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EMPIRICAL PAPER

Flexibility between immersion and distancing: A dynamic pattern with effect on depressive symptoms

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Abstract
Objective: Recent studies on immersion (first-person perspective) and distancing (third-person perspective) in psychotherapy have shown the potential of both perspectives in the treatment of depression. High levels of change were associated with transitions between immersion and distancing, suggesting that a dynamic pattern between them may result in a more adaptive view of reality. This study aimed to assess if higher flexibility between these perspectives, during clients reflection on negative experiences in the intermediate phase, is associated with lower levels of depressive symptoms at the end of treatment. **Method:** We analyzed the flexibility through frequency and magnitude of transitions between immersion and distancing, in representative sessions of the intermediate phase of therapy in 17 cases with depression. **Results:** The results showed that the higher frequency and lower magnitude in the intermediate phase predicted lower levels of depressive symptoms at the end of treatment. **Conclusion:** Immersion and distancing seem to work as dynamic processes, and greater flexibility between them in intermediate phase of therapy, characterized by frequent and fast transitions between the two perspectives, may be an adaptive pattern due to its effect on post treatment depressive symptoms.

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

Clinical or methodological significance of this article: This study launches a dynamic and integrative vision of immersed and distanced perspectives, using a methodology of analysis that allows the evaluation of these perspectives at a more detailed level. It contributes to the scientific and clinical practice by showing the potential of the flexibility between immersion and distancing to break rigid patterns regarding the way depressive clients reflect about their negative experiences. Therefore, it provides important clinical indications for therapeutic intervention in order to promote effective change in depressive symptoms.

Distancing and immersion are two contrasting reflective perspectives through which a person may view his or her own personal experience. In immersion, the person adopts a first-person perspective, while in distancing, he or she reflects on personal events in a third-person, or observational, stance (Nigro & Neisser, 1983; Robinson & Swanson, 1993). Previous studies have found that a decrease in immersion and an increase in distancing at the end of psychotherapy were associated with good outcomes (e.g., Barbosa et al., 2017, 2019; Couto et al., 2016). Up to now, these results have been interpreted as the consequence of a linear or progressive association between clinical improvement and the development of the clients' perspectives that are used to reflect on their experiences. In other words, success of psychotherapy has been associated with

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a linear movement from immersion to distancing throughout the treatment.

A complementary view, however, is also worth considering. A recent deeper analysis of a case suggested precisely a more dynamic view by finding high levels of change to be associated with transitions between immersion and distancing in therapy (Barbosa et al., 2018). Thus, it is possible to argue, that in good outcome cases, immersion and distancing are cyclically feeding each other, creating greater flexibility in the kind of perspective assumed. The evolutionary pattern of a client's perspective may therefore be nonlinear or unstable, or in other words, the change may involve periods of greater flexibility between the immersed and distanced perspectives.

This assumption is consistent with the notion and importance of instability according to the dynamic systems theory. This model argues that periods of instability, i. e., greater ability to transition between internal processes, reflecting flexibility in the way the processes occur, are needed to break rigid and maladaptive patterns, allowing new and more adaptive self-configuration to be achieved (Hayes et al., 2007). Therefore, this model advocates this phenomenon as potentially beneficial in psychotherapy, which has been supported by studies showing its association with psychotherapeutic change (e.g., Fisher et al., 2011). On this basis, the present study intended to assess, for a clinical sample under treatment for depression, whether higher flexibility in the client's perspective about his or her experience is associated with lower levels of depressive symptoms.

The Linear Pattern Between Immersion and Distancing During Therapy for Depression

When making sense of their past personal experiences, people reflect on them according to an immersed or distanced perspective. In the immersed perspective, people live in the experience (Nigro & Neisser, 1983; Robinson & Swanson, 1993), reflecting on it with the same eyes through which they experienced the event (i.e., in the first person) (Ayduk & Kross, 2010b). People therefore focus on specific details of an experience (e.g., Kross et al., 2005; Kross et al., 2012), and the current thoughts, feelings, and behaviors accord with those experienced in the past (McIsaac & Eich, 2004; Nigro & Neisser, 1983; Robinson & Swanson, 1993). An example account of an immersed perspective would be as follows:

> We were having dinner when my father told me that I have to send more job applications because it will be very difficult for me to land a job. I just wanted to cry. I feel frustrated. No one believes in me and in my abilities.

In contrast, with the distanced perspective, the person adopts a different position regarding the experience, namely that of an observer (Nigro & Neisser, 1983; Robinson & Swanson, 1993), thus reflecting on it as a third person (Ayduk & Kross, 2010b). In this perspective, people have a broader vision of the experience, seeing themselves as if looking through someone else's eyes (Kross et al., 2012; Nigro & Neisser, 1983; Robinson & Swanson, 1993). People therefore focus more on explaining and exploring the feelings, thoughts, and behaviors, integrating them in a way of insight and closure (e.g., Kross et al., 2005, 2012). An example account of the same experience as above with a distanced perspective could be as follows:

> My father is like this with everyone. He has to encourage us by pointing out what we have not accomplished and what we need to do, so I was using the fact that I still do not have a job as evidence that I am failing.

It should be noted that both the immersed perspective and the distanced perspective are associated to different psychological processes and capacities, but not unique or identical to these processes or capabilities. For example, processes related to emotional involvement, such as emotional arousal, somehow tend to imply an immersed perspective so that emotion is activated and re-experienced (Elliott et al., 2004; Greenberg, 2002). However, it is also conceivable episodes of immersion without emotional arousal, and vice-versa. In the case of the distanced perspective, metacognitive theories recognize distancing as a key process by promoting the disidentification from internal experience (e.g., Bernstein et al., 2015; Wells, 2000). Thus, distancing can be considered a process involved in the ability to decenter oneself from one's thoughts and feelings. However, arguably, decentering also encompasses other processes, such as metacognitive awareness, and reduced reactivity to mental contents, something not necessarily entailed in the notion of distancing (Bernstein et al., 2015).

Research thus far into immersion and distancing across the therapeutic process has shown the potential benefits of these two perspectives when people with depression reflect on their negative experiences (Barbosa et al., 2017, 2018, 2019). Studies conducted with specific therapies, namely emotion-focused therapy (EFT, see Barbosa et al., 2018, 2019) and cognitive–behavioral therapy (CBT, see Barbosa et al., 2017), indicate that a decrease in immersion and an increase in distancing was a

common evolutionary pattern over the therapeutic process in good outcome cases of psychotherapy for depression. In contrast, high levels of immersion and low levels of distancing throughout therapy characterized the prevalent and stable perspective patterns in poor outcome cases (Barbosa et al., 2019). Moreover, in these studies, the change in a client's perspective over the course of therapy, from more immersion to more distancing, was related to a reduction in depressive symptoms to non-clinical levels (Barbosa et al., 2017, 2019).

Although such results associate immersion with psychopathological states, clinical studies argue that the negative effects of immersion only occur when immersion is used excessively and persistently (Barbosa et al., 2019). Immersion can have positive therapeutic effects, especially at the beginning of the therapy (Barbosa et al., 2017, 2018, 2019), overcoming avoidance of painful experience, even if it implies a more negative affect (Barbosa et al., 2018).

Overall, these findings support the existence of a progressive or linear evolutionary pattern regarding the client's perspective for experiences, one in which greater immersion is beneficial at the beginning of therapy as long as it is followed by a subsequent increase in distancing throughout the therapeutic process (Barbosa et al., 2017, 2018, 2019).

Although the studies support this linear pattern of evolution in the way people reflect on their negative personal experiences, it should be noted that these studies did not consider the potential dynamics between these two processes. This requires a more fine-grained analysis of the dynamics of these phenomena as they happen over time in a session, making possible other complementary views about the way they occur in therapy.

The Dynamic Pattern Between Immersion and Distancing in Therapy for Depression

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

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

Moreover, several studies have shown an association between destabilization and better therapeutic outcomes (e.g., Gumz et al., 2010; Hayes et al., 2007; Schiepek et al., 2014). Following the destabilization of the system, a more adaptive configuration of the self is achieved by returning to a state of homeostasis or stability (Fisher et al., 2011). For example, clinical symptoms are expected to decrease gradually throughout the therapeutic process, reaching significant clinical improvements by the end of treatment (Schiepek et al., 2014). However, before the symptoms stabilize at non-clinical levels, several studies have found fluctuations in clinical symptoms during treatment, and these have been associated with therapeutic change (e.g., Ebner-Priemer et al., 2009; Gumz et al., 2010; Schiepek, 2009; Schiepek et al., 2014; Schiepek & Strunk, 2010).

In line with these findings, we expected that periods of flexibility between perspectives (i.e., dynamic

transitions between immersion and distancing), when re-experiencing and observing the negative experience, may create a positive impact on the rigid way that the self reflects on it. Thus, we hypothesize that the change pattern characterized by the decrease in immersion and increase in distancing in people with depression may represent a more macroscopic view of a more dynamic microscopic model of transition between the immersed and distanced perspectives, which is associated with psychological well-being. Specifically, more flexibility in the reflection on the negative experience, as characterized by the ability to move more easily from one perspective to another, may have a positive effect on depressive symptoms.

Purpose and Aims of the Present Study

We analyzed immersion and distancing moment-by-moment in a clinical sample with depression in order to assess how the level of flexibility in the clients' reflection patterns for negative experiences, during the working phase of the therapy, was associated with clinical symptoms at the end of treatment. We used the frequency (number of transitions between immersion and distancing) and magnitude (time spent before the transition from one perspective to another) as measures of flexibility. These measures allowed assessment of the nonstationary phenomena in short time-series (Ebner-Priemer et al., 2009; von Neumann et al., 1941), more precisely, to detect and assess variations in perspective (immersed and distanced) moment by moment. We expect a negative association between frequency and depressive symptoms and a positive association between magnitude and depressive symptoms. It is also our aim to illustrate how the flexibility between immersion and distancing emerged in clients' speech, presenting excerpts from two clinical cases in the sample in order to exemplify high and low flexibility.

Method

Clients

This study included 17 clients, comprising 14 women (82%) and 3 men (18%) aged between 20 and 48 years, $M = 33.06$, $SD = 9.48$. Nine clients were single, five were married, and three were divorced. Just one client completed the 6th grade, one the 9th grade, five the 12th grade, and ten had higher education. Nine clients were professionally active, nine were unemployed, two were students, and one was a student worker. These clients were part of a sample of a randomized clinical trial (RCT) entitled "Decentering and change in psychotherapy—ISMAI Depression Study" (Salgado, 2014). This RCT aimed to compare the clinical efficacy of EFT and CBT for clients diagnosed with depressive disorders. All participants met the following inclusion criteria in pre-treatment assessment session: (a) diagnosed with a major depressive disorder; (b) not taking medication; and (c) a global assessment of functioning score higher than 50. The exclusion criteria were (a) a high risk of suicide; (b) currently receiving other treatment for depression; (c) current or previous diagnosis of one of a number of DSM-IV Axis I Disorders —namely panic, substance abuse, psychosis, bipolar, eating disorder—or one of a number of DSM-IV Axis II Disorders—namely borderline, antisocial, narcissistic, or schizotypal. For the assessment of these criteria, the Structural Clinical Interview was used to assess the DSM-IV-TR I (First et al., 2002) and II (First et al., 1997), as well as the Beck Depression Inventory-II (BDI-II) for the Portuguese population (Coelho et al., 2002). The therapeutic modality was randomly assigned to each client. Both EFT and CBT comprised 16 weekly sessions of psychotherapy, which were video recorded. The 17 clients who participated in the present study were randomly selected from the 50 clients who completed all 16 sessions. Ten clients were treated through EFT, while seven clients were treated through CBT. All participants signed an informed consent form authorizing the analysis of their data for scientific publication. This document stated the purposes and procedures of the RCT, and in particular, provided information about the anonymization of their personal data in order to ensure the confidentiality.

Therapists

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

Therapy

As stated previously, the clients in our sample were treated through EFT or CBT, following the

intervention protocols used in the ISMAI Depression Study (Salgado et al., 2010). The EFT protocol was based on the work of Greenberg and Watson (2006) and Elliott et al. (2004) on EFT intervention for depression. According to this protocol, and to EFT principles, the therapists encourage clients to access their maladaptive emotional schemes and through emotional processing, transform them into more congruent and adaptive ones. With emotional processing, EFT helps clients to be able to create new meanings, as well as more adaptive emotional responses, that are more compatible with their needs.

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

Measures

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

Measure of immersed and distanced speech (MIDS). The MIDS is an observational measure that assesses immersed and distanced perspectives by analyzing the client's speech in the transcribed sessions. Based on theoretical definition and prior research on immersion and distancing (e.g., Ayduk & Kross, 2010b; Kross et al., 2005, 2012; Kross & Ayduk, 2008, 2009; Nigro & Neisser, 1983; Robinson & Swanson, 1993), MIDS classifies the client's speech as immersed or distanced according to five mutually exclusive categories: two for immersion, two for distancing and one for other content.

The *what statements* and *attributive statements* are the immersed speech categories, and they allow the identification of the first-person perspective. These statements focus on describing *what happened/what did I think* (*what statements*) or *how did I feel* (*attributive statements*) in the experience and are characterized by the presence of details of events, thoughts, feelings, and behaviors as they happened in the situation experienced by the client. The following statements illustrate *what statements* and *attributive statements* categories, respectively: "I went to my room and cried for a long time" and "I felt sad" (Barbosa et al., 2019, p. 743).

The *insight statements* and *closure statements* comprise the distanced speech categories, and they allow the identification of the observer perspective. These statements focus on explaining and/or exploring the experience and are characterized by the exploration and integration of several particularities of the experience (*insight statements*) or an overall view about the experience that also considers present and past experiences (*closure statements*). The following statements illustrate *insight statements* and *closure statements* categories, respectively: "He does not respect me because I never established any limits" and "I see my past as a difficult moment of my life that brought implications in what I am today" (Barbosa et al., 2019, p. 743).

When an identification of these categories is not possible, the speech is classified as *other statements*.

It should be noted that MIDS aims to identify the immersed or distanced perspective by considering the contents of statements that show the egocentric or the observer perspective. However, MIDS does not evaluate the adaptability of content expressed by the client. For example, in *insight statements* the client may report an understanding of the causes of his/her feelings. While this may seem like a positive phenomenon, the client may be interpreting the experience based on evidences that only allows immediate relief, but they are not the most realistic or adjusted interpretation, so it is ineffective in solving the problem (Gross, 2007). Whether these are helpful or unhelpful statements, they would be classified as distancing.

The preliminary results for the psychometric qualities of MIDS indicated a Cronbach's Alpha of .95 for immersion and 0.91 for distancing, with the interrater reliability for the coders' pairs ranging from Cohen's Kappa 75 to .96 (Barbosa et al., 2017). These results show a high internal

consistency for immersion and distancing, as well as a good-to-strong interrater reliability for the coders' pairs (Hill & Lambert, 2004).

Procedures

In this study, the sessions 4, 8 and 12 were selected as representative of the intermediate/working phase of therapy. This is in line with the intervention protocols used in the ISMAI depression study, which considers the intermediate phase of therapy from session 4 to session 12, inclusive (Beck et al., 1979; Elliott et al., 2004; Greenberg & Watson, 2006), as well as with other studies that use specific sessions to represent this phase of the therapy (e.g., Goldman et al., 2005; Hill, 2009). The sessions 4, 8 and 12 were analyzed in all cases in order to assess the flexibility between immersion and distancing. For this purpose, these sessions were previously transcribed verbatim according to the guidelines suggested by Mergenthaler and Stinson (1992). Then, for each session, we identified the excerpts corresponding to the main negative experience that the client brought to the therapy. This was needed to ensure that we captured immersion and distancing only when the client was reflecting on negative experiences (negative material). Moreover, prior relevant studies into immersion and distancing in therapy, on which this study is based, used the same procedure (e.g., Barbosa et al., 2017, 2018, 2019). The excerpts identified with this negative experience were later analyzed for immersion and distancing using MIDS. After identifying the moments of immersion and distancing, the flexibility between these perspectives was calculated using the measures of flexibility described in this study.

Additionally, depressive symptoms were assessed by the BDI-II scores in the assessment session and in the session 16.

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

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

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

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

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

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

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

Due to a nonlinear change of individual client magnitude scores, the logarithmic transformation of MSSD was considered most appropriate to quantify change in magnitude scores (Diggle et al., 2002).

Assessment of depressive symptomatology. BDI-II scores obtained in the assessment session and in session 16, by 17 clients, assessed the presence of depressive symptoms in the pre-treatment and at the end of treatment, respectively. None of the cases showed evidence of deterioration.

Data analysis. All statistical analyses were performed using IBM software SPSS (version 25.0) for Windows. When tests for normal distribution were required, Shapiro Wilk's test (Field, 2018) was done.

We calculated Pearson correlation coefficients to analyze intercorrelations between the flexibility measures and, thus, to assess the strength of the relationship between the variables. The results produced by these variables were extracted from the same data and it was expected these variables to be associated. A not very high relationship allowed us to rule out the possibility of the variables measuring the same thing. Two simple linear regression models were used to assess the association between each flexibility measure in the intermediate phase of therapy, and the depressive symptoms at the end of therapy.

In order to complement these analysis, two clinical cases were selected from the studied sample, one with low flexibility (transitions characterized by lower frequency and higher magnitude) and the other with

high flexibility (transitions characterized by higher frequency and lower magnitude). Representative clinical vignettes were extracted to illustrate how these phenomena manifested in these clients' speech.

Results

Descriptive analysis of the flexibility measures during the intermediate phase of therapy showed that frequency ranged from 18 to 75 ($M = 41.1$; $SD = 15.58$) and magnitude from 4.42 to 6.47 ($M = 5.21$; $SD = .51$). Depressive symptoms in the pre-treatment ranged from 19 to 39 ($M = 28.53$; $SD = 5.92$) and at the end of treatment ranged from 0 to 29 ($M = 10.64$; $SD = 9.33$).

A significant correlation between frequency and magnitude of transitions between immersion and distancing was observed, $r\ (17) = -.64$, $p = .006$, indicating a moderate relationship between them ($.30 > r > \pm .70$; Cronk, 2006).

Concerning the frequency of the transitions between immersion and distancing, the regression model was significant and explained 38% of the variance in the posttest depressive symptoms, $F\ (1, 15) = 9.33$, $p = .008$, $R^2 = .383$. Specifically, the frequency of transitions between the two perspectives in the intermediate phase of therapy negatively predicted depressive symptom levels at the end of treatment, $\beta = -.62$, $SE = .12$, $B = -.37$; $t = -3.05$, $p = .008$.

A significant regression model was also found for the magnitude of transitions between perspectives and explained 18% of the variance in the depressive symptoms at the end of the treatment, $F\ (1, 15) = 3.27$, $p = .091$, $R^2 = .179$. Specifically, the magnitude of transition between the two perspectives in the intermediate phase of therapy positively predicted depressive symptom levels at the end of treatment, $\beta = .42$, $SE = 6.81$, $B = 12.32$; $t = 1.81$, $p = .091$, confirming our hypothesis.

The following cases illustrated the results obtained. Anna's case (a fictitious name) is an example of low flexibility between the two perspectives. The transitions between perspectives were characterized by an average frequency of 18 and a magnitude of 5.63 per session in the intermediate phase of the therapy. Anna presented a BDI-II score of 33 in the pre-treatment and of 16 at the end of treatment. In turn, Sandra's case (again a fictitious name) is an example of high flexibility between the two perspectives. The transitions between perspectives were characterized by an average frequency of 51 and a magnitude of 4.98 per session in the intermediate phase of therapy. Sandra presented a BDI-II score of 35 in the pre-treatment and of 6 at the end of treatment. Figures 1 and 2 show how the transitions occurred moment-by-moment in Anna's and Sandra's cases, respectively. Stronger ups and downs over time can be observed in Anna's case when compared with Sandra's case (i.e., there were moments in which Anna retained a perspective for a long period of time, especially for the immersed perspective). Conversely, Sandra visibly presented more changes between perspectives and weaker ups and downs over time, remaining in each perspective for less time, showing how she moved faster between them. In Sandra's case, there was less discrepancy in terms of the time spent in each perspective moment-by-moment than in Anna's case (see the tendency lines in Figures 1 and 2).

In the following, excerpt paragraphs are presented from Anna's and Sandra's cases to give a better understanding of the psychological meaning of high or low flexibility between the immersed and distanced perspective. The text that is representative of the immersed perspective is expressed in italics, while the text that is representative of the distanced perspective is underlined.

In both cases, negative experiences were associated with problems in the relationships with their respective husbands. Anna felt rejected by her husband.

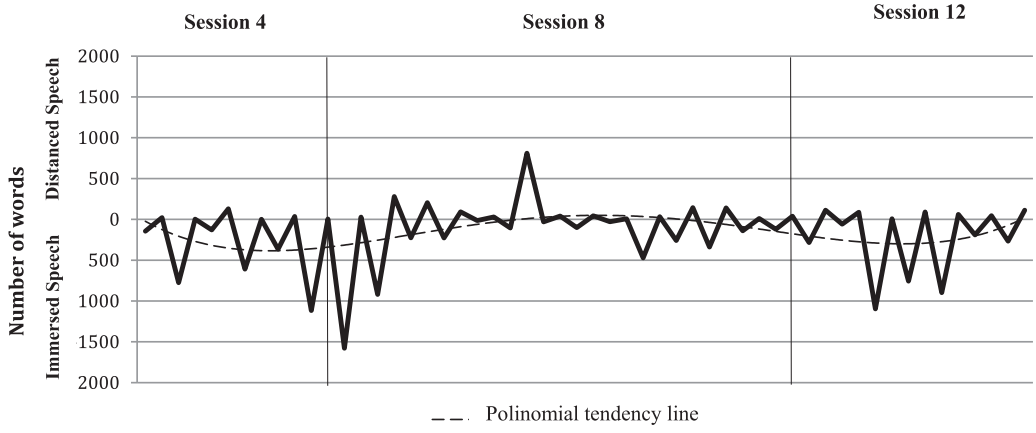

Figure 1. Transition between immersion and distancing in Anna's case.

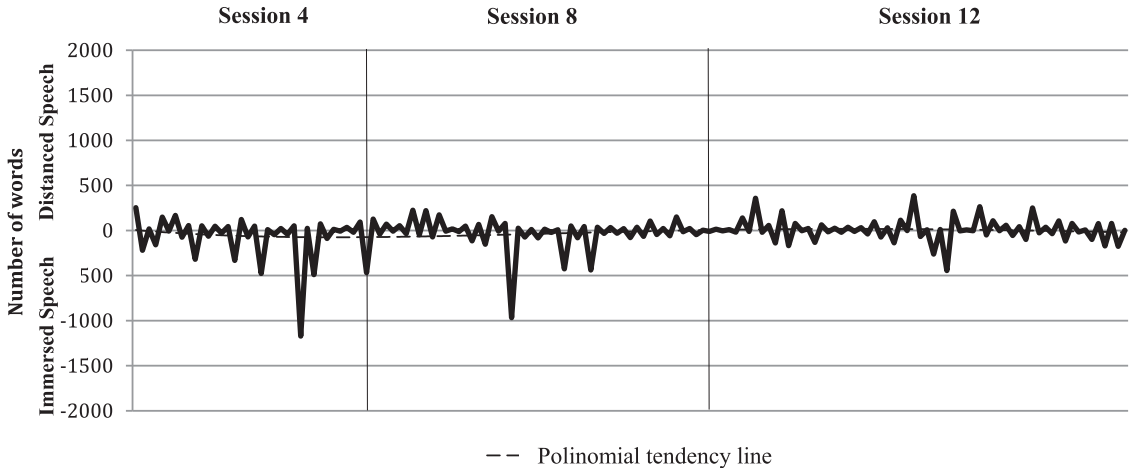

Figure 2. Transition between immersion and distancing in Sandra's case.

Throughout the process, her husband leaves home and later returns. In the excerpt below, the client talks about her husband's return.

Anna: He texted me, "Hello, good morning. I've been going crazy looking for answers to my life. I know that I have hurt you a lot and that I disappointed you and our daughters. It's with my heart crying that I ask for forgiveness. I also know that I cannot be happy away from you and our daughters. I would like to try to unite the family once again, but I feel we all have to do things differently, mainly I. If you allow, I would like to return to our home. I am willing to be a different and a better man. I just need to heal my lacerated soul. kisses, I love you very much." I was speechless … I answered that if it was his will, we were willing to receive him with open arms. I did not contact him. On Wednesday, he appeared at home. Meanwhile, he brought things a little bit each day and he came home definitely. However, I am not very excited because I do not see great changes. It's all the same, the same routines. He arrives at eight o'clock for dinner, goes to the couch, and if I tell him something, he says that he doesńt want to do anything. If I ask him some kind of more intimate question, he answers "You and your difficult questions. Leave me in my corner." Why did he come home? I still have not had the courage to ask him, but I want to ask him, "What did you really come for?"

Therapist: You did not have the courage to ask him this?

Anna: No, I did not have the courage. I thought I was going to be a little annoying. I don't know … I did not have the courage. I wonder if I created too many expectations. No one changes from one day to another, as is evident. Aha, I also could not expect him to come home a completely transformed man, the super-loving man that he never was … I also cannot wait for this. And then the days went by and I was appeasing what I had here inside, because I'm more lucid about things. I confess that I do this, but I'm not as blind as before: for me the solution to my life involved living with him, knowing he was home. Now, I don't think in the same way.

Therapists: Okay, what solutions do you have for your life?

Anna: Aha, I already see with good eyes that he leaves home, and I live alone with the girls. It was something that tormented me before but now no longer.

Therapist: What is different?

Anna: I think that I'm more rational, more lucid, more … that time during which I was alone showed me that I have abilities or skills that maybe I thought I did not have to control the stuff … that perception on many occasions is part of the problem and not part of the solution for the problem … It's a bit like this … but it hurts a lot because I think that a relationship cannot be one day at a time, and I think I've lived for a long time on a razor's edge. I never know very well what I can count … It was so many years together. I built a family, and it was not worth it. I feel defeated. I do not know what else to do. His coldness hurt … I just feel like crying. It's confusing for the girls. They don't know what to do. (The client then tells of another episode in which her husband rejects her.) (Session 8)

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

Sandra: Francisco [husband, fictitious name] does not admit failures at work, but when we are

working together and I fail, he gets very upset, screams, and almost insults me, and I do not really like this character he has. I'm offended, very hurt … but you know, I think that I need this Francisco because I did not want an irresponsible person with me without knowing how to do things. He gives me security. He worries that if there is a deadline to do something, if there is something to buy, if there is an important thing to do, if it is necessary to call someone to solve some problem. I do not have this autonomy. I trust him in all these things.

Therapist: We spoke in the previous session that we sometimes think we do not have the skills to do certain things, but we never really try to do them.

Sandra: That's right. I never had to do these things. He is the leader at work.

Therapist: He's the leader at work and in other contexts, especially for household chores, in taking care of children?

Sandra: I am the leader at home. I do not see him in this role.

Therapist: Why do you think this happens?

Sandra: Because I do everything for him, or at least I used to do everything for him, he did not have to make an effort. There was no need for him to come home and ask me for a pair of socks, because I knew he needed a pair of socks. He did not have to ask me, for example, where the napkins are, because I knew he was going to sit at the table and would need a napkin.

Therapist: You are saying that when we do not practice, we accommodate the situation. Last week we talked about the new things in which you are more autonomous at work.

Sandra: I'm less afraid. I have more confidence in me … In fact, I'm very insecure. I know I am, but lately I risk a little more.

Therapist: And when you do take a risk, how do you feel?

Sandra: A good feeling.

Therapist: Mm-hmm

Sandra: If I do not risk, I do not know what the result is.

Therapist: Mm-hmm, what you are telling me is that when we do not take risks, we avoid bad things, but we also avoid good things.

Sandra: How can I know what the result is? … I'm not so passive … the things I'm saying are not said by me, aha, but it's more those who surrounds me.

Therapist: Mm-hmm, exactly, you told me of your children …

Sandra: Yes, my children are my best critics. (She then tells of a situation where she took the initiative to solve a situation at work and the children praised her.) (Session 8)As we can see from these excerpts, Anna describes the events in detail, focusing on the negative feelings that these moments provoke (immersion). The moments of distancing are interrupted by the description of her suffering that was caused by her husband's rejection (immersion). Sandra, on the other hand, moves more rapidly between the description of the experience (immersion) and a reflection of this experience from another angle (distancing), constructing new meanings and reinforcing them with examples of her own experience (immersion).

Discussion

The results of this study show that higher flexibility between immersion and distancing in the intermediate phase of therapy were associated with lower levels of depressive symptoms at the end of treatment. This finding supports our initial hypothesis regarding the potential effect of transitions between perspectives in clinical symptoms when people with depression reflect on a negative experience in therapy. Specifically, higher frequency of transitions between the two perspectives in the intermediate phase of therapy was associated with lower levels of depressive symptoms, indicating that may be important for a client to learn to shift frequently from one perspective to the other, alternating between a view of the negative experience through a first-person perspective to more reflective one through a third-person perspective as many times as possible. Moreover, lower magnitude for those changes was also associated with lower levels of depressive symptoms. In this sense, fast transitions between immersion and distancing may be helpful in the working phase, emphasizing the importance of the clients spending shorter periods in each perspective. In short, this study raises the possibility that in people diagnosed with depression, frequent and fast transitions between immersion and distancing in the working phase of the therapeutic process is an adaptive way of reflecting on the negative experience that has a positive effect on post treatment depressive symptoms. With this finding, we support the existence of a discontinuous or nonlinear pattern in a client's reflection on an experience. This is coherent with dynamic systems theory, which argues that changes in psychotherapy occur in discontinuous and nonlinear ways (e.g., Gumz et al., 2010; Hayes et al., 2007).

Flexibility is needed to break the problematic and rigid self-configuration (Fresco et al., 2006; Kashdan & Rottenberg, 2010; Moore & Fresco, 2007). In fact, depression is associated with problematic patterns characterized by a rigid and stable

self-organization which maintains the depressive symptomatology (Fisher et al., 2011). In addition, previous studies have shown that depressive people tend to reflect according to an immersed perspective (e.g., Barbosa et al., 2017, 2018; Couto et al., 2016; Kross & Ayduk, 2009; Kross et al., 2009, 2012), and while this pattern remains stable, it may hinder any symptomatic improvement (Barbosa et al., 2019). Based on these studies and dynamic systems theory (e.g., Ebner-Priemer et al., 2009; Hayes et al., 2007; Schiepek, 2009; Schiepek et al., 2014; Schiepek & Strunk, 2010), we believe that an increase in the flexibility between immersion and distancing in people with depression involves instability in the personal system for the reflection on a negative experience, thus creating fluctuations between perspectives that break with the rigid and maladaptive patterns that are mainly characterized by the immersed perspective. The focus on a negative experience, according to an immersed perspective, tends to promote ruminative cycles, which are common in people with depression, preventing the construction of new meanings (e.g., Ayduk & Kross, 2010a; Kross et al., 2012) and increasing the intensity (Kross et al., 2014, 2012) and duration of the negative affect (Verduyn et al., 2012). In contrast, the distanced perspective has been considered as a mechanism to fight against rumination (e.g., Ayduk & Kross, 2010a; Kross et al., 2012), and it is associated with lower intensity (Kross et al., 2014, 2012) and shorter duration (Verduyn et al., 2012) of the affect. In this sense, the transitions from an immersed to a distanced perspective may prevent rumination cycles and the exacerbation of a negative affect, helping the client to see other facets of the experience.

However, our results also suggest the importance of high flexibility in the transitions from distancing to immersion. In accordance with dynamic systems theory, constant returns to a previous position is expected until a more significant change occurs (Fisher et al., 2011), as happened with other processes that have been already studied (e.g., Basto et al., 2018). Moreover, there may be benefits to spending just a little time in a distanced perspective before returning to immersion. This suggestion agrees with a previous study that showed that avoidance was associated with greater levels of distancing and that immersion seemed an essential perspective to overcome avoidance and become aware of a problem (Barbosa et al., 2018). Sometimes, when attempting to avoid the suffering that results from a negative experience, people avoid any involvement with that experience, instead observing and representing it in a superficial way, which prevents any adaptive contact with the negative experience (e.g., Barbosa et al., 2018; Foa & Kozak, 1986). A reflection of an experience from an immersed perspective may be useful when this happens, because it is making them more aware (Barbosa et al., 2018).

In summary, in depression, we believe that the flexibility between immersion and distancing may prevent or break rumination patterns from resulting over long periods in the immersed perspective, and it may also promote contact with new points of view about an experience without the avoidance that results from maladaptive distancing. Higher flexibility between perspectives probably enables reciprocal influences between them, promoting change in the way people cognitively represent an experience and exhibit better emotional regulation. This accords with a previous study that argues that immersion and distancing may work as coordinated processes in psychotherapeutic change, thus allowing a more adaptive vision of reality (Barbosa et al., 2018). However, these hypotheses need greater empirical support.

Conclusion, Clinical Applications, Limitations, and Further Studies

In conclusion, our findings support the hypothesis that a decrease in immersion and an increase in distancing being associated with symptoms may just be an overview of a more dynamic model of transition between the immersed and distanced perspectives. In depression specifically, higher flexibility between these perspectives when a client reflects on a negative experience in the intermediate phase of therapy may be an adaptive pattern associated to lower levels of depressive symptoms at the end of treatment. While encouraging a distanced perspective in depression should be important in order to break rigid reflection patterns for an experience, immersion also seems to play a role in reconstructing the experience. The immersed and distanced perspectives may not be opposing forces but rather related processes that can work in a coordinated and productive way. These observations may provide important clinical indications for therapeutic intervention. Specifically, the intermediate phase of therapy seems to be a phase in which the therapist should be aware of the manner in which the client reflects on negative experiences. Fast and frequent transitions between re-experiencing the experience and observing it in this phase may be a sign of therapeutic progress. It may therefore be useful to apply therapeutic strategies to promote the transition between these two perspectives in order to foster greater flexibility in the reflection of an experience. Some studies have shown that the use of the first person pronouns ("I" and "My") implies that one adopts the "self" position, while

the use of the third person pronouns to refer to oneself ("he/she" and "his / her own name") implies observing oneself (e.g., Kross et al., 2014; Kross & Ayduk, 2017). Is it a useful strategy to encourage the client to switch between these two types of language to increase flexibility between perspectives? Another study found greater variability of therapist competencies associated with greater variability in the client's perspectives (Couto et al., 2016). Can greater diversity of therapeutic competences promote greater flexibility between client perspectives? How the therapist can foster flexibility between client perspectives needs to be clarified in future studies.

Our results should be read with caution. The immersion and distancing coding procedures is quite time consuming, which prevented the constitution of a substantial sample. In turn, the small size, as well as, the specificity of our sample prevented more robust statistical analyses that would make the findings more representative and generalizable. For example, the characteristics of the sample did not allow to extract a prediction model with the two flexibility measures, preventing the effects of their interaction on levels of depressive symptoms. Thus, research with larger samples, as well as, in cases diagnosed with other disorders and treated with other therapeutic approaches is needed to assess and refine our results. This is an exploratory study and some reflections about results are only hypotheses that need empirical support. Moreover, it is not possible to extract from our results the effect of flexibility between perspectives on the improvement of depressive symptoms, or even on depressive symptoms throughout treatment. These issues would be addressed in future studies.

Since our results are congruent with dynamic systems theory regarding the importance of flexibility in the intermediate phase of therapy, it would also be interesting to explore the evolution of transitions between immersion and distancing in the remaining phases in order to establish if their evolution occurs as expected according to this model (e.g., Fisher et al., 2011). In particular, we would see if it evolves from a more rigid pattern characterized mainly by the immersed perspective in the initial phase into a more flexible pattern in the intermediate phase, and later back into to a less flexible pattern that is characterized by greater moments of distancing in the final phase of the treatment. Lastly, it would be interesting to relate the data on the flexibility with other measures to assess the productivity of this content, in order to understand the role of flexibility not only in symptomatology, but also for the integration of experience and the creation of productive new meanings. With this type of studies will be possible to clarify if flexibility between perspectives is an indicator factor of others psychologic capacities.

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