subjects who were vulnerable to depression than in the less vulnerable population, which showed a greater ability to use positive emotional resources against the negative experiences. Some authors have argued that depression can be seen as a result of successive dysfunctional attempts to regulate emotions and of excessive use of maladaptive strategies like rumination (Campbell-Sills & Barlow, 2007; Kring & Werner, 2004). In fact, depressed people have difficulty in accepting negative emotions and a lower perception of the meaning of their own emotions

(Rude & McCarthy, 2003). Thus, promoting adaptive ways and skills of emotion regulation as acceptance of negative emotions seems to be very relevant to the process of change and therefore to the success of psychotherapy (Barlow, Allen, & Choate, 2004). For Watson and colleagues (2011), emotion regulation should be a target of change in psychotherapy.

Berking and colleagues (2008) argued that therapeutic success may be related to the development and training of emotion regulation strategies, since many of the problematic issues that lead individuals to seek therapy are in fact based on uncertainties about the meaning of their emotions and a lack of abilities to regulate them. Psychotherapy can then provide the client with adaptive ways of controlling unregulated emotions (Ochsner & Gross, 2005). As mentioned before, emotion regulation involves consciousness, symbolization, and adaptive use of emotions to deal with possibly difficult situations (Greenberg, 2002). Every emotion has its own purpose, so therapists should guide their interventions based on the individual situation and the ongoing emotional process. Indeed, Watson (2007) stated that it is important to identify the key aspects to be used with clients to adapt the different ways of working better to solve the problems brought to the therapeutic process. Therapists should lead clients to understand their problems, goals, and objectives, demonstrating that they are involved and interested in solving their problems based on pillars such as the congruence and openness of both parties. Leading clients to develop their acceptance, modification, and tolerance of negative emotions is the largest and most consistent gain that can be achieved through therapeutic intervention.

Thus, several forms of psychotherapy, sometimes with different theoretical conceptions, seem to share the idea that emotional work, including emotion regulation, is a critical requirement for a good therapy outcome (Elliot, Watson, Goldman, & Greenberg, 2004; Greenberg, 2006; Greenberg & Pascual-Leone, 2006; Whelton, 2004). Providing the exploration and identification of clients' emotions in the therapeutic process certainly appears to be a core issue for change (Greenberg, 2008). Subsequently, the assessment of emotion regulation through the therapeutic process can help in gaining an understanding of the development of the same.

In recent years some measures have been developed with good psychometric features and with different methodologies (e.g., self-report; observational and psychophysiology) (Sloan & Kring, 2007). Actually, a considerable number of measures can be used in psychotherapy research and practice. Sloan and Kring (2007) asserted that it is important to include these measures as an indicator of the effectiveness of the therapy. However, they stressed that therapists should use these measures as an indicator of psychotherapy progress to provide a form of monitoring of the process.

In the field of psychotherapy research and practice, we should be aware that these several measures assess different aspects of the emotional process, like emotional experience, emotional expression, and emotion regulation (Sloan & Kring, 2007). Another consideration that should be taken into account is the fact that different measures have different conceptions of these processes, as is the case of emotion regulation. Sloan and Kring (2007) reviewed these measures and made suggestions regarding the appropriate selection of them. Based on a literature review, we will present below some of the most used measures of emotion regulation in psychotherapy research and practice.

Self-report measures

The Emotion Regulation Questionnaire (ERQ; Gross & John, 2003)

The ERQ (Gross & John, 2003) is based on the process model of emotion regulation pioneered by Gross (1998), which contemplates different emotion regulation strategies. The perspective of the model is that emotion regulation strategies can be classified into

two categories: antecedent focused and response focused. The ERQ was designed to assess the individual differences in two of them: cognitive reappraisal and expressive suppression (Sloan & Kring, 2007).

Cognitive reappraisal is defined as an antecedent cognitive strategy, since it occurs before a person faces the situation and looks for a change in its emotional impact. On the other hand, expressive suppression is a response-focused strategy because it occurs when the person is already engaged in the situation and feeling the emotion and is seeking the inhibition of the ongoing emotion-expressive behavior (Sloan & Kring, 2007).

The ERQ is composed of a 10-item scale, each item of which measures respondents' tendency of emotion regulation in terms of cognitive reappraisal and expressive suppression on a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree), with higher scores reflecting a better emotion regulation tendency. Earlier research by Gross and John (2003) conducted with a sample of 1483 undergraduate students showed an adequate factor structure and Cronbach's alpha (on average .79 for cognitive reappraisal and .73 for expressive suppression).

The ERQ was translated into Portuguese and validated for the Portuguese population by Vaz and Martins (Questionário de Regulação Emocional – QRE; 2009). To evaluate the replication of the two factors of the original model, the authors conducted a principal component analysis followed by varimax rotation that confirmed the existence of two explanatory factors accounting for 49.64% of the variance in a sample of 851 participants. The first factor was assigned to cognitive reappraisal and explained 32.77% of the variance, and the second factor was emotion suppression and explained 16.78% of the variance. In the Portuguese version, 1 item is not part of the same scale as in the original version, corresponding to item 5 (“When I’m faced with a stressful situation, I force myself to think about that situation in a way to help me stay calm”). In the original version, this item belongs to the scale of cognitive reappraisal, and in the Portuguese version it is integrated into emotion suppression. Vaz and Martins (2009) considered that the difference in psychometric behavior of this item may be related to the cultural differences between Portugal and the United States of America. In the Portuguese sample, the change of thought associated with the experienced emotion can be interpreted as a way to suppress the enthusiasm that the individual intends to express, taking control of emotion activation and then greater discomfort (Vaz & Martins, 2009). Test-retest analysis with a 6-week interval revealed acceptable time stability for both scales (Vaz & Martins, 2009).

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)

Gratz and Roemer (2004) developed this self-report measure to assess the complexities and clinical difficulties of emotion regulation in adults. The DERS contains 36 items for which clients are asked to indicate how often each applies to themselves on a 5-point Likert-type scale that ranges from 1 (almost never) to 5 (almost always). The specific emotion regulation difficulties assessed are: a) non-acceptance of emotional responses (non-acceptance); b) difficulties in engaging in goal direction when experiencing unpleasant emotion (goals); c) impulse control difficulties (impulse); d) lack of emotional awareness (awareness); e) limited access to emotion regulation strategies (strategies); and f) lack of emotional clarity (clarity) (Sloan & Kring, 2007). In the DERS higher scores indicate more difficulties in regulating emotions.

The initial validity study of the scale reported that the six factors are significantly correlated and that the total DERS has a high degree of internal consistency ($\alpha = .93$), as each of the six subscales has a Cronbach's $\alpha > .80$. Good test-retest reliability for a period between four and eight weeks (.80) was also found. In the case of the subscales, the results

indicated a modest to good test–retest reliability: non-acceptance (.69); goals (.69); impulse (.57); awareness (.68); strategies (.89); and clarity (.80).

The DERS was translated into Portuguese and adapted to the Portuguese population by Vaz, Vasco, and Greenberg (Escala de Dificuldades de Regulação Emocional – EDRE; 2009, cit. Coutinho, Ribeiro, Ferreirinha, & Dias, 2010). In the Portuguese version, high to moderate internal consistency values were found for the six subscales, with the non-acceptance (.87), impulse (.84), and strategies (.83) subscales showing higher alpha values. The results showed a very similar factor structure to the original version, very good test–retest reliability ($r = .82$), and very good internal consistency (Cronbach's $\alpha = .93$).

This study provided an important starting point that could fill a gap experienced by Portuguese clinicians in terms of emotion regulation assessment. The authors found statistically significant differences between clinical and non-clinical subjects in terms of difficulties in emotion regulation that represent empirical support for the idea that these difficulties are in some way related to clinical problems.

Emotion Regulation Skills Questionnaire (ERSQ; Berking & Znoj, 2008)

The ERSQ is a 27-item self-report measure that was developed to assess the adaptive emotion regulation skills taking into account the Adaptive Coping with Emotions Model (ACE; Berking, 2010, cit. Berking et al., 2011). The ACE model contemplates 9 dimensions/abilities in the process of emotion regulation: (a) be aware of emotions, (b) identify and label emotions, (c) correctly interpret emotion-related body sensations, (d) understand the prompts of emotions, (e) actively modify negative emotions to feel better, (f) accept negative emotions when necessary, (g) tolerate negative emotions when they cannot be changed, (h) confront (vs. avoid) distressing situations to attain important goals, and (i) compassionately support oneself in emotionally distressing situations (Berking et al., 2011).

Each ability is assessed on a five-point Likert-type scale (0 = not at all to 4 = almost always) and with a subscale of three items preceded by the stem, “Last week ...”: “I paid attention to my feelings” (awareness); “my physical sensations were a good indication of how I was feeling” (sensations); “I was clear about what emotions I was experiencing” (clarity); “I was aware of why I felt the way I felt” (understanding); “I accepted my emotions” (acceptance); “I felt I could cope with even intense negative feelings” (tolerance); “I did what I had planned, even if it made me feel uncomfortable or anxious” (readiness to confront distressing situations); and “I was able to influence my negative feelings” (modification). The ERSQ total score is computed as the average of all the items (Berking, Orth, Wupperman, Meier, & Caspar, 2008).

Berking and colleagues (2011) stated that the ERSQ total score showed adequate-to-good internal consistency (Cronbach's $\alpha = .90$) and adequate retest stability ($r_{tt} = .75$; 2-week interval). The support for the dimensionality of the measure was provided by the exploratory and confirmatory factor analyses, and the sensitivity to change has been demonstrated in multiple samples of clients in psychotherapeutic treatment. All the scales have shown negative associations with measures of ill-being, psychopathology, and emotion regulation difficulties and positive associations with measures of well-being and mental health (Berking & Znoj, 2008).

In our review we did not find a Portuguese version of the ERSQ.

Cognitive Emotion Regulation Questionnaire (CERQ; Garnefsky, Kraaij, & Spinhoven, 2001)

The CERQ is a multidimensional self-report measure consisting of 36 items in a 5-point Likert response format ranging from 1 (almost never) to 5 (almost always), which have been used to assess the conscious cognitive components of emotion regulation (Garnefski &

Kraaij, 2007). Specifically, 9 cognitive emotion regulation strategies are distinguished, each of them referring to a person's thoughts after experiencing a negative or traumatic event. They are: acceptance, positive refocusing, refocusing on planning, positive reappraisal, putting into perspective, self-blame, rumination, catastrophizing, and blaming others.

The CERQ has shown good psychometric properties with alpha coefficients ranging between .70 and .80 and can be applied to people over the age of 12 years. Lately a short version has been developed, containing 18 items that could be used as a fast screening instrument that is useful, for instance, for psychiatric patients (Garnefski & Kraaij, 2006).

The CERQ was translated into Portuguese and validated for the Portuguese population by Castro, Soares Pereira, Chaves, and Macedo (Questionário da Regulação Emocional Cognitiva – QREC; 2013) with a sample of 344 university students. The Portuguese version of the CERQ revealed good psychometric properties, like a Cronbach's alpha of "very good" (.89) and a high, positive, and significant test-retest correlation coefficient ($r = .58$; $p < .001$). The factorial structure of the Portuguese version also significantly overlaps with the original version.

Emotion Regulation Profile – Revised (ERP-R; Nelis, Quoidbach, Hansenne, & Mikolajczak, 2011)

The ERP-R is a revision of the Emotional Regulation Profile Questionnaire, an unpublished measure (ERP-Q; Quodiach, Nelis, Mikolajczak, & Hansenne, 2007, cit. Nelis et al., 2011). The ERP-R includes the regulation of positive emotions, which was not included in the original ERP.

The ERQ-R is a vignette-based measure that includes 15 scenarios with different situations in terms of the types of emotion elicited (e.g. fear, shame, anger, sadness, among others), which are followed by 8 possible reactions. For each scenario people are asked to choose the strategy(ies) (4 adaptive and another 4 maladaptive) that best illustrates their most likely reaction in that situation. In the original study, the reliability of the global ERP-R score was good ($\alpha = .84$), and the 2-factor analysis showed satisfactory internal consistency (down-regulation of negative emotions $\alpha = .83$ and up-regulation of positive emotions $\alpha = .79$). In terms of convergent and discriminant validity, the ERP-R demonstrated evidence with a large number of other variables (Nelis et al., 2011).

There is a short version of these measures that was adapted to and validated for the Brazilian population by Gondim and colleagues (cit. Rocha, 2015). In this version only 6 scenarios are presented. It is also composed of the 2 dimensions corresponding to the 2 types of emotion regulation strategies: up-regulation of positive emotions – joy, admiration, and pride (3 items, $\alpha = .60$) – and down-regulation of negative emotions – sadness, jealousy, and fear (3 items, $\alpha = 0.60$) (Gondim et al., cit. Rocha, 2015). The measurement of the 2 factors is performed by the score in each scenario. Each scenario provides 8 response options and the individual receives 1 point for each functional strategy activated and -1 point for each dysfunctional strategy chosen. Thus, the individual scores between -4 and 4 points.

Observational measures

In our review of the literature, we found just one observational measure of emotion regulation processes, namely the Observer Measure of Affect Regulation.

Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006)

The O-MAR is an observational measure that allows the assessment of clients' affect regulation in terms of multiple domains and emotion regulation strategies. This scale was developed based on the theoretical and empirical literature related to emotion regulation and emotional processes and allows the rating of clients' level of emotion regulation at the

moment when they are evaluated (Watson, McMullen, Prosser, & Bedard, 2011). Clients' affect regulation is assessed based on five subscales of emotional processing: 1) Level of Awareness; (2) Modulation and Arousal; (3) Modulation and Expression; (4) Acceptance of Affective Experience; and (5) Reflection on Experience. Each of the subscales is rated on a seven-point Likert scale with lower scores reflecting lower levels of functioning. The average of the five ratings gives an overall score of affect regulation.

Watson and colleagues (2011) reported that the preliminary findings showed that the O-MAR has high internal consistency (early O-MAR = .86; late O-MAR = .93). The O-MAR's scores also demonstrate evidence of construct and predictive validity.

Usually data collection for emotional processes' research is carried out with self-report measures. These measures could be retrospective (relative to the emotional experience of individuals in the past) or in the present by the analysis of the individual emotional responses at the moment. However, in addition to the use of self-report measures to assess the emotional processes, we can apply observational measures (Watson et al., 2011). In the case of randomized control trials, this could be a particularly important or the only way to study these processes when they were not contemplated at the beginning of the research.

The aim of this study

The manual of application of the O-MAR is available from the authors (Watson & Prosser, 2006). Nevertheless, the original manual lacks specific examples of the different levels of emotion regulation. Therefore, besides translating the manual into the Portuguese language, our main goal was to expand the manual with specific useful clinical illustrations of the different coding possibilities. Based on the consensual discussion of four different cases, we will present each domain and the level of the O-MAR with those clinical vignettes in the remainder of this article. Our goal is to support the future training of judges and to increase the reliability of the application of this scale.

2. METHOD

Judges and auditor

The procedure was carried out by two judges and an auditor. The two judges were master's students in clinical and health psychology and the auditor was a doctoral student in psychology with previous training in empathy and emotion-focused therapy. It is important to mention that the judges and the auditor were not aware of the therapeutic outcome of each case.

Clinical material

The clinical sample for this work consisted of four clients who participated in the ISMAI Depression Study (Salgado, 2014), a randomized clinical trial (RCT) for the treatment of depression, which compared the efficacy of two empirically supported therapeutic models for the treatment of this disorder – cognitive-behavioral therapy (CBT) and emotion-focused therapy (EFT). All the clients in this RCT were initially evaluated and diagnosed with a mild or moderate major depressive disorder, and they completed sixteen sessions of psychotherapy with trained therapists. The inclusion criteria for the ISMAI Depression Study were being diagnosed with a major depressive disorder (AGF > 50) and not being medicated. The exclusion criteria were: currently taking medication or following another form of treatment; currently or previously being diagnosed with one of the following DSM-IV Axis I disorders: substance abuse, panic, bipolar, psychosis, or eating disorder; having one of the following DSM-IV Axis II disorders: antisocial, narcissistic, borderline, or schizotypal; or being at

high risk of suicide. All the four clients who made up part of this sample met the criteria for inclusion in the study after being assessed with the Structural Clinical Interview for the DSM-IV-TR (First, Spitzer, Gibbon, & Williams, 2002). They were all equally randomly assigned to the CBT group treatment or to the EFT group treatment. Three of the selected cases were part of the CBT group and the other case belonged to the EFT group. The sessions were recorded with the consent of the client to allow their further study. The cases used for the manual elaboration were randomly selected among those who had completed the sixteen sessions of psychotherapy at the time and were available with tapes. We present below a brief description of the cases selected.

Case A

The depressive symptoms were particularly related to being unemployed and overweight, difficulties in terms of body image, and relationship difficulties with her mother.

Case B

The depression symptoms were associated with difficulties in the relationship with the client's husband and difficulty in dealing with her mother's illness. There was also some performance anxiety and complaints about occupational lack of self-actualization.

Case C

The depression symptoms were related to difficulties in personal relationships, difficulties in being alone and trusting people, and problems with systematic engagement in new relationships. The client's unstable relationship with her father and some conflicts within the family were also a problem.

Case D

The depressive symptoms were associated with relationship problems with the client's ex-husband and difficulties in her relationship with her father. At the same time, some anxiety and easy irritability were particularly related to not being able to keep her family together.

Measure

Observer Measure of Affect Regulation (O-MAR; Watson & Prosser, 2006) – Unpublished measure developed in the Department of Adult Education and Counseling Psychology, OISE, University of Toronto

As referred to earlier in the literature review, the O-MAR is an observational measure used to assess clients' level of emotion regulation in the therapy process. The scale includes five domains (subscales) in terms of emotion regulation, each rated with a score ranging from one to seven points from a series of instructions, with one being the value associated with the lowest level of functioning and seven the value associated with the highest level of functioning. The final score of the client's emotional level is the average of the ratings. Watson and Prosser (2006) mentioned in the scale that the domain "awareness/labeling" refers to the emotion experience and to its level of arousal. Regarding the domain "modulation of arousal/experience," it assesses the capacity to vary and adjust the intensity, duration, and/or state as well as the ability to generate and sustain emotional experiencing. "Modulation of expression" is related to a visible outward expression/display of emotions, while "acceptance of experience" involves the inner relationship that the person has with his or her own feelings (if they are accepted, suppressed, neglected, avoided, annihilated, controlled, nurtured, etc.). Finally, "reflective of feelings/experience" refers to the level of reflection of the client. The

domains (subscales) of emotion regulation assessed are presented below but not in as much detail as in the original scale.

Table 1 – O-MAR subscales

Awareness/Labeling
1. Very low awareness;
2. Labeling of behaviors and action tendencies or somatic sensations, with little awareness of emotional experience;
3. Labeling of some emotions without awareness or awareness without labeling;
4. Some awareness; undifferentiated description of feelings using simple terms; few emotion words;
5. Some differentiated labeling of feelings with restriction in range; increased awareness of arousal and emotions;
6. Differentiated description of feelings using a range of feeling terms;
7. Highly differentiated description of feelings – finely attuned to nuances. Aware of momentary flow and tracking it.
Modulation of Arousal/Experience
1. Excessively under- or over-modulated;
2. Modulation somewhat impairs functioning in a number of different areas or significantly impairs functioning in one or two areas;
3. Some modulation but strategies usually don't enhance functioning;
4. Some modulation and use of strategies that enhance functioning;
5. Increased modulation that enhances functioning;
6. Modulation frequently enhances functioning; frequently functioning well;
7. Modulation enhances functioning in most areas of life.
Modulation of Expression
1. Excessively under- or over-modulated expression of emotions;
2. Expression/response impairs functioning;
3. Expression/response sometimes appropriate but still significant over/under-modulation of expression evident;
4. Increased modulation of expression;
5. Expression somewhat enhances functioning;
6. Expression/response frequently enhances functioning; frequently functioning well;
7. Expression/response enhances functioning in most areas of life. Not over- or under-modulated.
Acceptance of Experience
1. Denial/disavowal of experience (repression, annihilation). Emotion is cut off;
2. Very negative evaluation of experience. Rigid standards about experience and expression;
3. Negative evaluation of experience but standards around experience and expression are not as rigid. Feelings often not owned;
4. Some negative evaluation of certain aspects of experience but acceptance of other aspects;
5. Moderate acceptance of experience. Recognition of experience with some attempts to use it to guide actions;
6. Approaching 7 but not quite as high (accepting but may not be as nurturing as at level 7);
7. High acceptance of experience (nurturing). Emotions fairly to fully integrated.
Reflective of Feelings/Experience
1. No reflection. Simple presentation of a problem with no reflection;
2. Primarily ruminative;
3. Some rumination. Some reflection;
4. Little rumination. A little reflection but not posing questions;
6. Fairly high reflection. Beginning to solve questions; entertaining new perspectives;
7. High reflection. Questions posed are solved or being solved at the moment. Resolution.

Procedures

The first phase of this work involved the translation of the scale into the Portuguese language. Consent for the translation of the scale and its adaptation to the Portuguese population was obtained through personal contact with one of the scale authors (Jeanne Watson).

In this first phase, to achieve conceptual definitions, it was necessary to clarify the concepts that are part of the original O-MAR to ensure that they will be equivalent in

the Portuguese language/culture. Some concepts were not recognized or were meaningless, so work was undertaken to accommodate the cultural values. The initial translation was subsequently reviewed by experts in the field via a spoken reflection process. The final phase was a backward translation carried out by a bilingual person to check that the translated version actually reflects the contents of the original version.

The second phase was the application of the scale to psychotherapy sessions following the instructions of the authors, coding the middle 20 minutes of the sessions (Watson et al., 2011). To gain a perspective of the cases' progress throughout the sessions and simultaneously to allow the collection of data for future works, 5 sessions were evaluated by case (S1/S4/S8/S12/S16). In total 20 sessions of the 4 randomly selected cases (Case A, Case B, Case C, and Case D) were observed and rated. The initial procedure was rating, followed by a discussion and an attempt to reach inter-judge agreement (consensual discussion; Hill, Thompson, & Williams, 1997). Thus, the middle 20 minutes of each session were viewed and then each judge rated the 5 subscales. At the end of this process, each rating of each subscale of the O-MAR was discussed until consensus was reached. At the end of each case, the judges selected extracts that could represent good examples of each level and domain, and later on these were subjected to a consensual discussion with the auditor. After assessing the 20 sessions, the excerpts that best exemplify each level were selected. Thus, the manual provides a total of 70 excerpts, specifically 2 excerpts for each level of each domain of the scale. In this article, however, we will present only 1 clinical vignette per level.

3. RESULTS

In this section we present some excerpts from the manual that illustrate each level of emotion regulation of each subscale, followed by a brief justification for the selection of that passage.

Domain: Awareness/Labeling

For this domain the selected clinical vignettes are as follows:

Level 1: Very low awareness

T: ... but do you feel sad?

C: I don't know how to describe ... I think the right word is tired ... (Case C/s4/13.30 sec.)

The client shows very little awareness of feelings and emotions and the labeling is mainly somatic.

Level 2: Labeling of behaviors and action tendencies or somatic sensations, with little awareness of emotional experience

C: ... I take everything very seriously, everything, and I'm always there "hammering" the same ... I don't know what for, because it doesn't take me anywhere ... (Case B/s1/14.22 sec.)

The client labels behaviors and action trends but has little awareness of the emotional experience.

Level 3: Labeling of some emotions without awareness or awareness without labeling

C: ... I will seriously think a little more about me ... I feel very, very, very stuck in a hole ...

T: Mm-hmm.

C: Really a lot ... (Case B/s1/58.20 sec.)

The client is aware that something does not feel right ("stuck in a hole") but cannot label the emotion.

Level 4: Some awareness; undifferentiated description of feelings using simple terms; few emotion words

C: ... I don't know what you do to me here but I am much better ... I go with ideas a little more organized ... I go with another spirit and I face problems in another way ... Maybe I feel safest now ... I don't know ... (Case B/s12/2.06 sec.)

The client reveals some awareness and describes feelings using simple terms. However, few words translate into an emotional state.

Level 5: Some differentiated labeling of feelings with restriction in range; increased awareness of arousal and emotions

C: ... The problem is that I don't have an obvious reason for this ... do you realize? Whatever ...

T: I don't want to look for the reason ... I just want to know how it is ... how is it inside ... what is happening?

C: How am I? First of all I feel like an idiot ...

T: Mm-hmm.

C: And then is like ... furthermore ... I feel lost, frightened, alone ... (Case D/s4/1.58 sec.)

The client shows some differentiation in identifying feelings but with a restricted range and little experience of consciousness. There is increased awareness of arousal and of emotion.

Level 6: Differentiated description of feelings using a range of feeling terms

C: ... I'm feeling as someone else ... no doubt ... by the way I don't need to feel ... people around me say that I'm not the same person I was ... I'm much better, much more positive ... I'm not very playful ... I am not ... But I like some jokes sometimes. I am more extroverted than I was ... I was much shrunken, very shy. This project changed me ... (Case B/s16/50.52 sec.)

The client reveals awareness and a wide range of terms about feelings. She also uses metaphorical language.

Level 7: Highly differentiated description of feelings – finely attuned to nuances. Aware of momentary flow and tracking it

C: I don't know ... I speak for me ... I am a bit insecure. In fact, I am very insecure, I know I am ... It costs me to take the first step, I do not throw myself easily and lately I venture a little more ... I venture.

T: And when you take the risk, how do you feel?

C: It is something new, a good feeling, some of these risks are not always calculated ... Then I regret it, but it is done, and I really have to be that way ... If I don't take the risk, I won't know what the flavor is ...

T: Mm-hmm, in other words, what you tell me is that when we don't take risks we avoid the bad things but also avoid the good things ...

C: Because ... How do I know the result if I did not get there?

T: Therefore, you are taking risks, a little bit more ...

C: A little more ... let's not think I've changed completely, which is not true ... I'm still insecure and shy ...

T: Did you want to change completely?

C: I don't know ... I am used to the person I am ... This is my character, my way of being and I don't believe that people change radically from day to night ... but I was a little more retiring ... not now ... I'm a little bit untied ... (Case B/s8/7.28 sec.)

The client shows herself to be very aware of the arousal and experience and reveals a differentiated description of feelings.

Domain: Modulation of Arousal/Experience

For this domain the selected clinical vignettes are the following:

Level 1: Excessively under- or over-modulated

(Talking about the client's difficulty in maintaining her personal relationships)

C: (with a very monochord voice) ... I am beginning to fall into disbelief of myself, and ...

T: And that means what? That you will probably never be able to develop a loving relationship?

C: I don't know ... I don't know what does it mean ... Honestly I don't know what it means, you know, I don't miss games, but I miss seeing myself excited about something, with someone ...

T: Mm-hmm.

C: And I can't, is that ... (Case C/s16/23.15 sec.)

In this case over-modulation significantly impairs functioning. The affect is very low, the voice is monotonic, and there is numbness, as if the client is not feeling what she is saying.

Level 2: Modulation somewhat impairs functioning in a number of different areas or significantly impairs functioning in one or two areas

C: ... In these days I was so depressed for being upset with my mother that I didn't feel like doing anything ... So I stayed stuck at home and I still felt even more depressed, and then I eat what I shouldn't eat and I become even more depressed because I eat and I should not ... So, when I have this type of conflict or so is when I feel worse ... (Case A/s1/57.23 sec.)

In this example, the client is relating an example of how she has been under-modulating her feelings and how that leads her to episodes in which she breaks her diet (she is fasting, because she needs to lose weight). The client's modulation significantly impairs her functioning: she still takes refuge in food when feeling depressed. There is also significant rumination, discomfort, and depression.

Level 3: Some modulation but strategies usually don't enhance functioning

C: ... We had a snack at my house, and of course it always has bread with something, and other things, and I ate a little bit of everything ... it was not correct but it wasn't overkill.

T: It was an exception to our system but ...

C: It was not exaggerated ...

T: It was not exaggerated ...

C: And that's why I get frustrated, I could understand if I had not lost weight, if I had kept, but my frustration is "Gee! I make so much effort to achieve weight loss, I pass all the week making enough effort and then I leave off the normal just for one day and instead of keeping the weight, which is what happens to ordinary mortals, my weight just increases, why?" That causes me a lot of confusion ... (Case A/s4/6.29 sec.)

There are some modulation strategies but they do not improve the global functioning. Thus, she was able to express her frustration and not let herself immediately engage in a binge episode. However, this does not make a real change to her global well-being.

Level 4: Some modulation and use of strategies that enhance functioning

C: After I arrived there at the weekend, because of a handful of little things, it looks like it will all just go downhill, all the effort that I went downhill, and I was a bit down because of that ... I was sad ... but then I think that I have to have the courage not to give up. (Case A/s4/1.45 sec.)

In this passage activation is apparent and intense feelings are acknowledged, but there is also some indication that the client uses adaptive coping strategies to modulate her emotions.

Level 5: Increased modulation that enhances functioning

(Talking about her emotional change)

C: ... Before, I had no time to think right or wrong, and most of the time I thought wrong, because everything that is done in a rush and impulsive most of the time is bad, and I had many troubles for being like that, and my mother said "don't do that ... count to ten," but when I had arrived at three I had lost count, "one, three, ten ..." and now ...

T: Is it calmer?

C: I'm more thoughtful, you see Dr?

T: Mm-hmm.

C: Of course that doesn't mean to have times that I'm not 100% right?

T: It feels that somehow that person, who felt so down, so depreciated, looks like she was growing, right?

C: Exactly, it was really ... not in size but in strength, in ability ...

T: Security.

C: Autonomy, security, and I think that I'm much more ...

T: Much higher ...

C: Exactly, I'm big! I am tiny in size but big ... in depth, I'm big ... (Case D/s12/34.58 sec.)

The client's modulation improves her functioning despite occasional difficulties. She expresses her feelings in an embodied way.

Level 6: Modulation frequently enhances functioning, and the client is frequently functioning well

(Talking about therapeutic change observed by the client)

T: And looking at you today, what do you see?

C: Hum ... I'm much more pleased with myself, I am much more satisfied with others ... I feel much stronger, more able to make decisions regardless of their impact.

T: Mm-hmm.

C: I feel more quiet, I can soothe myself ... I take a breath ... Doesn't mean I go free of my explosive state sometimes because it is already part of my way of being ... (Case D/s16/57.11sec.)

The client is able to soothe herself, distract herself, and solve her problems. Modulation often improves her functioning.

Level 7: Modulation enhances functioning in most areas of life

(Talking about the improvement in the relationship with her ex-husband)

C: ... Alone with him ... of course I won't go out, that's unquestionable, right? Especially because I have ...

T: A person ...

C: And my mind tells me that this should not be done, right? But when I go for a stroll with the kids, of course, they are two kids and they are selfish, and he says, "you could also come." Why don't I go? There is no problem, to everywhere I go, I know very well what I should do, there is no problem, and I think that this is how it should be ...

T: Feels safer, more determined ...

C: I feel ... I feel ...

T: And this, gives us power ...

C: And there is no longer any doubt if I would do well or not ... What happened, happened, the decisions that were taken, were taken, I already said that there are decisions that I don't know if I made well ...

T: You are quieter, calmer.

C: Completely, it gives me more peace and quiet and I appreciate myself more ... (Case D/s12/53.42 sec.)

The client's modulation improves her functioning and her emotions are well modulated. She retrieves the experience in a way that allows her to have a friendly relationship again with her ex-husband.

Domain: Modulation of Expression

For this domain the selected clinical vignettes are as follows:

Level 1: Excessively under- or over-modulated expression of emotion

(Talking about her ex-boyfriend)

C: ... I first did not find him very funny ... I noticed him later ... and then we started talking and we started going out, and he is also like me ... fantastic ... because I have this aim to hit always on those who are the wrong ones ... (Case C/s1/58 sec.)

The response significantly impairs functioning in a number of different areas. She expresses no feelings or needs in the way in which she related to her ex-boyfriend.

Level 2: Expression/response impairs functioning

(Talking about her possibility of going back to the gym, something that would be very good for her and that she would like to do)

C: ... But I don't do it because I can't leave my husband to work alone and it would be only me enjoying that pleasure.

T: Mm-hmm.

C: Because I would have to tell him ... To feel less pressured ... (Case B/s1/54.15 sec.)

The expression/response impairs functioning. The client wants and feels that it would be beneficial to return to physical activity, but by over-modulating her experience she refuses to do so exclusively due to not wanting to leave her husband to work alone and due to being afraid of what he might say. Needs are expressed but with some embarrassment and little liveliness.

Level 3: Expression or response sometimes appropriate but still significant over/under-modulation of expression evident

(Talking about her difficulty in telling people that she is unemployed)

C: ... I find it ridiculous, ridiculous ... I'm so irritated with myself for not being able to tell people openly, because it is like that ... I try to explain why this has happened and sometimes I think like this "ok ... At that time I wasn't ok, I didn't feel right," so I was not feeling comfortable to justify ... because I was really very, very down.

T: Mm-hmm ...

C: Then, to lie is like a snowball, right? Going, growing, growing and we're in such a way that we don't even know where we should turn ... (Case A/s4/52.47 sec.)

In this passage there is some expression of feelings but with a high level of complaints mixed with some withdrawal and anger.

Level 4: Increased modulation of expression

(Talking about a course)

C: Oh yes, more, I won in terms of contact, trust, in contact with the unknown ... both with colleagues and with trainers ...

T: Of the institution.

C: Yeah ... I am in the training and I feel perfectly at ease to put questions that are sometimes even a bit nonsensical or ridiculous ... I don't think about it ...

T: Mm-hmm.

C: Before I thought thirty times, "and now I ask you this? But is this nonsense? Will it look bad?" Now I don't feel this so much ... I feel better in that sense, I won a lot in terms of confidence, I won so much ... I express myself better ... (Case A/s12/23.35 sec.)

There is an expression of feelings but still without identifying needs. Something that was previously seen as negative (out of the comfort zone, contact with strangers) is now faced with some security.

Level 5: Expression somewhat enhances functioning

(Talking about the help that the therapy has been giving)

C: ... I don't believe in miracles, they don't even exist, I have to look inside of me, I have to make an effort, have to stop being lazy, in the good sense ... Mm-hmm... But really, yes ... I think this effort is really worth it.

T: Mm-hmm.

C: I'm feeling a little bit of courage.

T: What is this courage?

C: Mm-hmm ... Valuing me a little bit more ... (Case B/s4/7.28 sec.)

Somehow, expression promotes functioning. The client expresses feelings and needs with some strangeness and caution, which can be seen in the constant hesitations in her speech.

Level 6: Expression/response frequently enhances functioning; frequently functioning well

(The client talks about a job interview)

C: ... I forced myself to take the first step and schedule the interview ... Mm-hmm ... Also because at that time I was feeling capable of doing it, I didn't feel so down, so insecure, I already felt a greater ability to be with the unknown, and then it was also that push from our talks, isn't it? Okay, now we have to go, we are already at a stage where we need to progress, isn't it ... (Case A/s12/12.26 sec.)

In this passage there is an expression of feelings and needs that promote functioning.

Level 7: Expression/response enhances functioning in most areas of life. Not over- or under-modulated

(The client talks about her feelings)

C: ... I feel more confident ... like this ... as you had told me several times, I don't have to be accepted by all because we don't accept all of ...

T: Mm-hmm ...

C: Each of us is as one is ... I do not have to be accepted by everyone, I know I do not like everyone else, no doubt, but in my way I try to do my best and I don't get down my head so much.

T: Mm-hmm ...

C: I don't walk with my head in the sand, I face things differently, in another way, more positive ... (Case B/s12/24.15 sec.)

The expression/response promotes functioning in most areas of life. She understands needs and action tendencies and clearly expresses herself in a way that promotes her functioning. The expression/answer meets the implicit need of the feelings. The way in which the client expresses her feelings promotes herself and her relationship with others.

Domain: Acceptance of Experience

For this domain the selected clinical vignettes are the following:

Level 1: Denial/disavowal of experience (repression, annihilation). Emotion is cut off

(Talking about men who have passed through her life)

C: ... I don't feel what people expect me to feel ...

T: Mm-hmm ... And what do you feel for them now?

C: I don't even stop to think, to analyze, or to find out.

T: Mm-hmm ...

C: Perhaps I could like it, but since I don't give it time, I don't understand, and if the person leaves the circle, I don't miss that person ... (Case C/s1/13.18 sec.)

In this passage there is an annihilation or disavowal of the experience and the emotion is cut off. The client does not feel anything for other people.

Level 2: Very negative evaluation of experience. Rigid standards about experience and expression

(The client talks about the absence of her ex-husband and how that affects her children)

C: I know that my kids need to feel that their father loves them ... and I know they need it, they even say "oh I don't need my father for anything" but suddenly I realize that there is something missing ...

T: That they feel something missing ...

C: And it is like this ... Sometimes I like to snoop in my daughters' things because ... even to be aware because at certain ages they often don't feel at ease ...

T: Do not tell things ...

C: And I got to catch some small clippings wherein the older one talked about her father, and of course I know she feels hurt ... I know ... I know ... she feels hurt.

T: Sad ...

C: Because she misses her father, she even said “I miss you and you abandoned me when I needed you most” ... (Case D/s8/20.13 sec.)

The client is externally focused (on her children lacking the presence of their father): too focused on her children’s feelings without focusing on herself.

Level 3: Negative evaluation of experience but standards around experience and expression are not as rigid. Feelings are often not owned

C: ... I can’t explain why, it is something that perhaps we can also work on ... I was ashamed to tell people that I’m unemployed. I didn’t say ... even today many people don’t know that I’m unemployed ... at that time I didn’t feel good and therefore I couldn’t even talk, I couldn’t say ... (Case A/s1/10.57 sec.)

In this passage there is a negative evaluation of experience with some focus on herself. She expresses needs but is negligent in terms of feelings.

Level 4: Some negative evaluation of certain aspects of experience but acceptance of other aspects

(The client talks about a discussion she had with a boyfriend)

C: ... I felt embarrassed by the things he said ... I think my thought was “I have to leave here, I want to be out of here, get me out of here” ... hmm ... he told me the truest things, right?

T: Mm-hmm ...

C: And the truth sometimes is hard to listen to ...

T: Mm-hmm ...

C: And I did not even oppose him, because I thought I shouldn’t even try to argue, because he was right ...

T: Mm-hmm.

C: And arguing would have been creating more stories and more fantasies and feeding things that made no sense, so I did not even defend myself ... (Case C/s4/5.05 sec.)

Although the client did not like to hear some critical remarks, ultimately she recognized and accepted the criticisms and did not avoid the feeling of embarrassment.

Level 5: Moderate acceptance of experience. Recognition of experiences with some attempts to use them to guide actions

T: In relation to weight issues, how are we? Have you gone for your walks?

C: The weight issue is always like that, it goes up and down, up and down, but I do not let myself go down ...

T: Because you have already created other habits, haven’t you?

C: Exactly, and I’m starting raising up ... (Case A/s16/19.06 sec.)

There is a moderate acceptance of experience.

Level 6: Approaching 7 but not quite as high (accepting but may not be as nurturing as at level 7)

C: I was at 181.5 lbs, I never got out from there, but okay ... It's to say that was not too bad, I understand that even failing ...

T: You don't explode ...

C: Right ... it doesn't mean that everything goes back behind, so I am a little more used to, I realize that I will go slowly but at the end of the week I didn't stay so stressed and so nervous ... (Case A/s8/2.23 sec.)

The acceptance is approaching level 7 but still not that high. The client accepts the experience and no longer deregulates emotionally but it is not at its maximum. Emotion is tightly integrated and awareness is evident about what her emotions/feelings really are.

Level 7: High acceptance of experience (nurturing). Emotions fairly to fully integrated

C: ... When I started the treatment, everything that was expected are all my little big trophies ... and it is for all those changes that have occurred that I feel great, I feel more capable, stronger, more relaxed, more confident.

T: Mm-hmm.

C: I don't need others to respect me because I respect myself and that's enough, is not it? But I demand that they respect me ...

T: Mm-hmm, and you are feeling that?

C: And I'm feeling it ... (Case D/s16/67.35 sec.)

The client shows a high level of acceptance and is connected with the experience. There is emotional congruence and valuation of feelings.

Domain: Reflective of Feelings/Experience

For this domain the selected clinical vignettes are as follows:

Level 1: No reflection. Simple presentation of a problem with no reflection

C: I don't feel capable to manage anything alone, anything, anything at all ... (Case B/s1/16.12 sec.)

There is no reflection, only a very simple and general presentation of a problem.

Level 2: Primarily ruminative

C: I have a huge amount of shame because I think people should look at me and say: "she's so fat, she's misshapen." I can't say that I felt it from friends ... That, I don't feel ... but one thing was, if I was so fat throughout all life, but as I was before and how I am now, it is a very big change in physical terms, and not only but particularly in physical terms ... (Case A/s1/9.57 sec.)

In this passage the discourse is mainly ruminative, telling the same story and not adding anything new.

Level 3: Some rumination. Some reflection

C: ... But I place the weight as the big factor ... it is not the only one, of course, but I place it as the major factor of feeling less ...

T: Lively?

C: Exactly ... maybe I talk less and feel less comfortable than when I felt good ... (Case A/s1/62.45 sec.)

In this passage there is some reflection but also some rumination. The client was reflective enough to conjecture a possible connection between her depression and her weight. Nevertheless, she was still ruminating about her weight.

Level 4: Little rumination. A little reflection but not posing questions

C: ... I would like to have more confidence in myself and say what I think at the time ... when I think that is not right ... if I decided at the time I wouldn't stay with that ... massacring me ... (Case B/s4/11:50 sec.)

There is little rumination and some reflection but without questions. The client is aware of what she does and of the consequence but does not look at the experience in a new way.

Level 5: Moderate reflection. Posing questions. Working with/looking at experiences in a new way

C: I think I don't put so much pressure on me to be perfect ... I face the error in a different way, perhaps more as learning, isn't it?

T: Mm-hmm.

C: Everyone makes mistakes and I will also make mistakes ... (Case A/s16/26.51 sec.)

In this excerpt the client is starting to engage in moderate reflection and in questioning her experience by tentatively arguing that maybe she is dealing with mistakes in a different way. She also views the experience in a new way, trying to gain clarification of the meaning.

Level 6: Fairly high reflection. Beginning to solve questions; entertaining new perspectives

T: In what do you feel more confident?

C: I am able to make decisions.

T: Mm-hmm ...

C: Without being worried about what will or may happen, I assume my responsibilities, and before, I didn't even assume anything.

T: Mm-hmm.

C: Now if I have to do it, I will do it, and I will endure the consequences, I'm an adult, bigger, but I also think that I lose more if I do not try ... (Case B/s16/22.26 sec.)

The client is showing a high level of reflection. She is beginning to solve her issues and create new perspectives, showing that she knows what she needs and what actions she should take.

Level 7: High reflection. Questions posed are solved or being solved in the moment. Resolution

C: ... I don't get out of here and get into my car with my problems solved. What I have to do is to get out of here and face them in another way.

T: Mm-hmm.

C. Because they are not solved, and I know that with another stance I could lead this in another way ...

T: Mm-hmm ...

C: I also accommodate myself to everything and I can't change all these things from one day to another. It is necessary to change a little inside here, in myself, but it's not from one day to another, you know ... (Case B/s4/25.01 sec.)

Questions are being solved at the moment and there is a high degree of reflection in the way in which the client talks about her experience.

4. FINAL REMARKS

Currently, in the field of emotion regulation research, there are some measures with good psychometric features, and some of them have been validated for the Portuguese population. However, all of the measures validated for the Portuguese population are self-report measures. As mentioned before, in some cases the only way to collect data implies the use of observational measures. Moreover, from a clinical point of view, it is important to develop these kinds of measures as guidelines for the training of future professionals. In our review we did not find any observational measure to assess emotion regulation in the clinical context adapted to the Portuguese population. Consequently, this work represents an important step in filling a gap that currently exists.

In addition, the current work stemmed from the need to support the training of judges – and for training psychotherapists or other professionals interested in assessing emotion regulation – in the application of this measure, expanding the original manual with clinical vignettes. As an innovative measure in Portugal, this measure could be an important resource to facilitate the growth of understanding of the functioning of emotion regulation in different populations and with different symptomatology.

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THE ALCALAR MODEL, A QUALITY OF LIFE PERCEPTION: A COMPARATIVE STUDY OF INSTITUTIONALIZED ELDERLY PEOPLE

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ABSTRACT

Summary: A comparative evaluation was carried out of *quality of life* (QoL) perception in different communitarian residential institutional environments for senior citizens.

Method: A cross-sectional comparative study was conducted using a deductive and descriptive statistical method on a sample of 50 senior inhabitants of the retirement village St. Joseph of Alcalar (Alcalar group), 56 senior residents of traditional retirement homes (RSS group) and 52 senior attendees of day care institutions (DCI group). This research comprised two self-applicable questionnaires for elderly citizens, WHOQOL-BREF and WHOQOL-Old PT. We evaluated 158 senior citizens selected from 22 institutions.

Results: The QoL levels perceived by the Alcalar retirement village inhabitants were predominantly higher than the QoL levels perceived by the group of RSS residents and the DCI attendees. The trend in QoL results obtained from the Alcalar retirement village inhabitants was not absolute because it was surpassed by the DCI attendees' results in some (few) areas assessed with both WHOQOL scales.

Conclusion: The Alcalar retirement village group globally showed higher levels of quality of life perception than the other two groups of residents and attendees, respectively, from RSSs and DCIs.

Keywords: Alcalar, Elderly, Quality of Life, Retirement Village.

JEL Classification: D61, H53, I31, I38

1. THE GENESIS OF THE CONCEPT OF QUALITY OF LIFE AND ITS APPLICATION

Over the last decades of the twentieth century and the dawn of this millennium, the expression *quality of life* has been increasingly used in common language and has become customary in the current vocabulary. Historically, the expression “quality of life” was originally coined publicly in 1964 by President Lyndon Johnson in a speech in which he stated that “(...) progress on social goals cannot be measured by the size of our bank balance. They can only be measured by the quality of lives our people lead (...)” (Ribeiro, 2005: 95).

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